



Underwritten by  
 United of Omaha Life Insurance Company  
 Mutual of Omaha Insurance Company  
 Mutual of Omaha Affiliates

3300 Mutual of Omaha Plaza  
 Omaha, NE 68175-0001  
 Toll Free (800) 775-8805  
 Fax (402) 997-1898  
 Email submitgrpacc@mutualofomaha.com

## Group Accident Claim Form - Express Benefit

### Section 1 - Policyholder/Employer Information

Employer Name	Group Number
	G000 ____ _
Employer Address	Employer Phone Number

### Section 2 - Claimant Statement (completed by employee/member)

Claimant/Patient Name: First/Last			
Claimant/Patient Date of Birth: Mo./Day/Yr.	Sex: M/F		
Relationship to Employee: Self/Dependent/Spouse/Domestic Partners			
Employee Name: First/Last	Social Security Number		
Employee Date of Birth: Mo./Day/Yr.	Sex: M/F		
Address	City	State	ZIP Code
Phone	Email		

### Section 3 - Accident/Injury Details

Date of Accident: Mo./Day/Yr.	Location of Injury: On or Off Job
Was claimant injured in a Motor Vehicle Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the accident investigated by Law Enforcement? <input type="checkbox"/> Yes <input type="checkbox"/> No
To date, has the patient sought medical treatment for any injury sustained as a result of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, briefly describe the type of treatment received and from whom?	
Explanation of Accident/Injury(s)	

### Section 4 - Acknowledgement & Signature

**Fraud Warning:** 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. (Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, MA, MD, ME, NJ, NM, NY, OH, OR, PR, RI, TN, VA, VT and WA. Please read the specific fraud warning for your state of residence included with this form or available online at [www.mutualofomaha.com](http://www.mutualofomaha.com).)

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information provided on this form is true and complete to the best of my knowledge and belief.

SIGNATURE OF CLAIMANT	DATE
SIGNATURE OF PATIENT, IF AGE 18 OR OLDER (AND NOT THE CLAIMANT) <input type="checkbox"/> Check if Patient is deceased or incapable of signing	DATE