Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Phone 800-877-5176 Fax 402-997-1865 Email newdisabilityclaim@mutualofomaha.com

Section 1 – Employee Statement (Answer all questions to avoid delay)

Current Employer's Name	Group ID Number	Job Title	Hours Worked per Week

Name

Address	City	State	ZIP

(Area Code) Home Telephone Number	(Area Code) Cellular Telephone Number	Social Security Number

Email Address

Date of Birth	Height	Weight	Dominant Hand: ☐Right ☐Left	☐Male ☐Female	☐Single ☐Married	☐Widowed ☐Divorced

Date of Disability (1st Day Absent)	Date First Treated	Estimated Return to Work Date

Nature of illness and when symptoms first appeared, or describe how and where accident occurred.

Was the disability work related? ☐Yes ☐No Have you filed a Workers' Compensation claim? ☐Yes ☐No

Was disability related to a motor vehicle accident or is another third party liable? ☐Yes ☐No

Physician's Name

Other income you have filed for, are receiving, or are eligible for:

	Amount	Date Claim Filed	Date Benefits Began
Workers' Compensation	$		
State Disability	$		
Other	$		

Overpayment Notice: Should you become overpaid at anytime during the duration of this claim we, Mutual of Omaha Insurance Company (Mutual) or United of Omaha Life Insurance Company (United), will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Mutual or United to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

Important Notice: If you have group life insurance through your employer, please contact your benefits administrator as soon as possible to determine what options are available to you to continue your life insurance. Some options require action within 31 days of the date you stop working/insurance ends for life insurance to continue.

If your coverage is written in California, North Carolina or Michigan and includes Survivor Benefits, please check your policy to determine if you can elect a survivor benefit beneficiary. If so, you may obtain a Beneficiary Designation form on the Internet or from your employer.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee's Signature: _____ **Date:** _____

MRN: 01165569
Prefer: SUZANNE
CHILES, MARY
9/19/1950
HAR: 58305692
CSN: 1108657272
BCBS ILLINOIS
ENC: 28577406
ORFALY, ROBERT

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Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

3. You may release information to:

   Group Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   Mutual of Omaha Plaza
   Omaha, NE 68175-0001

   Or

   Fax 402-997-1865

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.

6. This authorization will expire 24 contiguous months after the date signed.

7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.

8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

_____

_____ _____
Signature of Claimant Date

If Applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.

Printed Name of Legal Representative: _____

Signature of Legal Representative: _____

Type of Legal Representative: _____

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THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Authorization to Disclose Health Information to My Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will remain in effect for 24 contiguous months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Group Disability Management Services
Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Or
Fax 402-997-1865

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

_____

(Printed Name and Address)

_____ _____

Signature Date

or

If Applicable: I am the legal representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative: _____

Signature of Legal Representative: _____

Type of Legal Representative: _____

Date: _____

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Section 2 – Employer's Statement (Answer all questions to avoid delay)

Company Name	Group ID Number	Master Policy Number

Class No. or Description	Division/Location No. or Description

Address	City	State	ZIP

Email Address

Employee's Name:	Employee's Phone Number

Weekly earnings as defined by the Plan: _____
(Please note: Benefits will be calculated based on premium received.)
Salary Effective Date: _____

Number of weekly hours worked: _____

Was disability caused by employment? ☐Yes ☐No Has workers' compensation claim been filed? ☐Yes ☐No

Does the Employee contribute toward the premium? ☐Yes ☐No

If yes, what percent is paid by the Employee? _____% Is it Pre-tax or Post-tax? _____

Employee's payroll classification ☐Exempt ☐Non-Exempt ☐Salaried ☐Hourly ☐Union ☐Non-Union ☐Other

How was the Employee paid?

Is this Employee eligible for salary continuation/sick leave? ☐Yes ☐No If yes, what is the weekly amount? $_____
When do benefits begin? _____ End? _____

Date of Hire:	Date Covered Under This Plan:

Does Mutual of Omaha cover the Employee for group long-term disability? ☐Yes ☐No

Does United of Omaha Life Insurance Company cover the Employee for group life? ☐Yes ☐No If so, please complete the following.

Name of Employee's beneficiary according to your records: _____ Relationship to Employee: _____

Important Notice: For Employees age 60 or over, refer to the policy provisions regarding group life continuation and conversion rights.

Does Mutual of Omaha cover the employee under an additional short-term disability policy? ☐Yes _____ (policy number) ☐No

Please contact Employee's direct supervisor and then circle the strength demand below which best describes the Employee's job:

Circle One		
	S – Sedentary	10 lbs. Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing may be required.
	L – Light	20 lbs. Maximum lifting with frequent lift/carry up to 10 lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls.
	M – Medium	50 lbs. Maximum lifting with frequent lift/carry up to 25 lbs.
	H – Heavy	100 lbs. Maximum lifting with frequent lift/carry up to 50 lbs.
	V – Very Heavy	Over 100 lbs. Lifting with frequent lift/carry over 50 lbs.

Employee's Job Title	Last Day at Work

What was the Employee's employment status on the first day absent?

Description of major job duties – Please attach job description	Has the Employee returned to work? ☐Yes ☐No a) If yes, when? b) If not, what is the estimated return to work date?

Can the Employee's job be modified? ☐Yes ☐No

Signature of Person Completing Claim Form	Title of Person Completing Claim Form

Date Signed	(Area Code) Phone Number	(Area Code) Fax Number	Email Address

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Section 3 – Attending Physician's Statement (Answer all questions to avoid delay)

Employer Name	Group ID Number

Name of Patient (Last, First, MI) – Please Print	Date of Birth
Chiles, Mary Suzanne	09/19/1950

Diagnoses	ICD-9 Code(s)
Psoriatic arthritis, pain of right hand	L40.50, M79.641

Symptoms	Date symptom first appeared
right hand pain, worse at proximal interphalangeal joint	Patient reported ~2020

Initial date of treatment:	Last date of treatment:	Next date of treatment/office visit:
02/22/2022	04/04/2022	surgery 06/28/22, postop appt 07/14/2

Is disability due to: ☐ Accident/Injury ☒ Sickness

Is the disability work related? ☐ Yes ☒ No

If applicable, list the surgical procedure(s) – Describe fully and provide dates if any.

Right middle, ring and little finger proximal interphalangeal joint fusion surgery 06/28/22.

If disability is due to Pregnancy, please provide the information below:

Date of Last Monthly Period	Expected Date of Delivery	Expected Type of Delivery
		☐ Vaginal ☐ Cesarean Section

Actual Date of Delivery	Actual Type of Delivery
	☐ Vaginal ☐ Cesarean Section

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room? ☐ Yes ☐ No	Date treated	Name of Hospital	Name of Physician
Did another physician treat or will be treating the patient? ☐ Yes ☐ No	Date treated	Physician's Name and Address	
Was the patient hospital confined? ☐ Yes ☐ No	Date Confined In Hospital: From_____ To_____	Name of Hospital	
Did patient have outpatient surgery in a hospital or ambulatory surgical center? ☒ Yes ☐ No	Date of Surgery 06/28/22	Name of Facility Oregon Health & Sciences University	

Functional Limitations – Abilities

Indicate frequency per day the listed activity can be performed.

(n = never, o = occasional, f = frequent, c = constant)

Lifting	Carrying
o 1-5 lbs.	o 1-5 lbs.
n 6-10 lbs.	n 6-10 lbs.
11-25 lbs.	11-25 lbs.
26-50 lbs.	26-50 lbs.
51-100 lbs.	51-100 lbs.
Over 100 lbs.	Over 100 lbs.

Indicate longest single time duration each activity can be performed.

f Sitting	n Kneeling		R: Finger Dexterity
f Total time on feet			L: Finger Dexterity
f Standing		Inside	R: Below Shoulder
f Walking			L: Below Shoulder
o Bending		Outside	R: Above Shoulders
o Squatting		Working with Others	L: Above Shoulders
o Stooping		Other (explain)	

Reaching

Please notify us if the Employee returns to work after the submission of this form.

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Mental Limitations – Abilities

	Excellent	Good	Fair	Guarded
Judgment/Decision making				
Deal with work stresses				
Function independently				
Concentration/Attention span				
Emotional lability				
Caring for self/family				
Estimate overall prognosis				

not assessed by orthopedics

The patient has been continuously disabled (unable to work) from 06/27/22 to 07/19/22

Is the patient able to work with job modifications? ☒ Yes ☐ No on 07/19/22

The patient should be able to work ☐ Full-time ☐ Part-time on _____ or a specific date is unavailable, in
☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Other (please specify)

Remarks and/or treatment plan

Patient is unable to work from 06/27/22 until 7/19/22 can return light duty. Light duty restrictions include no lifting above 11b, 10 minute break from typing every hour, typing at reduced speed. return to full duty to be evaluated at post op appt 7/14/

Name of the Attending Physician – Please Print	Specialty/Degree(s)	Tax Identification Number
Robert Orfaly / Amy Sothern-PAC	MD, Orthopedics	931176109
Address (No., Street, City, State, ZIP)	**(Area Code) Telephone Number**	**(Area Code) Fax Number**
3303 S Bond Ave Portland OR 97239	(503) 494 6400	(503) 346 6844

If necessary, whom can we contact at the attending physician's office for additional information?

Name: Patient Access Specialists (Area Code) Telephone Number: 503 494 6400

Signature of Attending Physician: Amy Sothern PAC Date: 06/16/22

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