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

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 Employer/Policyholder should complete Section A – Employer's Statement
- Complete Section B – Employee's Statement should be completed by the Employee
- The employee should read, sign and date the AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA-COMPLIANT) form
- The Attending Physician's statement should be completed by the primary medical provider treating the Employee for the 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 returned to your employer for processing:

Sullivan County Dept. of Education

Attn: Tina Dade

Fax – 1-423-354-1004

Or email – tina.dade@sullivank12.net

All portions of these forms must be completed in order to expedite your claim.

Claim Application for Short-term Disability

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

(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

SECTION A – EMPLOYER'S STATEMENT

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.

Tina Dade : Employee Benefits Coord. — 423-354-1085
Print Name & Title of Official Representative — Telephone Number

Signature ____________________ Date

SECTION B – EMPLOYEE'S STATEMENT

Policyholder/Employer Name: ____________________

Policyholder/Employer Address: ____________________

Name: ____________________ Date of Birth: ________ Social Security #: ________

Address: ____________________ Phone #: ________
Street Address City State Zip Code

Your Occupation: ____________________ ☐ Full-Time ☐ Part-Time

Gross Annual Salary: ____________________

☐ Right-handed ☐ Left-handed

☐ Male ☐ Female

Hours worked per regular work week: ____

Date of injury or sickness: ________

Date of first treatment: ________

Have you ever had same or similar condition in the past? ☐ Yes ☐ No

Describe how and where injury occurred or describe the onset and nature of your medical condition including symptoms:

Date you returned to work: ________
☐ Full-Time
☐ Part-Time

Treated by: ____________________

Medical Provider: ____________________
Name Street Address City State Zip Code

Doctor: ____________________
Name Street Address City State Zip Code

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 and understanding the state specific fraud statements.

Signature of Employee ____________________ Date ________

Name of Employee (Please print) ____________________

G-27065 (MARK III) 5/4/15

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 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.

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

Group Policy No. 612880 Name of Employer Sullivan County Schools TN

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)

Claim Application for Short-term Disability

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

(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

THIS STATEMENT MUST BE COMPLETED BY A MEDICAL PROVIDER – PLEASE PRINT OR TYPE

SECTION C – ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: ____________ Date of Birth: ________ Height: _____ Weight: _____

Date person was unable to work because of impairment: Month ________ Day ______ Year ________

Diagnosis impacting function: ____________ Secondary diagnosis: ____________

Nature of treatment: ____________

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: ____________

Dates of Treatment for this condition

Date of first visit Month ________ Day ________ Year ________

Date of last visit Month ________ Day ________ Year ________

Next office visit Month ________ Day ________ Year ________

Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) ____________

If "Hospital Confined", give name and address of medical provider ____________

Confined from ________ through ________

Was this patient referred to you? ☐ Yes ☐ No

If yes, to whom and what is his/her specialty? ____________

Have you referred this patient to another treating provider? ☐ Yes ☐ No

If yes, to whom and what is his/her specialty? ____________

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.

Attending Physician's Signature: ____________ Date: ________

Medical Provider's Name (Please Print): ____________

Telephone Number: ____________ Fax Number: ____________ Tax ID#: ________

Office Address: ____________

Street *City* *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.

American United Life Insurance Company®
a ONEAMERICA® company
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

© 2016 American United Life Insurance Company®. All rights reserved. OneAmerica® and the OneAmerica banner are all trademarks of OneAmerica Financial Partners, Inc.