

Group Life Insurance – Proof of Death Claim Form

Products and financial services provided by American United Life Insurance Company® a ONEAMERICA® company
 One American Square, P.O. Box 7106
 Indianapolis, IN 46207-7106
 1-800-553-3522
 Fax 317-285-7666
 www.employeenefits.aul.com



This form is to be completed by the Employer/Policyholder

Instructions – Please read carefully and submit all required information

- 1) Proof of Death must be furnished without expense to American United Life Insurance Company® (AUL). Each question must be answered completely, accurately, and truthfully. AUL reserves the right to obtain further information when necessary.
- 2) A certified death certificate is required. If not available, the Physician's Statement on the reverse side of the form may be completed by the Insured's attending Physician.
- 3) If the policy offers Accidental Death Benefits and accidental death may have occurred, the following will need to be supplied to AUL: a) police reports, b) any newspaper stories about the accident, c) toxicology reports, d) autopsy report and e) medical reports related to treatment following the accident.
- 4) If the policy offers a Repatriation Benefit, an Accidental Death may have occurred, and the insured died either 200 miles away from his principal place of residence or death occurred outside of the United States, the following will need to be supplied: a) Written documentation showing the location of the insured's Accidental Death, and; b) written documentation showing the amount incurred for the transportation expenses for returning the insured.
- 5) When proceeds are payable to the Estate of the Insured, Trust, a minor or mentally incompetent beneficiary, the legal representative (i.e. Executor, Trustee, Guardian, Conservator) must supply legal documentation showing his appointment, the correct TIN using IRS Form W-9, and a copy of a bank account statement showing an account has been opened in the name of the entity (i.e. Estate, Trust, Guardianship, Conservatorship).
- 6) Enclose all applications/enrollment forms for AUL's coverage for this insured along with the most recent beneficiary designation. If no beneficiary has been designated and this benefit can be paid using a small estate affidavit, then a copy of the obituary and a copy of the closest surviving relatives' driver's license and IRS Form W-9 must be provided to verify the individual's relationship to the decedent.
- 7) All communications should be sent to: **Group Claims Department**, American United Life Insurance Company®, P.O. Box 7106, Indianapolis, Indiana 46207-7106

Employer/Policyholder's Statement

1. Name Of Insured _____ Date of Birth _____
 2. Address _____ Social Security No. _____
 No. Street City State Zip
 Date Of _____
 3. Employment _____ Job Title _____
 Was Evidence of Insurability Submitted? _____ Hours Worked Per Week _____ Class _____
 Effective Date _____
 Of Insurance: Life _____ Supplemental/Voluntary _____
 4. Amount Of Insurance Claim _____
 Life AD&D Supplemental/Voluntary
 5. Salary _____ Date Of Death _____ Date To Which Premiums Were Paid _____
 Last Day Insured If Employment Ceased Prior to Death, Give Date _____
 6. Physically At Work _____ Reason: _____

For Union Groups Only:

- A. Was member in good standing on coverage effective date? Yes No
 B. Was member in good standing at his date of death? Yes No
 C. Date to which all dues and assessments were paid _____

Beneficiary Information - ALL information MUST be provided to AUL before claim can be evaluated for approval and payment.

First Name	Last Name	Birthdate	Social Security Number	Phone Number	Address

Benefit Check Should Be Forwarded To: Employer/Policyholder For Delivery Directly To Beneficiary

The undersigned represents and warrants any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees: 1) any insurance coverage or benefits is contingent upon any statements 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 have read, understand, and retained the notices, limitations, and exclusions for his/her records.

Employer (Policyholder) _____ Group Policy Number _____
 Address _____ Phone No. _____
 No. Street City State Zip Ext. Email
 Date _____ By _____
 Title and Printed Name of Authorized Representative (required) Signature of Authorized Representative (required)

Proof of Death – Physician’s Statement – (To be completed only when the certified death certificate is unavailable.)

1. (A) Deceased’s Legal Name _____

(B) Residence At Death _____

(C) Age At Death _____ Occupation _____

2. (A) Date Of Death _____

(B) Place Of Death _____

3. (A) Immediate Cause Of Death and Underlying Cause _____

(B) Contributory Cause Of Death Or Any Chronic Ailments _____

(C) Date Of Last Medical Treatment _____

(D) The Deceased Was Totally Disabled And Unable To Work At His Usual Occupation From _____

Please indicate the manner of death: Natural Accident Suicide Murder Pending investigation Could not be determined

Describe Briefly any events and /or facts relevant to the manner of death _____

The undersigned medical provider represents and warrants any information or documents provided to 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.

_____ M.D.
Date *Printed Name* *Signature*

Street Address _____
City *State* *Zip*

Phone Number/Email

Fraud Warnings *(For use in AR, 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 is 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.

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, Washington D.C.

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.