UnitedHealthcare

Claim Form and Instructions for Group Accident Insurance Employer

Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing the employee's request for benefits.**

You are required to include the following documentation (as applicable):

- ☐ Payroll (if Exempt Employee) or timesheets (if Non-Exempt Employee) for the 3 months prior to the accident/medical event
- ☐ Copy of the enrollment form for the year the accident occurred
- ☐ Present status of any compensation claim, claim number, copy of the first report of injury **IF** Employee was injured at work
- ☐ Most recent beneficiary designation **IF** the claim is being filed for Accidental Death

Completed form should be sent directly to UnitedHealthcare Specialty Benefits:

Mail:
UnitedHealthcare Specialty Benefits
PO Box 31328
Salt Lake City, UT 84131-0321

Email (email is unsecured unless you are a registered Cicso user):
FPCustomerSupport@uhc.com

Phone:
800-539-0038

Fax:
888-505-8550

General Demographics

INFORMATION ABOUT THE COVERED EMPLOYEE (Please answer all questions)			
Employee's Name (first, middle initial, last)			Social Security Number
Street Address, City, State, ZIP Code			
Phone Number		Date of Birth	Gender ◯ M ◯ F
Group Accident Policy Number	Policy Effective Date (mm/dd/yy)	Date of Hire	Effective Date of Coverage
Insurance Class	Last Day Worked	Returned to Work? ◯ Yes ◯ No Date	Regular Scheduled Hours per week

Employer Contribution to premium: ◯ Yes ◯ No If Yes: ◯ Pre-tax ◯ Post-tax

Does the employee contribute to premium? ◯ Y ◯ N *(If yes, provide a copy of enrollment form for current plan year)*

If yes, does s/he contribute on a PRE or POST tax basis? ◯ Pre Tax ◯ Post Tax

What percentage does s/he contribute to their LTD premium? %

Employee's Occupation:	Plan Level: ◯ Silver ◯ Gold ◯ Platinum ◯ Plan A ◯ Plan B ◯ Employee ◯ +Dependents	Employee's Work Status ◯ Part Time ◯ Exempt ◯ Seasonal ◯ Full Time ◯ Non-Exempt ◯ Temporary

EMPLOYER INFORMATION	
Employer's Name (Parent Company/Policyholder)	Group Accident Policy Number
Employer's Address, City, State, ZIP Code	

Final Signature and Certification

Name of person completing this form	E-mail address
Title	Phone number Ext
Signature (eSignature is allowed)	Date Signed

(Rev. 06/18)
UA 7.2020

UnitedHealthcare

Claim Form and Instructions for Group Accident Insurance Employee

Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing the employee's request for benefits.**

You are required to include the following documentation (as applicable):

- ☐ Employee's Accident Statement
- ☐ Authorization of Personal Representative *(if applicable)*
- ☐ Disclosure Authorization
- ☐ Attending Physician's Statement

Please answer all questions: date(s) of treatment; Diagnosis (ICD-10) codes; provide initial treatment notes including narrative of accident, resulting injuries and treatment; results of Diagnostic Imaging; hospital and physical therapy items can be obtained directly from your health care provider(s).

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Phone:
800-539-0038

Fax:
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Claimant please check the box(es) of the required documents you will be submitting, for each of the specified Covered Benefits below.

Covered Benefit	Required Documentation	Check Box	Covered Benefit	Required Documentation	Check Box
Accidental Death	Copy of certified death certificate	☐	Blood/Plasma/Platelets	Copy of itemized hospital bill	☐
Accidental Dismemberment	Contact information for treating facility/provider	☐	Burns	Contact information for treating facility/provider	☐
Ground/Air Ambulance	Copy of bill from ambulance service	☐	Coma	Contact information for treating facility/provider	☐
Emergency Room Treatment	Copy of treatment notes	☐	Concussion	Contact information for treating facility/provider and copy of ImPACT study, if performed	☐
Physician Office/Urgent Care	Copy of treatment notes	☐	Dental Emergency	Contact information for treating facility/provider	☐
Hospital Admission	Copy of itemized hospital billing statement	☐	Dislocation/Separated Joint	Contact information for treating facility/provider	☐
Hospital Confinement	Copy of itemized hospital billing statement	☐	Eye Surgery	Contact information for treating facility/provider and copy of operative report, if available	☐
Hospital ICU Admission	Copy of itemized hospital billing statement	☐	Family Child Care	Facility's license number, as well as documentation from the facility showing dates of service	☐
Hospital ICU Confinement	Copy of itemized hospital billing statement	☐	Family Lodging	Copy of billing statement showing dates of lodging and charges for room/board	☐
Follow-Up Physician Treatment	Date of treatment and contact information for facility/provider	☐	Fracture	Site of fracture and whether or not fracture was surgically repaired. Additionally, contact information for treating physician	☐
Medical Appliance	Copy of prescription for appliance	☐	Laceration	Size of laceration, type of treatment received (i.e., stitches, staples, glue) and contact name of treating physician/facility	☐
Physical Therapy	Dates of service and contact information for treating facility/provider	☐	Major Diagnostic Exam	Copy of imaging report, if available	☐
Prosthetic Device/Artificial Limb	Contact information for physician who prescribed the device/limb	☐	Organized Sporting Activity	Documentation of the organization the claimant is a part of and of his/her participation on the date of the accident	☐
Rehabilitation Unit	Copy of itemized billing statement from rehab facility	☐	Paralysis	Contact information for treating physician/facility	☐
Abdominal/Thoracic Surgery	Contact information for treating facility/provider and copy of operative report, if available	☐	Tendon/Ligament/Rotator Cuff/Knee Cartilage	Contact information for treating facility/provider and copy of operative report, if available	☐
Ruptured Disc	Contact information for treating facility/provider	☐	Transportation	Copy of billing statement showing transportation	☐
Skin Graft	Contact information for treating facility/provider	☐			

UnitedHealthcare

TO BE COMPLETED BY THE CLAIMANT OR BENEFICIARY			
Employee's Name (first, middle initial, last)			Social Security Number
Street Address, City, State, ZIP Code			
Employer's Name/Group or Policy Number (if known)	Date of Birth Phone Number		Gender ◯ M ◯ F
Was the Employee disabled prior to the date of the accident? ◯ Yes ◯ No		If Yes, date disability began	
Check one: ◯ On-Job ◯ Off- Job		Date the accident occurred (not when treated)	
Please explain exactly how the accident happened and what injuries resulted.			

- **Please attach any copy of reports as a result of the accident such as police, motor vehicle accident, worker compensation or incident reports that document the accident.**
- **If the patient's companion required lodging as a result of the patient's hospital confinement, please submit the hotel receipt(s).**
- **Hospital confinement must meet the mileage requirement stated in the policy. Please check the policy for the mileage requirement and to verify this expense is covered.**

INFORMATION ABOUT THE CLAIMANT			
Claimant's Name (first, middle initial, last) if not Employee			Social Security Number
Street Address, City, State, ZIP Code			
Phone Number	Date of Birth	Gender ◯ M ◯ F	Relationship to Employee

INFORMATION ABOUT THE DEPENDENT (if claim is for Dependent Benefits)			
Dependent's Name (first, middle initial, last) if not Employee			Social Security Number
Street Address, City, State, ZIP Code			
Phone Number	Date of Birth	Gender ◯ M ◯ F	Relationship to Employee

CLAIMANT OR BENEFICIARY SIGNATURE (if under 18, signature of parent or guardian is required)

Final Signature and Certification

The above statements are true and complete to the best of my knowledge and belief.
I acknowledge that I have read the applicable Fraud Warning Notice provided with this claim form.

Name of person completing this form	Phone Number
Signature (eSignature is allowed)	Date Signed

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com
Mail: PO Box 31328 Salt Lake City, UT 84131-0321

(Rev 05/2021)

DISCLOSURE AUTHORIZATION – Supplemental Health **TO BE COMPLETED BY EMPLOYEE**

Participant's Name _____

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, pharmacy benefit manager, insurance company, health maintenance organization or similar entity to provide access to or to give UnitedHealthcare Insurance Company (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and non-medical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental illness, psychiatric, drug or alcohol use, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome). If my Plan Administrator sponsors both a supplemental health plan underwritten or administered by the Company and a medical plan of any type written by another UnitedHealth Group Company, the information and records described in this form may also be given to any UnitedHealth Group Company which administers such medical or supplemental health benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, insurance company or reinsurer, consumer reporting agency, insurance support organization, Claimant's agent, employer, group policyholder, benefit plan administrator, or governmental agency to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, employee/employment records, earnings or finances, prior claims files and claim history, work history and work related activities.

I UNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable and to administer any other feature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the duration of the claim, but not to exceed 12 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures, by notifying the Company in writing. The information obtained will not be disclosed to anyone EXCEPT: (a) reinsuring companies; (b) the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); (c) fraud or overinsurance detection bureaus; (d) anyone performing business, medical or legal functions with respect to the claim or the plan; (e) for audit or statistical purposes; (f) as may be required or permitted by law; or (g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drugs or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to permit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, I understand that if I do so, the Company may deny my claim for benefits pursuant to the plan. The use and further disclosure of information disclosed hereunder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant or
Claimant's Authorized Representative:_____ Date: _____

PLEASE SIGN AND DATE IN INK

Relationship, if other than Claimant: _____

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com
Mail: PO Box 31328, Salt Lake City, UT 84131-0321

(Rev 10/2020)
UA 10.2020

AUTHORIZATION OF PERSONAL REPRESENTATIVE **TO BE COMPLETED BY EMPLOYEE**

At my request, and for my convenience, I, _____ hereby authorize **UnitedHealthcare Insurance Company** and any representatives thereof involved in the administration of my hospital indemnity insurance claim to recognize _____ as my Authorized Personal Representative in relation to such claim.

In connection therewith, I understand that _____ may be given access to information concerning my claim, including personally identifiable health information, and hereby authorize the disclosure of such information to said person when requested or as may be necessary to carry out the purpose of this Authorization. I direct that **UnitedHealthcare Insurance Company** not require any further authentication of the identity of my Authorized Personal Representative beyond the identification of his/her name in writing or orally at the time of any communication.

I further understand that any information provided to my authorized personal representative hereunder may be subject to further disclosure by said person, and I agree to hold **UnitedHealthcare Insurance Company** and its representatives harmless in connection with any such disclosure.

This Authorization shall remain valid so long as my claim shall remain open, but I understand that it may be revoked in writing by me at any time.

Date: ____/____/_____

Signature: _____

PLEASE SIGN AND DATE IN INK

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:
Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com
Mail: PO Box 31328, Salt Lake City, UT 84131-0321

ATTENDING PHYSICIAN'S STATEMENT

UnitedHealthcare

TO BE COMPLETED (for employee) BY PHYSICIAN

PATIENT INFORMATION	
Patient's Name (first, middle initial, last)	Date of Birth
Street Address, City, State, ZIP Code	Gender ◯ M ◯ F

ATTENDING PHYSICIAN'S STATEMENT (to be completed by Physician)		
Name and address of where services were rendered		
Date accident occurred:	Date patient was first seen for accident:	Diagnosis codes or ICD10 Codes:
Was the patient hospitalized? ◯ Yes ◯ No	If Yes, note dates of hospitalization: Date Admitted: Date Discharged:	Type of hospital stay : ◯ Inpatient ◯ Outpatient ◯ Observation
Was there any radiology tests such as X-ray, CT Scan, MRI? ◯ Yes ◯ No	Has patient had similar condition in the past? ◯ Yes ◯ No If Yes, please describe:	
Are there any other conditions affecting the patient? ◯ Yes ◯ No If Yes, please describe:		
Did the patient undergo any surgical procedures as a result of the accident, illness or injury?? ◯ Yes ◯ No If Yes, please provide details and CPT codes:		

ATTENDING PHYSICIAN'S SIGNATURE

Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief.
I acknowledge that I have completed this form in its entirety.

Physician's Name	Degree & Specialty	NPI Number
Street Address	Phone Number	Fax Number
Are you related to this patient? ◯ Y ◯ N If yes, what is the relationship?		
Physician's Signature (eSignature is allowed)		Date Signed

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Mail: PO Box 31328, Salt Lake City, UT 84131-0321

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 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.

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.

RESET

PO Box 31328 Salt Lake City, UT 84131-0321
Tel 800 539 0038
Fax 888 505 8550

Claims Department
Direct Deposit Agreement
For Payment of Benefit to Financial Institution

Section 1 (to be completed by benefit recipient)

Name of Benefit Recipient

UHCSB Claim Number

UHCSB Policy Number

Social Security Number

Telephone Number

Address (Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

"I authorize UnitedHealthcare Specialty Benefits to direct the net amount of my benefit payment to be deposited directly by electronic funds transfer and credited to my account as indicated at the financial institution designated below. If any payments made are dated after the date of my death, I hereby authorize and direct the said financial institution on my behalf and on behalf of my executors or administrators to refund any such payments to UnitedHealthcare Specialty Benefits and to charge the same to my account."

Signature of Benefit Recipient (eSignature is allowed)

Date Signed

Section 2

Name of Financial Institution

Address ((Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

Routing Number (9 digit number in lower left corner of check)

Bank Account Number (numbers following the Routing Number)

Type of Account ☐ Checking ☐ Savings (check one)

Attaching a Voided Blank Check will Expedite Processing Your Claim