Long-Term Disability Insurance Claim Packet

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
P.O. Box 9060
Portland, ME 04104
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
Disability.claims@oneamerica.com

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Long-Term Disability Claim Filing Instructions

INSTRUCTIONS – PLEASE READ CAREFULLY AND SUBMIT ALL REQUIRED INFORMATION

We offer four options for filing a long-term disability claim:

1. Call our disability claims team at **1-855-517-6365** (Spanish available). A claims representative is available to assist you between 8 am and 6 pm ET, Monday through Friday. When calling, you should have the following information readily available: Employee's personal information (including social security number), Employer's Name, Group policyholder number, Employee's hire date, contact information for doctors, hospitals or clinics treating the Employee and dates of treatment. You should also have information regarding a worker's compensation or state disability claim if one has been or will be filed.

If you do not wish to call the disability claims team, please complete the following forms and send the forms and supporting documentation to us by:

2. Email to Disability.claims@oneamerica.com;
3. Fax to 1-844-287-9499; or
4. Mail to American United Life Insurance Company, P.O. Box 9060, Portland, ME 04104.

If you have any questions when completing the claim forms, please call a claims representative at 1-855-517-6365.

All questions should be answered fully and accurately before a decision on benefit entitlement can be made. All forms should be completed as follows:

Employer's Statement for Disability Insurance Claim Form – The policyholder (Employer) should complete in full.

Employee's Statement for Long-Term Disability Insurance Claim Form – The Employee should complete this form.

Attending Physician Statement – The primary medical provider treating the Employee for the conditions related to this injury or sickness should complete this form. A list of current medications should be attached to the form.

Authorization for Release of Information – The Employee should read, sign and date this form. This form is required for us to obtain additional documentation to support this claim.

Direct Deposit Authorization Agreement – This form should be completed by the Employee if he/she wishes to have disability payments deposited into his/her bank account. Banking information specified on the form should be attached.

Disability Insurance Claim Form

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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 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.

_____ _____
Print Name & Title of Official Representative Telephone Number

_____ _____
Signature Date Email Address

Employee's Statement for Long-Term Disability Insurance Claim Form

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To Be Completed By Employee *(please print)*

If the claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.

1. Employee's Name		**2.** Social Security Number	
Street/Box/Apt.		**3.** Phone Number	
City, State, Zip		**4.** Email Address	
5. Height	**6.** Weight	**7.** Gender ☐ Male ☐ Female	**8.** Date of Birth
9. Employer's Name		**10.** Employer's Address	
11. Employer's Phone Number		City, State, Zip	
12. Occupation	**13.** List Occupation Duties ☐ Hourly ☐ Salaried ☐ Executive ☐ Management ☐ Union		
14. Date of accident or first symptoms	**15.** Date Last Worked	**16.** Are you unable to work due to *(check one)* ☐ Accidental Injury ☐ Illness ☐ Pregnancy	
17. Date you returned to work _____ ☐ Full-Time ☐ Part-Time		**18.** If you have not returned to work, date you expect to return _____ ☐ Full-Time ☐ Part-Time	

19. Describe in detail, when, where and how accidental injury occurred, or nature of disability and first symptoms

20. Is your accidental injury or illness related to your occupation? ☐ Yes ☐ No If yes, explain:	**21.** Have you filed a Worker's Compensation Claim? ☐ Yes ☐ No If no, do you intend to? ☐ Yes ☐ No If no, explain:

22. When were you first treated for your accidental injury or illness?

Hospital	Address/Phone Number	Date(s)
Doctor	Address/Phone Number	Date(s)

23. Have you ever had same or similar condition in the past? ☐ Yes ☐ No If yes, list name and address of Hospital/Doctor below.

Hospital	Address/Phone Number	Date(s)
Doctor	Address/Phone Number	Date(s)

G-31148 (MARK III_LTD_Packet) 11/14/18

Employee's Statement for Long-Term Disability Insurance Claim Form

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Employee Name	Employer Name and Policy Number

24. Are you receiving any of the following? *(check each benefit you are receiving)*

	Amount	Begin Date	End Date		Amount	Begin Date	End Date
☐ Worker's Compensation	$			☐ Unemployment	$		
☐ Social Security/ Veteran's Administration	$			☐ Other *(Retirement Income)*	$		
☐ State Disability	$			☐ Auto Insurance Wage Replacement*	$		
☐ Vacation/Sick/PTO	$			*If yes, give name and address of Insurer below.			

Insurer Name(s)	Address

25. Marital Status	**26.** If Married, Spouse Name and SSN	**27.** Spouse Date of Birth
☐ Single ☐ Married ☐ Divorced ☐ Widowed		

28. Is Spouse Employed?	**29.** List children under age 25 *(Names and Dates of Birth)*
☐ Yes ☐ No	

Tax Withholding

If benefits are approved, do you want federal income taxes withheld from your payments? ☐ Yes ☐ No

If yes, complete the following:

I request federal income tax withholding from my sick pay payments. I want the following amount withheld from each payment:

$ _____ Monthly (long-term disability)

The minimum amount we can withhold is $88 per month for monthly payments. Amounts entered must be in whole dollar amounts. (For example, $35 not $34.50) Tax withholding cannot reduce the net amount of each sick pay payment to less than $10.00. This designation will remain in effect until you change or revoke it. You may change or revoke Federal Tax Withholding by providing an updated IRS W-4S form to us. Please refer to IRS form W-4S for additional information. If you elect not to have federal income tax withheld, you remain liable to pay your taxes for the taxable portion of these payments.

Signature

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.

Employee Name *(please print)*	Date

Employee Signature

X

Attending Physician Statement for Disability Claim

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To Be Completed By Physician

Patient Name		Employer's Name	
Height	Weight	Blood Pressure *(last visit)*	Date of Birth

1. Patient is/was unable to work due to *(check one)*
☐ Injury ☐ Illness ☐ Pregnancy

2. Diagnosis *(include complications and ICD 9 or ICD 10)*

For Pregnancy, Complete Items 3-6 *(If Normal Pregnancy, only complete 3-6 and skip to item 25)*

3. Last Menstrual Period (LMP) Date	**4.** Expected Date of Delivery	**5.** Date First Treated	**6.** Date Last Treated

For All Conditions Except Normal Pregnancy, Complete The Following Items

7. Date symptoms first appeared or accident happened?	**8.** Date patient was advised to stop working	**9.** Is condition due to injury or illness arising out of patient's employment? ☐ Yes ☐ No

10. Has patient ever had same or similar condition? If yes, state when and describe
☐ Yes ☐ No

11. Date of First Visit	**12.** Date Last Visit	**13.** Frequency of Visits

14. Objective Findings *(x-rays, EKG's, lab data and clinical findings)*	**15.** Subjective Symptoms

16. Nature of Treatment *(surgery, medications, etc.)* Provide medication dosage and frequency

17. Names and addresses of patient's other physicians	**18.** Name of physician you referred this patient to

19. Has patient been hospitalized If yes, give name and address
☐ Yes ☐ No From _____ to _____

20. Restrictions you have placed on patient *(what the patient SHOULD NOT do)*	**21.** Limitations of Patient *(what the patient IS INCAPABLE of doing)*

22. Mental Impairment *(if applicable)* Provide 5 AXIS Diagnosis

I
II
III
IV
V

23. If this is a cardiac condition, what is the functional capacity? *(American Heart Association)*
☐ Class 1 - No Limitation ☐ Class 2 - Slight Limitation ☐ Class 3 - Marked Limitation ☐ Class 4 - Complete Limitation

24. Has maximum medical improvement been achieved? If no, when do you expect a fundamental change?
☐ Yes ☐ No ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ More than 6 weeks

G-31146 (Packet) 10/10/18

Attending Physician Statement for Disability Claim

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Employee Name	Employer Name and Policy Number

25. If employer is able to accommodate patient's limitations and restrictions, is patient able to return to work? ☐ Yes ☐ No

If yes, what date could employment begin?

26. Current Functional Ability

a. In an 8 hour work 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 Work Activity	10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.
_____ Hrs. Light Work 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 Work Activity	50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.
_____ Hrs. Heavy Work Activity	100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing.

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 Number

Office Address

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) 10/10/18

Discretionary Authority

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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:

1. Arkansas
2. Alaska
3. California
4. Colorado
5. Hawaii
6. Kentucky
7. Illinois
8. Maine
9. Minnesota
10. Missouri
11. Montana
12. Michigan
13. New Jersey
14. New York
15. Oregon
16. Rhode Island
17. South Dakota
18. Texas
19. Utah
20. Vermont
21. Washington
22. Washington, D.C.
23. Non-ERISA governed policies in New Hampshire

Authorization for Release of Information – HIPAA Compliant

(Excluding Psychotherapy Notes)

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

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Claimant Name:	Claimant Date of Birth:
Claim Number:	Employer Name and 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, 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 Personal Representative's Authority (if applicable): _____
(*If signed by authorized representative, attach verification of identity.)

G-27041 12/5/18

Direct Deposit Authorization Agreement

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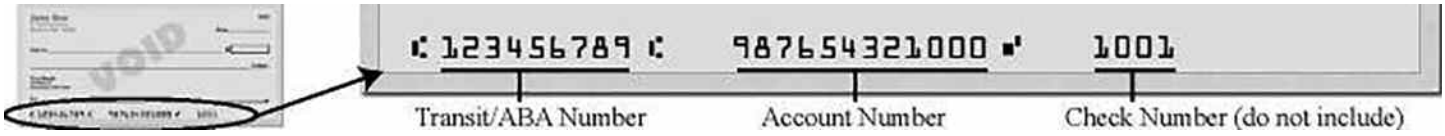
☐ New Direct Deposit ☐ Change to Current Direct Deposit ☐ Cancel Direct Deposit

PLEASE PRINT	
Name:	Social Security Number:

Please fill out either the Checking Account Information Section or the Savings Account/Credit Union Information Section. American United Life Insurance Company® (AUL) will only deposit to one account.

CHECKING ACCOUNT INFORMATION	
Obtain this information directly from the bottom of your check. Please include a copy of a **voided check**.	
Name of Financial Institution:	
Address of Financial Institution:	
Transit/ABA Number:	Account Number:



SAVINGS ACCOUNT / CREDIT UNION INFORMATION	
Please obtain this information from your financial institution. The information on your deposit slip is not applicable for this purpose.	
Name of Financial Institution:	
Address of Financial Institution:	
Transit/ABA Number:	Account Number:

AUTHORIZATION

I authorize American United Life Insurance Company® (AUL) to electronically deposit all payments due me from the policy identified above 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:

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