

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.

## 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.

# Employee Statement for Disability Insurance Claim Form

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

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

One American Square, P.O. Box 7003, Indianapolis, IN 46207-7003 • 1-855-517-6365 • Fax 1-844-287-9499 • [disability.claims@oneamerica.com](mailto:disability.claims@oneamerica.com)

**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 <input type="checkbox"/> Male <input type="checkbox"/> 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		<input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Executive <input type="checkbox"/> Management <input type="checkbox"/> Union <input type="checkbox"/> 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) <input type="checkbox"/> Accidental Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy <input type="checkbox"/> Motor Vehicle Accident (MVA)		If Related to MVA, Provide Attorney Name and Phone Number	
19. Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, Date Returned <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	If NO, Date Expected to Return <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, Explain	
22. Have you filed a Worker's Compensation Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		If NO, do you intend to? <input type="checkbox"/> Yes <input type="checkbox"/> 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			

Employee Name	Employer Name	Employer Policy Number
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**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
<input type="checkbox"/> Worker's Compensation	\$		
<input type="checkbox"/> Social Security/Veteran's Administration	\$		
<input type="checkbox"/> State Disability (provide state) _____	\$		
<input type="checkbox"/> Paid Family Medical Leave	\$		
<input type="checkbox"/> Vacation/PTO/Salary Continuance	\$		
<input type="checkbox"/> Sick Pay	\$		
<input type="checkbox"/> Short-Term Disability	\$		
<input type="checkbox"/> Unemployment	\$		
<input type="checkbox"/> Other (Retirement Income)	\$		
<input type="checkbox"/> Auto Insurance Wage Replacement	\$		

27. Marital Status

Single  Married  Divorced  Widowed

28. Spouse Name

29. Spouse Date of Birth

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 included here.

Employee Signature	Date
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Employee Printed Name

# Policyholder Statement for Disability Insurance Claim Form

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

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

One American Square, P.O. Box 7003, Indianapolis, IN 46207-7003 • 1-855-517-6365 • Fax 1-844-287-9499 • [disability.claims@oneamerica.com](mailto:disability.claims@oneamerica.com)

**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 <input type="checkbox"/> No Coverage		12. Original Long-Term Disability Coverage Effective Date <input type="checkbox"/> No Coverage	
13. How many months per year does Employee work?		14. Employee Work Location	
15. Regular Work Schedule (check all that apply) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Seasonal <input type="checkbox"/> Shift Work			16. Regular Scheduled Weekly Hours
17. Regular Workdays (check all that apply) <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, Date Returned <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
23. Was Employee at work when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No		If NO, Select Status <input type="checkbox"/> Terminated <input type="checkbox"/> Family Medical Leave (FML) <input type="checkbox"/> Laid Off <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Resigned <input type="checkbox"/> Sick Leave <input type="checkbox"/> Vacation/PTO <input type="checkbox"/> Other _____	
24. How is Employee paid? (check one) <input type="checkbox"/> Hourly \$ _____ (hourly rate) <input type="checkbox"/> Salary <input type="checkbox"/> Commission <input type="checkbox"/> Other _____			
25. How often is Employee paid? (check one) (if earnings vary, provide pay stubs supporting earnings as defined in the policy) <input type="checkbox"/> Weekly \$ _____ <input type="checkbox"/> Bi-Weekly \$ _____ <input type="checkbox"/> Semi-Monthly \$ _____ <input type="checkbox"/> Monthly \$ _____ <input type="checkbox"/> 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) <input type="checkbox"/> Bonus \$ _____ <input type="checkbox"/> Commission \$ _____ <input type="checkbox"/> Overtime \$ _____ <input type="checkbox"/> W-2 \$ _____ (if applicable, provide W-2(s) and year-end pay stub(s) for period(s) indicated in the policy) <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax			
27. Date of Last Salary Increase	28. On the job injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, include initial injury/illness report		

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

29. Employee is Eligible for: (now or in the future)				If YES, Weekly or Monthly Gross Amount	Frequency	Provider Name/Address	Date Benefits Begin	Date Benefits End
	Yes	No	Unknown					
Salary Continuation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Disability Pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Retirement Pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
State Disability If YES, list state _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Paid Family Medical Leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Vacation/PTO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Sick Pay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$				
Has Workers' Comp. claim been filed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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 included here.

Authorized Employer Representative Signature (the above statements are true and complete to the best of my knowledge)

Authorized Employer Representative Printed Name

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.**

# Attending Physician Statement for Disability Claim

American United Life Insurance Company<sup>®</sup> a OneAmerica Financial<sup>®</sup> company  
One American Square, P.O. Box 7003, Indianapolis, IN 46207-7003 • 1-855-517-6365 • Fax 1-844-287-9499 • [disability.claims@oneamerica.com](mailto:disability.claims@oneamerica.com)

Patient Information – To Be Completed By Physician			
1. Patient Name		2. Employer Name	
3. Height	4. Weight	5. Blood Pressure ( <i>last visit</i> )	6. Date of Birth
7. Reason Patient Is/Was Unable to Work ( <i>check one</i> ) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy			
8. Primary Diagnosis ( <i>include complications and International Classification of Diseases (10th revision) (ICD 10)</i> )			
9. Secondary Diagnosis ( <i>include complications and ICD 10</i> )			
For Routine Pregnancy, Complete Items 10-16 ( <i>then skip to item 33</i> )			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ( <i>x-rays, EKG's, lab data and clinical findings</i> )		26. Subjective Symptoms	
27. Nature of Treatment ( <i>surgery, medications, etc.; provide medication dosage and frequency</i> )			
28. Names and Addresses of Patient's Other Physicians		29. Name of Physician You Referred This Patient To	
30. Has patient been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, when do you expect a fundamental change? <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> 3-4 weeks <input type="checkbox"/> 5-6 weeks <input type="checkbox"/> More than 6 weeks		

Employee Name		Employer Name		Employer Policy Number	
<b>For All Conditions Except Routine Pregnancy, Complete the Following Items (continued)</b>					
33. Has patient been released to return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, Date Released <input type="checkbox"/> Full-Time <input type="checkbox"/> 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.			
<b>Signature</b>					
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 Printed Name					
Degree/Specialty					
Phone Number		Fax Number		Tax ID Number	
Office Address		City/Town		State	ZIP Code

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.

**Authorization for Release of Information – HIPAA Compliant**

(Excluding Psychotherapy Notes)

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



**To be signed, dated, and returned by the insured/claimant.**

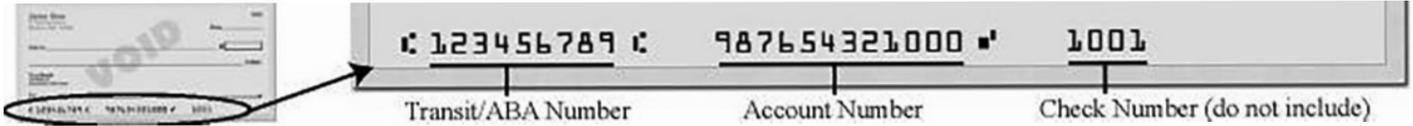
Claimant Name		Claimant Date of Birth
Claim Number	Employer Name	Employer Policy Number
<p>I authorize any licensed physician, any other medical practitioner or provider, pharmacy benefit manager, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government 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 (<i>including psychiatric, sexually transmitted diseases, alcohol, and drug abuse, and, where permitted by law, HIV/AIDS information</i>) 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.</p> <p>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.</p> <p>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.</p> <p><b>If you reside in California, Connecticut, Maine, or Massachusetts:</b>                  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 (<i>for self-insured business</i>) is required each time results are released.</p> <p><b>If you reside in Vermont:</b>                  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.</p>		
Claimant Signature ( <i>or Authorized Representative</i> )		Date
Description of Authorized Representative’s Authority ( <i>if applicable</i> ) ( <i>If signed by Authorized Representative, attach verification of identity.</i> )		

# Direct Deposit Authorization Agreement

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

One American Square, P.O. Box 7003, Indianapolis, IN 46207-7003 • 1-855-517-6365 • Fax 1-844-287-9499 • [disability.claims@oneamerica.com](mailto:disability.claims@oneamerica.com)

New Direct Deposit    Change to Current Direct Deposit    Cancel Direct Deposit

Please Print		
Name		Social Security Number
Account Information		
Type of Account <input type="checkbox"/> Checking <input type="checkbox"/> Savings <i>(American United Life Insurance Company<sup>®</sup> (AUL) will only deposit to one account.)</i>		
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		
<p>I authorize American United Life Insurance Company<sup>®</sup> (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.</p>		
Signature		Date