Claim Forms and Instructions
Group Accident Insurance

1. COMPLETE: Employer's Group Accident Protection Plan Statement (Page 2) in FULL.

2. COMPLETE: Employee's Group Accident Protection Plan Statement (Page 3) in FULL.

3. COMPLETE: Disclosure Authorization (Page 4). This will allow us to secure additional information, if necessary, to make a decision on your claim for benefits. Please make a copy to provide to your treating physician(s).

4. COMPLETE: Authorization of Personal Representative (Page 5). This form is optional and not required to file a claim. If you would like us to discuss your claim with anyone other than you, we require your authorization prior to us releasing personally identifiable health information.

5. TRANSMIT: Completed forms and attachments to:

UNITEDHEALTHCARE SPECIALTY BENEFITS
PO Box 7466
Portland, ME 04112-7466
Tel: 800-539-0038 Fax: 888-505-8550

6. PROVIDE: The Attending Physician's Statement (Pages 6-7 and/or page 8, if applicable) to the physician(s) treating you. If you have more than one physician, you may make copies or obtain additional Attending Physician's Statements from your employer.

7. PROVIDE: A copy of your Disclosure Authorization to your physician(s).

8. INSTRUCT: Your physician(s) to respond to any requests for information from us by sending requested records to:

UNITEDHEALTHCARE SPECIALTY BENEFITS
PO Box 7466
Portland, ME 04112-7466
Tel: 800-539-0038 Fax: 888-505-8550

ALL PORTIONS OF THIS CLAIM FORM PACKAGE MUST BE COMPLETED TO AVOID UNDUE DELAY IN PROCESSING YOUR REQUEST FOR BENEFITS.

Group Accident Insurance Claim Form

Have you provided the Employee with Instructions and Claim Form?	Mail or fax this form to:
./ Instructions (Page 1) ./ Employee Accident Protection Plan Statement (Page 3) ./ Disclosure Authorization (Page 4) ./ Authorization of Personal Representative (Page 5) ./ Attending Physician's Statement (Page 6-8)	UNITEDHEALTHCARE SPECIALTY BENEFITS PO Box 7466 Portland, ME 04112-7466 Tel: 800-539-0038 Fax: 888-505-8550

TO BE COMPLETED BY THE EMPLOYER
(Please answer all questions)

Employee Name (Last, First, MI)		Group Number	Policy Effective Date (MM/DD/YYYY)
		3040000	01/01/2015
Employee Date of Hire	**Employee Date of Birth**	**Social Security Number**	**Employee Effective Date of Coverage**

If this coverage has been cancelled, please provide the date and reason	Last Date Worked

Employee's Occupation	Employee's Work Status
	__X__ Full-Time _____ Exempt _____ Seasonal _____ Part-Time _____ Non-Exempt _____ Temporary

Number of hours worked per week. _____ Please provide payroll or timesheets for the 3 months prior to the accident.	Plan Level: __X__ Silver _____ Gold _____ Platinum	Insurance Class

Has this claim been considered in connection with worker's compensation coverage? _____Yes _____No

If yes, please provide the present status of the compensation claim, claim number and a copy of the first report of injury.

./ Please attach a copy of the employee's signed enrollment form for the current plan year. - Online Enrollment Only
./ Please attach a copy of the employee's job description if the claim is for the employee.
./ If the claim is being filed for accidental death, please include a copy of the most recent beneficiary designation.

Employer Contribution to Premium? _____Yes __X__ No If yes, _____Pre-tax _____Post-tax

If Post-Tax*: _____% Paid by Employer 100 % Paid by Employee

*If this section is blank, we will assume 100% employer contribution and any benefit may be considered taxable income.

Employer Signature

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Employer (Name of policyholder, if other)	Address		
Grande Cheese Company	Hwy 49 Dairy Rd.		
City	**State**	**Zip Code**	**Phone Number**
Brownsville	WI	53006	920-269-7200

Name (please print)	Title

Signature of person completing form	Date

Group Accident Insurance Claim Form

Please be sure to send (1) The date(s) of treatment (2) Diagnosis (ICD-9) codes (3) Copies of any related itemized bills - doctor, ambulance, emergency room, hospital, and physical therapy. These items can be obtained directly from your health care provider(s).

TO BE COMPLETED BY THE CLAIMANT OR BENEFICIARY

Employee Name (Last, First, MI)	Gender ___ M ___ F	Date of Birth	Social Security Number

Relationship to Employee _____Spouse _____Dependent _____Self _____Domestic Partner _____Beneficiary _____Other

Name (Claimant or Beneficiary)	Gender ___ M ___ F	Date of Birth	Social Security Number (Claimant or Beneficiary)

Mailing Address (Street or PO Box)	Home Telephone	Alternate Telephone

City	State	Zip Code

Check One: _____On-Job _____Off-Job Date the accident occurred (not when treated) _____

Give a brief description of the accident

If applicable, please attach a copy of your accident or police report giving details of the accident, a copy of the toxicology report if you were the driver in a motor vehicle accident, and a copy of a certified death certificate, if requesting death benefits.

If the patient's companion required lodging as a result of the patient's hospital confinement, please submit the hotel receipt(s). Hospital confinement must meet the mileage requirement stated in the policy. Please check the policy for the mileage requirement and to verify this expense is covered.

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

CLAIMANT OR BENEFICIARY SIGNATURE (If under age 18, signature of parent or guardian is required)

Name (please print)	Parent or Guardian Name (if applicable, please print)
Signature	Date

Disclosure Authorization

(To be Completed by the 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 Unimerica Life Insurance Company, Unimerica Life Insurance Company of New York, 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 800-539-0038 Fax 888-505-8550

Authorization of Personal Representative

(To be Completed by the Employee, if Applicable)

At my request, and for my convenience, I, _____hereby authorize Unimerica Life Insurance Company, Unimerica Life Insurance Company of New York, UnitedHealthcare Insurance Company (Company) and any representatives thereof involved in the administration of my group accident 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 the 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 the 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: _____

RETURN TO: UnitedHealthcare
Specialty Benefits PO Box 7466
Portland ME 04112-7466
Tel 800-539-0038 Fax 888-505-8550

Group Accident Insurance Claim Form

TO BE COMPLETED BY TREATING PHYSICIAN, SURGEON OR PROVIDER			
Patient Name (Last, First, MI)	Gender ___ M ___ F	Date of Birth	Patient Address
Insured's Name (Last, First, MI) *If different from patient	Gender ___ M ___ F	Date of Birth	Insured's Address *if different from patient
Patient's Relationship to Insured: _____Self _____ Spouse _____Child _____ Other		Was the accident related to the patient's employment? _____Yes _____No	
Date first consulted for this accident	Date of accident	Expected Return to Work Date	
Name and address of referring physician(s) (if applicable)			
For services related to hospitalization, please provide hospitalization dates Admitted_____ Discharged_____		Name and address of facilities where services were rendered	
Is this an HIV occupational injury? _____Yes _____ No Date of initial HIV antibody test			

Please fully describe procedures, medical services and/or supplies furnished for each date given.

Date of Service	Place of Service	Procedure Code *See Below	Procedure Description	Diagnosis Code (ICD9)	Other

Place of Service Codes: 11-Dr's Office 12-Patient's Home 21-Inpatient Hospital 22-Outpatient Hospital 23--Emergency Room Hospital 32-Nursing Facility 41-Ambulance Land 42-Ambulance Air/Water 61-Comprehensive Inpatient Rehabilitation Facility 62-Comprehensive Outpatient Rehabilitation Facility _____- Other (Please Specify)

Continue to page 7

Group Accident Insurance Claim Form

(continued from page 6)

TO BE COMPLETED BY PHYSICIAN, SURGEON OR PROVIDER

Section 1 (Complete if patient is claiming a disability related to this accident.)

Physical impairment (*as defined in the Federal Dictionary of Occupational Titles)

_____ Class 1 No limitations of functional capacity; capable of heavy work. No restrictions (0-10%)
_____ Class 2 Medium manual activity (15-30%)
_____ Class 3 Slight limitation of functional capacity; capable of light work (35-55%)
_____ Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (60-70%)
_____ Class 5 Severe limitations of functional capacity; incapable of minimum (sedentary) activity (75-100%)

Section 2 (Complete if patient is claiming a disability related to this accident.)

Mental Impairment (if applicable):

_____ Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitations)
_____ Class 2 Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitation)
_____ Class 3 Patient is able to engage in only limited stress situations/engage in only limited interpersonal relations (moderate limitation)
_____ Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation)
_____ Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitation)

Section 3 (Complete if patient is claiming a disability related to this accident.)

Please describe any limitations* your patient has in his/her activities (*limitations - activities that cannot be performed)

Section 4 (Complete if patient is claiming a disability related to this accident.)

Please list any restrictions* you have placed on your patient's activities (*restrictions - activities that should not be done to prevent worsening of the injury)

HEALTHCARE PROVIDER SIGNATURE

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Health Care Provider Name (Please Print)	Specialty	Telephone	
Address	City	State	Zip Code
Signature	Date	Medical ID #	

Are you, the physician, related to this patient? _____Yes _____ No If yes, what is the relationship? _____

Group Accident Insurance Claim Form

TO BE COMPLETED BY THE ATTENDING PHYSICIAN IF THE CLAIMANT IS REQUESTING A DISMEMBERMENT CLAIM

Patient Name (First, Last, MI)	Date of Birth	Date first consulted for the injury described	Date of last treatment

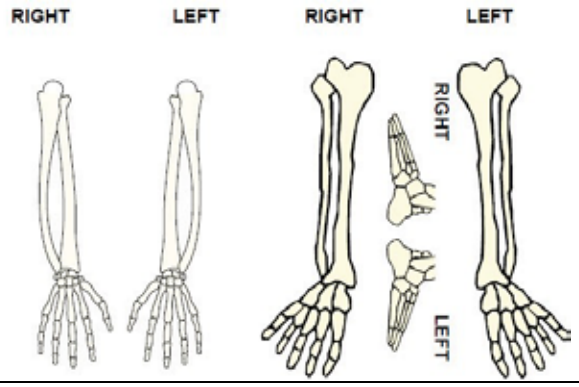
Describe the exact nature, location, and extent of all injuries sustained

To be completed for amputations

Which limbs were severed or amputated?

State the dates on which the severances of amputations occurred.

State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or knee joint indicate on the chart the exact point of severance.



State the cause of the amputations.

Please give the names of other physicians that have attended this patient and the dates of their first and last treatments reported to you.

Was the injury described solely responsible for the loss? _____ Yes _____ No
If, not please give the particulars of any contributing cause or causes.

To be completed only for loss of vision

Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notations) or less with correction and the vision remaining in each eye.

Date: _____

Snellen Notations: O.D.v / Uncorrected / Corrected /
O.S.v / / /

Give the date and vision found on last eye examination.

Date: _____

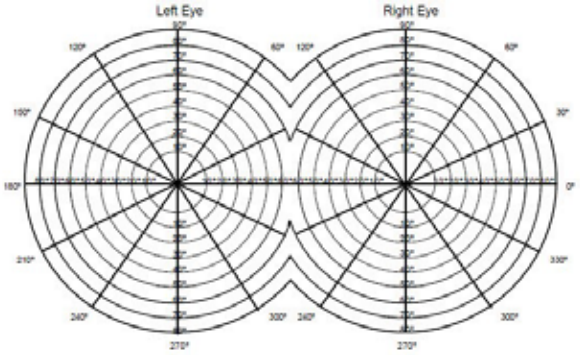
Snellen Notations: O.D.v / Uncorrected / Corrected /
O.S.v / / /

State the case of loss of vision.

Indicate whether recover or useful vision is possible by operation or treatment.

O.D. _____Operation ____Treatment
O.S. _____Operation ____Treatment

If the fields of vision are contracted, show contraction on chart below.



HEALTHCARE PROVIDER SIGNATURE

I acknowledge that I have read the applicable Fraud Warning Notices provided with this claim form.

Health Care Provider Name (Please Print)	Specialty	Telephone	
Address	City	State	Zip Code
Signature	Date	Medical ID #	

Are you, the physician, related to this patient? _____Yes _____ No If yes, what is the relationship? _____

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 claimants in California:

UnitedHealthcare may terminate your coverage and/or deny any claim under the policy if it is determined that you: knowingly, and with actual intent to deceive, presented false information in this application; and such statement was the basis for UnitedHealthcare's approval of your coverage under the policy.

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.

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.