# Lump Sum Disability Insurance Claim Packet

*Products and financial services provided by*
*American United Life Insurance Company®*
*a OneAmerica® company*
*P.O. Box 7003*
*Indianapolis, IN 46207*
*1-855-517-6365*
*Fax 1-844-287-9499*
*disability.claims@oneamerica.com*

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## Lump Sum Disability Insurance Filing Instructions

**INSTRUCTIONS – PLEASE READ CAREFULLY**

- All questions must be answered fully and accurately before a decision on benefit entitlement can be made.
- The Employee's Statement for Lump Sum Disability Insurance Claim form should be completed by the Employee.
- The Employee should enclose a copy of his/her driver's license or other government issued photo ID.
- The Employee should read, sign and date the Authorization for Release of Information form.
- The Policyholder's Statement for Lump Sum Disability Insurance Claim form should be completed by the Employer.
- The Employer should attach a copy of the employee's current job description.
- The Employer should attach a copy of the employee's enrollment forms.
- The Attending Physician's Statement for Lump Sum Disability Insurance Claim should be completed by the primary medical provider treating the Employee for the conditions related to this injury or sickness.
- The Employee should complete the Direct Deposit Authorization Agreement if he/she wishes to have payment deposited into his/her bank account. Banking information specified on the form should be attached.

If you have questions when completing this form, please call a claims representative at 1-855-517-6365.

Completed forms and communications should be sent to:

American United Life Insurance Company®
P.O. Box 7003
Indianapolis, IN 46207

Or

Fax: 1-844-287-9499

Or

*disability.claims@oneamerica.com*

# Lump Sum Disability Insurance
# Policyholder's Statement

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## Policyholder's Statement for Lump Sum Disability Insurance Claim Form

**Please enclose a copy of all enrollment forms and a current job description for this employee.**

Employer Name: _____ Policyholder Number: _____

Employee Name: _____ Employee Phone Number: _____

Employee Address: _____

City: _____ State: _____ Zip Code: _____

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

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

Effective Date of Employee Insurance: _____

Date Employee was last physically/Actively at Work: _____

Reason for stopping work: ☐ Sickness/Injury ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ FMLA
☐ Other Leave of Absence ☐ Other Reason: _____

Is sickness or injury due to employment? ☐ Yes ☐ No

If "Yes", has Employee filed a Worker's Compensation Claim? ☐ Yes ☐ No

Date returned to work: _____ ☐ Full-Time ☐ Part-Time

If part-time, number of hours worked per week: _____

If Employee has not returned to work, estimated return to work date: _____

Date employment terminated: _____ Date insurance coverage terminated: _____

Employee occupation: _____ Insurance Class/Option: _____

Employee is: ☐ Hourly ☐ Salary ☐ Executive ☐ Management ☐ Salaried/Non-exempt

(Check all that apply) ☐ Bargaining ☐ Non-bargaining

Are the Employee's wages subject to FICA tax? ☐ Yes ☐ No

If "Yes", is Employee subject to: ☐ Full FICA tax ☐ Medicare portion only

Percentage of Employee/Employer contribution to premium for this disability coverage (as of policy year of disability):

Employee ☐ 100% ☐ Other _____ % Is Employee contribution: ☐ Pre-tax deduction

Employer ☐ 100% ☐ Other _____ % ☐ Post-tax deduction

The undersigned represents any 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 that any insurance coverage or benefits are contingent upon any statements made to AUL or its third party administrator 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.

_____ _____
Name of Policyholder (Company) Print Name & Title of Official Representative

_____ _____
Mailing Address of Policyholder (Company) Signature

_____ _____
Telephone Number Fax Number

_____ _____
Email Address Date



G-24113 (Packet) 7/19/19

# Lump Sum Disability Insurance
# Employee's Statement

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## Employee's Statement for Lump Sum Disability Insurance Claim Form

**To avoid processing delay, all questions must be answered fully and accurately.**
A copy of your driver's license or other government issued photo ID must be attached.

Employee Name: _____ Policyholder Name and Number: _____

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

Employee Address: _____

City: _____ State: _____ Zip Code: _____

Employee Phone Number: _____ Employee Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Name of Spouse: _____ Spouse's Date of Birth: _____

Spouse's Gender: ☐ Male ☐ Female

Dependent Children's names and dates of birth: _____

_____

Name of Employer: _____ Employer Phone Number: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Your Occupation and Title: _____

Are you? ☐ Right Handed ☐ Left Handed

Essential duties of your job at the time of the sickness or injury: _____

How many hours were you regularly working per week with your present employer? _____

Are you authorized to work/reside in the U.S.? ☐ Yes ☐ No

Was your job modified after the onset of symptoms? ☐ Yes ☐ No

If "Yes", why? _____

Did/Do you have any other income producing activities or are you self employed? ☐ Yes ☐ No

If "Yes", please describe your activity, job, number of hours worked per week, earnings, and how long you have been working in this capacity: _____

_____

Are you currently in military service? ☐ Reserves ☐ Active Date active service began: _____

Date of injury or date first noticed symptoms: _____ Date you last worked: _____

Date returned to work: _____ ☐ Full Time ☐ Part Time

Describe how and where sickness and/or injury occurred or describe the onset and nature of your condition including symptoms. If more space is needed, attach sheet of paper. _____

What events led up to your need to file this claim? _____

_____

Describe your current treatment plan for the sickness and/or injury: _____

_____

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Employee Name: _____ Policyholder Name and Number: _____

Does your return to work or treatment plan include a modified work arrangement? If not, why not?_____

_____

Have you applied for Social Security Disability benefits? ☐ Yes ☐ No
If "No", do you intend to file? ☐ Yes ☐ No
Have you been approved for Social Security Disability benefits? ☐ Yes ☐ No
If "Yes", effective date of Social Security Disability benefits: _____

If your request for Lump Sum Disability Insurance benefits is approved, do you want us to withhold federal income taxes? ☐ Yes ☐ No
If "Yes", complete, sign and attach IRS form W-4S ($88.00 Minimum Withholding)

**1. Medical Treating Sources**

a. Please list all over the counter and prescribed medications:

| Medication | Dosage | Frequency | Prescribed by | Pharmacy |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

b. Please list all medical providers:

| Medical Provider | Address/Phone Number | Last Appointment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

c. Have you been hospitalized due to this sickness or injury? ☐ Yes ☐ No If "Yes", please provide:

| Hospital Name | Address | Dates of Confinement |
|---|---|---|
| | | |
| | | |

d. Please list all pharmacies you utilize:

| Pharmacy Name | Address | Phone |
|---|---|---|
| | | |
| | | |
| | | |

e. Provide the names and addresses of your current and previous medical/health insurance carrier:

| Carrier | Address | Phone | Policy/Medical Record Number |
|---|---|---|---|
| | | | |
| | | | |

**Lump Sum Disability Insurance**
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Employee Name: _____ Policyholder Name and Number: _____

**2. Training, Education and Experience**

a. **Educational History**

Do you have a high school diploma or GED certificate? ☐ Yes ☐ No Highest grade completed: _____

Degree? ☐ BA ☐ BS ☐ MA ☐ MS ☐ CAGS ☐ PhD ☐ Other _____

Date received: _____

College/University/Trade School: _____ Major: _____

Other training and/or licenses/certificates held: _____

Other languages spoken: _____

b. **Computer Skills**

How would you rate your current computer skills? ☐ Poor ☐ Fair ☐ Good ☐ Very Good

How long have you used computers: _____ Years _____ Months

Do you have a computer at home? ☐ Yes ☐ No If "Yes", do you have access to the internet? ☐ Yes ☐ No

If "Yes", Type of Access: ☐ Dial Up Modem ☐ DSL ☐ Cable Modem ☐ Other _____

How often do you use your computer? _____ Hours per Week _____ Hours per Day

Are you proficient in any of the following:
☐ Word Processing ☐ Spreadsheets ☐ Databases
☐ Email ☐ Presentation ☐ Desktop Publishing
☐ Instant Messaging ☐ Social Media Websites (ie Facebook)

c. **Additional Skills, Hobbies, Interests, Clubs, Church Organization, Etc.**

_____

_____

_____

d. **Do you plan to travel?** ☐ Yes ☐ No
**Do you plan to travel or live abroad?** ☐ Yes ☐ No

e. **Employment History**

List all past employers, attaching a separate sheet if necessary.

Employer: _____ Job Title: _____

City: _____ State: _____ Industry: _____ Salary: $ _____

Job duties/responsibilities (describe what you did): _____

_____

Do you have supervisory experience? (please describe): _____

Employer: _____ Job Title: _____

City: _____ State: _____ Industry: _____ Salary: $ _____

Job duties/responsibilities (describe what you did): _____

_____

Do you have supervisory experience? (please describe): _____

Employer: _____ Job Title: _____

City: _____ State: _____ Industry: _____ Salary: $ _____

Job duties/responsibilities (describe what you did): _____

_____

Do you have supervisory experience? (please describe): _____

**Lump Sum Disability Insurance**
**Employee's Statement**

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Employee Name: _____ Policyholder Name and Number: _____

f. **Military History**

☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Other: _____

Job Title: _____ Highest rank achieved: _____

Duties (describe what you did): _____

_____

g. **Transportation Information**

Do you have a valid driver's license? ☐ Yes ☐ No Do you have transportation? ☐ Yes ☐ No

List any endorsements (i.e. Hazmat, CDL): _____ List any restrictions to your license: _____

What type of vehicle do you drive? _____ Automatic or manual transmission: _____

Do you have handicapped plates or a placard? ☐ Yes ☐ No If "Yes", date issued: _____

**3. Activities of Daily Living**

a. Do you require assistance with any of the following?

Bathe ☐ Yes ☐ No Dress ☐ Yes ☐ No Toilet ☐ Yes ☐ No

Transfer ☐ Yes ☐ No Eat ☐ Yes ☐ No

Type of assistance required: _____

_____

b. Are you involved with any volunteer activities? ☐ Yes ☐ No

If "Yes", please describe: _____

_____

c. Describe your sleep habits: _____

How have they changed since work ceased? _____

_____

d. Do you grocery shop? ☐ Yes ☐ No If "No", why not? _____

When you grocery shop, do you use a motorized cart? ☐ Yes ☐ No

Are you able to do housework? ☐ Yes ☐ No

Do you have laundry facilities in your home? ☐ Yes ☐ No

Are you able to do the laundry? ☐ Yes ☐ No

e. What type of exercise programs are you regularly engaged in performing (i.e. Aerobics, etc.)? _____

_____

Did you exercise regularly prior to your sickness or injury? ☐ Yes ☐ No

f. Do you have children, grandchildren or other children that you care for? ☐ Yes ☐ No

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Employee Name: _____ Policyholder Name and Number: _____

g. Please describe in detail your activities in a typical 24 hour period: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The Lump Sum Disability Insurance benefit may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Lump Sum Disability Insurance benefit qualifies for favorable tax treatment, the benefits may be excludable from the person's income and not subject to federal taxation. The person is advised to consult with a qualified tax advisor about circumstances under which he/she could receive Lump Sum Disability Insurance benefits excludable from income under federal law.

Receipt of the Lump Sum Disability Insurance benefit may affect a person's, his/her spouse's, or his/her family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. The person is advised to consult with a qualified financial advisor and with governmental agencies concerning how receipt of such a payment will affect a person's, his/her spouse's, or his/her family's eligibility for government benefits or entitlements.

The undersigned represents any 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 that any insurance coverage or benefits are contingent upon any statements made to AUL or its third party administrator 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: _____

Name of Employee (please print): _____

Date: _____

# Lump Sum Disability Insurance
# Attending Physician's Statement

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Employee Name: _____ Policyholder Name and Number: _____

## Attending Physician's Statement for Lump Sum Disability Claim Form

**Please attach copies of all medical records and test results.**

Name of Patient: _____ ☐ Male ☐ Female Date of Birth: _____
*First Middle Last*

Blood Pressure *(last visit)* Date: _____ ☐ Left-handed

Height: _____ Weight: _____ Systolic: _____ / Diastolic: _____ ☐ Right-handed

### 1. History

a. Is this condition due to: ☐ Sickness ☐ Injury

b. When did symptoms first appear or injury occur: _____

c. Date patient was unable to work because of stated impairment: _____

d. Date you first restricted patient's ability to work due to this condition: _____

e. Has patient ever had same or similar condition? ☐ Yes ☐ No
If "Yes", state when and describe: _____

f. Was this patient referred to you? ☐ Yes ☐ No
If "Yes", by whom and what is his/her specialty? _____

g. Have you referred this patient to another treating provider? ☐ Yes ☐ No
If "Yes", to whom and what is his/her specialty? _____

### 2. Diagnosis

a. Primary diagnosis impacting function: _____ ICD9/10 Code(s) _____
Nature of treatment (including surgery or other procedures):

_____

_____

b. Secondary diagnosis impacting function: _____ ICD9/10 Code(s) _____
Nature of treatment (including surgery or other procedures):

_____

_____

c. Subjective Symptoms: _____

_____

_____

d. Tests Conducted: ☐ X-rays ☐ CT Scan ☐ MRI ☐ EKG ☐ Lab Work ☐ Psychological Testing

e. Objective findings: _____

_____

_____

### 3. Dates of Treatment for this condition

a. Date of first visit: _____

b. Date of last visit: _____

c. Next office visit: _____

d. Frequency: ☐ Weekly ☐ Monthly ☐ Other: _____

e. Does treatment regimen include a return to work component if functional improvement is anticipated? ☐ Yes ☐ No

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Employee Name: _____ Policyholder Name and Number: _____

**4.** Is the patient required to take any prescription medication regularly for the stated condition? ☐ Yes ☐ No

If "Yes", please list all current prescribed medications:

| Medication | Dosage | Frequency | Prescribed by | Pharmacy |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**5. Progress**

a. Has patient ..... ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

b. Is patient ..... ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

If "Hospital Confined", give name and address of location: _____

Dates of Confinement: _____

c. Do you expect any significant improvement in the future? ☐ Yes ☐ No

If "Yes", when?: ☐ 1 Month ☐ 1 - 3 Months ☐ 3 - 6 Months ☐ 6 - 12 Months ☐ Other

If "No", why not? _____

**6. Restrictions and Limitations**

a. What restrictions, if any, have you placed upon your patient? _____

_____

_____

b. When were these placed and when do you anticipate lifting them? _____

_____

c. How have these restrictions or limitations changed since the patient ceased work? _____

_____

**7. Cardiac (if applicable)**

a. Functional Capacity (American Heart Assoc. Standards) ☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

b. Was this patient referred to cardiac rehab? ☐ Yes ☐ No

c. Why, or why not? _____

**8. Mental / Nervous Impairment** (if applicable)

☐ 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 interpersonal relations (Marked limitations)

☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitations)

a. Please define what is considered "stress" as it applies to this patient. _____

b. What stress and problems in interpersonal relations has patient had on patient's prior job? _____

c. Remarks: _____

_____

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**9.** Is the patient competent to endorse checks and direct the use of proceeds thereof? ☐ Yes ☐ No

**10. Current Functional Ability**

a. In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity?
(please indicate appropriate number of hours):

| | | |
|---|---|---|
| ____ Hrs. | Sedentary Activity | 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours. |
| ____ Hrs. | Light Activity | 20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours. |
| ____ Hrs. | Medium Activity | 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing. |
| ____ Hrs. | Heavy Activity | 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing. |

b. Please check appropriate box:

| | Occasionally | 0% to 33% | Frequently | 33% to 66% | Continuously | 66% to 100% |
|---|---|---|---|---|---|---|
| Bending | ☐ | | ☐ | | ☐ | |
| Climbing | ☐ | | ☐ | | ☐ | |
| Reaching | ☐ | | ☐ | | ☐ | |
| Kneeling | ☐ | | ☐ | | ☐ | |
| Squatting | ☐ | | ☐ | | ☐ | |
| Crawling | ☐ | | ☐ | | ☐ | |
| Push/pull | ☐ | No. of lbs. ____ | ☐ | No. of lbs. ____ | ☐ | No. of lbs. ____ |
| Lifting (lbs.) | ☐ | No. of lbs. ____ | ☐ | No. of lbs. ____ | ☐ | No. of lbs. ____ |

What is this assessment based on? ☐ Observed activity ☐ Measured activity ☐ Physical therapy report

c. Please list current restrictions (activities which should not be performed) and limitations (activities which can not be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific. _____

_____

_____

_____

d. Upper Extremity Function – Please indicate upper extremity functional capabilities:

| | | | |
|---|---|---|---|
| Simple grasp | ☐ Left | ☐ Right | Comments _____ |
| Pinch | ☐ Left | ☐ Right | Comments _____ |
| Fine manipulation | ☐ Left | ☐ Right | Comments _____ |
| Power grip | ☐ Left | ☐ Right | Comments _____ |
| Repetitive motion | ☐ Left | ☐ Right | Comments _____ |

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 the following pages.

Attending Physician's Signature: _____ Date: _____

Medical Provider's Name (Please Print): _____

Degree / Specialty: _____

Telephone Number: _____ Fax Number: _____ Tax ID#: _____

Office Address: _____
Number/Street

_____
City or Town State Zip Code

## Fraud Notices

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- **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 and denial of insurance benefits.



G-31012 (Disability) 7/16/19

# Discretionary Authority

*Products and financial services provided by American United Life Insurance Company® a OneAmerica® company*

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The following discretionary authority rights shall apply to all policies except the states below.

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if American United Life Insurance Company® (AUL) (or its third party administrator) 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 (or its third party administrator) 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 (or its third party administrator'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 (or its third party administrator) 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. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its designated third party administrator.

Such discretionary authority shall not apply in the following states for life and disability as indicated:

**Life:**

1. Alaska
2. California
3. Colorado
4. District of Columbia
5. Kentucky
6. Michigan
7. New Hampshire
8. New Jersey
9. New York
10. Oklahoma
11. Oregon
12. Rhode Island
13. South Dakota
14. Texas
15. Utah
16. Vermont
17. Washington

**Disability:**

1. Alaska
2. Arkansas
3. California
4. Colorado
5. District of Columbia
6. Hawaii
7. Illinois
8. Kentucky
9. Maine
10. Maryland
11. Michigan
12. Minnesota
13. Missouri
14. Montana
15. Nevada
16. New Hampshire
17. New Jersey
18. New Mexico
19. New York
20. Oklahoma
21. Oregon
22. Rhode Island
23. South Dakota
24. Texas
25. Utah
26. Vermont
27. Washington



G-25673 (Packet) 2/13/20

# Authorization for Release of Information – HIPAA Compliant

(Excluding Psychotherapy Notes)

**To be signed, dated, and returned by the insured/claimant.**

*Products and financial services provided by*
*American United Life Insurance Company®*
*a OneAmerica® company*
*One American Square, P.O. Box 7003*
*Indianapolis, IN 46207*
*1-855-517-6365*
*Fax 1-844-287-9499*
*disability.claims@oneamerica.com*

ONEAMERICA®

| Claimant Name | | Claimant Date of Birth |
|---|---|---|
| Claim Number | Employer Name | Employer Policy Number |

I authorize any licensed physician, any other medical practitioner or provider, pharmacy benefit manager, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to American United Life Insurance Company® (AUL) and AUL's reinsurer(s) excluding psychotherapy notes and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records *(including psychiatric, sexually transmitted diseases, alcohol, and drug abuse, and, where permitted by law,* ***HIV/AIDS*** *information)* which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by AUL, AUL's reinsurer(s) and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing AUL or AUL's reinsurer(s) to assist with the evaluation and adjudication of my current disability claim or another disability claim insured by AUL and/or to report aggregate claims information to AUL. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Attn: Privacy Officer, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206. However, such revocation is not effective to the extent that AUL or AUL's reinsurer(s) have relied previously upon this authorization for the use or disclosure of my protected health information. I understand that AUL cannot condition the payment of a claim on my signing this authorization. However, I understand that my revocation of, or my failure to sign this authorization may impair AUL's ability to evaluate my current disability claim and as a result, lack of required information may be a basis for denying that current disability claim for benefits.

**If you reside in California, Connecticut, Maine, or Massachusetts:**
This authorization excludes the release of information and test results about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant or employee-claimant *(for self-insured business)* is required each time results are released.

**If you reside in Vermont:**
This authorization EXCLUDES the release of any information and test results about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING AUL to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and AUL shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

| Claimant Signature *(or Authorized Representative)* | Date |
|---|---|

Description of Authorized Representative's Authority *(if applicable)*
*(If signed by Authorized Representative, attach verification of identity.)*



G-27041 8/25/21

# Direct Deposit Authorization Agreement

*Products and financial services provided by*
*American United Life Insurance Company®*
*a OneAmerica® company*
*One American Square, P.O. Box 7003*
*Indianapolis, IN 46207*
*1-855-517-6365*
*Fax 1-844-287-9499*
*disability.claims@oneamerica.com*

ONEAMERICA®

☐ New Direct Deposit ☐ Change to Current Direct Deposit ☐ Cancel Direct Deposit

| **Please Print** | |
|---|---|
| Name | Social Security Number |

**Account Information**

Type of Account

☐ Checking ☐ Savings *(American United Life Insurance Company® (AUL) will only deposit to one account.)*

| Name of Financial Institution | | |
|---|---|---|
| Financial Institution Street Address | | |
| City | State | ZIP Code |
| Transit/ABA Number | Account Number | Check Number<br>Do Not Include |

Checking Account information can be found at the bottom of your check. Savings Account information can be obtained from your financial institution.


**Authorization**

I authorize American United Life Insurance Company® (AUL) to electronically deposit all payments due me into the account identified above. I discharge and release AUL from further liability for any payments so deposited to my account. I authorize AUL to pursue corrections, if necessary, to any amounts credited to my account in error. AUL will notify me of the error and amount of overpayment.

Any such payments shall be returned to AUL by the Financial Institution if funds are available in my account or shall be returned to AUL by me, my legal representative, my estate or my heirs if the funds in my account are not sufficient to make the required correction.

I understand that AUL may terminate this electronic fund transfer at any time and for any reason and may make payments by check instead. I also understand that I may revoke this authorization at any time by written request which will be effective when received and acknowledged by AUL at its Home Office.

| Signature | Date |
|---|---|
| | |



G-28291 12/8/21

*Products and financial services provided by*
*American United Life Insurance Company®*
*a OneAmerica® company*
*P.O. Box 7003*
*Indianapolis, IN 46207*
*Fax: 1-844-287-9499*
*Toll Free Phone: 1-855-517-6365*
*Disability.claims@oneamerica.com*

ONEAMERICA®

In the state of California, the following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

California Insurance Code 790.03

**(h)** Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

**(i)** Canceling or refusing to renew a policy in violation of Section 676.10.

**(j)** Holding oneself out as representing, constituting or otherwise providing services on behalf of the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code without a valid agreement with the California Health Benefit Exchange to engage in those activities.

In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov or by calling the department's consumer information line at 1-800-927-HELP (4357). You may also obtain a copy of this law and these regulations free of charge from this insurer.