Disability Insurance Claim Form

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
300 Southborough Drive, Suite 200
South Portland, ME 04106
Fax: 207-766-3448
Toll Free Phone: 1-866-258-8744

OneAmerica®

Disability Insurance Filing Instructions
INSTRUCTIONS – PLEASE READ CAREFULLY

- All questions must be answered fully and accurately before a decision on benefit entitlement can be made
- The Employer/Policyholder should complete Section A – Employer's Statement
- Complete Section B – Employee's Statement should be completed by the Employee
- The employee should read, sign and date the AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA-COMPLIANT) form
- The Attending Physician's statement should be completed by the primary medical provider treating the Employee for the conditions related to this injury or sickness

If you have questions when completing this form, please call an American United Life Insurance Company® representative at 1-866-258-8744.

Completed forms and communications should be sent to:

American United Life Insurance Company®
c/o Disability RMS
300 Southborough Drive, Suite 200
South Portland, ME 04106

Or

Fax: 207-766-3448

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

Claim Application for Short-term Disability

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(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

SECTION A – EMPLOYER'S STATEMENT

Employee's Name: _____	Date of Hire: _____ Last date worked: _____
Actual number of hours worked per week: _____	Reason for stopping work: ☐ Disability ☐ Termination ☐ Other _____

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, or its third party administrator, DRMS, decides in its discretion the applicant is entitled to them. The employer/policyholder acknowledges reading and understanding the state specific fraud statements.

_____ _____
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 #: _____
Street Address City State Zip Code

Your Occupation: _____ ☐ Full-Time ☐ Part-Time

Gross Annual Salary: _____

☐ Right-handed ☐ Left-handed	☐ Male ☐ 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? ☐ Yes ☐ No	Describe how and where injury occurred or describe the onset and nature of your medical condition including symptoms:			Date you returned to work: _____ ☐ Full-Time ☐ Part-Time

Treated by: _____

Medical Provider: _____
Name Street Address City State Zip Code

Doctor: _____
Name Street Address City State Zip Code

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, or its third party administrator, DRMS, decides in its discretion the applicant is entitled to them. The undersigned acknowledges reading and understanding the state specific fraud statements.

Signature of Employee _____ Date _____

Name of Employee (Please print) _____

G-22414 (MARK III) 11/6/15

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 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

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Group Policy No. _____ Name of Employer _____

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 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 authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), American United Life Insurance Company® (AUL) and AUL's reinsurer(s) *excluding psychotherapy notes* and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and, where permitted by law, **HIV/AIDS** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Disability RMS, 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, including Custom Disability Solutions, employed by or representing Disability RMS, AUL or AUL's reinsurer(s) to assist with the evaluation and adjudication of my current disability claim or another disability claim insured by AUL and/or to report aggregate claims information to AUL. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying Disability RMS 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. 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 Disability RMS' and AUL's ability to evaluate my current disability claim and that a lack of required information may be a basis for denying that current disability claim for benefits.

If you reside in **California, Connecticut, Maine, or Massachusetts: This authorization excludes the release of information and test results about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant or employee-claimant (for self-insured business) is required each time results are released.

***If you reside in **Vermont:** This authorization EXCLUDES the release of any information and test results about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING Disability RMS 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 Disability RMS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name: _____ Date of Birth: _____

Claimant Signature (or Authorized Representative): _____ Date: _____

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

Claim ID: _____

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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: _____

For Pregnancy Disabilities

Are there any present complications or anticipated difficulties in connection with:

Pregnancy ☐ Yes ☐ No

Delivery ☐ Yes ☐ No Expected Date of Delivery: _____

Post Partum ☐ Yes ☐ No Actual Date of Delivery: _____ ☐ Vaginal ☐ C-Section

If yes to any of these, please specify in detail: _____

Dates of Treatment for this condition

Date of first visit Month _____ Day _____ Year _____

Date of last visit Month _____ Day _____ Year _____

Next office visit Month _____ Day _____ Year _____

Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) _____

If "Hospital Confined", give name and address of medical provider _____

Confined from _____ through _____

Was this patient referred to you? ☐ Yes ☐ No

If yes, to whom and what is his/her specialty? _____

Have you referred this patient to another treating provider? ☐ Yes ☐ No

If yes, to whom and what is his/her specialty? _____

Return to work plan

Have you discussed a return to work plan with your patient? ☐ Yes ☐ No

The date you released patient to return to work _____ ☐ Full-time ☐ Reduced hours ☐ 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): _____

Telephone Number: _____ Fax Number: _____ Tax ID#: _____

Office Address: _____

Street *City* *State* *Zip Code*

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