

Claim Form

Special Risk Services
P.O. Box 31156
Omaha, Nebraska 68131
Claim Inquiries
1-800-524-2324



SEE REVERSE SIDE FOR FRAUD LANGUAGE

To Be Completed By Organization/School

Policy Number: _____
 Organization/School Name: _____
 Address: _____
 Phone No. (____) _____ - _____
 Name of team/sport (if applicable): _____ Type of Activity _____
 Interscholastic/intercollegiate P.E. class _____
 Intramural Practice Game Jr. Varsity Varsity _____
(activity involved)
 Dates of event (if student-date school started): _____
 At the time of injury, was the insured involved in an activity sponsored by the Policyholder? Yes No
 Under whose supervision? _____ Was he/she a witness? Yes No
 If employed, was injury/sickness related to claimant's employment? Yes No

Type of Benefits Claimed

Accident-Medical Date of Accident _____
Hour a.m. p.m.
 Dental Location of accident _____
 Sickness-Medical Description of accident _____
 Type of injury or illness _____
 Loss of Time First treatment date _____
 Dates claimed _____

Dated: _____

Signature of Organization/School Official & Title

To Be Completed By Claimant — Or By Parent/Legal Guardian If Claimant Is A Minor

Claimant's Name: _____
 Social Security Number: _____ - _____ - _____ Age: _____ Male Female
 Address of Parents, Guardian or Claimant: _____
 Home Phone No. (____) _____ - _____

Name and address of Family Physician: _____
 Phone No. (____) _____ - _____

Has treatment been completed? Yes No

Father, Guardian or Claimant's (if adult)
 Employer, Name and Address: _____
 Phone No. (____) _____ - _____

Mother or Spouse's Employer, Name and Address: _____
 Phone No. (____) _____ - _____

Name of all companies providing your insurance coverage or prepaid health plans.

Name of Company	Address	Policy or Certificate No.
_____	_____	_____

Individual
 Group (Eff. Date _____)

Are benefits due for this claim under these other insurance coverages? Yes No

If yes, attach copies of explanation of payments from primary carrier.

I hereby certify that all above information is true and complete.

Signature _____ Date _____

Payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.

Authorization for Release of Information

To all physicians, medical or dental practitioners, hospitals, clinics or other providers of medical or dental services, employers or insurers, or other persons having material nonmedical information about the patient.

You are authorized to release to Mutual of Omaha Insurance Company or any consumer reporting agency acting on its behalf all information concerning medical, dental and hospital records, including psychiatric, alcohol and drug abuse information, or any occupational information or information regarding other insurance coverage about the patient. This information will be used solely for the purpose of evaluating claims for benefits.

I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability benefits, I understand that it is valid for the duration of the claim.

I have the right to receive a copy of this authorization upon request. A photocopy of this form is as valid as the original.

_____ (Date)

_____ (Name of Patient)

_____ (Claimant or Parent/Person Legally Responsible if Claimant is a Minor)

_____ (Relationship)

I hereby certify that all above information is true and complete.

Signature _____ Date _____

Important Claim Notice

California Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

District of Columbia & Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For All States Other Than Those Above: Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. This notice does not apply in Virginia.