

American United Life Insurance Company<sup>®</sup> a OneAmerica Financial<sup>®</sup> company  
One American Square, P.O. Box 368, Indianapolis, IN 46206-0368 • 1-317-285-1877



## Instructions - Please Read Carefully and Submit All Required Information

The form is to be completed by the Employee and Employer. The Employer should submit all completed forms to the Small Business Association of Michigan per the directions below.

All group and traditional life and disability business forms should be submitted to Small Business Association of Michigan (SBAM), and the SBAM Member Care team will forward to the appropriate party at OneAmerica Financial.<sup>®</sup> Submit to:

1. Email to [membercare@sbam.org](mailto:membercare@sbam.org)
2. Mail forms to: Small Business Association of Michigan  
101 S. Washington Square, Suite 900  
Lansing, MI 48933
3. Overnight forms to: Small Business Association of Michigan  
101 S. Washington Square, Suite 900  
Lansing, MI 48933

If you have any questions when completing this form, please contact the SBAM Member Care Team at [membercare@sbam.org](mailto:membercare@sbam.org) or 1-877-949-7226.

## Waiver of Premium Claim Filing Instructions

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

**Policyholder Statement for Waiver of Premium Claim Form** – The Policyholder (*Employer*) should complete this form and submit the following information.

- Submit all forms requesting or changing group life insurance coverage. 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.
- Employee's current job description.

**Employee Statement of Claim Form** – The Employee should complete this form.

**Attending Physician Statement** – The Primary Medical Provider treating the Employee for the conditions related to this injury or sickness should complete this form.

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

OneAmerica Financial<sup>®</sup> prides itself on being there when our customers need us most and we are pleased to offer Frequently Asked Questions (FAQs) regarding Employee Benefits life insurance claims on our website, [www.oneamerica.com/claims](http://www.oneamerica.com/claims).

# Policyholder Statement for Waiver of Premium Claim



American United Life Insurance Company® a OneAmerica Financial® company  
 One American Square, P.O. Box 7106, Indianapolis, IN 46207-7106 • 1-800-553-3522 • Fax 1-317-285-7663 • [waiverclaims.employeebenefits@oneamerica.com](mailto:waiverclaims.employeebenefits@oneamerica.com)

Section I – Employee Information					
Policyholder Name			Policyholder Number		
Employee Name			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Employee Street 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		Employee Occupation			
Date Employee was Last Physically/Actively at Work			Date Active Pay Status Ceased		
Has Employee Returned to Work <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, Date of Return to Work		Returned to Work <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
Is Employee Returning in an Accommodated Job <input type="checkbox"/> Yes <input type="checkbox"/> No		Was Employee Given Application to Port/Convert Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Date Given _____		Date Premiums Were Paid for This Employee	
Gross Annual Salary \$	Date of Last Salary Change	Gross Annual Salary Includes <input type="checkbox"/> Commissions <input type="checkbox"/> Bonuses <input type="checkbox"/> Overtime <input type="checkbox"/> Based on W-2 (attach last W-2)			
Employment Status (check all that apply) <input type="checkbox"/> Hourly <input type="checkbox"/> Executive <input type="checkbox"/> Management <input type="checkbox"/> Salaried/Non-Exempt <input type="checkbox"/> Salary/Exempt <input type="checkbox"/> Bargaining <input type="checkbox"/> Non-Bargaining					
Please Indicate Type of Retirement Plan Employee is/was Enrolled <input type="checkbox"/> 401(k) <input type="checkbox"/> 403(b) <input type="checkbox"/> 457 <input type="checkbox"/> Employer Sponsored Defined Benefit Plan <input type="checkbox"/> Employer Sponsored Defined Contribution Plan <input type="checkbox"/> Other _____					
Is this Employee receiving, or eligible for, an Employer Sponsored retirement plan benefit? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, what date did/will they begin receiving the retirement plan benefit? _____					
Is the Employee receiving, or eligible for, an Employer Sponsored disability retirement plan benefit?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, what date did/will they begin receiving the plan benefit? _____ If YES, will the disability retirement plan benefit automatically roll over to a regular retirement plan benefit when the Employee reaches a certain age? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No At what age will the benefit roll to the regular retirement plan benefit? _____					
<b>Identify All Coverage, Classes, and Volume of Coverage for the Employee. This Information is Required for Claim Processing</b>					
<input type="checkbox"/> Basic Term Life	Class _____	Volume _____			
<input type="checkbox"/> Basic AD&D	Class _____	Volume _____			
<input type="checkbox"/> Voluntary Term Life	Class _____	Volume _____			
<input type="checkbox"/> Voluntary AD&D	Class _____	Volume _____			
<input type="checkbox"/> Supplemental Life	Class _____	Volume _____			
<input type="checkbox"/> Supplemental AD&D	Class _____	Volume _____			

Employee Name		Policyholder Name		Policyholder Number		
<b>Section II – Dependent Information</b>						
<b>Identify All Coverages and Volume of Coverage</b>						
<input type="checkbox"/> Basic Dependent Term Life						
<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Family	Class _____	Volume _____	Option # _____
<input type="checkbox"/> Basic Dependent AD&D						
<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Family	Class _____	Volume _____	Option # _____
<input type="checkbox"/> Voluntary/Supplemental Dependent Life						
<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Family	Class _____	Volume _____	Option # _____
<input type="checkbox"/> Voluntary/Supplemental Dependent AD&D						
<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	<input type="checkbox"/> Family	Class _____	Volume _____	Option # _____
Spouse Name			Spouse Social Security Number		Spouse Date of Birth	
Effective Date of Insurance		Was Evidence of Insurability Required <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Premiums Were Paid for Dependent Coverage		
<b>Dependent Child(ren) Name(s)</b>					<b>Date of Birth</b>	
<b>Section III – Policyholder Information</b>						
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 acknowledges reading, understanding, and retaining the notices, limitations, exclusions, and state specific fraud statements included on the following pages.						
<input type="checkbox"/> I understand that premium must continue to be paid during the Waiver of Premium Elimination Period.						
Policyholder Name			Policyholder Number			
Street Address		City		State	ZIP Code	
Phone Number		Fax Number		Email		
Is This Plan Governed by ERISA <input type="checkbox"/> Yes <input type="checkbox"/> No		Printed Name & Title of Authorized Representative of Policyholder				
Signature of Authorized Representative of Policyholder					Date	

# Employee Statement of Claim

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: 1-317-285-7663  
waiverclaims.employeebenefits@oneamerica.com



## Section I – Employer Information

To avoid processing delay, all questions must be answered fully and accurately.

Name of Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
City State Zip Code

## Section II – Employee Information

Employee Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Gender:  Male  Female

Employee Address: \_\_\_\_\_  
City State Zip Code

Daytime Phone Number: \_\_\_\_\_ Employee Email Address: \_\_\_\_\_

Would you like communication via secure email instead of through U.S. Mail?  Yes  No

Are you?  Right-Handed  Left-Handed Gross Annual Salary: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

Name of Spouse: \_\_\_\_\_

Spouse's Gender:  Male  Female Is Spouse employed?  Yes  No

Dependent Children's Names and Dates of Birth: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you receiving unemployment benefits?  Yes  No

Are you retired?  Yes  No

If yes, are you receiving regular benefits under your employer's retirement or pension plan?  Yes  No

If yes, date payments began: \_\_\_\_\_

Are you receiving disability benefits under your employer's retirement or pension plan?  Yes  No

If yes, date payments began: \_\_\_\_\_

Are you receiving Social Security Disability Benefits?  Yes  No

If yes, please attach a copy of your Social Security Award notice.

If no, what is the status of your Social Security Disability application? \_\_\_\_\_

Are you receiving short-term or long-term disability benefits?  Yes  No

If yes, from what company do you receive disability benefits? \_\_\_\_\_

Are you receiving any other disability benefits?  Yes  No

If yes, what is the name of the entity paying the benefits? \_\_\_\_\_

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Employee Name: \_\_\_\_\_ Employer Name and Policy Number: \_\_\_\_\_

## Section III – Employment Information

Date you were last physically/actively at work: \_\_\_\_\_

Reason for stopping work:  Sickness/Injury  Terminated  Resigned  Layoff  Retired  FMLA  
 Other Leave of Absence  Other Reason: \_\_\_\_\_

Your Occupation and Title: \_\_\_\_\_

You are:  Hourly  Salary  Executive  Management  Salaried/Non-exempt  
(Check all that apply)  Bargaining  Non-bargaining

Essential duties of your job at the time of the sickness or injury: \_\_\_\_\_

How many hours were you regularly working per week with this employer? \_\_\_\_\_

Are you legally authorized to work/reside in the U.S.?  Yes  No

Was your job modified after your symptoms began?  Yes  No

If yes, what modifications were made? \_\_\_\_\_

Have you returned to work with this employer?  Yes  No  Full-Time  Part-Time

Have you returned to work with another employer?  Yes  No  Full-Time  Part-Time

If yes, name of employer: \_\_\_\_\_

Are you self-employed or do you have any other income producing activities?  Yes  No

If yes, please describe your activity, job, number of hours worked per week, earnings, and how long you have been working in this capacity: \_\_\_\_\_

## Section IV – Claim Information

Date of injury or date first noticed symptoms: \_\_\_\_\_

List all medical problems that you see a doctor for: \_\_\_\_\_

Describe how and where sickness and/or injury occurred or describe the onset and nature of your condition including symptoms. If more space is needed, attach separate sheet of paper. \_\_\_\_\_

Describe your current treatment plan for the sickness and/or injury: \_\_\_\_\_

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Employee Name: \_\_\_\_\_ Employer Name and Policy Number: \_\_\_\_\_

## Section V – Medical Treating Sources

Please list all current over the counter and prescribed medications you are taking (if additional space is needed, attach separate sheet):

Medication	Dosage	Frequency	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all pharmacies you currently use:

Pharmacy Name	Address	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all current medical providers seen for this condition (if additional space is needed, attach separate sheet):

Medical Provider	Address/Phone Number	Last Appointment	Next Appointment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been hospitalized due to this sickness or injury?  Yes  No

If yes, please provide:

Hospital Name	Address	Dates of Confinement
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Section VI – Training, Education and Experience

### Educational History

Do you have a high school diploma or GED certificate?  Yes  No Highest grade completed: \_\_\_\_\_

Degree?  BA  BS  MA  MS  PhD  Other: \_\_\_\_\_

Date received: \_\_\_\_\_

College/University/Trade School Name: \_\_\_\_\_ Major: \_\_\_\_\_

Other training and/or licenses/certificates held: \_\_\_\_\_

Languages spoken: \_\_\_\_\_

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Employee Name: \_\_\_\_\_ Employer Name and Policy Number: \_\_\_\_\_

## Section VI – Training, Education and Experience (continued)

### Computer Skills

How would you rate your current computer skills?  Poor  Fair  Good  Very Good

How long have you used computers? \_\_\_\_\_ Years \_\_\_\_\_ Months

Do you have a computer at home?  Yes  No

If yes, do you have access to the Internet?  Yes  No

If yes, type of access:  Satellite Internet  DSL  Cable Modem  Other: \_\_\_\_\_

How often do you use your computer? \_\_\_\_\_ Hours per Week \_\_\_\_\_ Hours per Day

Are you proficient in any of the following:  Word Processing  Spreadsheets  Databases  
 Email  Presentation  Social Media Websites (e.g., Facebook)

### Employment History

List employers for last 15 years, attaching a separate sheet if necessary or attach resume.  Resume Attached

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Industry: \_\_\_\_\_ Salary: \$ \_\_\_\_\_

Job duties/responsibilities (describe what you did): \_\_\_\_\_

Do you have supervisory experience? (please describe): \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Industry: \_\_\_\_\_ Salary: \$ \_\_\_\_\_

Job duties/responsibilities (describe what you did): \_\_\_\_\_

Do you have supervisory experience? (please describe): \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Industry: \_\_\_\_\_ Salary: \$ \_\_\_\_\_

Job duties/responsibilities (describe what you did): \_\_\_\_\_

Do you have supervisory experience? (please describe): \_\_\_\_\_

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Employee Name: \_\_\_\_\_ Employer Name and Policy Number: \_\_\_\_\_

**Section VI – Training, Education and Experience (continued)**

**Military History**

Are you currently in the military service?  Reserves  Active  No Date active service began: \_\_\_\_\_

Army  Navy  Air Force  Marines  Other: \_\_\_\_\_

Job Title: \_\_\_\_\_ Highest rank achieved: \_\_\_\_\_

Describe your duties: \_\_\_\_\_

**Transportation Information**

Do you have a valid driver’s license?  Yes  No Do you use public transportation?  Yes  No

Do you have transportation?  Yes  No Do you need assistance to travel?  Yes  No

If yes, describe what assistance is needed and who assists you: \_\_\_\_\_

List any endorsements (e.g., Hazmat, CDL): \_\_\_\_\_

List any restrictions to your license: \_\_\_\_\_

What type of vehicle do you drive? \_\_\_\_\_  Automatic  Manual transmission

Do you have handicapped plates or a placard?  Yes  No If yes, date issued: \_\_\_\_\_

**Section VII – Activities of Daily Living**

Do you live alone?  Yes  No

Do you require assistance with any of the following?

Bathing:  Yes  No Dressing:  Yes  No Toileting:  Yes  No

Transferring:  Yes  No Eating:  Yes  No

Type of assistance required: \_\_\_\_\_

Are you involved with any volunteer activities?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have difficulty sleeping?  Yes  No Do you usually take naps?  Yes  No

How have your sleep habits changed as a result of this condition? \_\_\_\_\_

Are you able to do housework?  Yes  No

Check types of housework you perform:

Household Repair  Car Repair  Dishes  Vacuuming  Trash  Dusting  Lawn and Gardening

Describe any assistance required: \_\_\_\_\_

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Employee Name: \_\_\_\_\_ Employer Name and Policy Number: \_\_\_\_\_

## Section VII – Activities of Daily Living (continued)

Do you have laundry facilities in your home?  Yes  No

Are you able to do the laundry?  Yes  No

Describe any assistance required: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you prepare your own meals?  Yes  No

If yes, which meals do you prepare?  Breakfast  Lunch  Dinner

If no, who helps you? \_\_\_\_\_

Have your eating habits changed since your condition began?  Yes  No

Provide examples of the types of meals you prepare/eat and any changes in your eating habits: \_\_\_\_\_  
\_\_\_\_\_

Do you handle your own finances?  Yes  No

Explain what you do (e.g., write checks, pay mortgage, maintain bank records, make bank deposits); or who assists you: \_\_\_\_\_  
\_\_\_\_\_

How has this changed since your condition began? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you exercise regularly?  Yes  No

Did you exercise regularly prior to your sickness or injury?  Yes  No

Do changes in your routine upset you?  Yes  No

If yes, what is your response or reaction to these changes? \_\_\_\_\_  
\_\_\_\_\_

Do you have problems with your memory?  Yes  No

If yes, describe the problems and how often they occur: \_\_\_\_\_  
\_\_\_\_\_

Do you shop?  Yes  No

What kinds of shopping do you do?  Food  Clothes  Gifts  Other: \_\_\_\_\_

How often do you shop?  Daily  Twice a week  Weekly  Monthly

Approximate time spent on shopping: \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly

Do you require assistance when you shop?  Yes  No

If yes, describe the assistance you require: \_\_\_\_\_  
\_\_\_\_\_

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Employee Name: \_\_\_\_\_ Employer Name and Policy Number: \_\_\_\_\_

## Section VII – Activities of Daily Living (continued)

Do you have childcare responsibilities?  Yes  No

If yes, what care are you able to provide?

- Bathe       Change clothes       Change diaper       Feed       Carry  
 Play activities       Lift       Read       Other: \_\_\_\_\_

Approximate time spend on childcare activities: \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly

Do you require assistance to perform any of these activities?  Yes  No

If yes, describe the assistance you need, who provides this assistance and how frequently you require this assistance:

\_\_\_\_\_  
\_\_\_\_\_

Do you read?  Yes  No

If yes, what do you read?  Books  Magazines  Newspaper  Other: \_\_\_\_\_

Approximate time spent reading: \_\_\_\_\_ Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly

Do you watch TV?  Yes  No

If yes, how many hours do you watch daily? \_\_\_\_\_

What types of hobbies or activities do you participate in?

- Fishing  Crafts  Sewing  Swimming  Computer  Continuing Education Courses  Movies  
 Sports  Hunting Type: \_\_\_\_\_  Other: \_\_\_\_\_

How often do you engage in these activities/hobbies?  Daily  Weekly  Monthly  Other: \_\_\_\_\_

Has there been any change in your interests and hobbies since this condition began?  Yes  No

If yes, describe the changes and the assistance you require: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you an active member of any clubs or community organizations?  Yes  No

If yes, describe your responsibilities and activities: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How often do you engage in these activities?  Daily  Weekly  Monthly  Other: \_\_\_\_\_

Do you hold any positions in your clubs or community organizations?  Yes  No

If yes, describe them: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you do volunteer work?  Yes  No

If yes, describe your volunteer activities, including the location, duties performed, hours, and frequency of participation:

\_\_\_\_\_  
\_\_\_\_\_



***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.

# Attending Physician Statement

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Employee Name: \_\_\_\_\_ Employer Name and Number: \_\_\_\_\_

## Attending Physician's Statement

**Please attach copies of all medical records and test results.**

Name of Patient: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_  
*First Middle Last*

Blood Pressure (last visit) Date: \_\_\_\_\_  Left-handed  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Systolic: \_\_\_\_\_ / Diastolic: \_\_\_\_\_  Right-handed

### 1. History

- a. Is this condition due to:  Sickness  Injury
- b. When did symptoms first appear or injury occur: \_\_\_\_\_
- c. Date patient was unable to work because of impairment: \_\_\_\_\_
- d. Date you first restricted patient's ability to work due to this condition: \_\_\_\_\_
- e. Has patient ever had same or similar condition?  Yes  No  
If "Yes", state when and describe: \_\_\_\_\_
- f. Was this patient referred to you?  Yes  No  
If "Yes", by whom and what is his/her specialty? \_\_\_\_\_
- g. Have you referred this patient to another treating provider?  Yes  No  
If "Yes", to whom and what is his/her specialty? \_\_\_\_\_

### 2. Diagnosis

- a. Primary diagnosis impacting function: \_\_\_\_\_ ICD9/10 Code(s) \_\_\_\_\_  
Nature of treatment (including surgery or other procedures): \_\_\_\_\_
- b. Secondary diagnosis impacting function: \_\_\_\_\_ ICD9/10 Code(s) \_\_\_\_\_  
Nature of treatment (including surgery or other procedures): \_\_\_\_\_
- c. Subjective Symptoms: \_\_\_\_\_
- d. Tests Conducted:  X-rays  CT Scan  MRI  EKG  Lab Work  Psychological Testing
- e. Objective findings: \_\_\_\_\_

### 3. Dates of Treatment for This Condition

- a. Date of first visit: \_\_\_\_\_
- b. Date of last visit: \_\_\_\_\_
- c. Next office visit: \_\_\_\_\_
- d. Frequency:  Weekly  Monthly  Other: \_\_\_\_\_

# Attending Physician Statement

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) 285-7663  
waiverclaims.employeebenefits@oneamerica.com



Employee Name: \_\_\_\_\_ Employer Name and Number: \_\_\_\_\_

4. Is the patient required to take any prescription medication regularly for the condition?  Yes  No  
If "Yes", please provide a listing of all current prescribed medications.

## 5. Progress

- a. Has patient .....  Recovered  Improved  Unchanged  Retrogressed  
b. Is patient .....  Ambulatory  House confined  Bed confined  Hospital confined

If "Hospital Confined", give name and address of location: \_\_\_\_\_

Dates of Confinement: \_\_\_\_\_

- c. Do you expect any significant improvement in the future?  Yes  No  
If "Yes", when?:  1 Month  1 - 3 Months  3 - 6 Months  6 - 12 Months  Other  
If "No", why not? \_\_\_\_\_

## 6. Restrictions and Limitations

- a. What restrictions, if any, have you placed upon your patient? \_\_\_\_\_  
b. When were these placed and when do you anticipate lifting them? \_\_\_\_\_

## 7. Return to Work Plan

- a. Is patient capable of working? Patient's Prior Job:  Yes  No Any Other Work:  Yes  No  
b. Have you discussed a return to work plan with your patient?  Yes  No  
c. The date you released patient to return to work \_\_\_\_\_  Full-time  Reduced hours Number of hours \_\_\_\_\_  
d. Please identify your recommendations for any job modification that would enable the patient to return to work \_\_\_\_\_

## 8. Cardiac (if applicable)

- a. Functional Capacity  Class 1 (No Limitation)  Class 2 (Slight Limitation)  
(American Heart Assoc. Standards)  Class 3 (Marked Limitation)  Class 4 (Complete Limitation)  
b. Was this patient referred to cardiac rehab?  Yes  No

## 9. Mental / Nervous Impairment (if applicable)

- Class 1 – Patient is able to function under stress and engage in interpersonal relations (No limitations)  
 Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (Slight limitations)  
 Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (Moderate limitations)  
 Class 4 – Patient is unable to engage in stress situations or engage interpersonal relations (Marked limitations)  
 Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitations)

- a. Please define what is considered "stress" as it applies to this patient. \_\_\_\_\_  
b. What stress and problems in interpersonal relations has patient had on patient's prior job? \_\_\_\_\_  
c. Remarks \_\_\_\_\_

10. Is the patient competent to endorse checks and direct the use of proceeds thereof?  Yes  No

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Employee Name: \_\_\_\_\_ Employer Name and Number: \_\_\_\_\_

## 11. 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 stand-  
 ing 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.

b. Please check appropriate box:

	Occasionally	0% to 33%	Frequently	33% to 66%	Continuously	66% to 100%
Bending	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Climbing	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Reaching	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Squatting	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Crawling	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Push/pull	<input type="checkbox"/>	No. of lbs. _____	<input type="checkbox"/>	No. of lbs. _____	<input type="checkbox"/>	No. of lbs. _____
Lifting (lbs.)	<input type="checkbox"/>	No. of lbs. _____	<input type="checkbox"/>	No. of lbs. _____	<input type="checkbox"/>	No. of lbs. _____

What is this assessment based on?  Observed activity  Measured activity  Physical therapy report

c. Upper Extremity Function – Please indicate upper extremity functional capabilities:

- Simple grasp                     Left     Right    Comments \_\_\_\_\_
- Pinch                             Left     Right    Comments \_\_\_\_\_
- Fine manipulation             Left     Right    Comments \_\_\_\_\_
- Power grip                       Left     Right    Comments \_\_\_\_\_
- Repetitive motion              Left     Right    Comments \_\_\_\_\_

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 and understands the Discretionary Authority & Fraud Warnings on the following pages.

Attending Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Provider's Name (Please Print): \_\_\_\_\_

Degree / Specialty: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Office Address: \_\_\_\_\_  
 Number/Street

City or Town

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 and denial of insurance benefits.

American United Life Insurance Company<sup>®</sup> a OneAmerica Financial<sup>®</sup> company

**General Fraud Warning:** 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.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**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.

**Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, West Virginia:** 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 is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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, 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:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing 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.

**Hawaii:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**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, Virginia, 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.

**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:** 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, as provided in RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma: WARNING:** 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.

**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 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.

**Texas:** Any person who knowingly presents a 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.

**Vermont:** Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.



American United Life Insurance Company®  
 Pioneer Mutual Life Insurance Company\*  
 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. I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB.

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 – this will delay the process because the Privacy Officer does not review records or handle billing.***

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.*

**Examiner’s Name:** \_\_\_\_\_

**Return to: Employee Benefits Claims – Buzz G329**