

Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
 United of Omaha Life Insurance Company
 S-1 Group Disability Management Services
 Mutual of Omaha Plaza
 Omaha, NE 68175-0001
 800-877-5176 Fax (402) 997-1865



Part I – Employee Statement (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Employer Name		Policy Number	Job Title	Hours Worked per Week
Name				
Address		City	State	ZIP
(Area Code) Phone Number			Social Security Number	
Date of Birth	Height	Weight	Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Date of Disability (1st Day Absent) (Mo.)/(Day)/(Year)		Date First Treated (Mo.)/(Day)/(Year)		Physician's Name
Nature of illness and when symptoms first appeared, or describe how and where accident occurred.				
Was the disability work related? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you filed a Worker's Compensation Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Other income you have filed for, are receiving, or are eligible for:				
	Amount	Date Claim Filed	Date Benefits Began	
Workers' Compensation	_____	_____	_____	
State Disability	_____	_____	_____	
Other	_____	_____	_____	

Part II – Employer's Statement (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Company Name		Policy Number	Class	Division or Location
Address		City	State	ZIP
Street				
Weekly earnings as defined by the Plan: (Please note: Benefits will be calculated based on premium received.)			No. of Hours Scheduled to Work Weekly: _____	
Was disability caused by employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has workers' compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the employee contribute toward the premium? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what percent is paid by the employee? _____ % Pre-tax _____ Post-tax _____?				
Is this employee eligible for salary continuation/sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the weekly amount? \$ _____				
When do benefits begin? _____ End _____				
Date of Hire (Mo.)/(Day)/(Year)		Date Covered Under This Plan		
Is employee covered for long-term disability by a Mutual of Omaha/United of Omaha policy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is employee covered for Group Life by a United of Omaha policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, and it would appear your employee's disability will last longer than 6 months, please answer the following questions: Effective Date of Life Insurance _____ Annual Salary _____				
Date Insurance Terminated or if not Terminated, "paid to" date _____ Master Policy Number _____ Insurance Class _____				
Amount of Insurance on the last day worked _____				
Please contact employee's direct supervisor and then circle the strength demand below which best describes the employee's job:				
	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.		
Circle	M - Medium	50 Lbs. Maximum lifting with frequent lift/carry up to 25 Lbs.		
One	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 (Mo.)/(Day)/(Year)	On that day, did the employee work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, how many hours were worked?	
Description of major job duties – please attach Job description		Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?		
Signature/Title		Date	(Area Code) Phone Number	(Area Code) Fax Number

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

Part III – Attending Physician’s Statement (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Employer Name	Policy Number
Name of Patient (Last, First, M.I.) – Please Print	Date of Birth
Diagnosis	ICD-9 Code
Symptoms	Date symptoms first appeared (Mo. Day Year)
Is disability due to:	Accident/Injury Sickness Work related? <input type="checkbox"/> Yes <input type="checkbox"/> No

If Disability is Due To Pregnancy, Please Provide the Information Below:
 LMP: _____ Expected Date of Delivery: _____ Actual Date of Delivery: _____ Type: C-Section Vaginal

Name of Surgical Procedure (Describe fully and provide dates if any)

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Treated in Emergency Room	Name of Hospital	Physician
Was the patient treated by another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Treated	Physician’s Name and Address	
Was the patient hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Confined In Hospital From _____ To _____		Name of Hospital
Did patient have outpatient surgery in a hospital or ambulatory surgical center? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Surgery	Name of Facility	

Functional Limitations - Abilities

indicate frequency per day the listed activity can be performed. (n - never, o - occasional, f - frequent, c - constant)	Indicate longest single time duration each activity can be performed.																																			
<table style="width:100%;"> <tr> <td style="width:50%;">Lifting</td> <td style="width:50%;">Carrying</td> </tr> <tr> <td>_____ 1-5 lbs.</td> <td>_____ 1-5 lbs.</td> </tr> <tr> <td>_____ 6-10 lbs.</td> <td>_____ 6-10 lbs.</td> </tr> <tr> <td>_____ 11-25 lbs.</td> <td>_____ 11-25 lbs.</td> </tr> <tr> <td>_____ 26-50 lbs.</td> <td>_____ 26-50 lbs.</td> </tr> <tr> <td>_____ 51-100 lbs.</td> <td>_____ 51-100 lbs.</td> </tr> <tr> <td>_____ over 100 lbs.</td> <td>_____ over 100 lbs.</td> </tr> </table>	Lifting	Carrying	_____ 1-5 lbs.	_____ 1-5 lbs.	_____ 6-10 lbs.	_____ 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.	<table style="width:100%;"> <tr> <td>_____ Sitting</td> <td>_____ Kneeling</td> <td>_____ R Finger Dexterity</td> </tr> <tr> <td>_____ Total time on feet</td> <td>_____ L</td> <td></td> </tr> <tr> <td>_____ Standing</td> <td>_____ Inside</td> <td>_____ R Below Shoulder</td> </tr> <tr> <td>_____ Walking</td> <td>_____ L</td> <td></td> </tr> <tr> <td>_____ Bending</td> <td>_____ Outside</td> <td>_____ R Above Shoulders</td> </tr> <tr> <td>_____ Squatting</td> <td>_____ Working with Others</td> <td>_____ L</td> </tr> <tr> <td>_____ Stooping</td> <td>_____ Other (explain) _____</td> <td></td> </tr> </table>	_____ Sitting	_____ Kneeling	_____ R Finger Dexterity	_____ Total time on feet	_____ L		_____ Standing	_____ Inside	_____ R Below Shoulder	_____ Walking	_____ L		_____ Bending	_____ Outside	_____ R Above Shoulders	_____ Squatting	_____ Working with Others	_____ L	_____ Stooping	_____ Other (explain) _____	
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} Reaching

Mental Limitations - Abilities

	Excellent	Good	Fair	Guarded
Judgement/decision making	_____	_____	_____	_____
Deal with work stresses	_____	_____	_____	_____
Function independently	_____	_____	_____	_____
Concentration/attention span	_____	_____	_____	_____
Emotional liability	_____	_____	_____	_____
Patient follows recommendations	_____	_____	_____	_____
Caring for self/family	_____	_____	_____	_____
Estimate overall prognosis	_____	_____	_____	_____

The patient has been continuously disabled (unable to work) from _____ to _____

The patient should be able to work Full-time Part-time on (date) _____ or in 1 mth. 1-3 mths. 3-6 mths. Other _____

Remarks

Name of Attending Physician - Please Print	Tax Identification Number
Address (No., Street, City, State, ZIP Code)	Telephone Number Fax Number
Signature of Attending Physician	Date Signed