SBMA

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

Claim forms and supporting documentation may be emailed to claims@sbmamec.com or mailed to:
SBMA
2307 Fenton Pkwy # 107-126
San Diego, CA 92108

Group Hospital Indemnity Insurance

Employer Portion

Employer Name

Group Number
G000 C 7 G G

Employer Address

Employer Phone Number

Employee/Claimant Portion

Employee Name: First/Last

Social Security Number

Employee Date of Birth: Mo./Day/Yr.

Sex: M/F

Mailing Address | City | State | ZIP Code

Phone | Email

Does the Employee have major medical insurance? ❑ Yes ❑ No

If this claim is NOT for the Employee, please complete the following:

Relationship to Employee: ❑ Self ❑ Dependent ❑ Spouse ❑ Domestic Partners

Patient Name: First/Last

Social Security Number

Patient Date of Birth: Mo./Day/Yr.

Sex: M/F

1. If your condition is due to an illness or pregnancy, answer the following questions.

What is the diagnosis/condition?

What is the date you were first treated by a physician?

For pregnancy only, what is your delivery date?

2. If your condition was due to an injury, answer the following questions.

What is the date you were first treated by a physician?

When did the injury occur?

Where and how did the injury occur? (Include Police Report if applicable)

Hospital Admission & Confinement

Hospitalized: ❑ Yes ❑ No Admit Date

Discharge Date

Name of Facility

Phone Number

Address

Reason for Admission/Confinement

(continued on back)

Supporting Claim Documentation: Please send us documentation with the claimant's name, provider name, and dates of services/ treatments received. The documentation should also have diagnoses/conditions listed.

- ❑ **Medical Records:** Hospital and/or Physician Office Records, Admission and Discharge Summaries (Not Discharge Instructions), Diagnostic Test Results, Radiology Reports, Laboratory Results, Operative or Procedure Reports, Physician Consultation Notes and/or Home Nursing Visit Notes.
- ❑ **Itemized Bills – Diagnosis and procedure codes must be included with the following documents:** Provider invoice or receipt, Hospital (Form – UBO4), Ambulance, Surgery or Procedure, Diagnostic Testing, Radiology, Laboratory, Home Nursing Visits, Medication, and/or Wellness Test Results, EOBs.

Agreement and Signature

I understand this is a supplement to health insurance and is not a substitute for Major Medical Coverage. This is not qualifying health coverage ("Minimum Essential Coverage") that satisfies the health coverage requirement of the Affordable Care Act. If you don't have Minimum Essential Coverage, you may owe an additional payment with your taxes.

I acknowledge that the IRS limits the types of supplemental insurance that an individual who participates in a Health Savings Account (HSA) may have, while still maintaining the tax-exempt status of HSA contributions. The IRS allows additional insurance that provides benefits for "a fixed amount per day (or other period) of hospitalization." Anyone who has or plans to open an HSA, should consult tax and legal advisors to determine which supplemental benefits may be purchased by employees with an HSA.

I understand that should this claim be overpaid for any reason, it is the obligation of the recipient of the benefit payment to repay any such overpayment in accordance with the terms of the policy.

I acknowledge that incomplete information on this form may delay processing of the claim. If the Company requests additional information to complete processing of this claim, I understand that any delay in response may delay processing of the claim.

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 and statements provided on this form are true and complete to the best of my knowledge and belief. If applicable: I am not the person whose personal information is to be disclosed, but I am legally authorized to grant permission on behalf of that person and have completed.

Signature of Claimant Date

Signature of Patient, if age 18 or older (and not the claimant) Date

If applicable, I signed on behalf of the insured as _____ (indicate relationship). If legal guardian, power of attorney designee, conservator, beneficiary or personal representative, please attach a copy of the document granting authority.

Printed Name of Legal Representative

Signature of Legal Representative Date

Please use this portion of the form to provide any necessary information related to your claim:

Authorization to Release Personal Information

1. I (the undersigned) authorize any physician, medical or dental practitioner, pharmacist, other health care provider, hospital, clinic, or medical facility, insurer, reinsurer, insurance services support organization, employer, government agency, consumer reporting agency, or insurance policy or benefit plan administrator to release records containing the Personal Information of:
   Name of Claimant _____
   (Last) (First) (Middle)
   Date of Birth_____/_____/_____ Social Security Number_____-_____-_____
   This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.
2. **Personal Information to be released:**
   - data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), X-rays, films or correspondence, and any medical condition I may now have or have had;
   - any information regarding insurance or benefit plan coverage, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history)
3. **You may release my Personal Information to:**

   Staff Benefits Managment & Administrators (SBMA)
   Hospital Indemnity Claims
   Email: claims@sbmamec.com

4. **I understand my Personal Information will be used by Mutual to evaluate my claim for benefits, or as required or permitted by law, and that if I refuse to sign this Authorization, my claim for benefits may not be paid. I also authorize Mutual to release my Personal Information as follows:**
   - to its reinsurer, or other persons or organizations performing business, legal or insurance support services in connection with my claim(s); or
   - to a vendor specializing in the application for Social Security Disability Benefits; or
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans to my employer for use in discussions with Mutual regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise required or permitted by law or as I further authorize
5. I understand my Personal Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
6. I understand that I may revoke this Authorization at any time by providing a written request to Mutual at the address above. If I revoke this Authorization, it will not affect any use or disclosure of Personal Information that occurred prior to Mutual's receipt of my revocation. If written revocation is not received, this Authorization will remain valid until 24 contiguous months after the date signed.
7. 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 _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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Electronic Funds Transfer (EFT) Authorization

Direct Deposit of Benefit Payments

I understand that by completing this form, I am authorizing United of Omaha Life Insurance Company to directly deposit into my bank account via Electronic Funds Transfer (EFT) payment(s) due to me under a contract issued by United of Omaha to my financial institution with the information provided below, for credit to my account. Furthermore, I authorize and direct the bank to charge said account or the account of my estate for any payment made in error as determined by United of Omaha and to refund any such payment made subsequent to my death or made in error and to refund any such payment to United of Omaha upon its written request to the bank.

I further understand and agree

1. that it is my responsibility to ensure that all bank information reported on this form is accurate and correct for the appropriate deposit of my payment(s) and that United of Omaha can rely on this information and will have no obligation to ensure the correctness of the information. Completion of this form is not a guarantee that benefits will be paid.
2. that any payment(s) made into an incorrect bank account pursuant to the information reported on this form, will be forfeited by me and that United of Omaha has no obligation to retrieve those funds or make replacement payment(s) to me.
3. for myself, my heirs, executors and estate to indemnify and hold United of Omaha harmless from any and all loss or damage of any nature whatsoever, including costs or attorney's fees incurred by reason of said bank acting pursuant to this Authorization.
4. that United of Omaha is not responsible for any bank charges or other costs associated with or arising out of this agreement.
5. that if my bank is not able to accept EFTs, checks will be mailed to my residence. I reserve the right to revoke and cancel this authorization. Such revocation and cancellation shall be effective within 5 business days following United of Omaha's receipt of the notice.

Payee Information	**Bank Information**
Full Name	Bank Name
Address	Address
Address	Address
City	City
State and ZIP Code	State and ZIP Code
Telephone Number ( )	Telephone Number ( )
Social Security Number	Account Number
Policy Number	Bank ABA Routing/Transit Number
Claim Number	❑ Checking ❑ Savings *(Check only one)*

Please attach EITHER **a voided check for checking** OR **a deposit slip for savings** and return with this form

X _____ _____

Payee Signature Date

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