UnitedHealthcare®

Claim Form and Instructions for Group Hospital Indemnity Insurance 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) for the year in which the hospitalization took place, and the prior year
- ☐ Payroll for 12 weeks prior to hospitalization
- ☐ Copy of approved medical evidence of insurability, if required at the time of enrollment

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:
800-539-0038

General Demographics

INFORMATION ABOUT THE COVERED EMPLOYEE			
Employee's Name (first, middle initial, last)			Social Security Number
Street Address, City, State, ZIP Code			
Phone Number		Date of Birth	Gender ◯ M ◯ F
Location/Division	Insurance Class	Date of Hire	Date of Coverage
Employee Contribution to premium: ◯ Yes ◯ No	If Yes: ◯ Pre-tax ◯ Post-tax	If Post-tax: % paid by employer % paid by employee	
Employee's Occupation:	Regular Scheduled hours per week	Employee's Work Status ◯ Part Time ◯ Full Time ◯ Exempt ◯ Non-Exempt ◯ Seasonal ◯ Temporary	

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	Dates of Confinement that you are claiming	Gender ◯ M ◯ F

EMPLOYER INFORMATION			
Employer's Name (Parent Company/Policyholder)		Group Hospital Indemnity 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

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)
UA 1.2020

UnitedHealthcare®

Claim Form and Instructions for Group Hospital Indemnity Insurance 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 Hospital Indemnity Statement
- ☐ Providing Attending Physician's Statement to the physician(s) treating you
- ☐ Provide a copy of the completed Employee's Disclosure Authorization
- ☐ Provide a copy of the completed Employee's Authorization of Personal Representative *(if applicable)*

The benefits that you may be eligible to receive under this policy will be determined by the billing records, complete with revenue codes, provided by the hospital or facility where you received treatment. To help expedite your claim, please provide a copy of the billing records provided by the hospital or facility where you received treatment. If you do not have a copy of the billing records we will obtain a copy direct from the hospital or facility at no cost to you. However, please understand that this may delay the claim process.

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: 800-539-0038

INFORMATION ABOUT THE COVERED EMPLOYEE		
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

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

INFORMATION ABOUT THE HOSPITAL/FACILITY/PHYSICIAN	
Name of Hospital or Facility:	Address of Hospital or Facility:
Name of Admitting/Treating Physician	Address (if different than above):
Telephone Number:	Reason for Confinement

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

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(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: _____

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Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com **Mail:** PO Box 7466 Portland ME 04112-7466

(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

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ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

PATIENT INFORMATION		
Full Name (First, Last, Middle Initial):	Social Security Number:	Date of Birth:

ATTENDING PHYSICIAN'S STATEMENT (to be completed by Physician)		
Nature of Sickness or Injury:		
ICD10 Code:	Date Admitted: Date Discharged:	
Name of Hospital or Facility:	Address of Hospital or Facility:	Telephone Number:
Name of Admitting/Treating Physician	Address (if different than above):	Telephone Number (if different than above):

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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Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com **Mail:** PO Box 7466 Portland ME 04112-7466

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 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)