

# Disability Claim Filing Instructions

## Have you...

1. Completed the Employee's Statement in full?
2. Had the physician treating you complete the Attending Physician's Statement, and had it returned to you?
3. Had your Employer complete the Policyholder's Statement, and had it returned to you?

PLEASE HAVE YOUR EMPLOYER ATTACH A COPY OF THE FOLLOWING DOCUMENTS TO THIS FORM:

- The Workers' Compensation claim(s) and Approval/Denial Notification
  - The prior year's W-2 form OR, if no W-2 is available, list the Gross Monthly Earnings for the past 12 months just prior to the date of disability and last paycheck
  - The current job description
  - If coverage is summary billed, please provide a copy of the enrollment form.
4. Read, signed and dated the Authorization for Release of Information?

**Submit the completed statements to the address below  
or fax to 1-207-591-3048**

**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®  
c/o Disability RMS  
One Riverfront Plaza  
Westbrook, Maine 04092-9700**



AMERICAN UNITED LIFE INSURANCE COMPANY®

*a ONEAMERICA® company*

# Employee's Statement For Disability Claim

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



Group Disability Policy Number \_\_\_\_\_

Notice of Claim for:  Short Term Disability Benefits  Long Term Disability Benefits

(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

Please enclose a copy of your driver's license or another picture identification issued by the state.

NAME OF EMPLOYEE		EMPLOYEE'S SOCIAL SECURITY - -			
EMPLOYEE'S ADDRESS		STREET & NUMBER		CITY	STATE ZIP
TELEPHONE NUMBER ( ) -		CELL PHONE NUMBER ( ) -		DATE OF BIRTH / /	
<input type="checkbox"/> RIGHT-HANDED <input type="checkbox"/> LEFT-HANDED		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED		IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
NUMBER OF DEPENDENT CHILDREN					
LIST NAMES AND DATES OF BIRTH OF SPOUSE AND DEPENDENT CHILDREN					
HOW MANY HOURS WERE YOU REGULARLY WORKING PER WEEK WITH YOUR PRESENT EMPLOYER? _____ hrs. Authorized to work/reside in US? <input type="checkbox"/> Yes <input type="checkbox"/> No		GROSS ANNUAL WAGES: (During the 12 months just prior to your disability - for this employer only) \$ _____		PLEASE INDICATE HOW YOU ARE PAID (Check all that apply): <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Other _____ <input type="checkbox"/> Includes commissions <input type="checkbox"/> Includes bonuses	
NAME OF EMPLOYER			EMPLOYER'S TELEPHONE NUMBER ( ) -		
EMPLOYER'S ADDRESS		STREET & NUMBER		CITY	STATE ZIP
YOUR OCCUPATION & TITLE		ESSENTIAL DUTIES OF YOUR JOB AT THE TIME OF DISABILITY			
DATE OF INJURY OR DATE FIRST NOTICED SYMPTOMS OF SICKNESS / /		DATE YOU LAST WORKED BECAUSE OF DISABILITY: / /		DATE YOU RETURNED TO WORK ON A PART-TIME BASIS: / /	
DATE YOU RETURNED TO WORK ON A FULL-TIME BASIS: / /		IS YOUR INJURY OR SICKNESS RELATED TO YOUR OCCUPATION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF "YES", EXPLAIN:  DID YOU FILE FOR WORKERS' COMPENSATION? <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. IF MORE SPACE IS NEEDED, PLEASE ATTACH SHEET OF PAPER.			
DATE FIRST TREATED / /		IF "HOSPITAL CONFINED," GIVE NAME AND ADDRESS HOSPITAL: _____ Name Street Address City State Zip CONFINED FROM _____ THROUGH _____			
HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES," WHEN? _____		TREATED BY: _____ MEDICAL PROVIDER: _____ Name Street Address City State Zip DOCTOR: _____ Name Street Address City State Zip			

PLEASE COMPLETE ALL PAGES OF THIS FORM

Group Policy Number \_\_\_\_\_ Name of Employee \_\_\_\_\_

**(TO BE COMPLETED BY EMPLOYEE)**

**FOR PREGNANCY DISABILITY ONLY:**

Are there any present complications or anticipated difficulties in connection with the following?

- (a) Pregnancy  YES  NO Date of last menstrual period: \_\_\_\_\_ Expected date of delivery: \_\_\_\_\_  
 (b) Delivery  YES  NO Actual date of delivery: \_\_\_\_\_  Vaginal  C-Section  
 (c) Post Partum  YES  NO

If "YES" to any of these, please specify in detail: \_\_\_\_\_

As a result of this disability, are you, your spouse or any of your dependent children receiving amounts from any of the following?

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
<input type="checkbox"/>	<input type="checkbox"/>	Vacation Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sick Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Salary Continuance	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Local, State or National Association or Society Disability Income Plan	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	No Fault Insurance	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation Disability	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefits (disability or retirement)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Income (normal, early, or disability)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other STD/LTD Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU OR WILL YOU APPLY FOR BENEFITS DESCRIBED ABOVE?  YES  NO  
 TYPE \_\_\_\_\_ DATE APPLICATION FILED \_\_\_\_\_  
 TYPE \_\_\_\_\_ DATE APPLICATION FILED \_\_\_\_\_

IF YOUR REQUEST FOR BENEFITS IS APPROVED, DO YOU WANT US TO WITHHOLD FEDERAL INCOME TAXES?  
 YES  NO IF YES, COMPLETE, SIGN, AND ATTACH W-4S. (\$88 MINIMUM PER MONTH)

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, understanding and retaining the notices, limitations, and exclusions for his/her records. The undersigned acknowledges reading and understanding the state specific fraud statements on page 3.

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, Oregon**

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**

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**Colorado**

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**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 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.

**Pennsylvania**

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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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**Policyholder's Statement For Disability Claim**

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 c/o Disability RMS  
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 Westbrook, ME 04092-9700  
 Fax: 1-207-591-3048  
 Toll Free Phone: 1-866-258-8744



Group Disability Policy Number \_\_\_\_\_

Information for:  Short Term Disability Benefits  Long Term Disability Benefits

NAME OF EMPLOYEE			OCCUPATION		IS DISABILITY DUE TO EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
EMPLOYEE ADDRESS (City, State, Zip Code)							
EMPLOYEE TELEPHONE NUMBER				INSURANCE CLASS			
DATE EMPLOYED / /	DATE INSURED / /	DATE LAST WORKED / /	REASON FOR STOPPING WORK <input type="checkbox"/> Disability <input type="checkbox"/> Dismissed <input type="checkbox"/> Resigned <input type="checkbox"/> Layoff <input type="checkbox"/> Retired <input type="checkbox"/> Family Medical Leave of Absence <input type="checkbox"/> Other Leave of Absence <input type="checkbox"/> Other Reason _____				
DATE RETURNED TO WORK / / <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK	IF EMPLOYEE HAS NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE: / /		DATE EMPLOYMENT TERMINATED / /	DATE DISABILITY INSURANCE TERMINATED		
ACTUAL NUMBER OF HOURS WORKED PER WEEK _____ hours	GROSS MONTHLY SALARY: (Provide salary last reported and approved by AUL in writing.) \$ _____		PLEASE INDICATE HOW THE EMPLOYEE IS PAID (check all that apply): <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Other _____ <input type="checkbox"/> Hourly Rate: _____ <input type="checkbox"/> Includes commissions (Provide last 12 months of commissions with claim) <input type="checkbox"/> Includes bonuses				
IS EMPLOYEE SUBJECT TO FICA TAX? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", IS EMPLOYEE SUBJECT TO <input type="checkbox"/> FULL FICA TAX? <input type="checkbox"/> MEDICARE PORTION ONLY?							
PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN (AS OF POLICY YEAR OF DISABILITY) EMPLOYEE <input type="checkbox"/> 100% <input type="checkbox"/> OTHER _____% IS EMPLOYEE CONTRIBUTION: <input type="checkbox"/> PRE-TAX DEDUCTION? EMPLOYER <input type="checkbox"/> 100% <input type="checkbox"/> OTHER _____% <input type="checkbox"/> AFTER-TAX DEDUCTION?							
EMPLOYEE ELIGIBLE FOR:							
YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
<input type="checkbox"/>	<input type="checkbox"/>	Vacation Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Sick Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Salary Continuance Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Local, State or National Association or Society Disability Income Plan	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	No Fault Insurance	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Disability	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefits (disability or retirement)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Income (normal, early, or disability)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other STD/LTD Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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 has received, reviewed, and complied with AUL's written instructions including but not limited to AUL's administration guide. 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 undersigned acknowledges reading and understanding the state specific fraud statements on page 2.

\_\_\_\_\_  
 Name of Policyholder (Company)  
 \_\_\_\_\_  
 Mailing Address of Policyholder (Company)  
 (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Print Name & Title of Official Representative  
 \_\_\_\_\_  
 Signature Date  
 (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Fax Number

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

**(THIS STATEMENT MUST BE FILLED IN COMPLETELY BY A MEDICAL PROVIDER – PLEASE PRINT OR TYPE)**

<b>6. CARDIAC</b> (if applicable)			
Functional capacity (American Heart Assoc. standards)	<input type="checkbox"/> Class 1 (No limitation)	<input type="checkbox"/> Class 2 (Slight limitation)	<input type="checkbox"/> Class 4 (Complete limitation)
	<input type="checkbox"/> Class 3 (Marked limitation)		
<b>7. CURRENT FUNCTIONAL ABILITY</b>			
a. In an 8 hour 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 Activity	10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.		
____ Hrs. Light 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 Activity	50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.		
____ Hrs. Heavy 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting (lbs.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No. of lbs. _____	No. of lbs. _____	No. of lbs. _____
	No. of lbs. _____	No. of lbs. _____	No. of lbs. _____
What is this assessment based on? <input type="checkbox"/> Observed activity <input type="checkbox"/> Measured activity <input type="checkbox"/> Physical therapy report			
c. Please list current restrictions (activities which should not be performed) and limitations (activities which can not be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Please be specific. _____			
_____			
_____			
d. Upper Extremity Function – Please indicate upper extremity functional capabilities:			
Simple grasp	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
Pinch	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
Fine manipulation	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
Power grip	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
Repetitive motion	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Comments _____
<b>8. MENTAL HEALTH ABILITY</b> (if applicable)			
What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?			
_____			
_____			
<b>9. RETURN TO WORK PLAN</b>			
a. Have you discussed a return to work plan with your patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
b. The date you released patient to return to work: ____/____/____ <input type="checkbox"/> Full-time <input type="checkbox"/> Reduced hours Number of hours: _____			
Mo. Day Year			
c. Please identify your recommendations for any job modifications that would enable the patient 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 on page 3.

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 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, Oregon**

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 representative 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 reward 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 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.

**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.

**PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE**



*American United Life Insurance Company®  
a ONEAMERICA® company  
c/o Disability RMS  
Fax: 1-207-591-3048  
Toll Free Telephone: 1-866-258-8744*

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