Group Life Insurance – Proof of Death Claim Form

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
1-800-553-3522
Fax 317-285-7666
www.employeebenefits.aul.com

INSTRUCTIONS – PLEASE READ CAREFULLY AND SUBMIT ALL REQUIRED INFORMATION

This form is to be completed by the Employer.

- An authorized representative of the Employer should complete Section I and include all forms requesting group life insurance coverage.
- Enclose all historic and current beneficiary forms for group life insurance.
- Proof of Death must be furnished without expense to American United Life Insurance Company® (AUL). Each question must be answered completely, accurately, and truthfully. AUL reserves the right to obtain further information needed to determine eligibility for benefits and the proper payee.
- An original certified death certificate is required.
- If the policy offers Accidental Death Benefits and accidental death may have occurred, the following will need to be supplied to AUL: a) police reports, b) any newspaper stories about the incident, c) toxicology reports, d) autopsy report, and e) medical reports related to treatment following the incident.
- If the policy offers a Repatriation Benefit, an accidental death occurred, and occurred outside of the United States, the following will need to be supplied: a) written documentation showing the location of the insured's death, and b) written documentation showing the amount incurred for the transportation expenses for returning the insured.
- When proceeds are payable to the Estate of the Insured, Trust, or a minor or mentally incompetent beneficiary, the legal representative (i.e. Executor, Trustee, Guardian, Conservator) must supply legal documentation showing his authority to receive and deposit the funds, the correct TIN using IRS Form W-9, and a copy of a bank account statement showing an account has been opened in the name of the payee (i.e. Estate, Trust, Guardianship, Conservatorship).
- If no beneficiary has been designated and an estate will not be opened, the proceeds might be able to be paid using a small estate affidavit (assuming amount owed is below state dictated amount). A copy of the obituary, and a copy of the closest surviving relatives' driver's license(s) to verify the individual's relationship to the decedent should be submitted to allow AUL to evaluate if the affidavit is viable.

Completed forms and communications should be sent to:

Employee Benefits Claim Department
American United Life Insurance Company®
PO Box 7106
Indianapolis, IN 46207-7106

Or

Fax (317) 285-7666

Or

Email: lifeclaims.employeebenefits@oneamerica.com

Group Life Insurance – Proof of Death Claim Form

Notice of claim for:

☐ Employee

☐ Dependent

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
1-800-553-3522
Fax 317-285-7666
www.employeebenefits.aul.com

OneAmerica®

Section I: Statement of Employer – To be completed by Employer

Policyholder Name: _____ Policyholder Number: _____

Employee Name: _____ Gender: ☐ Male ☐ Female

Employee Address: _____

City State Zip

Employee Social Security Number: _____ Employee Date of Birth: _____

Employee Hire Date: _____ Number of Hours Worked Per Week: _____

Effective Date of Employee Insurance: _____ Was Evidence of Insurability required? ☐ Yes ☐ No

Employee Occupation: _____ Employee Class: _____

Date Employee was last Physically/Actively at Work: _____

Was Employee given Application to Port or Convert Group Coverage? ☐ Yes ☐ No Date given: _____

How was notice of portability or conversion given? _____

Date through which premiums are paid for this employee: _____

Gross Annual Salary $ _____	Employee is: ☐ Hourly ☐ Executive ☐ Management (check all that apply) ☐ Salaried / Non-exempt ☐ Salary/Exempt ☐ Bargaining ☐ Non-bargaining

Does Gross Amount Salary include: ☐ Commissions ☐ Bonuses ☐ Overtime

For Union Groups Only:

Date to which all dues and assessments were paid for this employee: _____

Was member in good standing on coverage effective date? ☐ Yes ☐ No

Was member in good standing at his (or dependent's) date of death? ☐ Yes ☐ No

Indicate reason for date last Physically/Actively at Work:

☐ 1. Termination of Employment

☐ 2. Reduction of Hours

☐ 3. Layoff ☐ Permanent ☐ Temporary

☐ 4. Retirement: Date of Retirement _____

☐ 5. Disability: Date of Disability _____

☐ 6. Entered Active Military Service: Date Entered _____

☐ 7. Other _____

☐ 8. FMLA ☐ Self ☐ Family

☐ 9. Leave of Absence

☐ 10. Illness/Injury: Date of Illness/Injury _____

Contact Information for Employee claim - Please provide the following information for each individual listed on the beneficiary form(s).

First Name	Last Name	Birthdate	Social Security Number	Phone Number	Mailing & Email Address

Group Life Insurance – Proof of Death Claim Form

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
1-800-553-3522
Fax 317-285-7666
www.employeebenefits.aul.com

OneAmerica®

Employee Name: _____ Policyholder Name/Number: _____

Section I: Statement of Employer – To be completed by Employer (continued)

Employee Claim - (Please complete this section if claim is for Employee)

Date of Death: _____

Did employment cease prior to death? ☐ Yes ☐ No

If "Yes", was the Employee on an Approved Leave of Absence? ☐ Yes ☐ No

If "Yes", what type of Leave of Absence? _____

Identify all coverages and amounts of claim:

☐ Basic Term Life	Class _____	Volume _____
☐ Basic AD&D	Class _____	Volume _____
☐ Voluntary Term Life	Class _____	Volume _____
☐ Voluntary AD&D	Class _____	Volume _____
☐ Supplemental Life	Class _____	Volume _____

Dependent Claim - (Please complete this section if claim is for a Dependent)

Name of Dependent: _____ Relationship to the Employee: _____

Dependent's Date of Birth: _____ Dependent's Social Security Number: _____

Marital Status of Dependent: _____ Is Dependent a Full-Time Student? ☐ Yes ☐ No

If Dependent Child is over 19 and a full-time student, please send documentation from the educational institution of full-time student status and a copy of the employee's most recent federal tax return.

Effective Date of Dependent Insurance: _____ Was Evidence of Insurability required? ☐ Yes ☐ No

Date through which premiums are paid for this dependent: _____ Dependent's Date of Death: _____

Identify all coverages and amounts of claim:

☐ Basic Dependent Term Life ☐ Spouse ☐ Child	Class _____	Volume _____	Option # _____
☐ Basic Dependent AD&D ☐ Spouse ☐ Child	Class _____	Volume _____	Option # _____
☐ Voluntary/Supplemental Dependent Life ☐ Spouse ☐ Child	Class _____	Volume _____	Option # _____
☐ Voluntary/Supplemental Dependent AD&D ☐ Spouse ☐ Child	Class _____	Volume _____	Option # _____

The undersigned represents and warrants information or documents 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, understands, and has retained the notices, limitations, and exclusions for his/her records.

Policyholder: _____ Policyholder Number: _____

Address: _____
Street Address City State Zip

Phone Number: _____ Fax Number: _____

Email Address: _____

Date: _____

_____ _____
Printed Name & Title of Authorized Representative Signature of Authorized Representative

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**