Group Life Insurance
Claim Packet

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
lifeclaims.employeebenefits@oneamerica.com

OneAmerica®

INSTRUCTIONS – PLEASE READ CAREFULLY AND SUBMIT ALL REQUIRED INFORMATION

This form is to be completed by the Employer.

We offer four options for filing a life claim. The following information may be sent to us via:

1. Fax to 317-285-7666
2. Email to lifeclaims.employeebenefits@oneamerica.com
3. Mail forms to:
   Employee Benefits Life Claims Department
   American United Life Insurance Company®
   PO Box 7106
   Indianapolis, IN 46207-7106
4. Overnight forms to:
   Employee Benefits Life Claims Department
   American United Life Insurance Company®
   250 W. North Street
   Indianapolis, IN 46202

If you have any questions when completing the claim forms, please call a claims representative at 1-800-553-3522.

All questions should be answered fully and accurately to avoid delays in claim processing. Forms should be completed as follows:

Group Life Insurance Claim Form – The Employer should complete this form.

The Authorized Representative of the Employer should:

- Submit all forms requesting or changing group life insurance coverage and all beneficiary designation forms completed for the group life insurance policy. This includes, but is not limited to, enrollment form, proof of enrollment from an electronic enrollment system, request to decrease coverage, request to increase coverage, and all Guaranteed Increase in Benefit (GIB) forms.
- Submit all forms within the timeframe specified in the policy.
- Submit the Employee's most recent W-2 if salary is based on W-2.
- Include a copy of the Certified Death Certificate.

Authorization for the Release of Health Related Information – This form should be completed and signed by the beneficiary or the next of kin who could have made medical decisions for the deceased.

Trust Affidavit – If the beneficiary is a trust, the Trustee of the Estate should complete and have this form notarized.

OneAmerica prides itself on being there when our customers need us most, and we are pleased to offer a beneficiary guide entitled *Day by Day*, which assists families in managing life after loss. The guide and Frequently Asked Questions (FAQs) regarding Employee Benefits life insurance claims can be found on our website www.oneamerica.com/claims.

Group Life Insurance Claim Form

Notice of claim for:

☐ Employee ☐ Dependent

TO BE COMPLETED BY EMPLOYER

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Section I – Employee Information

Employer Name: _____ Employer Policy Number: _____

Employee Name: _____ Gender: ☐ Male ☐ Female

Employee Address: _____

City State Zip Code

Employee Daytime Phone Number: _____

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

Employee Full Time Hire Date: _____ Number of Hours Worked Per Week: _____

Effective Date of Employee Insurance: _____ Was Evidence of Insurability required? ☐ Yes ☐ No

Employee Occupation: _____ Employee Class: _____

Date Employee was last Physically/Actively at Work: _____

Date Active Pay Status Ceased: _____

Did employment cease prior to death? ☐ Yes ☐ No

Was Employee given Application to Port or Convert Group Coverage? ☐ Yes ☐ No Date given: _____

How was notice of portability or conversion given? _____

Date through which premiums are paid for this employee: _____

Indicate reason for date last Physically/Actively at Work:

☐ 1. Termination of Employment Date: _____

☐ 2. Reduction of Hours Date: _____

☐ 3. Layoff ☐ Permanent ☐ Temporary Date: _____

☐ 4. Retirement: Date of Retirement _____

☐ 5. Disability: Date of Disability _____

☐ 6. Entered Active Military Service: Date Entered _____

☐ 7. Other _____

☐ 8. FMLA ☐ Self ☐ Family
FMLA Begin Date: _____
FMLA End Date: _____

☐ 9. Leave of Absence:
Reason for Leave of Absence: _____
Date Leave of Absence Began: _____

☐ 10. Illness/Injury: Date of Illness/Injury _____

Gross Annual Salary

$ _____

Date of Last Salary Change

_____

Employee is: (check all that apply)
☐ Hourly ☐ Executive ☐ Management
☐ Salaried / Non-exempt ☐ Salary/Exempt
☐ Bargaining ☐ Non-bargaining

Gross Annual Salary includes: ☐ Commissions ☐ Bonuses ☐ Overtime ☐ Based on W2

For Union Groups Only:

Date to which all dues and assessments were paid for this employee: _____

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

Was member in good standing at his (or dependent's) date of death? ☐ Yes ☐ No

Employee Date of Death: _____

Identify all coverage, classes and volume of coverage for the Employee. This information is required for claim processing:

☐ Basic Term Life	Class _____	Volume _____
☐ Basic AD&D	Class _____	Volume _____
☐ Voluntary Term Life	Class _____	Volume _____
☐ Voluntary AD&D	Class _____	Volume _____
☐ Supplemental Life	Class _____	Volume _____
☐ Supplemental AD&D	Class _____	Volume _____

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Employee Name: _____ Employer Name/Policy Number: _____

Section II – Dependent Information

Dependent Information - (Please complete the entire claim form if claim is for a Dependent)

Name of Dependent: _____ Relationship to the Employee: _____

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

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

If Dependent Child is over 19 and a full-time student, please send documentation from the educational institution of full-time student status and a copy of the employee's most recent federal tax return.

Effective Date of Dependent Insurance: _____ Was Evidence of Insurability required? ☐ Yes ☐ No

Date through which premiums are paid for this dependent: _____ Dependent's Date of Death: _____

Identify all coverages and volume of coverage:

☐ Basic Dependent Term Life
☐ Spouse ☐ Child Class _____ Volume _____ Option # _____

☐ Basic Dependent AD&D
☐ Spouse ☐ Child Class _____ Volume _____ Option # _____

☐ Voluntary/Supplemental Dependent Life
☐ Spouse ☐ Child Class _____ Volume _____ Option # _____

☐ Voluntary/Supplemental Dependent AD&D
☐ Spouse ☐ Child Class _____ Volume _____ Option # _____

Section III – Beneficiary Information

If additional beneficiaries are named, please attach a separate sheet listing remaining beneficiaries.

1. Beneficiary Name: _____
Beneficiary Social Security Number: _____
Beneficiary Date of Birth: _____
Beneficiary Mailing Address: _____
Address City State Zip Code
Beneficiary Daytime Phone Number: _____
Beneficiary Email Address: _____

2. Beneficiary Name: _____
Beneficiary Social Security Number: _____
Beneficiary Date of Birth: _____
Beneficiary Mailing Address: _____
Address City State Zip Code
Beneficiary Daytime Phone Number: _____
Beneficiary Email Address: _____

3. Beneficiary Name: _____
Beneficiary Social Security Number: _____
Beneficiary Date of Birth: _____
Beneficiary Mailing Address: _____
Address City State Zip Code
Beneficiary Daytime Phone Number: _____
Beneficiary Email Address: _____

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Employee Name: _____ Employer Name/Policy Number: _____

Section III – Beneficiary Information *(Continued)*

4. Trust/Estate Beneficiary *(Complete this section if an Estate or Trust is the named beneficiary.)*

Please attach the Trust/Estate Document and IRS Form SS-4 for verification of Tax ID Number. If the beneficiary is a trust, please complete the enclosed Trust Affidavit.

Trust or Estate Name: _____

Trust or Estate Tax ID Number: _____

Trustee or Estate Personal Representative: _____

Trustee or Estate Personal Representative Mailing Address:

_____

Address City State Zip Code

Trustee or Estate Personal Representative Daytime Phone Number: _____

Trustee or Estate Personal Representative Email Address: _____

5. Contact Information for Employee claim

☐ No beneficiary designation on file.

If no beneficiary has been designated on an AUL form or a Prior Carrier form for the same coverage, please indicate the name and contact information for the person who supplied the copy of the Death Certificate below and check the no beneficiary designation on file box. AUL will contact this person with instructions concerning what additional information is required to determine the proper payee.

Contact Name: _____

Address: _____

Address City State Zip Code

Daytime Phone Number: _____ Relationship to Deceased: _____

Email Address: _____

If no beneficiary has been named and an Estate has been or will be established, please provide Estate information in number 4, above.

Section IV – Employer Information

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: 1) any insurance coverage or benefits are contingent upon any statements made to AUL as being complete and correct, and 2) benefits under any policy will be paid only if AUL determines the applicant is entitled to them. The undersigned has read, understands, and has retained the notices, limitations, and exclusions for his/her records and the Discretionary Authority & Fraud Warnings on the following pages.

Employer: _____ Policyholder Number: _____

Address: _____

Address City State Zip Code

Phone Number: _____ Fax Number: _____

Email Address: _____ Is this plan governed by ERISA? ☐ Yes ☐ No

Date: _____

_____ _____

Printed Name & Title of Authorized Representative of Employer Signature of Authorized Representative

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.

Discretionary Authority

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The following discretionary authority rights shall apply to all Life Insurance policies except the states below:

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if American United Life Insurance Company® (AUL) 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 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 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 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.

Such discretionary authority shall not apply in the following states:

1. Arkansas
2. Alaska
3. California
4. Hawaii
5. Kentucky
6. Illinois
7. Maine
8. Montana
9. New Jersey
10. New York
11. Oregon
12. Rhode Island
13. Vermont
14. Washington
15. Non-ERISA governed policies in New Hampshire and Utah

Authorization for the Release of Health Related Information

(HIPAA Compliant Form)

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OneAmerica®

Employee Name:	Deceased Name:
Your Relationship to Deceased:	Deceased Date of Birth:
Group Policyholder Number:	Claim Number:

I authorize any employer; health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy; pharmacy benefit manager; medical facility; other health care provider; insurance company; insurance support organization; the MIB, Inc. (formerly known as Medical Information Bureau); or other organization or person that has provided payment, treatment or services to the deceased or on his/her behalf within the past 10 years or has any records or knowledge of the deceased's health within the past 10 years (the "Providers") to disclose the deceased's entire medical record, prescription history, supplies provided with any other protected health information concerning the deceased to any company listed as a OneAmerica® company ("the Company"), its reinsurers or any agent, attorney, insurance support organization or other authorized representative acting on their behalf. 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 psychiatric history, as well as 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 the deceased's personal health information to MIB.

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

This protected health information will be used in evaluating and administering my claim for benefit. The authorization will be valid for the duration of the claim or one year after the date it is signed. A photocopy of this authorization will be 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 the Privacy Manager, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206. **(Do not send this form, medical records, etc. to the Privacy Manager.)** I understand that a revocation is not effective to the extent that any of the deceased's Providers have already relied on this authorization to disclose information about the deceased or to the extent that the Company has a legal right to contest a claim under an insurance policy. 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 that it will not be redisclosed by the Company except as authorized by me or as required by law.

_____ _____

Beneficiary Signature *Date*

Trust Affidavit

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OneAmerica®

Please print all information with the exception of signatures.

Group Policyholder Number _____ Deceased's Name _____

Trust Tax ID _____
Please attach the Trust document and IRS Form SS-4 for verification for Tax ID number.

I, _____ , affirm that the _____
Name of Trustee *Name of Trust*

Agreement executed by _____ on _____ is in full force and effect
Name of Trustee(s) who created Trust *Date of Trust*

and has not been amended, modified, or revoked, and the current Trustee(s) is/are: _____
Name(s) of Trustee(s)

I understand that American United Life Insurance Company® will rely on the statements that I have made in this affidavit.

_____ _____
Current Trustee Printed *Current Trustee Printed*

Date: _____ By: _____
Trustee Signature

County of: _____ Subscribed and sworn before me

State of: _____ this _____ day of _____ , _____

at _____
Location

_____ _____
Notary Name *Notary Signature*

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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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.