

# NOTICE OF CLAIM – ACCELERATED BENEFITS

- Employer:**
1. Indicate patient's name on Part B, then forward to physician to complete.
  2. Upon return of Part B, complete Part A
  3. Send immediately to United HealthCare Insurance Company at the address indicated above, and retain a copy for your records.

## PART A

Employer				Phone Number		
Employer Address (No., Street, City, State, Zip Code)						
Policyholder Name (if different from Employer)						
Employee Name (Last, First, M.I.)				Employee Social Security #		
Date Employed	Effective Date of Coverage	Class	Group	<input type="checkbox"/> Union <input type="checkbox"/> Non-Union	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary	Wage/Salary \$

Policy Number(s)	Suffix	Account	Amount of Insurance	Effective Date of Present Amount of Insurance
			\$	
			\$	
			\$	

Dollar Amount Requested: \_\_\_\_\_ (up to 50% of the Basic Life to a maximum of \$50,000)

Has any part of this insurance been assigned?  Yes  No If yes, attached authorization form

Name (Last, First, M.I.)		Social Security Number	Date of Birth
Address (No., Street, City, State, Zip Code)			
If Claim is for Employee: Date Last Worked		Date of Disability	

**Any Person who knowingly and with intent to injure, defraud or deceive any insurance company files a notice of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law**

**EMPLOYEE:**

(IMPORTANT): Sign your name the way you would sign a check)	Signature	Date
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**EMPLOYER:**

Authorized by (please print)	Authorized Signature	Date
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Patient' Name

**PART B - to be completed by Attending Physician**

**Completed form should be returned to Patient's employer**

1. Diagnosis (including any complications)

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Objective Findings

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2. Is condition terminal  
 Yes       No  
 Life expectancy \_\_\_\_\_

3. Is the Patient confined in a nursing home with the expectation to remain in the nursing home for the rest of the Patient's life?  
 Yes       No      Date of Confinement      \_\_\_\_/\_\_\_\_/\_\_\_\_

4. Is this patient receiving continual home health care with the expectation that these services will be needed for the rest of his/her life?  
 Yes       No      Date of services first received      \_\_\_\_/\_\_\_\_/\_\_\_\_

5. DATES OF TREATMENT  
 Date of first visit for this condition      \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of last visit      \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Frequency       Weekly       Monthly       Other (Specify \_\_\_\_\_)  
 Date of examination      \_\_\_\_/\_\_\_\_/\_\_\_\_

6. Are you aware of any other treating physician?  
 Yes       No  
 If yes, name and address \_\_\_\_\_

7. MENTAL COMPETENCY  
 Is the patient competent to endorse checks and direct the use of the proceeds thereof?  
 Yes       No

PLEASE PRINT OR TYPE:

Doctor's Name	Specialty	Telephone Number
Mailing Address (No., Street, City, State, Zip Code)		

Physician's Signature	Date
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