Group Life Insurance Request For Accelerated Life Benefit 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

G-23772 12/6/12

Statement of Claim
Accelerated Life Benefit (ALB)

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
Employee Benefits Life Claims Department
P.O. Box 7106
Indianapolis, IN 46207-7106
1-800-553-3522 Fax 1-317-285-7666
www.employeebenefits.aul.com

OneAmerica®

All communications should be sent to: Employee Benefits Life Claims Department, American United Life Insurance Company®, P.O. Box 7106, Indianapolis, In 46207-7106

SECTION I – Statement of Employee – This section to be completed by Employee

1. Employer's Name _____ Policy Number _____
2. Name of Employee _____ ❑ Male ❑ Female Date of Birth _____
3. Employee's Social Security # _____ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced
4. Employee's Address _____
5. Daytime Telephone Number _____ Email _____
6. Claim is being made for ❑ Self ❑ Spouse

   If spouse, please provide spouse's name _____ Social Security # _____ Date of Birth _____
7. Amount of Request:

Employee Basic (check one)	❑ 25%	❑ 50%	❑ 75% (if available)
Employee Supplemental (check one)	❑ 25%	❑ 50%	❑ 75% (if available)
Employee Voluntary (check one)	❑ 25%	❑ 50%	❑ 75% (if available)
Spouse Basic (check one)	❑ 25%	❑ 50%	❑ 75% (if available)
Spouse Supplemental (check one)	❑ 25%	❑ 50%	❑ 75% (if available)
Spouse Voluntary (check one)	❑ 25%	❑ 50%	❑ 75% (if available)

8. If currently a Mississippi resident – Select payment: ❑ Lump sum; ❑ Periodic payment for fixed period from _____ to _____ ;
   ❑ Fixed amount $_____ from _____ until total ALB is depleted.

Receipt of an Accelerated Life Benefit will reduce your death benefit. Certain insured individuals permanently and totally disabled and diagnosed with a terminal condition may be eligible to request payment of an Accelerated Life Benefit under the group life insurance contract. A terminal condition is an injury or sickness that, despite appropriate medical care, is conclusively established to American United Life Insurance Company® (AUL) to result in the person's death within a specified time frame following the date of the Accelerated Life Benefit claim, as determined by AUL. After payment of Accelerated Life Benefits, the amount of the person's life insurance payable at death to the person's beneficiary will equal the amount of the person's life insurance if no Accelerated Life Benefit payment had been made minus the amount of the Accelerated Life Benefit payment minus an interest charge.

The Accelerated Life Benefit offered under the contract may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as the person's life expectancy at the time benefits are accelerated, or if the person uses the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Life Benefits qualify for favorable tax treatment, the benefits may be excludable from the person's income and not subject to federal taxation. Tax laws relating to Accelerated Life Benefits are complex. The person is advised to consult with a qualified tax advisor about circumstances under which he/she could receive Accelerated Life Benefits excludable from income under federal law.

Receipt of Accelerated Life Benefits 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 tax advisor and with social service agencies concerning how receipt of such a payment will affect a person's, his/her spouse's, or his/her family's eligibility for public assistance.

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 of Employee *Date*

_____ _____
Signature of Spouse (if claim is for spouse) *Date*

If you reside in a community property state, spousal consent and signature is required. Community property states include but are not limited to: AZ, CA, ID, LA, NM, NV, TX, WA, and WI.

_____ _____
Signature of Spouse *Date*

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SECTION II – 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.

1. Employee's Name: _____ Social Security #: _____ Date of Birth: _____

2. Amount of Salary: _____ ❑ Weekly ❑ Monthly ❑ Annual Employee's Occupation and Position _____

3. Employee's Hire Date _____ Employee's Effective Date of Insurance _____ Was Evidence of Insurability required? ❑ Yes ❑ No

4. Is the Employee's coverage in force? ❑ Yes ❑ No Date to which premiums were paid for this Employee: _____

5. Has this Employee ceased active work due to this illness? ❑ Yes ❑ No If yes, what was the last day worked? _____

6. Amount of Basic Insurance Coverage: _____ Amount of Supplemental/Voluntary Coverage: _____

If this claim is for a Dependent Spouse, please provide the following information:

7. Name of Dependent Spouse: _____ Social Security #: _____ Date of Birth: _____

8. Effective Date of Dependent Insurance: _____ Is the Dependent's coverage in force? ❑ Yes ❑ No Date to which premiums were paid for this Dependent: _____

9. Amount of Basic Coverage: _____ Amount of Supplemental/Voluntary Coverage: _____

The employer/policyholder represents and warrants any information or documents provided to AUL by the employer/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 its discretion the applicant is entitled to them.

Policyholder _____ Policy # _____ Phone # _____

Address _____ Email _____

City _____ State _____ Zip Code _____

_____ Title _____ Date _____
Signature of Authorized Representative

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SECTION III – Attending Physician's Statement – This section to be completed by medical provider.

Name of Patient: _____ Social Security #: _____ Date of Birth: _____

Your patient is requesting an Accelerated Life Benefit payment under his/her life insurance policy. In order to determine if benefits are owed, please complete the following questions and attach a copy of medical records for the patient's last visit.

1. Please provide all current diagnoses.

2. Please indicate the patient's prognosis.

3. Is the patient permanently and totally disabled from any occupation? ❑ Yes ❑ No

4. With appropriate medical care is the patient's life expectancy 12 months or less? ❑ Yes ❑ No
   If a resident of Kansas, Massachusetts, Vermont or Washington will patient's life expectancy be 24 months or less? ❑ Yes ❑ No

5. Please indicate any other details that would aid us with determining if benefits are owed.

6. Please provide the names and address of any other medical providers treating the patient.

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.

_____ _____ M.D.
Date *Printed Name* *Signature*

Board Certified Specialty _____

Street Address _____

_____
City *State* *Zip*

_____
Phone Number/Email

Fraud Warnings *(For use in AL, AR, DC, LA, NM, TX and WV)*

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Alaska

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any statement of claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Rhode Island

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire, Ohio

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

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**