Statement of Claim for Waiver of Premium Group Life Insurance 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

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Statement of Claim For Waiver of Premium

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a OneAmerica® company
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Indianapolis, IN 46207-7106
(800) 553-3522
Fax: (317) 285-7666
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OneAmerica®

Section I – Statement of Employer – This section to be completed by Employer

ENCLOSE A COPY OF EACH APPLICATION FOR COVERAGE AND A JOB DESCRIPTION FOR THIS EMPLOYEE.

Employee's Name _____ Social Security No. _____

Date of Birth _____ Occupation _____

Date Employed _____ Effective Date of Employee's Insurance _____ Class _____

Hours worked per week _____ Was Evidence of Insurability required? ☐ Yes ☐ No

Date premium payment was last made for the employee's life insurance _____

Amount of Insurance: Basic $ _____ Voluntary $ _____ Supplemental $ _____

Any Dependent Life Insurance? ☐ Yes ☐ No If yes, is coverage for: ☐ Spouse only, ☐ Children only, or ☐ Family

If Spouse only or Family was checked, please provide Social Security Number for the Spouse. _____

Amount of Dependent Insurance: Basic $ _____ Voluntary $ _____ Supplemental $ _____

Employee's last day of active work _____ Annual Salary on that date $ _____ ☐ Hourly ☐ Salary

Reason for ceasing work _____

Has there been any gaps in employment since date of hire? ☐ Yes ☐ No If yes, please explain. _____

Date employee returned to work. Full-Time _____ or Part-Time _____

Is the employee returning to work in an Accommodated Job? ☐ Yes ☐ No

Is this employee receiving, or eligible for, a retirement plan benefit? ☐ Yes ☐ No

If yes, as of what date did/will they begin receiving the retirement plan benefit? _____

If they are not receiving, or eligible for, a retirement plan benefit, then are they receiving, or eligible for a disability retirement plan benefit? ☐ Yes ☐ No

If yes, as of what date did/will they begin receiving the disability retirement plan benefit? _____

Will their disability retirement plan benefit ever automatically roll over to a retirement plan benefit when they reach a certain age? ☐ Yes ☐ No

If yes, as of what age would they begin receiving the retirement plan benefit? _____

The employer/policyholder represents and warrants any information or documents provided to American United Life Insurance Company® (AUL) by the employee/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 it discretion the applicant is entitled to them.

SPECIAL NOTE: Under some contracts, premium must continue to be paid during the Waiver of Premium elimination period. You will need to review your Policy to determine if premium payments are not needed.

Policyholder _____ Policy Number _____
(Name of the Employer or Participating Unit)

Address _____ Fax Number _____

City _____ State _____ Zip Code _____

Printed Name & Title of Authorized Representative *(required)* _____

Signature of Authorized Representative *(required)* _____

Date: _____ Telephone Number: _____ Email: _____

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Section II – Statement of Employee – This section to be completed by Employee

Name _____ Social Security No. _____

Address _____ Telephone Number _____

City _____ State _____ Zip Code _____

Gender: ☐ Male ☐ Female Date of Birth _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Name of Spouse _____ Spouse's Date of Birth _____

Dependent Children's names and dates of birth _____

Employer's Name _____

Employer's Address _____

Employer's City _____ State _____ Zip Code _____

Are you authorized to work/reside in the U.S.A.? ☐ Yes ☐ No Are you receiving any unemployment benefits? ☐ Yes ☐ No

State nature of sickness/illness/injury _____

Have you had this disability or a similar disabling condition before? ☐ Yes ☐ No If yes, please advise the first date of treatment._____

Please list the names and addresses of any other medical providers who have treated you for this condition. _____

_____

_____

_____

When was your last date worked? _____ When do you expect to return? _____

Since you last worked have you worked in any capacity? ☐ Yes ☐ No

Have Social Security Disability Benefits been awarded? ☐ Yes ☐ No

*If yes, **please attach a copy of your Social Security Award notice.**

*If no, what is the status of your Social Security Disability application? _____

Are you receiving disability benefits under a retirement plan? ☐ Yes ☐ No **OR** benefits under a pension plan? ☐ Yes ☐ No

If yes, please explain. _____

Are you receiving any other disability benefits? ☐ Yes ☐ No

If yes, what is the name of the entity paying the benefits? _____

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) any insurance coverage or benefit is contingent upon any statement 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 has retained the notices, limitations, and exclusions for his/her records.

Signature _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT

Return to: American United Life Insurance Company®
Employee Benefits Life Waiver Department
P.O. Box 7106
Indianapolis, IN 46207-7106
1-800-553-3522
Fax: 317-285-7666
www.employeebenefits.AUL.com

Any cost associated with the completion of this form is not the responsibility of AUL and will not be paid by AUL.

Name of Patient _____

Date of Birth _____ Patient's Height _____ Patient's Weight _____

Latest Blood Pressure Reading _____ / _____ As of (date) _____

Date patient became disabled due to present sickness, illness or injury _____

Diagnosis _____ ICD-9 Code(s) _____

Complications resulting from diagnosis _____

Objective findings (including current x-rays, EKG's, biopsy or any other special tests) _____

Subjective symptoms _____

List any restrictions and/or limitations

Date of first visit _____ List all dates of service _____

Frequency of visits _____ Nature of treatment (including surgery dates, therapy, and medications prescribed) _____

Has patient ☐ Recovered? ☐ Unchanged? ☐ Improved? ☐ Retrogressed?

Is patient ambulatory? ☐ Yes ☐ No If yes, please describe gait _____

Is an assistive device necessary for ambulation? ☐ Yes ☐ No Type of Device _____

Names and address of other treating physicians for this condition _____

Mental/Nervous Impairments (if applicable):

a. Please list your findings according to the DSM-IV-TR diagnostic codes. _____

b. Axis V (GAF) findings, please describe: _____

☐ 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 limitations)
☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Functional capacity (American Heart Association):

☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) Ejection fraction rating _____
☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation) as of (date) _____

Physical Impairments (As defined in Federal Dictionary of Occupational Titles):

☐ Class 1 - No limitation 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 limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

Remarks:

When will return to work be possible? ☐ Full-time ☐ Part-time Month/Day/Year _____

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.

Attending Physician's Name *(Please Print)* _____

Board Certified Specialty _____ Telephone Number _____

Address _____ Fax Number _____

City _____ State _____ Zip Code _____

Signature _____ Tax I.D. No. _____ Date _____

(No signature stamps please)

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**