

# Disability Claim Filing Instructions

## Employer will need to:

- Complete Section A – Policyholder’s Statement in full, sign and date

## Employee will need to:

- Complete Section B – Employee’s Statement in full, sign and date
- Read, sign and date the AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA-COMPLIANT) form
- Give form to treating physician to complete Section C – The Attending Physician’s Statement
- Submit Sections A, B & C and the signed authorization as follows:
  - > Mail to address below
  - > Fax to 1-207-591-3048

## Attending physician will need to:

- Complete the Attending Physician’s Statement in full, sign and date
- Return completed Attending Physician’s Statement to employee to submit to the address below.

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

**If you have any questions when completing this form,  
please call an AUL representative at:**

**Toll-Free Telephone Number 1-866-258-8744**

**American United Life Insurance Company®  
One Riverfront Plaza  
Westbrook, Maine 04092-9700**



AMERICAN UNITED LIFE INSURANCE COMPANY®

*a ONEAMERICA® company*

# Claim Application for Short-term Disability

Products and financial services provided by  
 American United Life Insurance Company®  
 a ONEAMERICA® company  
 One Riverfront Plaza  
 Westbrook, ME 04092-9700  
 Fax: 1-207-591-3048  
 Toll Free Phone: 1-866-258-8744



(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

## SECTION A – POLICYHOLDER’S STATEMENT

Employee’s Name: _____	Date of Hire: ___ / ___ / ___ Last date worked: ___ / ___ / ___
Actual number of hours worked per week: _____	Reason for stopping work: <input type="checkbox"/> Disability <input type="checkbox"/> Termination <input type="checkbox"/> Other _____
<p>The employer/policyholder represents and warrants any information or documents provided to American United Life Insurance Company® (AUL) by the employer/policyholder prior to and after the date coverage became effective and the facts and other matters contained in the foregoing are true and accurate to the best of the employer/policyholder’s knowledge and belief. The employer/policyholder understands and agrees: 1) any insurance coverage or benefit is contingent upon any statement made to AUL as being complete and correct; and 2) benefits under any policy will be paid only if AUL decides in its discretion the applicant is entitled to them. The employer/policyholder acknowledges reading and understanding the state specific fraud statements.</p>	
_____ Print Name & Title of Official Representative	_____ Telephone Number
_____ Signature	_____ Date

## SECTION B – EMPLOYEE’S STATEMENT

Policyholder/Employer Name: _____				
Policyholder/Employer Address: _____				
Name: _____ Date of Birth: ___ / ___ / ___ Social Security #: ___ / ___ / ___				
Address: _____ Phone #: ( _____ ) _____ - _____				
<i>Street Address                      City                      State                      Zip Code</i>				
Your Occupation: _____ <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time				
Gross Annual Salary: _____				
<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed	<input type="checkbox"/> Male <input type="checkbox"/> Female	Hours worked per regular work week: _____	Date of injury or sickness: ___ / ___ / ___	Date of first treatment: ___ / ___ / ___
Have you ever had same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	Describe how and where injury occurred or describe the onset and nature of your Medical condition including symptoms:			Date you returned to work: ___ / ___ / ___ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Treated by: _____				
Medical Provider: _____				
<i>Name                      Street Address                      City                      State                      Zip Code</i>				
Doctor: _____				
<i>Name                      Street Address                      City                      State                      Zip Code</i>				
<p>The undersigned represents and warrants any information or documents provided to American United Life Insurance Company® (AUL) by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned’s knowledge and belief. The undersigned understands and agrees: 1) any insurance coverage or benefit is contingent upon any statement made to AUL as being complete and correct; and 2) benefits under any policy will be paid only if AUL decides in its discretion the applicant is entitled to them. The undersigned acknowledges reading and understanding the state specific fraud statements.</p>				
Signature of Employee _____ Date ___ / ___ / ___				
Name of Employee (Please print) _____				

**Fraud Warnings** (For use in AR, DC, LA, NM, TX and WV)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

**Alaska**

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona**

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California**

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**Delaware, Idaho, Indiana, Oklahoma**

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Florida**

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Kentucky**

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of a claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Tennessee, Washington**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland, Rhode Island**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

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Group Policy No. \_\_\_\_\_

Name of Employer \_\_\_\_\_

Name of Employee (Please Print) \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)  
(HIPAA-COMPLIANT)  
(to be signed and dated by the insured/claimant)**

I authorize any licensed physician; any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically-related facility; federal, state or local government agency; insurance or reinsuring company; the Social Security Administration; consumer reporting agency or employer having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Workers Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS) and American United Life Insurance Company® (AUL) *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records; medical, dental and hospital records (including psychiatric, alcohol abuse, drug abuse and, where permitted by law, **HIV/AIDS** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Disability RMS, AUL and their representatives to evaluate and adjudicate my current disability claim, and be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Disability RMS or AUL to assist with the evaluation and adjudication of my current disability claim and/or to report aggregate claims information to AUL. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act's (HIPAA's) privacy rules, or any other federal or state law.

This authorization is valid during the pendency of my claim and shall expire on the date my claim ends. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Disability RMS at the address above in writing, of my revocation. However, such revocation is not effective to the extent that Disability RMS and/or AUL have relied previously upon this authorization for the use or disclosure of my protected health information. In addition, I understand that my revocation of or my failure to sign this authorization may impair Disability RMS's and AUL's ability to evaluate my current disability claim and as a result may be a basis for denying that current disability claim for benefits.

I understand that a physical exam of me may be ordered.

I understand that an investigative consumer report about me may be requested. These reports contain information about my character, general reputation, mode of living and health except as may be related directly or indirectly to my sexual orientation. The information may be obtained through interviews with me, my neighbors, friends and others who know me. Upon request, Disability RMS or AUL will give me the name and address of the consumer reporting firm so that I may request a copy of that report.

Claimant Signature (or Authorized Representative): \_\_\_\_\_ Date: \_\_\_\_\_

Description of Personal Representative's Authority (if applicable): \_\_\_\_\_  
(If signed by authorized representative, attach verification of identity)

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

## SECTION C – ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: _____ Date of Birth: ___ / ___ / ____ Height: _____ Weight: _____			
Date person was unable to work because of impairment: Month _____ Day _____ Year _____			
Diagnosis impacting function: _____ Secondary diagnosis: _____			
Nature of treatment: _____			
<b>For Pregnancy Disabilities</b>			
Are there any present complications or anticipated difficulties in connection with:			
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Delivery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expected Date of Delivery: ___ / ___ / ____
Post Partum	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Actual Date of Delivery: ___ / ___ / ____ <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
If yes to any of these, please specify in detail: _____			
<b>Dates of treatment for this condition</b>			
Date of first visit	Month _____	Day _____	Year _____
Date of last visit	Month _____	Day _____	Year _____
Next office visit	Month _____	Day _____	Year _____
Frequency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Other (specify) _____
If "Hospital Confined", give name and address of medical provider _____			
Confined from ___ / ___ / ____ through ___ / ___ / ____			
Was this patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, to whom and what is his/her specialty? _____			
Have you referred this patient to another treating provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, to whom and what is his/her specialty? _____			
<b>Return to work plan</b>			
Have you discussed a return to work plan with your patient <input type="checkbox"/> Yes <input type="checkbox"/> No			
The date you released patient to return to work ___ / ___ / ____ <input type="checkbox"/> Full-time <input type="checkbox"/> Reduced hours <input type="checkbox"/> Number of hours _____			
Please identify your recommendations for any job modification that would enable the patient to return to work _____			
The undersigned Medical Provider represents and warrants any information or documents provided to American United Life Insurance Company® (AUL) by this Medical Provider and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned Medical Provider acknowledges reading and understanding the state specific fraud statements.			
Attending Physician's Signature _____			Date ___ / ___ / ____
Medical Provider's Name (Please print) _____		Degree/Specialty _____	
Telephone Number ( _____ ) _____ - _____		Fax Number ( _____ ) _____ - _____ Tax ID# _____	
Office Address _____			
Street		City	State
		Zip Code	



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