Group Life Accidental Dismemberment Claim Form Packet

Products and financial services provided by
American United Life Insurance Company® | *a* OneAmerica® *company*
One American Square, P.O. Box 7106 | Indianapolis, Indiana 46207-7106 | 1-800-553-3522 | www.employeebenefits.aul.com

G-23773 12/10/12

Group Life Accidental Dismemberment Claim Form

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One American Square, P.O. Box 7106
Indianapolis, IN 46207-7106
Toll-Free (800) 553-3522
Fax (317) 285-7666
www.employeebenefits.aul.com

OneAmerica®

INSTRUCTIONS – PLEASE READ CAREFULLY

- Note: This form should only be used when the group insurance policy contains a provision for Accidental Dismemberment benefits.
- All questions must be answered fully and accurately before American United Life Insurance Company® (AUL) can determine if benefits are owed under the policy.
- A copy of each application/enrollment form for coverage with AUL for this insured or dependent spouse must be attached.
- Completed forms and communications should be sent to: Employee Benefits Claims Department, American United Life Insurance Company®, P.O. Box 7106, Indianapolis, Indiana 46207-7106. A completed and signed HIPAA authorization form along with a copy of any police report, medical records, and newspaper accounts related to the incident are required to be submitted along with this form.

G-6294 11/7/12

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CLAIMANT'S STATEMENT

Claimant's Full Name	Gender ☐ M ☐ F	Relationship to Insured	Date of Birth	Social Security Number

Home Address

Street City State Zip Code Phone Number

Date of Accident	Date first treated by medical provider for this loss	Email Address

List all medical providers seen following this accident

	Address	Dates of Treatment
Dr.		
Dr.		

List all medical facilities where you were treated for this accident

Name of Medical Facility	Address	Dates of Treatment

Describe in detail the accident

The undersigned represents and warrants any information or document provided to American United Life Insurance Company® (AUL) by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees: 1) any insurance coverage or benefit is contingent upon any statement made to AUL as being complete and correct, and 2) benefits under any policy will be paid only if AUL decides in its discretion the applicant is entitled to them. The undersigned has read, understood, and retained the notices, limitations, and exclusions for his/her records.

I authorize AUL to be able to request, obtain, and review any information necessary for: determining eligibility for insurance, determining eligibility for benefits and/or detecting or preventing fraud or misrepresentations. The authorization is directed, but not limited to any organization or person that has records or information about the accident, me or my medical records, my mental or physical condition, diagnosis, treatment or prognosis. This includes my employer, any medical provider, another insurance company, consumer reporting agencies, governmental agencies, and any other entity which may possess information related to this claim. This information may also be given by AUL to its representatives, investigators, consumer reporting agencies or its other insurance support agencies. This is valid during the pendency of the claim and shall expire on the date the claim finally ends, in 24 months, or when revoked in writing by me, whichever is later. I understand my revocation or failure to sign this authorization will impair AUL's ability to evaluate my claim and therefore can be a basis for denial of benefits under the policy. I can receive a copy of this authorization and I agree a copy of this authorization may be considered as a substitute for the original.

Date _____

Signature _____
This must be signed by the claimant, or if the claimant is not competent and/or physically able to complete the form, then the person's legal representative (spouse, parent, Power of Attorney, guardian, attorney).

EMPLOYER'S STATEMENT Enclose a copy of each application for coverage for this employee.

Name of Employee	Group Policy Number	Social Security Number	Amt. of Salary ☐ Weekly ☐ Monthly ☐ Annual

Amount of Basic Insurance Coverage	Amount of Supplemental/Voluntary Coverage	Amount of Benefits claimed for this Loss	Employee's Effective Date of Insurance

Employee's Hire Date	If claim is for employee, what was the last day the insured was physically at work?	Employee's Occupation and Position	Is the claimant's coverage in force? ☐ Yes ☐ No	Date to which premiums were paid for claimant

If this claim is for a Dependent Spouse, please provide the following information:

Name	Effective Date	Amt. of Basic Coverage	Amt. of Voluntary Coverage

When and where did accident occur?

Date	Time	Location	Did accident occur in course of employment? ☐ Yes ☐ No

Description of Accident

The employer/policyholder represents and warrants any information or document provided to AUL by the employer/policyholder prior to and after the date coverage became effective and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The employer/policyholder understands and agrees: 1) any insurance coverage or benefit is contingent upon any statement made to AUL as being complete and correct, and 2) benefits under any policy will be paid only if AUL decides in its discretion the applicant is entitled to them.

Employer/Policyholder ..... Address .....

Phone No. ..... Ext. .... City State Zip Code

Date ..... Email .....

By ....
Title and Printed Name of Authorized Representative (required) Signature of Authorized Representative (required)

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www.employeebenefits.AUL.com

ATTENDING PHYSICIAN'S STATEMENT

Complete portion of form that applies to loss incurred

Any expense associated with the completion of this form is the claimant's responsibility and will not be reimbursed by AUL.

Name of Claimant	Date of first treatment of claimant	Date of accident causing present loss

LOSS OF LIMB DUE TO AMPUTATION

1. *Did claimant lose either hand, foot, or thumb and index finger on the same hand due to said accident?*

2. *If yes, please indicate whether above or below the wrist or the ankle by circling the correct response.*

Right hand { above / below } *wrist: – Date of amputation* . . . . . *Right foot* { above / below } *ankle: – Date of amputation* . . . . . .

Right thumb and index finger – Date of amputation . . . . . .

Left hand { above / below } *wrist: – Date of amputation* . . . . . *Left foot* { above / below } *ankle: – Date of amputation* . . . . . .

Left thumb and index finger – Date of amputation . . . . . .

3. *Was the amputation due solely to above mentioned accident?* ☐ *Yes* ☐ *No*

3.(b) Give detail of accident.

3.(a) If not, was there any disease or condition prior to the date of the accident which might have served as a contributory cause? ☐ *Yes* ☐ *No*

4. *If medical providers other than yourself treated insured for this condition, please give the following:*

	Name of Medical Provider	Address	Date Treated
a.			
b.			

LOSS OF USE DUE TO PARALYSIS

1. *Did claimant lose use of upper and/or lower limbs of the body due to said accident?* ☐ *Yes* ☐ *No*

2. *If yes, please indicate which of the plegia conditions apply.*

Quadriplegia or Loss of Use of Upper and Lower Limbs of the Body . . . . . *Date of Loss* . . . . . .

Paraplegia or Loss of Use of Both Lower Limbs of the Body . . . . . *Date of Loss* . . . . . .

Herniplegia or Loss of Use of Upper and Lower Limbs on the Same Side of the Body . . . . . *Date of Loss* . . . . . .

Uniplegia or Loss of Use of One Limb of the Body . . . . . *Date of Loss* . . . . . .

3. *Was the loss of said limb due solely to the above mentioned accident?* ☐ *Yes* ☐ *No*

3.(a) If not, was there any disease or condition prior to the date of the accident, which might have served as a contributory cause?

3.(b) Give details of accident.

4. *If medical providers other than yourself treated insured for this condition, please give the following:*

	Name of Medical Provider	Address	Date Treated
a.			
b.			

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ATTENDING PHYSICIAN'S STATEMENT (continued)

Complete portion of form that applies to loss incurred

SEVERE BURNS

1. *Did claimant suffer burns due to said accident?* ☐ *Yes* ☐ *No*

2. *If yes, please indicate which of the conditions apply.*

   First degree, second degree or third degree burns . . . . . *Date of Loss* . . . . .

   What percentage of the body had third degree burns? . . . . . *Date of Loss* . . . . .

3. *Give accident details.*

4. *Were the burns the result of this accident?* ☐ *Yes* ☐ *No*

5. *If not, please provide details.*

4. *If medical providers other than you treated the insured for this condition, please provide the following:*

	Name of Medical Provider	*Address*	*Date Treated*
a.			
b.			

LOSS OF SIGHT

Note – Please use Snellen notation or its equivalent

1. *Record of Vision.*

		Uncorrected		*Corrected*	
a. Date of first observation	*R.E.*	*L.E.*	*R.E.*	*L.E.*	
b. Date of last observation	*R.E.*	*L.E.*	*R.E.*	*L.E.*	

2. *From what date has vision recorded in question 1b existed?*

   Right Eye *Left Eye*

3. *If patient is totally blind give the date this occurred*

   Right Eye *Left Eye*

4. *If eye has been enucleated give date*

   Right Eye *Left Eye*

5.(a) *In your opinion can vision be improved by treatment, operation or lenses?*

(b) *State what you have recommended*

6. *Give diagnosis and brief description of existing eye condition*

7. *Was loss of sight due solely to above mentioned accident?* ☐ *Yes* ☐ *No*

7.(b) *State briefly details of the accident*

7.(a) *If not, was there any disease or condition prior to the date of the accident which might have served as a contributory cause? Give details.*

8. *If medical providers other than yourself treated claimant for this condition, please give the following:*

	Name of Medical Provider	*Address*	*Date Treated*
a.			
b.			

9. *If treated at a medical facility give name of institution with dates of admission and discharge:*

Medical Facility	*Date Admitted*	*Date Discharged*

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ATTENDING PHYSICIAN'S STATEMENT (continued)

Complete portion of form that applies to loss incurred

LOSS OF SPEECH AND HEARING

1. *Please indicate when the loss of speech occurred.*

2. *Please indicate when the loss of hearing occurred.*

3. *Please indicate when the loss of speech and hearing occurred.*

4. *Give diagnosis and brief description of existing condition.*

5. *Was loss due solely to above-mentioned accident?* ☐ *Yes* ☐ *No*

5.(a) *State briefly details of the accident.*

5.(b) *If not, was there any disease or condition prior to the date of the accident which might have served as a contributory cause? Give details.*

6. *If medical providers other than yourself treated claimant for this condition, please give the following:*

	Name of Medical Provider	*Address*	*Date Treated*
a.			
b.			

7. *If treated at a medical facility give name of institution with dates of admission and discharge:*

Medical Facility	*Date Admitted*	*Date Discharged*

The undersigned medical provider represents and warrants any information or documents provided to AUL by this medical provider and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.

Date _____ Physician's Name _____
(Please print) *Title*

Phone: _____ Ext. _____ Signature _____

Address _____

_____
City *State* *Zip Code*

Email Address: _____

Fraud Warnings *(For use in AL, AR, DC, LA, NM, TX and WV)*

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.

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.

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.

California

For your protection California law requires the following to appear on this form. Any person who knowingly presents 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.

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 or 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.

Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any statement of claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance 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.

Maine, Tennessee, 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland, Rhode Island

Any person who knowingly or willfully presents a false or fraudulent claim for payment of 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.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire, Ohio

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

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any 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 a person to criminal and civil penalties.

Virginia

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 or a denial of insurance benefits.

American United Life Insurance Company®
Pioneer Mutual Life Insurance Company*
The State Life Insurance Company

Authorization for the Release of Health-Related Information
(HIPAA-Compliant Form)

_____ _____
Name of Proposed Insured/Patient (Please type or print.) Date of Birth

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider; insurance company; the MIB, Inc. (formerly known as Medical Information Bureau); or other organization or person that has provided payment, treatment or services to me or on my behalf within the past 10 years or has any records or knowledge of my health within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the partners of OneAmerica Financial Partners, Inc., as listed above. This includes information on the diagnosis or treatment of human immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that partners of OneAmerica® may:

1) underwrite my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
2) obtain reinsurance;
3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) administer coverage; and
5) conduct other legally permissible activities that relate to any coverage I have or have applied for with a OneAmerica financial partner.

This authorization shall remain in force for twenty-four (24) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Attention: Privacy Officer, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206.

Please <u>DO NOT</u> send medical records, etc. to the Privacy Officer – this will delay the process because the Privacy Officer does not review records or handle billing.

I understand that a revocation is not effective to the extent that any of My Providers have already relied on this authorization to disclose information about me or to the extent that OneAmerica partners have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by any OneAmerica partner except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, OneAmerica partner companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Signature of Proposed Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

**A stock subsidiary of American United Mutual Insurance Holding Company.*

Examiner's Name: _____ **Return to: Employee Benefits Claims – Buzz G225**