

American United Life Insurance Company[®] a OneAmerica Financial[®] 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 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.[®] Submit to:

1. Email to *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* or 1-877-949-7226.

Group Life Insurance Claim Filing Instructions

All questions should be answered fully and accurately to avoid delays in claim processing. Forms should be completed as follows:
The Authorized Representative of the Employer should:

1. Submit all forms within the timeframe specified in the policy.
2. The below supporting documentation is required to complete this process:
 - a. Copy of each Beneficiary designation signed by the Employee or copy of the Beneficiary designation from an electronic enrollment system.
Note: A maximum of eight Beneficiaries may be added. If additional Beneficiaries are named, you may attach a separate sheet listing any additional Beneficiaries.
 - b. If applicable, 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.
 - c. Employee’s most recent W-2 if salary is based on W-2.
3. The below supporting documentation may be attached if available (*These items are required to process the claim benefit.*):
 - a. Copy of the certified Death Certificate.
 - b. If Dependent claim and Dependent is full-time student:
 1. Documentation from the educational institution of full-time student status.
 2. Copy of Employee’s most recent federal tax return.
 - c. If the Beneficiary is a Trust or Estate:
 1. Trust/Estate Document
 2. IRS Form SS-4 for verification of Tax ID Number
4. Please provide any additional comments, notes, or attachments that may be applicable or relevant to the claim.

Authorization for the Release of Protected Health Information (PHI) of a Deceased Individual

As the Employer, please provide this form to the Personal Representative or the person who had the legal authority to make medical decisions for the deceased. The Personal Representative should complete, sign, and return the form to American United Life Insurance Company.[®]

OneAmerica Financial[®] prides itself of on being there when our customers need us most, and we are pleased to provide employees’ families with access to resources and tools to help them manage loss. Our online beneficiary guide is available for their reference on our website at <https://www.oneamerica.com/beneficiary-guide>.

Group Life Insurance Claim Form

To Be Completed By Policyholder

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 1-317-285-7666 • lifeclass.employeenefits@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	Employee Class	
Date Employee was Last Physically/Actively at Work		Date Active Pay Status Ceased	
Did Employment Cease Prior to Death <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 If YES, Date Given _____		
How Was Notice of Portability/Conversion 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	
Employee Is (<i>check all that apply</i>) <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			
Indicate Reason(s) for Date Last Physically/Actively at Work (<i>please select all that apply</i>)			
<input type="checkbox"/> Termination of Employment Date _____ <input type="checkbox"/> Reduction of Hours Date _____ <input type="checkbox"/> Layoff: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary Layoff Date _____ <input type="checkbox"/> Retirement: Date of Retirement _____ <input type="checkbox"/> Disability: Date of Disability _____ <input type="checkbox"/> Entered Active Military Service: Date Entered _____ <input type="checkbox"/> FMLA Type: <input type="checkbox"/> Self <input type="checkbox"/> Family FMLA Begin Date _____ FMLA End Date _____ <input type="checkbox"/> Leave of Absence Reason for Leave of Absence _____ Date Leave of Absence Began _____ <input type="checkbox"/> Illness/Injury: Date of Illness/Injury _____ <input type="checkbox"/> Other _____			
For Union Groups Only			
Is the Coverage Through a Union Group <input type="checkbox"/> Yes <input type="checkbox"/> No		Date All Dues and Assessments Were Paid for This Employee	
Was Member in Good Standing on Coverage Effective Date <input type="checkbox"/> Yes <input type="checkbox"/> No		Was Member in Good Standing at His (<i>or Dependent's</i>) Date of Death <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Name		Policyholder Name		Policyholder Number	
Section I - Employee Information (continued)					
Employee Date of Death					
Identify All Coverage, Classes, and Volume of Coverage for the Employee. This Information is Required for Claim Processing					
<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 _____		
Section II – Dependent Information					
Dependent Information (please complete the entire claim form if claim is for a Dependent)					
Dependent Name			Relationship to Employee		
Dependent Date of Birth	Dependent Social Security Number	Marital Status of Dependent <input type="checkbox"/> Single <input type="checkbox"/> Married		Is Dependent a Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If Dependent Child is over 19 and a full-time student, please send documentation from the educational institution of full-time student status and a copy of the Employee's most recent federal tax return.</i>					
Effective Date of Dependent Insurance			Was Evidence of Insurability Required <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date Premiums Were Paid for This Dependent			Dependent Date of Death		
Identify All Coverages and Volume of Coverage					
<input type="checkbox"/>	Basic Dependent Term Life	Dependent: <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Class _____	Volume _____	Option # _____
<input type="checkbox"/>	Basic Dependent AD&D	Dependent: <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Class _____	Volume _____	Option # _____
<input type="checkbox"/>	Voluntary/Supplemental Dependent Life	Dependent: <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Class _____	Volume _____	Option # _____
<input type="checkbox"/>	Voluntary/Supplemental Dependent AD&D	Dependent: <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Class _____	Volume _____	Option # _____
Section III – Beneficiary Contact Information					
Individual Beneficiary Contact Information					
A maximum of eight Beneficiaries may be added. If additional Beneficiaries are named, please attach a separate sheet listing remaining Beneficiaries contact information. In addition to providing the information for each Beneficiary, you must also submit a copy of each Beneficiary designation signed by the Employee or copy of the Beneficiary designation from electronic enrollment system.					
Beneficiary Name			Beneficiary Social Security Number	Beneficiary Date of Birth	
Beneficiary Mailing Address			City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email			

Employee Name	Policyholder Name	Policyholder Number
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Section III – Beneficiary Contact Information (continued)

Individual Beneficiary Contact Information

Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address		City	State ZIP Code
Beneficiary Daytime Phone Number	Beneficiary Email		
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address		City	State ZIP Code
Beneficiary Daytime Phone Number	Beneficiary Email		
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address		City	State ZIP Code
Beneficiary Daytime Phone Number	Beneficiary Email		
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address		City	State ZIP Code
Beneficiary Daytime Phone Number	Beneficiary Email		
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address		City	State ZIP Code
Beneficiary Daytime Phone Number	Beneficiary Email		
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address		City	State ZIP Code
Beneficiary Daytime Phone Number	Beneficiary Email		
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address		City	State ZIP Code
Beneficiary Daytime Phone Number	Beneficiary Email		
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address		City	State ZIP Code
Beneficiary Daytime Phone Number	Beneficiary Email		

Employee Name		Policyholder Name		Policyholder Number	
Section III – Beneficiary Contact Information (continued)					
Trust/Estate Beneficiary Contact Information (complete this section if an Estate or Trust is the named Beneficiary)					
Please attach the Trust/Estate Document and IRS Form SS-4 for verification of Tax ID Number.					
Trust/Estate Name		Trust /Estate Tax ID Number		Trustee/Estate Personal Representative	
Trustee/Estate Personal Representative Mailing Address		City		State	ZIP Code
Trustee/Estate Personal Representative Daytime Phone Number			Trustee/Estate Personal Representative Email		
Contact Information for Employee Claim					
<input type="checkbox"/> No Beneficiary designation on file. If no Beneficiary has been designated on an American United Life Insurance Company® (AUL) form or a prior Carrier form for the same coverage, please indicate the name and contact information for the person who supplied the copy of the certified Death Certificate. Check the "No Beneficiary designation on file" box. AUL will contact this person with instructions concerning what additional information is required to determine the proper payee. If no Beneficiary has been named and an Estate has been or will be established, please provide Estate information.					
Contact Name					
Street Address		City		State	ZIP Code
Daytime Phone Number	Relationship to Deceased		Email		
Section IV – Additional Information <i>(please provide any additional comments, notes, or attachments that may be applicable or relevant to the claim)</i>					
Section V – Policyholder Information					
The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees that: 1) any insurance coverage or benefits are contingent upon any statements made to AUL as being complete and correct, and 2) benefits under any policy will be paid only if AUL determines the applicant is entitled to them. The undersigned has read, understands, and has retained the notices, limitations, and exclusions for their records and the state specific fraud statements included on the following pages.					
Policyholder			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 the Policyholder				
Signature of Authorized Representative of the Policyholder				Date	

American United Life Insurance Company[®] a OneAmerica Financial[®] 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.

Authorization for the Release of Protected Health Information (PHI) of a Deceased Individual

HIPAA-Compliant Form

Products and financial services provided by American United Life Insurance Company* a OneAmerica® company
 One American Square, P.O. Box 7106
 Indianapolis, IN 46206-7106
 1-800-553-3522, Fax 317-285-7666
 lifeclaims.employeebenefits@oneamerica.com



As the Employer, please provide this form to the Personal Representative or the person who had the legal authority to make medical decisions for the deceased. The Personal Representative should complete, sign, and return the form to American United Life Insurance Company.®

Employee Name	Deceased Name
Your Relationship to Deceased	Deceased Date of Birth
Group Policyholder Number	Claim Number
<p>I hereby attest that I am the Personal Representative for the deceased, and I am therefore legally authorized by a court or by state law to act on behalf of the deceased individual or his or her estate. I authorize any employer; health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy; pharmacy benefit manager; medical facility; other health care provider; insurance company; insurance support organization; the MIB, Inc. (<i>formerly known as Medical Information Bureau</i>); or other organization or person that has provided payment, treatment, or services to the deceased or on his/her behalf within the past 10 years or has any records or knowledge of the deceased's health within the past 10 years (<i>the "Providers"</i>) to disclose the deceased's entire medical record, prescription history, supplies provided with any other protected health information concerning the deceased to any company listed as a OneAmerica® company (<i>"the Company"</i>), its reinsurers or any agent, attorney, insurance support organization or other authorized representative acting on their behalf. This includes information on the diagnosis or treatment of human immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and psychiatric history, as well as the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of the deceased's personal health information to MIB.</p> <p>By my signature below, I acknowledge that any agreements the deceased made to restrict his/her protected health information do not apply to this authorization and I instruct his/her Providers to release and disclose his/her entire medical record without restriction.</p> <p>This protected health information will be used in evaluating and administering my claim for benefit. The authorization will be valid for the duration of the claim or one year after the date it is signed. A photocopy of this authorization will be as valid as the original.</p> <p>I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the Privacy Manager, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206. (Do NOT send this form, medical records, etc. to the Privacy Manager.) I understand that a revocation is not effective to the extent that any of the deceased's Providers have already relied on this authorization to disclose information about the deceased or to the extent that the Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but that it will not be redisclosed by the Company except as authorized by me or as required by law.</p>	
Personal Representative Signature	Date