

UnitedHealthcare Accident Critical Illness & Hospital Indemnity Claim Process



FINANCIAL
PROTECTION



Follow these simple steps

1. Use the informational checklist below to gather the required information to start the claim process. Have this information ready when you call us. If someone makes the call for you, he or she will need to provide this information on your behalf.
2. Call us toll-free at **1-800-444-5854**. Hours of operation are Monday through Friday, 8 a.m. – 6 p.m. ET.
3. Sign and date the Authorization Form located on the back of this page. Give your physician the signed and dated form as well as fax a copy of the signed, dated form to us at 1-888-505-8550.

What happens next?

Every claim is unique. When you contact us at **1-800-444-5854**, we will learn more about your specific request, guide you through the claim process, answer your questions and tell you what to expect.

Information Checklist

Please have the following information ready when you call:

- Employer's name and location
- Your full name and Social Security number
- Your complete address and phone number
- Date of birth
- Marital status and number of dependents
- Last day you worked
- Description of medical condition
- Physician's name, address and phone number
- Dates of your first doctor's visit

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 24 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: _____

Relationship, if other than Claimant: _____

RETURN TO: UnitedHealthcare Specialty Benefits

PO Box 7466 Portland ME 04112-7466

Tel: 1-800-444-5854 Fax: 1-888-505-8550

If claimant does not sign this authorization and fails to obtain clarification of incomplete or inconsistent responses upon request, the claim may be denied. 29 C.F.R. §825.307(a). Claimant has the right to obtain a copy of this authorization after signed.