Unimerica®
Workplace Benefits
A UnitedHealth Group Company

NOTICE OF CLAIM - ACCELERATED BENEFITS

Unimerica Workplace Benefits
PO Box 30759
Salt Lake City UT 84130
1-866-293-1794

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 Unimerica 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	☐ Union ☐ Hourly ☐ Non-union ☐ 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, attach authorization form U35523 or U35524.

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

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)

Objective Findings

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 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 last 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