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, IN 46207-7106
Toll Free Phone: 1-800-553-3522
Fax: (317) 285-7666
lifeclaims.employeebenefits@oneamerica.com

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INSTRUCTIONS – PLEASE READ CAREFULLY AND SUBMIT ALL REQUIRED INFORMATION

Each question must be answered completely, accurately, and truthfully. AUL reserves the right to obtain further information needed to determine eligibility for benefits. Failure to provide all information or to complete the entire claim form may delay claim payments.

- This form should only be used when the group insurance policy contains a provision for Accidental Dismemberment benefits.
- Please refer to the group policy/certificate for benefit filing time frames.
- Section I – This section should be completed by the Claimant.
- Section II – This section should be completed by the Employer.
- The Employer should submit all forms requesting or changing group life insurance coverage. This includes, but is not limited to enrollment forms, request to decrease coverage, request to increase coverage and all Guaranteed Increase in Benefit (GIB) forms.
- Section III – This section should be completed by the claimant's attending physician.
- The Authorization for The Release of Health-Related Information should be signed and dated by the claimant. If the form is signed by a personal representative, the personal representation papers (e.g. Power of Attorney Document, Guardianship papers, etc.) should be included with the form.
- Copies of any police reports, medical records, toxicology reports and newspaper accounts related to the incident should be submitted with the claim form.

Completed forms and communications should be sent to:

Employee Benefits Claims Department
American United Life Insurance Company®
P.O. Box 7106
Indianapolis, IN 46207-7106

Or

Fax (317) 285-7666

Or

Email: *lifeclaims.employeebenefits@oneamerica.com*

Overnight Mailing Address:
250 W. North Street
Attn: EB Life Claims
Indianapolis, IN 46202

Group Life Accidental Dismemberment Claim Form

Notice of Claim for:

☐ Employee

☐ Dependent

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Section I – Claimant's Statement

Employee Name: _____ Policyholder Name and Number: _____

Date of Birth: _____ Social Security Number: _____ Gender: ☐ Male ☐ Female

Employee Address: _____

City: _____ State: _____ Zip Code: _____

Employee Daytime Phone Number: _____ Employee Email Address: _____

Claimant's Name *(if different than Employee)*: _____ Claimant Date of Birth: _____

Date of Incident: _____

Was a Police Department involved? ☐ Yes ☐ No If yes, please attach a copy of the original report and provide:

Name of Police Department involved: _____

Police Department Address: _____
Street Address *City* *State* *Zip Code*

Police Department Phone Number: _____ Name of Investigating Officer: _____

Describe in detail the incident:

_____

_____

_____

Date first treated by medical provider for this loss: _____

List all medical providers seen for this incident: *(attach additional sheet if necessary)*

Name of Physician	Address/Telephone Number	Treatment Dates

List all medical facilities where you were treated for this incident: *(attach additional sheet if necessary)*

Name of Facility	Address/Telephone Number	Treatment Dates

Please list all over the counter and prescribed medication used prior to and after the incident:
(attach additional sheet if necessary)

Medication	Dosage	Frequency	Prescribed by	Pharmacy

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 any insurance coverage or benefits are contingent upon any statements made to AUL as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

Signature of Employee: _____ Date: _____

Name of Employee *(Please Print)* _____

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Section II – Employer Statement - *To be completed by Employer*

Policyholder Name: _____ Policyholder Number: _____

Employee Name: _____ Employee Daytime Phone Number: _____

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: _____

Date Employee was last Physically/Actively at Work: _____

Date through which premiums are paid for this employee: _____

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

Gross Annual Salary includes: ☐ Commissions ☐ Bonuses ☐ Overtime ☐ Based on W2

Did incident occur in course of employment? ☐ Yes ☐ No

If "Yes", please complete the following questions.

When and where did incident occur? _____

Date: _____ Time: _____ Location: _____

Description of incident:

_____

_____

_____

_____

_____

Identify all coverage classes and amounts of coverage of the Employee. This information is required for claim processing:

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

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Employee Name: _____ Employer Name/Policy Number: _____

Section II – Employer Statement - *To be completed by Employer (continued)*

Dependent Information - (Please complete the entire Statement of Employer 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: _____

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 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 any insurance coverage or benefits are contingent upon any statements made to AUL as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

Policyholder: _____ Policyholder Number: _____

Address: _____
Street Address *City* *State* *Zip Code*

Phone Number: _____ Fax Number: _____

Email Address: _____ Is this plan governed by ERISA? ☐ Yes ☐ No

Date: _____

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

Group Life Accidental Dismemberment Claim Attending Physician Statement

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The treating physician should complete page 4, applicable sections on pages 5 and 6 and signature section on page 6.

Employee Name: _____ Employer Policyholder Number: _____

Section III – Attending Physician Statement

Name of Patient: _____ ☐ Male ☐ Female

Patient Date of Birth: _____

Date of Incident Causing Present Loss: _____ First Date of Treatment: _____

Details of Incident: _____

_____

_____

Loss due to:

☐ Loss of Limb due to Amputation

☐ Loss of Use due to Paralysis

☐ Severe Burns

☐ Loss of Sight

☐ Loss of Speech and/or Hearing

Was the loss due solely to the incident described above? ☐ Yes ☐ No

If No, was there any disease or condition prior to the date of the incident which might have served as a contributory cause? ☐ Yes ☐ No

If Yes, describe the disease or condition: _____

_____

_____

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

Name of Medical Provider	Address/Telephone Number	Treatment Dates

If treated in a medical facility, please give the following:

Name of Facility	Address/Telephone Number	Treatment Dates

Group Life Accidental Dismemberment
Claim Attending Physician Statement

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Employee Name: _____ Employer Policyholder Number: _____

Section III – Attending Physician Statement *(continued)*

I. Loss of Limb due to Amputation – *Check all that apply*

☐ Loss of Hand ☐ Right hand above wrist ☐ Right hand below wrist
☐ Left hand above wrist ☐ Left hand below wrist

☐ Loss of Foot ☐ Right foot above ankle ☐ Right foot below ankle
☐ Left foot above ankle ☐ Left foot below ankle

☐ Loss of Thumb and Index Finger at or above the metacarpophalangeal joint on the same hand
☐ Right hand ☐ Left hand

Date of Amputation: _____

II. Loss of use due to Paralysis – *Check all that 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: _____

☐ Hemiplegia or Loss of Use of Upper and Lower Limb of the Body Date of Loss: _____
☐ Right side ☐ Left side

☐ Uniplegia or Loss of Use of One Limb of the Body Date of Loss: _____

III. Severe Burns

Did patient suffer severe burns? ☐ Yes ☐ No

☐ First Degree Burns ☐ Second Degree Burns ☐ Third Degree Burns

What percentage of the body had third degree burns? _____

IV. Loss of Sight – *Please use Snellen Notation or Equivalent*

Uncorrected Vision: R.E. _____ L.E. _____ Date: _____

Corrected Vision: R.E. _____ L.E. _____ Date: _____

Date of First Observation: _____ Date of Last Observation: _____

Is patient Totally Blind? ☐ Yes ☐ No

If yes, Date of Total Blindness: ☐ R.E. _____ ☐ L.E. _____

Has eye been enucleated? ☐ Yes ☐ No

If yes, Date: ☐ R.E. _____ ☐ L.E. _____

In your opinion, can vision be improved with treatment, operation or lenses? ☐ Yes ☐ No

What is your treatment recommendation? _____

_____

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Claim Attending Physician Statement

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Employee Name: _____ Employer Policyholder Number: _____

Section III – Attending Physician Statement *(continued)*

V. Loss of Speech and/or Hearing

☐ Loss of Speech Date: _____ ☐ Loss of Hearing Date: _____

Please give diagnosis and brief description of existing condition: _____

_____

_____

The undersigned Medical Provider represents and warrants any information or documents provided to American United Life Insurance Company® (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. The undersigned Medical provider acknowledges reading and understanding the state specific fraud statements on page 7.

Attending Physician's Signature: _____ Date: _____

Medical Provider's Name *(Please Print)*: _____

Degree/Speciality: _____

Phone Number: _____ Fax Number: _____ Tax ID# _____

Office Address: _____
Number/Street

_____
City or Town *State* *Zip Code*

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 reward 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 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 and denial of insurance benefits.

Discretionary Authority

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The following discretionary authority rights shall apply to all Life Insurance policies except the states below:

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if American United Life Insurance Company® (AUL) decides in its discretion the claimant is entitled to them. Except for the functions the policy explicitly reserves to the Participating Unit or Trustee, AUL reserves the right to: 1) manage the policy and administer claims under it; and 2) interpret the provisions and resolve any questions arising under it.

AUL's authority includes, but is not limited to, the right to:
1) establish and enforce procedures for administering the policy and claims under it;
2) determine participants' eligibility for coverage and entitlement to benefits;
3) determine what information it reasonably requires to make such decisions; and
4) resolve all matters when a claim review is requested.

Any decision that AUL makes, in the exercise of its authority, will be conclusive and final subject to any rights under applicable laws such as the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA.

Such discretionary authority shall not apply in the following states:

1. Arkansas
2. California
3. Hawaii
4. Kentucky
5. Illinois
6. Maine
7. Montana
8. New Jersey
9. New York
10. Oregon
11. Rhode Island
12. Vermont
13. Washington
14. Non-ERISA governed policies in New Hampshire and Utah

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 DO NOT 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 2825**