Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company
Mutual of Omaha Affiliates

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Group Critical Illness/Hospital Indemnity/Accident Health Screening Benefit and Preventative Care Claim Form

Section 1 - Policyholder/Employer Information

Employer Name
GRAYSON COUNTY

Group Number
G000 A K D P

Employer Address
100 W HOUSTON ST #G2 SHERMAN, TX 75090

Employer Phone Number
(903) 813-4264

Section 2 - Claimant Statement (completed by employee/member)

Claimant/Patient Name: First/Last | Sex: M/F | DOB: Mo./Day/Yr. | Social Security Number

Employee Name: First/Last | Sex: M/F | DOB: Mo./Day/Yr. | Social Security Number

Relationship to Employee: ☐ Self ☐ Dependent ☐ Spouse ☐ Domestic Partners

Address | City | State | ZIP Code

Phone | Email

Does the Employee/Member have Major Medical Insurance or a Combination of Basic Hospital and Basic Medical Insurance? ☐ Yes ☐ No

Section 3 - Health Screening or Preventative Care Benefit Information

WHICH POLICY IS THIS BENEFIT BEING REQUESTED FOR? CHECK ALL THAT APPLY: ☐ Accident ■ Critical Illness ☐ Hospital Indemnity ☐ Unsure

PLEASE CHECK THE HEALTH SCREENING OR PREVENTATIVE CARE BENEFIT FOR WHICH THIS CLAIM IS BEING FILED:
Please refer to your Certificate of Coverage for benefits covered under your policy

Available on all Accident, Critical Illness, and Hospital Indemnity Plans:

- ☐ Abdominal aortic aneurysm ultrasound
- ☐ Blood test for triglycerides
- ☐ Bone marrow testing
- ☐ Bone density screening
- ☐ Breast ultrasound
- ☐ CA 15-3 (blood test for breast cancer)
- ☐ CA 125 (blood test for ovarian cancer)
- ☐ Carotid ultrasound
- ☐ CEA (blood test for colon cancer)
- ☐ Chest X-ray
- ☐ Colonoscopy
- ☐ CT angiography
- ☐ EKG (electrocardiogram)
- ☐ Double contrast barium enema
- ☐ Fasting blood glucose test
- ☐ Flexible sigmoidoscopy
- ☐ Hemoccult stool analysis
- ☐ Mammography
- ☐ Pap smear
- ☐ PSA (blood test for prostate cancer)
- ☐ Serum cholesterol test (HDL & LDL)
- ☐ SPEP (blood test for myeloma)
- ☐ Stress test (on a bicycle or treadmill)
- ☐ Thermography

Additional benefits ONLY Available on Hospital Indemnity Plans:

- ☐ Adult Immunization
- ☐ Angiogram
- ☐ Basic or Comprehensive Metabolic Screening
- ☐ Body Mass Index (BMI Assessment)
- ☐ Cancer Testing/Screening/Biopsy
- ☐ Child/Adolescent Exams or Sports Physicals
- ☐ Child/Adolescent Vaccines
- ☐ Dental/Hearing/Physician Annual Exam
- ☐ Diabetes Health Screening
- ☐ Domestic Violence Screening
- ☐ Echocardiogram (ECHO)
- ☐ Genetic Testing
- ☐ Hepatitis B/C Screening
- ☐ Lower Extremity Ultrasound
- ☐ Mental Health Evaluation
- ☐ Neurological Health Studies
- ☐ Neurological Imaging Studies
- ☐ Polysomnogram (Sleep Study)
- ☐ Prenatal/Perinatal Care
- ☐ Substance Abuse Screening
- ☐ Transmitted Diseases/Blood Borne Infection Screening
- ☐ Vascular Ultrasound

DATE THE TEST/PROCEDURE WAS PERFORMED (MM/DD/YYYY) | PHYSICIAN NAME | PHYSICIAN PHONE NUMBER

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information provided on this form is true and complete to the best of my knowledge and belief.

Section 4 - Acknowledgement & Signature

SIGNATURE OF INSURED | DATE