

Group Dependent Life Insurance – Proof of Death Claim Form

Products and financial services provided by American United Life Insurance Company® a ONEAMERICA® company
 One American Square, P.O. Box 7106
 Indianapolis, IN 46207-7106
 1-800-553-3522
 Fax: 317-285-7666
 www.employeebenefits.aul.com



This form is to be completed by the Employer/Policyholder

Instructions – Please read carefully and submit all required information

- 1) Proof of Death must be furnished without expense to American United Life Insurance Company® (AUL). Each question must be answered completely, accurately, and truthfully. AUL reserves the right to obtain further information when necessary.
- 2) A certified death certificate is required. If not available, the Physician's Statement on the reverse side of the form may be completed by the Insured's attending Physician.
- 3) If the policy offers Accidental Death Benefits and accidental death may have occurred, the following will need to be supplied to AUL: a) police reports, b) any newspaper stories about the accident, c) toxicology reports, d) autopsy report and e) medical reports related to treatment following the accident.
- 4) If the policy offers a Repatriation Benefit, an Accidental Death may have occurred, and the dependent died either 200 miles away from his principal place of residence or death occurred outside of the United States, the following will need to be supplied: a) Written documentation showing the location of the dependent's Accidental Death, and; b) written documentation showing the amount incurred for the transportation expenses for returning the dependent.
- 5) Enclose all applications/enrollment forms for AUL's coverage for this insured employee.
 - a) If the insured employee predeceased this dependent, we will also need a copy of the most recent beneficiary designation.
 - b) If the employee did not designate a beneficiary and an estate will not be opened, this benefit may be paid using a small estate affidavit (providing total benefit is below state mandated small estate levels). On behalf of the insured employee, please submit a completed Surviving Family Statement, form #G-20939 along with a copy of the obituary and a copy of the closest surviving relatives' driver's license to verify the individual's relationship to the decedent.
- 6) All communications should be sent to: **Employee Benefits Claims Department**, American United Life Insurance Company®, P.O. Box 7106, Indianapolis, Indiana 46207-7106

Employer/Policyholder's Statement

Employee Information:

Name of the Employee _____ Date of Birth _____ / _____ / _____

Address _____

Phone Number _____ Social Security Number _____

Date of Employment _____ / _____ / _____ Job Title _____

Employee's Class _____ Hours Worked Per Week _____ Salary \$ _____

Effective Date of Employee's Insurance:

Life _____ / _____ / _____ Supplemental / Voluntary Life _____ / _____ / _____

Amount of Employee's Insurance

Life \$ _____ AD&D \$ _____ Supp Life / Voluntary Life \$ _____

Was Evidence of Insurability Submitted? Yes No Is He / She Still Actively Employed? Yes No

For Union Groups Only:

A. Was member in good standing on coverage effective date? Yes No

B. Was member in good standing at his date of death? Yes No

C. Date to which all dues and assessments were paid _____

Dependent Information:

Name of Dependent _____ Relationship to the Employee _____

Dependent's Date of Birth _____ / _____ / _____ Dependent's Social Security Number _____

Marital Status of Dependent _____ Is Dependent Full-Time Student? Yes No

If Dependent Child is over 18 and a full-time student, please send a copy of the dependent's school transcript and a copy of the employee's most recent federal tax return.

Effective Date of Dependent Insurance _____ / _____ / _____ Was Evidence of Insurability Required? Yes No

Amount of Dependent Insurance \$ _____ Dependent's Date of Death _____ / _____ / _____

Date thru which premium for dependent insurance was paid _____

Benefit Check Should Be Forwarded To: Employer/Policyholder For Delivery Directly To Beneficiary

The undersigned represents and warrants 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: 1) any insurance coverage or benefits is contingent upon any statements 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. The undersigned have read, understand, and retained the notices, limitations, and exclusions for his/her records.

Employer (Policyholder) _____ Group Policy Number _____

Address _____ Phone No. _____

No. Street City State Zip Ext.

Email _____

Date _____ By _____

Title and Printed Name of Authorized Representative (required) Signature of Authorized Representative (required)

Proof of Death – Physician’s Statement – (To be completed only when the certified death certificate is unavailable.)

1. (A) Deceased’s Legal Name _____

(B) Residence At Death _____

(C) Age At Death _____ Occupation _____

2. (A) Date Of Death _____

(B) Place Of Death _____

3. (A) Immediate Cause Of Death and Underlying Cause _____

(B) Contributory Cause Of Death Or Any Chronic Ailments _____

(C) Date Of Last Medical Treatment _____

(D) The Deceased Was Totally Disabled And Unable To Work At His Usual Occupation From _____

Please indicate the manner of death: Natural Accident Suicide Murder Pending investigation Could not be determined

Describe Briefly any events and /or facts relevant to the manner of death _____

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*

_____ *Street* *City* *State* *Zip*

_____ *Telephone Number* *Email Address*

Fraud Warnings (For use in 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, Oregon

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 representative of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or reward payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, Oklahoma

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

Florida

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

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files 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

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

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.



AMERICAN UNITED LIFE INSURANCE COMPANY®
 PIONEER MUTUAL LIFE INSURANCE COMPANY*
 R.E. MOULTON, INC.
 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.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that partners of OneAmerica® may:

- 1) underwrite my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
- 2) obtain reinsurance;
- 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
- 4) administer coverage; and
- 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with a OneAmerica financial partner.

This authorization shall remain in force for twenty-four (24) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to:

Attention: Privacy Officer
 OneAmerica Financial Partners, Inc.
 One American Square
 P.O. Box 368
 Indianapolis, Indiana 46206

Please Do Not Send Medical Records, etc. to the Privacy Officer

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.*