

# Short-Term Disability Claim Form

Mutual of Omaha Insurance Company  
 United of Omaha Life Insurance Company  
 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)

<b>Employer Name</b>		<b>Policy Number</b>	<b>Job Title</b>	<b>Hours Worked per Week</b>
<b>Name</b>				
<b>Address</b>		<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>(Area Code) Phone Number</b>			<b>Social Security Number</b>	
<b>Date of Birth</b>	<b>Height</b>	<b>Weight</b>	<b>Dominant Hand:</b> <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
<b>Date of Disability (1st Day Absent) (Mo.)/(Day)/(Year)</b>		<b>Date First Treated (Mo.)/(Day)/(Year)</b>		<b>Physician's Name</b>
<b>Nature of illness and when symptoms first appeared, or describe how and where accident occurred.</b>				
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				
<b>Other income you have filed for, are receiving, or are eligible for:</b>				
	<b>Amount</b>	<b>Date Claim Filed</b>	<b>Date Benefits Began</b>	
Workers' Compensation	_____	_____	_____	
State Disability	_____	_____	_____	
Other	_____	_____	_____	

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

<b>Company Name</b>		<b>Policy Number</b>	<b>Class</b>	<b>Division or Location</b>
<b>Address</b>		<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>Weekly earnings as defined by the Plan:</b> (Please note: Benefits will be calculated based on premium received.)		<b>No. of Hours Scheduled to Work Weekly:</b> _____		
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 _____				
<b>Date of Hire (Mo.)/(Day)/(Year)</b>		<b>Date Covered Under This Plan</b>		
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.		
<b>Circle</b>	M - Medium	50 Lbs. Maximum lifting with frequent lift/carry up to 25 Lbs.		
<b>One</b>	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.		
<b>Employee's Job Title</b>		<b>Last Day at Work (Mo.)/(Day)/(Year)</b>	<b>On that day, did the employee work a full day?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No      If no, how many hours were worked?	
<b>Description of major job duties – please attach Job description</b>		<b>Has the employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, when?</b>		
<b>Signature/Title</b>		<b>Date</b>	<b>(Area Code) Phone Number</b>	<b>(Area Code) Fax Number</b>

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%;"><b>Lifting</b></td> <td style="width:50%;"><b>Carrying</b></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>	<b>Lifting</b>	<b>Carrying</b>	_____ 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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**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 \_\_\_\_\_