

United HealthCare Insurance Company  
PO Box 30759  
Salt Lake City UT 84130  
1-866-293-1794

# 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"/> Hourly	Wage/Salary
				<input type="checkbox"/> Non-union	<input type="checkbox"/> 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
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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)

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