Disability Insurance Claim Form

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

OneAmerica®

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 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 Employer's Statement for Disability Insurance Claim form should be completed by the Employer
- The Attending Physician's Statement for Disability Insurance Claim should be completed by the primary medical provider treating the Employee for the claimed conditions related to this injury or sickness

If you have questions when completing this form, please call an American United Life Insurance Company® representative at 1-855-517-6365.

Completed forms and communications should be sent to:

American United Life Insurance Company®
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106

Or

Fax: 1-844-287-9499

Or

OneAmerica.claims@customdisability.com

Disability Insurance Claim Form

Claim is being filed for:

☐ Voluntary Long Term Disability
☐ Lump Sum Disability

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Employee's Statement for 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: _____ Employer Name and Policy Number: _____

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

Employee Address: _____

City: _____ State: _____ Zip Code: _____

Employee Phone Number: _____ Employee Email Address: _____

Would you like communication via email instead of through U.S. Mail? ☐ Yes ☐ No

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: _____

Date Employee was last physically/Actively at Work: _____ Number of Hours Worked per Week: _____

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

Date returned to work: _____ If part-time, number of hours worked per week: _____

Date of injury or date first noticed symptoms: _____

Your Occupation and Title: _____

You are: ☐ Hourly ☐ Salary ☐ Executive ☐ Management ☐ Salaried/Non-exempt

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

Are you? ☐ Right Handed ☐ Left Handed Gross Annual Salary: _____

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: _____

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Employee Name: _____ Employer Name and Policy Number: _____

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: _____

_____

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

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

Carrier	Address	Phone	Policy/Medical Record 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): _____

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Employee Name: _____ Employer Name and Policy Number: _____

Employer: _____ Job Title: _____

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

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

_____

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

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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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 and warrants 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: 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 or its third party administrator decides in its discretion the applicant is entitled to them. The undersigned acknowledges reading, understanding and retaining the notices, limitations, and exclusions for his/her records. The undersigned acknowledges reading and understanding the state specific fraud statements on page 6.

Signature of Employee: _____

Name of Employee (please print): _____

Date: _____

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

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Group Policy No. _____ Name of Employer _____

Name of Employee *(Please Print)* _____

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA-COMPLIANT)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician; any other medical practitioner or provider, 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 or 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, Workers Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Custom Disability Solutions (CDS); American United Life Insurance Company® (AUL); and AUL's reinsurer(s). This excludes psychotherapy notes and includes, but is not limited to, any other mental or psychiatric records; medical, dental and hospital records (including psychiatric, alcohol abuse, 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 CDS, AUL, AUL's reinsurer(s) and their representatives to evaluate and adjudicate my current disability claim, and 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 CDS, AUL or AUL's reinsurer(s)to assist with the evaluation and adjudication of my current disability claim 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 the Health Insurance Portability and Accountability Act's (HIPAA's) privacy rules, or any other federal or state law.

This authorization is valid during the pendency of my claim and shall expire on the date my claim ends. 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 by notifying CDS at the address above in writing, of my revocation. However, such revocation is not effective to the extent that CDS and/or AUL have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of or my failure to sign this authorization may impair Disability CDS' and AUL's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

I understand that a physical exam of me may be ordered.

I understand that an investigative consumer report about me may be requested. These reports contain information about my character, general reputation, mode of living and health except as may be related directly or indirectly to my sexual orientation. The information may be obtained through interviews with me, my neighbors, friends and others who know me. Upon request, CDS or AUL will give me the name and address of the consumer reporting firm so that I may request a copy of that report.

Claimant Signature (or Authorized Representative): _____ Date: _____

Description of Personal Representative's Authority (if applicable): _____
(If signed by authorized representative, attach verification of identity)

Disability Insurance Claim Form

Claim is being filed for:

☐ Voluntary Long Term Disability
☐ Lump Sum Disability

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Employer's Statement for Disability Insurance Claim Form

TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED.

Employer's Name: _____

Employee's Name: _____

Date of Hire: _____ Last date worked: _____

Actual number of hours worked per week: _____

Reason for stopping work:
☐ Disability ☐ Termination ☐ Other _____

The employer/policyholder represents and warrants any information or documents provided to American United Life Insurance Company® (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 employer/policyholder'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 or its third party administrator decides in its discretion the applicant is entitled to them. The employer/policyholder acknowledges reading and understanding the state specific fraud statements.

_____ _____
Print Name & Title of Official Representative Telephone Number

_____ _____
Signature Date Email Address

G-27046 (MARK III) 5/14/15

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

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Delaware, Idaho, Indiana, Oklahoma

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Maryland, Rhode Island

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Employee Name: _____ Employer Name and Number: _____

Attending Physician's Statement for 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 claimed 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. For Pregnancy Disabilities

Are there any present complications or anticipated difficulties in connection with:

Pregnancy ☐ Yes ☐ No

Delivery ☐ Yes ☐ No Expected Date of Delivery: _____

Post Partum ☐ Yes ☐ No Actual Date of Delivery: _____ ☐ Vaginal ☐ C-Section

If yes to any of these, please specify in detail: _____

G-27047 (MARK III) 5/4/15

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Employee Name: _____ Employer Name and Number: _____

4. 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

5. Is the patient required to take any prescription medication regularly for the claimed condition? ☐ Yes ☐ No

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

Medication	Dosage	Frequency	Prescribed by	Pharmacy

6. 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? _____

7. 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? _____

8. 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? _____

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Employee Name: _____ Employer Name and Number: _____

9. 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 (Slight 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: _____

_____

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

11. 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 _____

Disability Insurance Claim Form

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

OneAmerica®

Employee Name: _____ Employer Name and Number: _____

12. Return to work plan

Have you discussed a return to work plan with your patient? ☐ Yes ☐ No
The date you released patient to return to work _____ ☐ Full-time ☐ Reduced hours ☐ Number of hours
Please identify your recommendations for any job modification that would enable the patient to return to work _____
_____

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 5.

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 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.

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Toll Free Phone: 1-855-517-6365