Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
P.O. Box 7003
Indianapolis, IN 46207
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
Disability.claims@oneamerica.com

ONEAMERICA®

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.

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

Account Information

Type of Account
☐ Checking ☐ Savings *(American United Life Insurance Company® (AUL) will only deposit to one account.)*

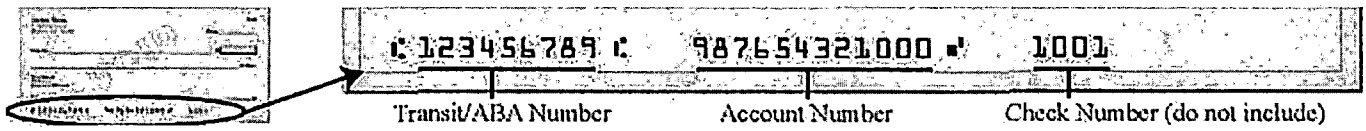
Name of Financial Institution

Financial Institution Street Address

City	State	ZIP Code

Transit/ABA Number	Account Number	Check Number Do Not Include

Checking Account information can be found at the bottom of your check. Savings Account information can be obtained from your financial institution.



Authorization

I authorize American United Life Insurance Company® (AUL) to electronically deposit all payments due me 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

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	Employer 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, sexually transmitted diseases, 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 Authorized Representative's Authority *(if applicable)*
(If signed by Authorized Representative, attach verification of identity.)

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 for life and disability as indicated:

Life:

1. Alaska
2. California
3. Colorado
4. District of Columbia
5. Kentucky
6. Michigan
7. New Hampshire
8. New Jersey
9. New York
10. Oklahoma
11. Oregon
12. Rhode Island
13. South Dakota
14. Texas
15. Utah
16. Vermont
17. Washington

Disability:

1. Alaska
2. Arkansas
3. California
4. Colorado
5. District of Columbia
6. Hawaii
7. Illinois
8. Kentucky
9. Maine
10. Maryland
11. Michigan
12. Minnesota
13. Missouri
14. Montana
15. Nevada
16. New Hampshire
17. New Jersey
18. New Mexico
19. New York
20. Oklahoma
21. Oregon
22. Rhode Island
23. South Dakota
24. Texas
25. Utah
26. Vermont
27. Washington

G-25673 (Packet) 2/13/20

Fraud Notices

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Indianapolis, IN 46207
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365
Disability.claims@oneamerica.com

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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) 7/16/19

Employee Name	Employer Name	Employer Policy Number

For All Conditions Except Routine Pregnancy, Complete the Following Items *(continued)*

33. Has patient been released to return to work? ☐ Yes ☐ No	If YES, Date Released ☐ Full-Time ☐ Part-Time	If NO, Anticipated Return to Work Date

34. 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.

Signature

The undersigned Attending Physician represents and warrants any information or documents provided to American United Life Insurance Company® (AUL) by this Attending Physician 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 Attending Physician acknowledges reading and understanding the state specific fraud statements on the following pages.

Attending Physician Signature	Date

Attending Physician Name *(please print)*

Degree/Specialty

Phone Number	Fax Number	Tax ID Number

Office Address	City/Town	State	ZIP Code

Attending Physician Statement for Disability Claim

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P.O. Box 7003
Indianapolis, IN 46207
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Fax 1-844-287-9499
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Patient Information – To Be Completed By Physician

1. Patient Name		**2.** Employer Name	
3. Height	**4.** Weight	**5.** Blood Pressure *(last visit)*	**6.** Date of Birth

7. Reason Patient Is/Was Unable to Work *(check one)*
☐ Injury ☐ Illness ☐ Pregnancy

8. Primary Diagnosis *(include complications and International Classification of Diseases (10th revision) (ICD 10))*

9. Secondary Diagnosis *(include complications and ICD 10)*

For Routine Pregnancy, Complete Items 10-16 *(then skip to item 33)*

10. Last Menstrual Period (LMP) Date	**11.** Expected Date of Delivery	**12.** Date First Treated	**13.** Date Last Treated
14. Date of Delivery	**15.** Type of Delivery	**16.** List Any Complications	

For All Conditions Except Routine Pregnancy, Complete the Following Items

17. Date symptoms first appeared or accident happened?	**18.** Date patient was advised to stop working?	**19.** Is condition due to injury or illness arising out of patient's employment? ☐ Yes ☐ No
20. Has patient ever had same or similar condition? ☐ Yes ☐ No	If YES, State When and Describe	

21. Date of First Visit	**22.** Date of Last Visit	**23.** Date of Next Office Visit	**24.** Frequency of Visits
25. Objective Findings *(x-rays, EKG's, lab data and clinical findings)*	**26.** Subjective Symptoms		

27. Nature of Treatment *(surgery, medications, etc.; provide medication dosage and frequency)*

28. Names and Addresses of Patient's Other Physicians	**29.** Name of Physician You Referred This Patient To

30. Has patient been hospitalized? ☐ Yes ☐ No	If YES, Beginning and Ending Dates	If YES, Provide Name and Address

31. Please provide us with your patient's current restrictions and limitations. Restrictions are defined as the actions that your patient should not be doing. Limitations are defined as the actions that your patient cannot do. We use this information to better understand your patient's current functional capacity. Responses of "no work" or "totally disabled" may not assist us in completing our review in a timely manner.

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

Employee Information – To Be Completed By Employer *(please print) (continued)*

29. Employee is Eligible for: *(now or in the future)*	Yes	No	Unknown	If YES, Weekly or Monthly Gross Amount	Frequency	Provider Name/Address	Date Benefits Begin	Date Benefits End
Salary Continuation	☐	☐	☐	$				
Disability Pension	☐	☐	☐	$				
Retirement Pension	☐	☐	☐	$				
State Disability If YES, list state _____	☐	☐	☐	$				
Unemployment	☐	☐	☐	$				
Social Security	☐	☐	☐	$				
Paid Family Medical Leave	☐	☐	☐	$				
Vacation/PTO	☐	☐	☐	$				
Sick Pay	☐	☐	☐	$				
Workers' Compensation	☐	☐	☐	$				
Has Workers' Comp. claim been filed?	☐	☐	☐	If Worker's Compensation has been denied, submit copy of denial with this claim.				

30. Are the Employee's current wages exempt from FICA?
☐ Yes ☐ No

Please complete the below premium questions. If not fully completed, this claim will be taxed at 100%.

31. Percentage of Employee/Employer contributions to premium for this disability coverage: *(if assistance is needed in determining the percentage, refer to the **Employer Disability Taxability Calculation Tool** at https://www.employeebenefits.aul.com/public/index.html#forms)*

Short-Term Disability ***(if the premium is a dollar amount, it should be converted to a percentage)***

Employee: ☐ 100% ☐ Other ____ % Are Employee Contributions: ☐ Pre-Tax Deduction ☐ Post-Tax Deduction
Employer: ☐ 100% ☐ Other ____ %

Long-Term Disability ***(if the premium is a dollar amount, it should be converted to a percentage)***

Employee: ☐ 100% ☐ Other ____ % Are Employee Contributions: ☐ Pre-Tax Deduction ☐ Post-Tax Deduction
Employer: ☐ 100% ☐ Other ____ %

If the plan is either a 2004-55 plan with a post-tax deduction or a gross-up, please complete as Employee paid post-tax for that plan type.

32. If coverage is Voluntary/Employee Contributes to premium, please include proof of enrollment and copy of paycheck stub *(year of disability and prior year).*

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 complete and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

Authorized Employer Representative Signature *(the above statements are true and complete to the best of my knowledge)*	
Authorized Employer Representative Name *(please print)*	Date
Employer Phone Number	Employer Email

Employer Street Address	City or Town	State	ZIP Code

A Job Description is required if Employee is out of work more than 6 weeks.

Policyholder Statement for Disability Insurance Claim Form

Claim is being filed for: ☐ Short-Term Disability ☐ Long-Term Disability ☐ Maternity

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Indianapolis, IN 46207
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Fax 1-844-287-9499
Disability.claims@oneamerica.com

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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.

Policyholder Information – To Be Completed By Employer *(please print)*

1. Policyholder Company Name	2. Policy Number	3. Policy Class of Covered Employee

Employee Information – To Be Completed By Employer *(please print)*

4. Employee Name	5. Social Security Number	6. Date of Birth

7. Street/Box/Apt. Address	City	State	ZIP Code

8. Phone Number	9. Date of Hire	10. Occupation *(include job description)*

11. Original Short-Term Disability Coverage Effective Date ☐ No Coverage

12. Original Long-Term Disability Coverage Effective Date ☐ No Coverage

13. How many months per year does Employee work?

14. Employee Work Location

15. Regular Work Schedule *(check all that apply)*
☐ Full-Time ☐ Part-Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal ☐ Shift Work

16. Regular Scheduled Weekly Hours

17. Regular Workdays *(check all that apply)*
☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

18. What was work schedule at time last worked? *(includes a reduced work schedule, if applicable)*
Number of Days Per Week _____ Number of Hours Per Week _____

19. Date Last Physically/Actively at Work	20. Hours Worked That Day	21. Anticipated Date Last Worked *(if still working)*

22. Has Employee Returned to Work? ☐ Yes ☐ No
If YES, Date Returned ☐ Full-Time ☐ Part-Time

23. Was Employee at work when disability began? ☐ Yes ☐ No
If NO, Select Status: ☐ Terminated ☐ Laid Off ☐ Resigned ☐ Vacation/PTO ☐ Family Medical Leave (FML) ☐ Leave of Absence ☐ Sick Leave ☐ Other _____
If NO, Date Status Began

24 How is Employee paid? *(check one)*
☐ Hourly $ _____ *(hourly rate)* ☐ Salary ☐ Commission ☐ Other _____

25. How often is Employee paid? *(check one)* ***(if earnings vary, provide pay stubs supporting earnings as defined in the policy)***
☐ Weekly $ _____ ☐ Bi-Weekly $ _____
☐ Semi-Monthly $ _____ ☐ Monthly $ _____
☐ Annually $ _____ *Please provide earnings amount as of date last worked.*

26. Based on the policy definition of earnings, does Employee receive any of the following? *(check all that apply)* ***(provide supporting payroll documentation)***
☐ Bonus $ _____ ☐ Commission $ _____ ☐ Overtime $ _____
☐ W-2 $ _____ ***(if applicable, provide W-2(s) and year-end pay stub(s) for period(s) indicated in the policy)***
☐ Pre-Tax ☐ Post-Tax

27. Date of Last Salary Increase	28. On the job injury or illness? ☐ Yes ☐ No If YES, include initial injury/illness report

G-31147 (Packet) 10/26/23

Employee Name	Employer Name	Employer Policy Number

Employee Information – To Be Completed By Employee *(please print) (continued)*

25. Have you ever had same or similar condition in the past?

☐ Yes ☐ No

If YES, Provide Name and Address of Hospital/Doctor Below

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

26. Are you receiving any of the following? *(now or in the future)* *(check each benefit you are receiving)*	Gross Amount	Begin Date	End Date
☐ Worker's Compensation	$		
☐ Social Security/Veteran's Administration	$		
☐ State Disability *(provide state)* _____	$		
☐ Paid Family Medical Leave	$		
☐ Vacation/PTO/Salary Continuance	$		
☐ Sick Pay	$		
☐ Short-Term Disability	$		
☐ Unemployment	$		
☐ Other *(Retirement Income)*	$		
☐ Auto Insurance Wage Replacement	$		

27. Marital Status	**28.** Spouse Name	**29.** Spouse Date of Birth
☐ Single ☐ Married ☐ Divorced ☐ Widowed		

30. List Children Under Age 25 *(Names and Dates of Birth)*

Tax Withholding

If benefits are approved, do you want federal income taxes withheld from your payments? *(if your benefits are non-taxable, taxes will not be withheld)*

☐ Yes ☐ No

If YES,

☐ Short-Term Disability *(weekly minimum $20)* $ _____

☐ Long-Term Disability *(monthly minimum $88)* $ _____

Employer self-funded plans have mandatory withholding requirements based on IRS Publication 15-A without a W-4.

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 complete and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

Employee Signature	Date

Employee Name *(please print)*

Employee Statement for Disability Insurance Claim Form

Claim is being filed for: ☐ Short-Term Disability ☐ Long-Term Disability

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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.

Employee Information -- To Be Completed By Employee *(please print)*

1. Employee Name			**2.** Social Security Number
3. Height	**4.** Weight	**5.** Gender ☐ Male ☐ Female	**6.** Date of Birth
7. Street/Box/Apt. Address	City	State	ZIP Code
8. Phone Number	**9.** Email		
10. Employer Name			**11.** Employer Phone Number
12. Employer Address	City	State	ZIP Code

13. Occupation ☐ Hourly ☐ Salaried ☐ Executive ☐ Management ☐ Union ☐ Other _____

14. List Occupation Duties

15. Date of Accident or First Symptoms	**16.** Date Last Physically/Actively at Work	**17.** Anticipated Date Last Worked *(if still working)*

18. Reason Unable to Work *(check one)*
☐ Accidental Injury ☐ Illness ☐ Pregnancy ☐ Motor Vehicle Accident (MVA)

If Related to MVA, Provide Attorney Name and Phone Number

19. Have you returned to work? ☐ Yes ☐ No	If YES, Date Returned ☐ Full-Time ☐ Part-Time	If NO, Date Expected to Return ☐ Full-Time ☐ Part-Time ☐ Unknown

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

21. Is your accidental injury or illness related to your occupation? ☐ Yes ☐ No	If YES, Explain	
22. Have you filed a Worker's Compensation Claim? ☐ Yes ☐ No	If NO, do you intend to? ☐ Yes ☐ No	If NO, Explain

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

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

24. Date of Next Office Visit

Disability Insurance Claim Packet

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
P.O. Box 7003
Indianapolis, IN 46207
1-855-517-6365
Fax 1-844-287-9499
Disability.claims@oneamerica.com

ONEAMERICA®

Instructions - Please Read Carefully and Submit All Required Information

We offer five options for filing a 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. Online Claim Form:
   Complete and submit your disability claim form, found at *www.employeebenefits.aul.com* in the Disability section of the Forms tab. This will automate the submission process.
3. Email to *disability.claims@oneamerica.com*;
4. Fax to 1-844-287-9499; or
5. Mail forms to:
   American United Life Insurance Company®
   P.O. Box 7003
   Indianapolis, IN 46207

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

Disability Insurance Claim Filing Instructions

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

Employee Statement for Disability Insurance Claim Form – The Employee should complete this form.

Policyholder Statement for Disability Insurance Claim Form – The Policyholder *(Employer)* should complete in full and submit the following information:

- Enrollment forms, requests for increase or decrease in coverage amount, approval of Evidence of Insurability, and/or enrollment information from the policyholder's electronic enrollment system.
- Most recent W-2 if salary is based on W-2.
- Employee's current job description.
- If coverage is Voluntary/Employee Contributes to premium, please include proof of enrollment and copy of paycheck stub for year of disability and prior year.

Attending Physician Statement for Disability Claim – 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.

It is the responsibility of you and your Employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

G-28203 11/1/23