



# NOTICE OF CLAIM – ACCELERATED BENEFITS

- Employer:**
1. Indicate patient's name on Part B, then forward to physician to complete.
  2. Upon return of Part B, complete Part A
  3. Send immediately to UnitedHealthcare Insurance Company at the address indicated above, and retain a copy for your records.

## PART A

|   |                            |       |       |  |  |                   |
|---|----------------------------|-------|-------|--|--|-------------------|
| Employer  |                            |       |       | Phone Number   |  |                   |
| Employer Address (No., Street, City, State, Zip Code) |                            |       |       |  |  |                   |
| Policyholder Name (if different from Employer)        |                            |       |       |  |  |                   |
| Employee Name (Last, First, M.I.)                     |                            |       |       | Employee Social Security #   |  |                   |
| Date Employed   | Effective Date of Coverage | Class | Group | <input type="checkbox"/> Union<br><input type="checkbox"/> Non-Union | <input type="checkbox"/> Hourly<br><input type="checkbox"/> Salary | Wage/Salary<br>\$ |

| Policy Number(s) | Suffix | Account | Amount of Insurance | Effective Date of Present Amount of Insurance |
|------------------|--------|---------|---------------------|---|
|                  |        |         | \$                  |   |
|                  |        |         | \$                  |   |
|                  |        |         | \$                  |   |

Dollar Amount Requested: \_\_\_\_\_ (up to the maximum amount as shown in the Accelerated Death Benefit in the Life Certificate of Coverage)

Has any part of this insurance been assigned?  Yes  No If yes, attached authorization form

|  |  |                        |               |
|--|--|------------------------|---------------|
| Name (Last, First, M.I.)                     |  | Social Security Number | Date of Birth |
| Address (No., Street, City, State, Zip Code) |  |                        |               |

|   |                    |
|---|--------------------|
| If Claim is for Employee:<br>Date Last Worked | Date of Disability |
|---|--------------------|

**I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.**

**EMPLOYEE:**

(IMPORTANT): Sign your name the way you would sign a check

|           |      |
|-----------|------|
| Signature | Date |
|-----------|------|

**EMPLOYER:**

|                              |                      |      |
|------------------------------|----------------------|------|
| Authorized by (please print) | Authorized Signature | Date |
|------------------------------|----------------------|------|



Patient' Name

**PART B - to be completed by Attending Physician**

Completed form should be returned to Patient's employer

1. Diagnosis (including any complications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Objective Findings

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Is condition terminal  
 Yes       No

Life expectancy \_\_\_\_\_

3. Is the Patient confined in a nursing home with the expectation to remain in the nursing home for the rest of the Patient's life?

Yes       No      Date of Confinement      \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Is this patient receiving continual home health care with the expectation that these services will be needed for the rest of his/her life?

Yes       No      Date of services first received      \_\_\_\_/\_\_\_\_/\_\_\_\_

5. DATES OF TREATMENT

Date of first visit for this condition      \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last visit      \_\_\_\_/\_\_\_\_/\_\_\_\_

Frequency       Weekly       Monthly       Other (Specify \_\_\_\_\_)

Date of examination      \_\_\_\_/\_\_\_\_/\_\_\_\_

6. Are you aware of any other treating physician?

Yes       No

If yes, name and address \_\_\_\_\_

7. MENTAL COMPETENCY

Is the patient competent to endorse checks and direct the use of the proceeds thereof?

Yes       No

PLEASE PRINT OR TYPE:

Doctor's Name

Specialty

Telephone Number

Mailing Address (No., Street, City, State, Zip Code)

Physician's Signature

Date

**FRAUD WARNING NOTICES: (Please review notice that applies in your state)**

**For claimants in 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.

**For claimants in 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.

**For claimants in 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.

**For claimants in California:**

UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

**For claimants in 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.

**For claimants in Connecticut:**

Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

**For claimants in 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.

**For claimants in District of Columbia:**

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the 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.

**For claimants in 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

**For claimants in Hawaii:**

**For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.**

**For claimants in Idaho:**

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

**For claimants in 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.

**For claimants in Kansas:**

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 may be guilty of fraud as determined by a court of law.

**For claimants in 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.

**FRAUD WARNING NOTICES: (Please review notice that applies in your state)**

**For claimants in 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 may include imprisonment, fines or a denial of insurance benefits.

**For claimants in Maryland:**

Any person who knowingly or willfully presents a false or fraudulent claim for payment for 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.

**For claimants in Minnesota:**

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

**For claimants in 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.

**For claimants in New Jersey:**

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

**For claimants in 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 penalties.

**For claimants in 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.

**For claimants in Oklahoma:**

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

**For claimants in Oregon:**

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 may be guilty of a crime and may be subject to fines and confinement in prison.

**For claimants in 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.

**For claimants in Tennessee and 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.

**For claimants in 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.

**For claimants in Vermont:**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

**For claimants in Virginia:**

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 false, incomplete, or misleading information may have violated state law.

**For claimants in All Other States:**

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.