INSTRUCTIONS

1. Complete the Leave of Absence Form and return it to Employee Benefits:

   Submit document(s) to:

   HonorHealth
   8125 N. Hayden Road
   Scottsdale, AZ 85258
   Fax: (480) 882-5802
   Email: employeebenefits@honorhealth.com

   HonorHealth
   2500 N. Utopia Road, Suite 100,
   Phoenix, AZ 85027
   Fax: (602) 331-5890
   Email: employeebenefits@honorhealth.com

2. You and the treating physician will need to complete the Short Term Disability Claim forms and submit them directly to Mutual of Omaha by one of the following options:
   a. Use the telephonic submission service by calling 866-379-9525. Select option 3, 2, then 1 or,
   b. Online- www.mutualofomaha.com/customer-service or,
   c. Faxing the paper copies to Mutual of Omaha at 402-997-1865 or,
   d. Email to Mutual of Omaha at newdisabilityclaim@mutualofomaha.com

You will hear directly from Mutual of Omaha on the status of your claim regarding approval or denial while on your medical leave.

Upon approval from Mutual of Omaha, your 60% payment will be made directly from payroll on regularly scheduled pay days.

You will hear directly from Employee Benefits regarding your FMLA eligibility.

HONORHEALTH

Leave of Absence Information

Medical or Maternity

Information

Leave of Absence

Leave of absence is used to document and authorize time away from work for surgery, in-patient admission, or time away in excess of seven calendar days for medical leave or family care leave. This includes the need for intermittent and reduced-schedule.

Family Medical Leave Act

The Family Medical Leave Act (FMLA) gives an eligible staff member the right to take up to 12 weeks of unpaid job-protected leave in a rolling 12-month period. Leave can be for the birth/adoption of a child, to care for a spouse, parent, or child with a serious health condition; or when the staff member is unable to work because of their own serious health condition. In addition, an eligible staff member may take up to 26 weeks of unpaid job-protected leave for military caregiver leave.

To be eligible, a staff member must complete 12-months of employment and have worked at least 1,250 hours during the 12-months immediately before the start of the leave.

The FMLA entitlement is determined by a rolling 12-month period measured backwards from the date a staff member uses family leave or medical leave.

FMLA runs concurrently with any paid leave offered by HonorHealth such as Paid Time Off (PTO), Short-Term Disability (STD), Workers' Compensation (WC). All days away from work (including intermittent absences, reduced schedule leave) will be counted toward the staff member's FMLA entitlement.

Periodic Reporting Requirements

While on leave, you may be required to furnish your Employee Benefits department with periodic written reports of your status and intent to return to work.

Intermittent and reduced schedule requires Certification of Serious Health Condition from a Health Care Provider.

Return to Work

If your medical (including maternity) condition keeps you off work more than 7 calendar days, you must take a copy of the written release from your treating physician to Corporate/Occupational Health for drug testing and final clearance to return to work. The urine drug test may be conducted up to 14 days prior to your scheduled return to work date. We recommend allowing sufficient time to be cleared by Corporate/Occupational Health.

Question & Answer

1) How do I apply for a Leave of Absence?
   Complete the Leave of Absence Request form. Submit the request form immediately to your Employee Benefits department. It is your responsibility to ensure that your Employee Benefits department receives the leave of absence request form. Please do not submit completed forms to your department.

2) What happens after I submit my request?
   You will receive a letter letting you know whether you are eligible for leave under the FMLA and whether your absences qualifies as job-protected leave under the FMLA.

3) Will I be paid during my leave?
   While on medical or maternity leave:
   - PTO must be used to supplement payment of approved STD benefits. However, the combined total of STD and PTO may not exceed 100% of regular wages.
   - WC payments will be paid through HonorHealth's claim administrator and PTO cannot be used.

   While on a family (post maternity) leave:
   - PTO must be used the same as normal scheduled work hours.

4) Is my job protected?
   If you are not eligible for job-protected leave under the FMLA, your position may be posted and filled. If you are eligible for FMLA, your job is protected during the first cumulative 12-week period while you are on a qualifying FMLA leave. If you remain off work beyond 12 weeks, your position may be filled permanently. Please discuss the status of your position with your department manager.

   If your position is not available when you are cleared to return to work, you may have up to 30 days to work with Recruiting to find another position for which you qualify. If a position is not secured within 30 calendar days, your employment will be separated.

5) How will my group health insurance premiums be paid?
   When you are not receiving a paycheck from SLHN you will be responsible for the cost of your benefit premiums. You will receive instructions on how to pay your premiums in a separate letter.

SEE POLICIES HR1317 (LEAVE OF ABSENCE) & HR1311 (FAMILY MEDICAL LEAVE (FMLA)) FOR ADDITIONAL DETAILS

Revised: June 2014

HONORHEALTH

LEAVE OF ABSENCE FORM

Medical or Maternity

Instructions – (1) This form should be completed by the staff member (or their designated personal representative) and returned to the Employee Benefits department as soon as possible. (2) It is the staff member's responsibility to ensure that Employee Benefits receives this completed form. Please do not submit to your department.

SECTION 1 – EMPLOYEE INFORMATION

Name (printed) _____ Employee # _____

Address _____ City _____ State _____ Zip Code _____

Work # _____ Home # _____ Cell # _____

May we communicate with you using your personal email? ☐No ☐Yes

Email: _____

SECTION 2 – REASON FOR REQUESTING LEAVE

I am requesting leave for the following reason:

☐ My own health condition – provide dates below(if applicable) Is the condition work related: Yes ☐ No ☐
Date of surgery/illness: _____ Date of in-patient admission _____

☐ Birth of my child; to care for my newborn child: Anticipated due date: _____
Do you plan to be off ☐ 6 weeks or ☐ 12 weeks?

SECTION 3 – DURATION OF LEAVE – DATES ARE REQUIRED TO BE PROVIDED

Date Leave Expected to Begin: _____ Date Leave Expected to End: _____

Will this leave be for a continuous period or intermittently? ☐Continuous ☐Intermittent/Reduced Schedule

SECTION 4 – SIGNATURE

I understand that all leave and duration are based on the medical certifications provided by my doctor. Failure to comply with any policies or procedures associated with my leave may result in denial of my leave and/or termination of my employment. I further understand that it is my responsibility to provide supporting documentation to the Employee Benefits department upon request.

Employee Signature **X** _____ Date _____

Submit document(s) to: HonorHealth 8125 N. Hayden Road, Scottsdale, AZ 85258 Fax: (480) 882-5802 Email: employeebenefits@honorhealth.com	HonorHealth 2500 N. Utopia Road, Suite 100, Phoenix, AZ 85027 Fax: (602) 331-5890 Email: employeebenefits@honorhealth.com

How to File a Short-term Disability Claim

HonorHealth
G0009P58

Your short-term disability plan helps protect your income in the event that you experience a disabling illness or injury. Short-term disability insurance can provide benefit payments when you're unable to work, allowing you to maintain a level of financial security for you and your family.

If you become disabled, the instructions below provide essential information to file a claim and authorize your physician to provide supporting medical information.

Filing Options:

Telephonic

1. Call to file your claim with a disability customer service representative:
   866-379-9525 Select opt 3, 2, then 1
2. The customer service representative will complete the *Telephonic Claim* form. You will need to provide your personal information as well as your injury/illness.
3. Following the call, Mutual of Omaha will mail you an *Authorization to Disclose Personal Information* form. This form can also be found at: www.mutualofomaha.com/customer-service. Complete, sign and submit the form to Mutual of Omaha. The form can be faxed to: 402.997.1865 or emailed to: newdisabilityclaim@mutualofomaha.com

Web

1. Find the *Short-Term Disability* online option at: www.mutualofomaha.com/customer-service
   - In the Forms tab, select "I am a Plan Member (Employee)" and click "go"
   - Choose the state your employer is headquartered in and click "Get Forms."
   - Under Disability Forms, select *Online Short-Term Disability Claim* form – Employee Statement.
2. Complete the online form by providing the requested information. You will also need to provide your physician or health care provider's contact information (phone, fax and mailing address).
3. Select "Submit" and you will receive a successful transmittal message.
4. Following claim submission please print the *Disability Claim Authorization to Disclose Personal Information* form. Complete, sign and submit the form to Mutual of Omaha. The form can be faxed to: 402.997.1865 or emailed to: newdisabilityclaim@mutualofomaha.com

Paper

1. To obtain the *Short-Terrm Disability Claim* form:
   Contact your HR Department
2. Complete Section 1 – *Employee's Statement* in full.
3. Complete and sign the *Authorization to Disclose Personal Information* form.
4. Send completed forms to Mutual of Omaha by fax: 402.997.1865 or email: newdisabilityclaim@mutualofomaha.com
5. Provide a copy of the *Authorization to Disclose Personal Information* form to your physician or health care provider, along with Section 3 – *Attending Physician Statement*. Instruct them to send the completed form to Mutual of Omaha.

A Guide for Successfully Completing the Group Short-Term Disability Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group short-term disability benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

- Prior to submission, make sure you have provided all required information and answered all questions completely and accurately. If information is missing or cannot be read, the processing of your form will be delayed.
- The following guidelines provide valuable information to help you successfully complete the form.
- Please make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Section 1: Employee Statement

This section is to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you.

- Group ID Number for your Employer will consist of eight characters, beginning with "G000" and followed by four additional letters or numbers specific to your Employer.
- Job Title is the title of your position held with the Employer.
- The Hours Worked per Week is the number of hours you worked per week for the Employer.
- Height should be provided in feet and inches.
- Weight should be provided in pounds.
- Dominant Hand indicates whether you are primarily right- or left-handed.
- Date of Disability is the first day you were absent from work because of the disabling condition.
- Date First Treated is the date you first sought medical care because of the disabling condition.
- Other Income means money you are currently receiving or have applied to receive from any source in addition to your claim for disability benefits with Mutual of Omaha/ United of Omaha.

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to my Employer

Both authorizations are to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you or your legal representative.

- By signing the authorization, you are applying for short-term disability benefits with Mutual of Omaha/United of Omaha and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

Guidelines for Section 2: Employer's Statement

This section is to be completed by the Employer. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Employer.

- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.
- Date Covered Under This Plan indicates the date in which the Employee's coverage became effective.
- If the Employee is eligible for salary continuation/sick leave, this does not include Mutual of Omaha/United of Omaha short-term disability benefits, paid time off or vacation compensation.

Guidelines for Section 3: Attending Physician's Statement

This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Attending Physician.

Required Fraud Warnings

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Please read – State specific warnings apply to the resident of such state

- **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.
- **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.
- **Arkansas/Kentucky/Louisiana/Maine/New Mexico/Ohio/Tennessee:** Any person who, with intent to defraud or knowing that he/she 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.
- **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.
- **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.
- **Kansas:** 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 as determined by a court of law.
- **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.
- **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 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.
- **Oregon:** 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 may be a crime and may subject such person to criminal and civil penalties.
- **Puerto Rico:** Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of 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 on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **Vermont:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.
- **Virgin Islands:** 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 penalties.
- **Virginia:** Any person who, with the 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 may have violated state law.

Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Phone 800-877-5176 Fax 402-997-1865 Email newdisabilityclaim@mutualofomaha.com

Section 1 – Employee Statement (Answer all questions to avoid delay)

Current Employer's Name	Group ID Number	Job Title	Hours Worked per Week

Name

Address	City	State	ZIP

(Area Code) Home Telephone Number	(Area Code) Cellular Telephone Number	Social Security Number

Email Address

Date of Birth	Height	Weight	Dominant Hand: ☐ Right ☐ Left	☐ Male ☐ Female	☐ Single ☐ Married	☐ Widowed ☐ Divorced

Date of Disability (1st Day Absent)	Date First Treated	Estimated Return to Work Date

Nature of illness and when symptoms first appeared, or describe how and where accident occurred.

Was the disability work related? ☐ Yes ☐ No Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

Was disability related to a motor vehicle accident or is another third party liable? ☐ Yes ☐ No

Physician's Name

Other income you have filed for, are receiving, or are eligible for:

	Amount	Date Claim Filed	Date Benefits Began
Workers' Compensation	$ _____	_____	_____
State Disability	$ _____	_____	_____
Other	$ _____	_____	_____

Overpayment Notice: Should you become overpaid at anytime during the duration of this claim we, Mutual of Omaha Insurance Company (Mutual) or United of Omaha Life Insurance Company (United), will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Mutual or United to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

Important Notice: If you have group life insurance through your employer, please contact your benefits administrator as soon as possible to determine what options are available to you to continue your life insurance. Some options require action within 31 days of the date you stop working/insurance ends for life insurance to continue.

If your coverage is written in California, North Carolina or Michigan and includes Survivor Benefits, please check your policy to determine if you can elect a survivor benefit beneficiary. If so, you may obtain a Beneficiary Designation form on the Internet or from your employer.

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 is guilty of a felony of the third degree.

Employee's Signature: _____ **Date:** _____

Arizona Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, alcohol or drug use, financial and occupational information.

3. You may release information to:

   Group Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   Or
   Fax 402-997-1865

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.

6. This authorization will expire 24 months after the date signed, except that disclosure of HIV-related information is authorized for 180 days from the date I sign it.

7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.

8. 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

Arizona Authorization to Disclose Health Information to My Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will remain in effect for 24 months from the date I sign it, except that disclosure of HIV-related information is authorized for 180 days from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Group Disability Management Services
Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Or
Fax 402-997-1865

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

_____

(Printed Name and Address)

_____ _____

Signature Date

or

If Applicable: I am the legal representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative: _____

Signature of Legal Representative:_____

Type of Legal Representative: _____

Date: _____

RETAIN A SIGNED COPY FOR YOUR RECORDS

FAX (402) 997-1865 Email newdisabilityclaim@mutualofomaha.com Form must be completed in full at no expense to Mutual of Omaha

Section 3 – Attending Physician's Statement (Answer all questions to avoid delay)

Employer Name	Group ID Number
Name of Patient (Last, First, MI) – Please Print	Date of Birth
Diagnoses	ICD-9 Code(s)
Symptoms	Date symptom first appeared

Initial date of treatment:	Last date of treatment:	Next date of treatment/office visit:
Is disability due to: ☐ Accident/Injury ☐ Sickness	Is the disability work related? ☐ Yes ☐ No	

If applicable, list the surgical procedure(s) – Describe fully and provide dates if any.

If disability is due to Pregnancy, please provide the information below:

Date of Last Monthly Period	Expected Date of Delivery	Expected Type of Delivery ☐ Vaginal ☐ Cesarean Section
Actual Date of Delivery	Actual Type of Delivery ☐ Vaginal ☐ Cesarean Section	

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room? ☐ Yes ☐ No	Date treated	Name of Hospital	Name of Physician
Did another physician treat or will be treating the patient? ☐ Yes ☐ No	Date treated	Physician's Name and Address	
Was the patient hospital confined? ☐ Yes ☐ No	Date Confined In Hospital: From_____ To_____	Name of Hospital	
Did patient have outpatient surgery in a hospital or ambulatory surgical center? ☐ Yes ☐ No	Date of Surgery	Name of Facility	

Functional Limitations – Abilities

Indicate frequency per day the listed activity can be performed.

(n = never, o = occasional, f = frequent, c = constant)

Lifting	**Carrying**
_____1-5 lbs.	_____1-5 lbs.
_____6-10 lbs.	_____6-10 lbs.
_____11-25 lbs.	_____11-25 lbs.
_____26-50 lbs.	_____26-50 lbs.
_____51-100 lbs.	_____51-100 lbs.
_____Over 100 lbs.	_____Over 100 lbs.

Indicate longest single time duration each activity can be performed.

_____ Sitting	_____ Kneeling		_____ R: Finger Dexterity
_____ Total time on feet			_____ L: Finger Dexterity
_____ Standing	_____ Inside	**Reaching**	_____ R: Below Shoulder
_____ Walking			_____ L: Below Shoulder
_____ Bending	_____ Outside		_____ R: Above Shoulders
_____ Squatting	_____ Working with Others		_____ L: Above Shoulders
_____ Stooping	_____ Other (explain)_____		

Please notify us if the Employee returns to work after the submission of this form.

 Form continued on Page 6

FAX (402) 997-1865 **Email newdisabilityclaim@mutualofomaha.com** **Form must be completed in full at no expense to Mutual of Omaha**

Mental Limitations – Abilities

	Excellent	Good	Fair	Guarded
Judgment/Decision making	_____	_____	_____	_____
Deal with work stresses	_____	_____	_____	_____
Function independently	_____	_____	_____	_____
Concentration/Attention span	_____	_____	_____	_____
Emotional lability	_____	_____	_____	_____
Caring for self/family	_____	_____	_____	_____
Estimate overall prognosis	_____	_____	_____	_____

The patient has been continuously disabled (unable to work) from _____ to _____

Is the patient able to work with job modifications? ☐ Yes ☐ No

The patient should be able to work ☐ Full-time ☐ Part-time on _____ or a specific date is unavailable, in
☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Other (please specify)

Remarks and/or treatment plan

Name of the Attending Physician – Please Print	Specialty/Degree(s)	Tax Identification Number
Address (No., Street, City, State, ZIP)	(Area Code) Telephone Number	(Area Code) Fax Number

If necessary, whom can we contact at the attending physician's office for additional information?

Name: (Area Code) Telephone Number:

Signature of Attending Physician Date

Please notify us if the Employee returns to work after the submission of this form.