Statement of Claim For
Waiver of Premium Group Life Insurance

American United Life Insurance Company®
a OneAmerica® financial partner
Group Life Waiver Department
P.O. Box 368
Indianapolis, IN 46206-0368
1-800-553-3522
Fax: 317-285-7666

EMPLOYER'S STATEMENT

POLICY NUMBER ________________

PLEASE SUBMIT A COPY OF THE EMPLOYEE'S JOB DESCRIPTION AND ALL ENROLLMENT CARDS.

Employee's Name ________________ Member No. or Social Security No. ________________
Date of Birth ________________ Occupation ________________
Hours worked per week ________________ Date Employed ________________ Effective Date of Insurance ________________
Was Evidence of Insurability Required? ☐ Yes ☐ No Date last premium payment was made for employee ________________
Amount of Insurance: Basic Volume $________________ Voluntary Volume $ ________________ Supplemental Volume $________________
Date employee ceased active work ________________ Annual Salary at that time $________________ ☐ Hourly ☐ Salary
Reason for ceasing work ________________
Please provide dates of any change of status ________________
Is employee, or will this employee be eligible for a disability or employer paid pension? ☐ Yes ☐ No
If yes, please provide type and date of eligibility ________________

I hereby certify that the employee described herein is insured as stated and that this claim is full and true to the best of my knowledge and belief.
Policyholder ________________ Telephone Number (_____)________________
Address ________________
City ________________ State ________________ Zip Code ________________

Authorized Person's Name and Title *(please print)*

Authorized Person's Signature

EMPLOYEE'S STATEMENT

Name ________________ Social Security Number ________________
Address ________________
City ________________ State ________________ Zip Code ________________
Date of Birth ________________ Telephone Number (_____)________________
State nature of illness/injury ________________
Have you had this or a similar condition before? ☐ Yes ☐ No If yes, please advise the first date of treatment. ________________
Please list the name and address of any other physician who has treated you for this condition. ________________

When was your last date worked? ________________ When do you expect to return? ________________
Since you last worked have you worked for any employer in any capacity? ☐ Yes ☐ No
Have Social Security Disability Benefits been awarded? ☐ Yes ☐ No If yes, please attach a copy of your Social Security Award notice.
If no, what is the status of your Social Security Disability application? ________________
Are you receiving a disability retirement? ☐ Yes ☐ No OR an Employer Paid Pension? ☐ Yes ☐ No If yes, please explain.

Are you receiving any long term disability benefits? ☐ Yes ☐ No If yes, what is the name of the carrier? ________________

Fraud Notice: 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 may be guilty of the crime of insurance fraud as determined by a court of competent jurisdiction. In Florida, any person who knowingly and with intent to injure files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. In New Jersey and Virginia, any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties. In Louisiana, Pennsylvania or Tennessee, 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 person to criminal and civil penalties. In Washington, a person who knowingly makes a false or misleading statement or impersonation, or who willfully fails to reveal a material fact in or relative to an application for insurance, to an insurer, is guilty of a gross misdemeanor.

I certify that the information furnished by me in support of this claim is true and correct.

I give you my permission to give American United Life Insurance Company® any information about me necessary for determining eligibility for insurance, determining eligibility for benefits, detecting or preventing fraud or misrepresentations. The word "you" refers to any organization or person that has records or knowledge about me or my medical history, mental or physical condition, diagnosis, treatment or prognosis. This includes my employer, any provider of health care, another insurance company, consumer reporting agencies and other insurance support agencies. This information may also be given by American United Life Insurance Company® to its legal representatives, consumer reporting agencies, or its other insurance support agencies. This authorization can be used for 24 months from the date below. I know I can receive a copy of this authorization. I agree that a copy of this authorization may be considered as valid as the original.

Signature ________________ Date ________________

ATTENDING PHYSICIAN'S STATEMENT

Return to: *American United Life Insurance Company®*
Group Life Waiver Department
P.O. Box 368
Indianapolis, IN 46206-0368
1-800-553-3522
Fax: 317-285-7666

Name of Patient ____________________

Date of Birth ____________________ Patient's Height ____________________ Patient's Weight ____________________

Date patient became disabled due to present illness or injury ____________________

Diagnosis (including complications) ____________________

Objective findings (including current x-rays, EKG's, biopsy or any other special tests) ____________________

Subjective symptoms ____________________

Date of first visit ____________________ List all dates of service ____________________

Frequency of visits ____________________ Nature of treatment (including surgery date and medications prescribed, if any) ____________________

Has patient ☐ Recovered? ☐ Unchanged? ☐ Improved? ☐ Retrogressed?

Is patient ambulatory? ☐ Yes ☐ No If yes, give a description? ____________________

Names and address of other treating physicians for this condition ____________________

List any restrictions, limitations, therapy ____________________

Mental/Nervous Impairments (if applicable):

a. Please list your findings according to the DSM-III multiaxial classification. ____________________

b. Axis IV findings, please describe: ____________________

- ☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Functional capacity (American Heart Association):

- ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
- ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

Physical Impairments (As defined in Federal Dictionary of Occupational Titles):

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%)
- ☐ Class 2 - Medium manual activity*. (15-30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work*. (35-55%)
- ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
- ☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)

Remarks: ____________________

When could trial employment commence? ☐ Full-time ☐ Part-time Month/Day/Year ____________________

Name *(Attending Physician)* Print ____________________

Board Certified Specialty ____________________ Telephone Number (_____) ____________________

Address ____________________

City ____________________ State ____________________ Zip Code ____________________

Signature ____________________ Tax I.D. No. ____________________ Date ____________________