MUTUAL of OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
1 800 775 1000
mutualofomaha.com

APPLICATION FOR LONG TERM CARE BENEFITS
TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Patient's Name: Date of Birth: Policy Number:

Patient's Address:

2. Principal Diagnoses:
ICD9 Code(s): _____ Date Diagnosed: _____ Recurring Condition(s)? ( ) Yes ( ) No
If Yes, please describe previous occurrences and dates._____

3. Is condition due to injury or sickness arising out of patient's employment? ( ) Yes ( ) No ( ) Unknown

4. Has the patient been confined in a hospital or nursing facility within the past 5 years? ( ) Yes ( ) No

If Yes, when and where:_____
_____

5. Is dependency in functional status due to organic mental impairment (i.e. Alzheimer's Disease or related disorders)?
( ) Yes ( ) No

If Yes, please indicate how you arrived at the diagnosis (i.e. history, physical exam, diagnostic testing, mental status exam, and evidence from previous treatment):
_____
_____

Type of mental status testing:_____ Score:_____

6. Is the patient competent to endorse checks or drafts and direct the use of the proceeds? ( ) Yes ( ) No

If No, who handles their financial affairs?_____

7. Patient Capabilities and Limitations. Indicate each activity of daily living the patient **cannot** perform without human assistance:

		Date Capability Ended	Expected Recovery Date
A. Eating	( )	_____	_____
B. Toileting	( )	_____	_____
C. Transferring	( )	_____	_____
D. Bathing	( )	_____	_____
E. Dressing	( )	_____	_____
F. Continence	( )	_____	_____

********** Please Complete Page 2 **********

8. If patient is residing at home, what services are being provided (check appropriate box)?

A. Skilled Services	B. Support Services	C. Family/Informal	D. Equipment
( ) Nursing	( ) Home Health Aide		( ) Wheelchair
( ) Therapist	( ) Homemaker		( ) Cane
( ) Hospice	( ) Adult Day Care		( ) Prosthesis
( ) Other Specify	( ) Hospice (Palliative)		( ) Walker
_____	( ) Respite		( ) Other Specify_____
	( ) Emergency Response System		
	( ) Other Specify		

9. If the patient is confined in an institution, could the patient be cared for under Home Care? ( ) Yes ( ) No

10. Recommended Plan of Care (include any treatments or therapies prescribed, including expected duration) to improve or maintain current functional status:

11. Prognosis and Goals (check appropriate box)

( ) Improvement in functional status expected -- less than 3 months.

( ) Improvement in functional status expected – 3 to 6 months.

( ) No change in functional status expected.

( ) Deterioration in functional status expected -- less than 3 months.

( ) Deterioration in functional status expected -- 6 to 12 months.

Date_____ Physician's Name_____ Tax ID/SS #_____

Physician's Signature_____ Phone (____)-____-____

Street Address_____ City_____ State_____ ZIP Code_____

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APPLICATION FOR LONG TERM CARE BENEFITS
TO BE COMPLETED BY CLAIMANT OR LEGAL REPRESENTATIVE

PART A.

1. Claimant's Full Name: Address: Policy Number:

2. Claimant's Phone Number: Date of Birth: Social Security Number

3. Height: _____ Weight: _____ Sex: ( ) Male ( ) Female

   Marital Status ( ) Single ( ) Married ( ) Widowed

4. Is the claimant eligible for, has applied for, or is receiving benefits from:

Other Long Term Care Coverage	( ) Yes	( ) No	Self Insured Employee Benefit Plan	( ) Yes	( ) No
Auto No Fault Coverage	( ) Yes	( ) No	Federal or State Government Program	( ) Yes	( ) No
Medicare	( ) Yes	( ) No	Workmen's Comp./Employer Liability	( ) Yes	( ) No

   If the claimant is receiving benefits, submit copies of the Explanation of Benefits along with their claim.

5. Describe the claimant's current condition and its cause:

6. Which of the following Activities of Daily Living does the claimant need assistance with (check boxes that apply)?

   ( ) Bathing ( ) Transferring
   ( ) Dressing ( ) Eating
   ( ) Toileting ( ) Other _____

7. Was the claimant hospitalized? ( ) Yes ( ) No If Yes, name and address of facility:

   Date Admitted: _____ Date Discharged: _____

8. Name and address of treating physician(s) or practitioner(s):

Name/Address	Telephone Number	Most Recent Date Consulted
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

********** Please Complete Page 2 **********

9. Has the claimant ever had the same, similar, or other condition(s) in the past? ( ) Yes ( ) No

Who treated them? Name _____ Phone ( )_____

Address_____

10. Name and address of person holding Power of Attorney/Guardianship/Trustee (if applicable)

_____

_____

_____

Date Effective: _____

Please enclose a copy of any Power of Attorney, Guardianship, or Trustee Papers with this claim form.

PART B: Complete for Confined Care

Type of Care: ( ) Nursing Home ( ) Assisted Living ( ) Hospice ( ) Respite ( ) Other_____

Name of Facility/Provider: _____

Address:_____

Phone ( )_____ Dates of Confinement: Beginning:_____ Ending: _____

PART C: Complete for Home Health Care or Community Care:

Type of Care: ( ) Home Health Care ( ) Adult Day Care ( ) Homemaker Services

( ) Outpatient Hospice ( ) Respite ( ) Emergency Medical Alert ( ) Other_____

Name of Facility/Provider:_____ Phone ( )_____

Address:_____

PART D: Contact Information:

Name, Address and Phone Number of Person(s) that we have your permission to contact if you or the claimant cannot be reached

_____

_____

_____

_____

Phone ( )_____

Please enclose copies of your bills with this claim form.

Date_____ **Signature**_____

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and additional companies which may become part of this group of companies and their successors.

- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to the claim representatives of Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

Purposes

The Personal Information will be used to evaluate my claim for benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain payment or eligibility for benefits under my plan of benefits. I also realize that if I refuse to sign, I will be responsible for submitting all necessary information to process the claim. This may result in additional expenses to me that may not be reimbursed.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

Mutual of Omaha Insurance Company
Attn: Individual Claims
Mutual of Omaha Plaza
Omaha, NE 68175-3100

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy/plan or a claim under the policy/plan.

Copy

I understand that I will retain a signed copy of the authorization and that a copy of this authorization is as valid as the original.

Names and Signatures

Name(s) used for medical records (**if different than the name below**): _____

_____

_____
Printed Name of Insured

_____ _____
Signature of Insured Date

or

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.

Printed Name of Legal Representative: _____

Signature of Legal Representative: _____

Type of Legal Representative: _____

Date: _____

This authorization complies with HIPAA and other Federal and State laws.

(Retain one Signed Copy for Your Records)

Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

** **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

** **Alaska:** A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

** **Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

** **Arkansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **California:** For your protection California law requires the following to appear on this form. 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.

** **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

** **Delaware:** Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

** **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

** **Florida:** 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.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **Kentucky:** 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.

** **Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

** **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison..

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

** **New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

** **New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

** **New York:** 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:** 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.

** **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

** **Pennsylvania:** 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.

** **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

** **Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **Texas:** 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.

** **Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

** **West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.