

# Statement of Claim for Child Care Benefit

Products and financial services provided by  
American United Life Insurance Company®  
a ONEAMERICA® company  
One American Square, P.O. Box 7106  
Indianapolis, IN 46207-7106  
(317) 285-1877  
1-800-553-3522  
Fax: (317) 285-7666  
www.employeebenefits.aul.com



## Instructions – Please read carefully – Complete and submit one claim form for each Eligible Child

- 1) This form must be completed by the Beneficiary and Child Care Facility when your group insurance policy contains a provision for Child Care Benefits or Dependent Spouse Child Care benefits.
- 2) All questions must be answered fully and accurately before American United Life Insurance Company® (AUL) can determine if benefits are owed under the policy.
- 3) The Beneficiary should complete Section I in its entirety. If not already submitted, please attach: (a) a certified copy of the decedent's Death Certificate; (b) a copy of the decedent's last Federal Income Tax Return showing the child as a dependent; (c) a copy of documentation from the Child Care Facility showing the Child's enrollment in that facility before and after the decedent's death; (d) documentation from the Child Care Facility showing payment of Child Care Expenses before and after the decedent's death; and (e) a copy of the child's birth certificate.
- 4) The Child Care Facility should complete Section II in its entirety and provide a copy of the Facility's State License.
- 5) All communications and completed forms should be sent to: **Employee Benefits Claims Department**, American United Life Insurance Company®, P. O. Box 7106, Indianapolis, Indiana 46207-7106.

## Section I – Statement of Beneficiary – This section to be completed by Beneficiary

Name of Beneficiary: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Address of Beneficiary: \_\_\_\_\_  
Street City State Zip Code

Beneficiary's Social Security Number: \_\_\_\_\_

Name of Eligible Child: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Child's Age: \_\_\_\_\_

Child's relationship to Decedent (check one):  Natural  Adopted  Step-Child  Guardianship

Other (Explain): \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Policyholder Number: \_\_\_\_\_

Name of Decedent: \_\_\_\_\_

Is the decedent the  Insured or  Dependent Spouse?

If the decedent is the dependent spouse, please advise the name of the insured employee.

The undersigned represents any information or documents provided to 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 that: 1) insurance coverage or benefits are contingent upon statements made to AUL as being complete and correct; and 2) benefits under any contract will be paid only if AUL decides in its discretion the applicant is entitled to them. The undersigned has read, understands, and retained the notices, limitations, and exclusions for his/her records.

Printed Name of Beneficiary (required) Beneficiary's Signature (required) Date

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**Section II – Statement of Child Care Facility – This section to be completed by Child Care Facility**

Name of Child Care Facility: \_\_\_\_\_

Facility Address: \_\_\_\_\_  
Street City State Zip

Child’s name: \_\_\_\_\_ Date child enrolled in this facility: \_\_\_\_\_

Dates of attendance before and after decedent’s date of death: From: \_\_\_\_\_ To: \_\_\_\_\_

Is this a State Licensed Facility (check one)?  Yes  No

Tax Identification Number of Facility: \_\_\_\_\_ Attach a copy of the State License for the facility.

The undersigned represents any information or documents provided to AUL by the undersigned and the facts and other matters contained in the foregoing are true and accurate to the best of the Child Care Facility’s knowledge and belief.

\_\_\_\_\_  
Printed Name of Child Care Facility Representative (required) Signature of Child Care Representative (required)

Date: \_\_\_\_\_ Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

**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.