UnitedHealthcare®

Claim Form and Instructions for Group Long Term Disability Employer

Instructions

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

As the employer, you are required to include the following documentation (as applicable):

- ☐ Enrollment Form (if employee contributes to premium)
- ☐ Job Description
- ☐ Paystub (most recent copy)
- ☐ Payroll Reports (please provide previous 24 months commissions)
- ☐ Workers' Compensation – First Report of Accident
- ☐ Life Insurance Enrollment Form, if elected

Completed form should be sent directly to UnitedHealthcare Specialty Benefits:

Mail:
UnitedHealthcare Specialty Benefits
PO Box 7466
Portland, ME 04112-7466

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

Fax:
888-505-8550

Phone:
888-299-2070

General Demographics

Employee's Name (first, middle initial, last)		Social Security Number	
Employee's Street Address	City	State	ZIP Code
Employee's Phone Number Employee's Work State	Date of Birth		
Employee's Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed	Employee's Dependent Name(s)	Date(s) of Birth	

Employer's Name (Parent Company)	Group LTD Policy Number	Phone Number	
Employer's Address	City	State	ZIP Code

Employment and Claim Information

Date of hire	Last day worked (physically)? Hours worked that day?	Insurance/Division Insurance Class
Effective date of LTD coverage	Was coverage effective date within the last 12 months? ◯ Y ◯ N If yes, what was the employee's effective date under prior plan?	
Occupation (please fill out physical demands analysis)	Were there any changes in the employee's job responsibilities due to the disabling condition prior to the employee becoming fully disabled? ◯ Y ◯ N	

Employment and Claim Information

Has employment been terminated? ◯Y ◯N If yes, termination date? Reason

Has employee returned to work? ◯Y ◯N If yes, return to work date?
Employee has returned to work in what capacity? ◯Full Time ◯Part Time

Are you willing to make return-to-work accommodations for the employee if needed? ◯Y ◯N

Was employee injured at work? ◯Y ◯N If yes, date of injury?
If yes, was Workers' Compensation filed? ◯Y ◯N
Name of Workers' Compensation Carrier Contact Name Contact Phone Number

Benefits and Earnings Information

Does the employee contribute to the LTD premium? ◯Y ◯N (If yes, please provide a copy of enrollment form)
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? %

Is the employee also covered under a Life Insurance Policy or Medical Policy provided by us? ☐ Life ☐ Medical

How is the employee paid?
Hourly $ (Per Hour)
Hours worked per week
Salaried $ (Annually)

We will request payroll information after the initial review of the claim

Does the employee receive other work related income?
Commissions $ Other, what type?
Bonuses $ Other $
Overtime $

Is the employee eligible now or in the future for a disability or retirement pension? ◯Y ◯N
If yes, please indicate the type:

Type	Date Eligible	Monthly Amount
Disability		$
Retirement		$
401K		$
Other		$

Is the employee currently receiving or eligible for any other income benefits?
Check all that apply.

Source of Income	Benefit Amount	Weekly or Monthly Benefit	Benefit Coverage Dates (MM/DD/YY)
Salary Continuance	$	◯ Wkly ◯ Mthly	From: Through:
Social Security Disability /Retirement	$	◯ Wkly ◯ Mthly	From: Through:
State Disability	$	◯ Wkly ◯ Mthly	From: Through:
Sick Pay	$	◯ Wkly ◯ Mthly	From: Through:
Unemployment	$	◯ Wkly ◯ Mthly	From: Through:
Short Term Disability	$	◯ Wkly ◯ Mthly	From: Through:
Auto No Fault	$	◯ Wkly ◯ Mthly	From: Through:
Pension or Retirement	$	◯ Wkly ◯ Mthly	From: Through:
Other Sources of Income Benefits	$	◯ Wkly ◯ Mthly	From: Through:

Please list name and contact info if Auto No Fault, Pension or Other:
Name Contact Information

Final Signature and Certification

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

PHYSICAL DEMANDS ANALYSIS TO BE COMPLETED BY EMPLOYER

Employee Name:	**Date:**
Company Name:	**Job Title:**
Location:	**Supervisor/Phone:**

Primary Function of Job (Please attach a copy of the current job description, if available)

Education/training requirements:	**License/trade requirements:**

Using the chart below, please identify the primary job functions *in sequence* or a *prioritized* list of the primary job functions in the left column. In the right column, please describe the physical and other demands for each of the job functions noted.

Primary Job Functions: Sequenced or Prioritized	**Job Demands (Posture, Force, Duration, Reps)**

Additional Duties:

Personal Protective Equipment Required:

JOB FUNCTIONS SUMMARY TO BE COMPLETED BY EMPLOYER

Employee Name:	Date:
Company Name:	

Work schedule for the job:

Hrs per day _____ Days per week _____
Shifts _____ Overtime hours _____
Break/lunch periods _____

Work pace: ☐Self ☐Incentive/piece rate ☐Machine ☐Set quota

Supervisory duties? ☐Yes ☐No

Work field data:

Machines/tools used: ☐Computer ☐Telephone ☐Manual hand tools ☐Calculator ☐Motor vehicle ☐Power hand tools ☐Fork Lift (sit) ☐Fork Lift (stand) ☐ _____ ☐ _____ ☐ _____

Materials used:_____

Describe work station: _____

STANDING/WALKING/SITTING REQUIREMENTS

Total hours at one time (please circle one for each)*

Standing	0	.5	1	2	3	4	5	6	7	8+
Walking	0	.5	1	2	3	4	5	6	7	8+
Sitting	0	.5	1	2	3	4	5	6	7	8+

* Total should equal number of hours worked in a day

Total hours during typical workday (please circle one for each)*

Standing	0	.5	1	2	3	4	5	6	7	8+
Walking	0	.5	1	2	3	4	5	6	7	8+
Sitting	0	.5	1	2	3	4	5	6	7	8+

* Total should equal number of hours worked in a day

Alternate sitting and standing as needed? ☐YES ☐NO

LIFTING/CARRYING EXPLANATION

Task Description Describe task, articles lifted or any mechanical assistance	**Article Weight** Typical	Maximum	**Point of lift Origin** (lift from where)	**Point of lift Termination** (set down where)	**Carrying Destination** (carry how far)	**Frequency/ Duration** (how often/how long)

TALKING/HEARING AND VISION

Talking:	Hearing:	Vision:	
☐ In person	☐ In person	☐ Near	☐ Field of vision
☐ On the phone	☐ On the phone	☐ Far	☐ Accommodation
☐ With public	☐ Full hearing required	☐ Midrange	☐ Depth perception
			☐ Color Vision

JOB FUNCTIONS SUMMARY TO BE COMPLETED BY EMPLOYER

PUSHING/PULLING EXPLANATION

Dynamic Pushing/Pulling (pushing/pulling an object and walking/moving with it)

Object/task description	**Force to start push** (force to get object moving)	**Force to maintain push** (force to keep object moving)	**Distance** (How far)	**Frequency** (How often)

OTHER PHYSICAL DEMANDS	Not Present	<33%	33 - 66%	>66%
Climbing	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Handling:				
1 hand control	☐	☐	☐	☐
2 hand control	☐	☐	☐	☐
Grasping:				
Right hand	☐	☐	☐	☐
Left hand	☐	☐	☐	☐
Grasp/turn:				
Right hand	☐	☐	☐	☐
Left hand	☐	☐	☐	☐
Finger dexterity	☐	☐	☐	☐
Reaching below shoulders	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐
Reaching across	☐	☐	☐	☐
Reaching to floor	☐	☐	☐	☐
Twisting of head	☐	☐	☐	☐
Twisting of back	☐	☐	☐	☐
Upper extremity ROM	☐	☐	☐	☐
Whole body ROM	☐	☐	☐	☐
Bending at the waist	☐	☐	☐	☐
Operate motor vehicle	☐	☐	☐	☐

WORK CONDITIONS	Not Present	<33%	33 - 66%	>66%
Heat	☐	☐	☐	☐
Cold	☐	☐	☐	☐
Wet/Humid	☐	☐	☐	☐
Fumes/Dust/Dirt	☐	☐	☐	☐
Confined Areas	☐	☐	☐	☐
High Places	☐	☐	☐	☐
Equipment in Motion	☐	☐	☐	☐
Safety Equip/Clothing	☐	☐	☐	☐
Burning Materials	☐	☐	☐	☐
Noise	☐	☐	☐	☐
Environmental:				
Mechanical	☐	☐	☐	☐
Chemical	☐	☐	☐	☐
Electrical	☐	☐	☐	☐
Sharp Tools	☐	☐	☐	☐
Slick Floors	☐	☐	☐	☐
Explosives	☐	☐	☐	☐
Radiant Energy	☐	☐	☐	☐
Material Handling	☐	☐	☐	☐
Possible Violence	☐	☐	☐	☐
Setting: Inside _____%		Outside _____%		

_____ _____ (_____)_____ _____

Person completing form Position Phone No. Date

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 7466 Portland ME 04112-7466

UnitedHealthcare®

Claim Form and Instructions for Group Long Term Disability Employee

Instructions

Please print completely. **Incomplete forms and missing documentation may result in a delay in processing your request for benefits.**

As the employee, you are required to include/complete the following documentation (as applicable):

- ☐ Employee Long Term Disability Statement
- ☐ Employee's Disclosure Authorization
- ☐ Employee's Authorization of Personal Representative *(if applicable)*
- ☐ Providing Attending Physician's Statement to the physician(s) treating you
- ☐ Provide a copy of the completed Employee's Disclosure Authorization
- ☐ Attach any copies of Social Security, Workers' Compensation, Retirement or any other income benefit awards and/or denials *(if applicable)*

Completed forms and any attachments should be sent directly to UnitedHealthcare Specialty Benefits:

Mail:
UnitedHealthcare Specialty Benefits
PO Box 7466
Portland, ME 04112-7466

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

Fax:
888-505-8550

Phone:
888-299-2070

General Demographics

Employee's Full Name (first, middle initial, last)			Social Security Number	
Street Address		City	State	ZIP Code
Phone Number	Date of Birth	Height	Weight	Gender ○M ○F
Marital Status ○ Single ○ Married ○ Divorced ○ Widowed			Is Spouse Employed? ○Yes ○No	
If married, Spouse's First and Last Name			Spouse's Date of Birth	
Employee's Dependent Name(s)			Date(s) of Birth	

Employer's Name (include division if applicable)	Employer's Phone Number

Employment and Claim Information

Date of hire	Date you first noticed symptoms of illness/injury	Date last worked (physically)? Hours worked that day? What date do you expect to return to work?

When were you first treated for your injury or illness?	Have you ever had the same or similar condition in the past? ○Y ○N If yes, when?	Have you returned to work? ○Y ○N Date you returned-Part Time Date you returned-Full Time

Your occupation (list job duties)	What parts of your job are you unable to do?

Please describe the onset and nature of your illness or injury

Is your claim a result of: ○Illness ○Accident	If accident, please provide the date and type of accident: Date Type

Was your injury or illness due to an auto accident? ○Y ○N If yes, have you filed an auto insurance claim? ○Y ○N	If yes, provide auto carrier name/address/phone number
Were you injured at work? ○Y ○N If yes, date of injury Was Workers' Compensation claim filed? ○Y ○N	Workers' Compensation carrier/contact name/phone number

Please provide the name, address and date you first saw the physician(s) who is/are treating you now and/or have treated you for a similar condition in the past. If more space is needed, please attach additional paper.

Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ○Y ○N
Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ○Y ○N
Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ○Y ○N
Physician Name	Phone # Fax #	Address	
Specialty	Date First Seen	Date Last Seen	Currently Treating? ○Y ○N

Benefits and Earnings Information

Are you receiving/have you applied for any of the following benefits (include benefits for you or any family member)? Please provide copies of any decisions, including denial and/or award notices for any benefits noted below.

Type of Benefit	*Applied for or appealed? State if pending*	*Benefit Amount*	*Payment Frequency*	*Benefit Coverage Dates (MM/DD/YY)*
Salary Continuance		$	◯ Wkly ◯ Mthly	From: Through:
Social Security Disability /Retirement		$	◯ Wkly ◯ Mthly	From: Through:
Family/Dependent Social Security Disability		$	◯ Wkly ◯ Mthly	From: Through:
State Disability		$	◯ Wkly ◯ Mthly	From: Through:
Sick Pay		$	◯ Wkly ◯ Mthly	From: Through:
Unemployment		$	◯ Wkly ◯ Mthly	From: Through:
Short Term Disability		$	◯ Wkly ◯ Mthly	From: Through:
Auto No Fault		$	◯ Wkly ◯ Mthly	From: Through:
Pension or Retirement		$	◯ Wkly ◯ Mthly	From Through:
Other Sources of Income		$	◯ Wkly ◯ Mthly	From Through:

Please list name and contact info for any of the "other" sources of income checked off:

Name Contact Information

If applied for any of the above benefits, please give additional details here:

Are you receiving, have previously received or applied for any type of payment from any employer's retirement member plan? ◯ Y ◯ N	If yes, provide employer name/address/phone number

Tax Information

If your request for benefits is approved, do you want the minimum amount of $88.00 per month withheld from your check for Federal Income Tax purposes? ◯ Y ◯ N	If you would like more than $88.00 withheld per month, check yes, and indicate the amount. ◯ Y ◯ N Amount $ / Monthly

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 7466 Portland ME 04112-7466

DISCLOSURE AUTHORIZATION **TO BE COMPLETED BY EMPLOYEE**

Participant's Name (Please Print):_____

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, employee assistance plan, 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 any disability, and also HIV related testing, infection, illness, and AIDS (Acquired Immune Deficiency Syndrome), as well as communicable diseases and genetic testing. If my Plan Administrator sponsors both a disability 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 disability benefits for the purpose of evaluating any claim that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, 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, including the Social Security Administration, 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, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage, 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, return to employment opportunities, 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, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; (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 7466 Portland ME 04112-7466

(Rev. 06/18)

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 disability 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 7466 Portland ME 04112-7466

ATTENDING PHYSICIAN'S DISABILITY STATEMENT TO BE COMPLETED (for employee) BY PHYSICIAN

Instructions

Please complete form in its entirety. Provide copies of supporting documents such as office visit notes, medical records, consultations, testing or imaging.

General Demographics of Patient

Patient's Name	Date of Birth	Height	Weight

Is the patient out of work due to Pregnancy? ◯ Y ◯ N

If yes, you are only required to fill out the following information AND complete the Signature Section:

Expected delivery date	If delivered, actual delivery date	Diagnosis and ICD-10 Code	Mode of delivery ◯ Vaginal ◯ C-Section

Patient Information

When did symptoms first appear or accident happen?	Date you advised patient to stop working?	Has patient ever had the same or similar condition in the past? ◯ Y ◯ N If yes, state when and describe:

Date of first visit for this illness?	Date of last visit	Diagnosis & ICD10 Code: Primary and Secondary (including complications)

Current symptoms and findings	Is the injury or illness work related? ◯ Y ◯ N

Was patient hospitalized? ◯ Y ◯ N	Name and Address of Hospital	Date Admitted	Date Discharged

Was surgery performed? ◯ Y ◯ N If yes, what procedure was performed?	CPT Code	Date of Surgery

Expected Return to Work Date	Can patient resume full duties upon return to work? ◯ Y ◯ N	If no, please explain

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ◯ Y ◯ N

Functional Capacity

Please check patient's Physical Capacity (Reference: Dictionary of Occupational Titles)

- ☐ Very heavy – frequent standing/walking, lift/carry over 100 lbs.
- ☐ Heavy – frequent standing/walking, lift/carry up to 100 lbs.
- ☐ Medium – frequent standing/walking, lift/carry up to 50 lbs.
- ☐ Light – frequent standing/walking, lift/carry up to 20 lbs.
- ☐ Sedentary – sitting most of the time, lift/carry up to 10 lbs.
- ☐ No work capacity – ADLs (Activities of Daily Living) only.

Please list any current physical RESTRICTIONS (patient should not do) and/or physical LIMITATIONS (patient cannot do). Please provide specific information in order for us to best evaluate your patient's claim for benefits.

Please check patient's Behavioral Health (Reference: DSM-IV-TR)

- ☐ GAF 61-70 – Some mild symptoms (some difficulty in social, occupational); generally functioning well.
- ☐ GAF 51-60 – Moderate symptoms (moderate difficulty in social, occupational); flat affect, occasional panic attacks, conflict with peers.
- ☐ GAF 41-50 – Serious symptoms (serious impairment in social, occupational); no friends, suicidal, unable to keep job.
- ☐ GAF 31-40 – Some impairment in reality testing, speech at times illogical, major impairment in several areas.
- ☐ GAF <30 – Behavior influenced by delusions and/or hallucinations; acts grossly inappropriate.

ATTENDING PHYSICIAN'S DISABILITY STATEMENT **TO BE COMPLETED (for employee) BY PHYSICIAN**

Please list any current behavioral health RESTRICTIONS (patient should not do) and/or behavioral health LIMITATIONS (patient cannot do). Please provide specific information in order for us to best evaluate your patient's claim for benefits.

What documented clinical or diagnostic findings do you have to support your patient's restrictions and/or limitations? Please attach supporting documentation as available.

What is your treatment plan? Please include medications. You may attach a printed sheet.

Is the patient a suitable candidate for any rehabilitation services such as physical/occupational/speech therapy, etc.?
Patient's Current Occupation? ◯ Y ◯ N Other Work? ◯ Y ◯ N
Is vocational counseling and/or retraining recommended?
Patient's Current Occupation? ◯ Y ◯ N Other Work? ◯ Y ◯ N

Other Treating Providers/Pending Referrals

Name	Specialty	City, State

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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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.

UnitedHealthcare Specialty Benefits

PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070
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 Disability 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)