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 207-766-3448

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
300 Southborough Drive, Suite 200
South Portland, ME 04106

ONEAMERICA®

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
300 Southborough Drive, Suite 200
South Portland, ME 04106
Fax: 207-766-3448
Toll Free Phone: 1-866-258-8744

OneAmerica®

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	☐ MALE ☐ FEMALE	
☐ RIGHT-HANDED ☐ LEFT-HANDED	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED	IS SPOUSE EMPLOYED? ☐ YES ☐ 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? ☐ Yes ☐ 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): ☐ Hourly ☐ Salaried ☐ Other _____ ☐ Includes commissions ☐ 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? ☐ YES ☐ NO	IF "YES", EXPLAIN: DID YOU FILE FOR WORKERS' COMPENSATION? ☐ YES ☐ 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? ☐ YES ☐ 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

G-18207 11/13/15

Please return to: *Disability RMS, 300 Southborough Drive, Suite 200, South Portland, ME 04106, Fax: 207-766-3448*

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
☐	☐	Vacation Pay	$_____	_____	_____	☐	☐
☐	☐	Sick Pay	$_____	_____	_____	☐	☐
☐	☐	Salary Continuance	$_____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$_____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$_____	_____	_____	☐	☐
☐	☐	No Fault Insurance	$_____	_____	_____	☐	☐
☐	☐	Unemployment Compensation Disability	$_____	_____	_____	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$_____	_____	_____	☐	☐
☐	☐	Retirement Income (normal, early, or disability)	$_____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$_____	_____	_____	☐	☐
☐	☐	Other (describe) _____	$_____	_____	_____	☐	☐

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 or its third party administrator, DRMS, 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)* _____

PLEASE COMPLETE ALL PAGES OF THIS FORM

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.

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Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any statement of 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

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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.

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OneAmerica®

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: _____

Policyholder's Statement For Disability Claim

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

OneAmerica®

Group Disability Policy Number _____

Information for: ☐ **Short Term Disability Benefits** ☐ **Long Term Disability Benefits**

NAME OF EMPLOYEE	OCCUPATION	IS DISABILITY DUE TO EMPLOYMENT? ☐ YES ☐ NO
EMPLOYEE ADDRESS (City, State, Zip Code)		
EMPLOYEE TELEPHONE NUMBER	INSURANCE CLASS	

DATE EMPLOYED	DATE INSURED	DATE LAST WORKED	REASON FOR STOPPING WORK ☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ Family Medical Leave of Absence ☐ Other Leave of Absence ☐ Other Reason _____

DATE RETURNED TO WORK ☐ FULL-TIME ☐ 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	GROSS MONTHLY SALARY: (Provide salary last reported and approved by AUL in writing.)	PLEASE INDICATE HOW THE EMPLOYEE IS PAID (check all that apply):
_____ hours	$ _____	☐ Hourly ☐ Salaried ☐ Other _____ ☐ Hourly Rate: _____ ☐ Includes commissions (Provide last 12 months of commissions with claim) ☐ Includes bonuses

IS EMPLOYEE SUBJECT TO FICA TAX? ☐ YES ☐ NO
IF "YES", IS EMPLOYEE SUBJECT TO ☐ FULL FICA TAX? ☐ MEDICARE PORTION ONLY?

PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN (AS OF POLICY YEAR OF DISABILITY)
EMPLOYEE ☐ 100% ☐ OTHER _____% IS EMPLOYEE CONTRIBUTION: ☐ PRE-TAX DEDUCTION?
EMPLOYER ☐ 100% ☐ OTHER _____% ☐ AFTER-TAX DEDUCTION?

EMPLOYEE ELIGIBLE FOR:

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

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 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 on page 2.

_____ _____
Name of Policyholder (Company) *Print Name & Title of Official Representative*

_____ _____
Mailing Address of Policyholder (Company) *Signature* *Date*

_____ _____
Telephone Number *Fax Number*

G-18209 11/9/15

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

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Alaska

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Arizona

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Delaware, Idaho, Indiana, Oklahoma

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Florida

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Kentucky

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Maine, Tennessee, Washington

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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

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Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon

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Pennsylvania

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Virginia

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Attending Physician's Statement For Disability Claim

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a OneAmerica® company
c/o Disability RMS
300 Southborough Drive, Suite 200
South Portland, ME 04106
Fax: 207-766-3448
Toll Free Phone: 1-866-258-8744

OneAmerica®

Name of Employer/Policyholder _____

Name of Employee *(Please Print)* _____

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

Name of Patient First Middle Last	☐ Male ☐ Female	Date of Birth
Height _____ Weight _____	Blood Pressure (last visit) Systolic _____ /Diastolic _____	☐ Left-handed ☐ Right-handed

1. HISTORY

a. Is condition due to ☐ Sickness? ☐ Injury?
b. When did symptoms first appear or injury occur? Month _____ Day _____ Year _____
c. Date patient was unable to work because of impairment Month _____ Day _____ Year _____
d. Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when and describe.

e. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No Please explain:

f. Was this patient referred to you? ☐ Yes ☐ No If "Yes", by whom and what is his/her specialty?

g. Have you referred this patient to another treating provider? ☐ Yes ☐ No If "Yes", to whom and what is his/her specialty?

2. DIAGNOSIS

a. Diagnosis impacting function: _____ ICD9 Code(s) _____

Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____

b. Secondary diagnosis impacting function: _____

Nature of treatment (including surgery and medications prescribed, if any, including dosage and frequency) _____

c. Subjective symptoms: _____

d. Objective findings (including current X-rays, EKGs, laboratory data and any clinical findings): _____

3. FOR PREGNANCY DISABILITY ONLY

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

4. DATES OF TREATMENT FOR THIS CONDITION

a. Date of first visit Month _____ Day _____ Year _____
b. Date of last visit Month _____ Day _____ Year _____
c. Next office visit Month _____ Day _____ Year _____
d. Frequency ☐ Weekly ☐ Monthly ☐ Other (specify)

5. PROGRESS

(a) Has patient . . . . . ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?
(b) Is patient . . . . . ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?
If "Hospital Confined", give name and address of medical provider _____

Confined from _____ through _____

PLEASE COMPLETE ALL PAGES OF THIS FORM

G-18210 11/13/15

Please return to: *Disability RMS, 300 Southborough Drive, Suite 200, South Portland, ME 04106, Fax: 207-766-3448*

Name of Employee *(Please Print)* _____

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

6. CARDIAC (if applicable)
Functional capacity (American Heart Assoc. standards) ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

7. CURRENT FUNCTIONAL ABILITY

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	☐		☐		☐	
Climbing	☐		☐		☐	
Reaching	☐		☐		☐	
Kneeling	☐		☐		☐	
Squatting	☐		☐		☐	
Crawling	☐		☐		☐	
Push/pull	☐	No. of lbs. _____	☐	No. of lbs. _____	☐	No. of lbs. _____
Lifting (lbs.)	☐	No. of lbs. _____	☐	No. of lbs. _____	☐	No. of lbs. _____

What is this assessment based on? ☐ Observed activity ☐ Measured activity ☐ 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	☐ Left	☐ Right	Comments _____
Pinch	☐ Left	☐ Right	Comments _____
Fine manipulation	☐ Left	☐ Right	Comments _____
Power grip	☐ Left	☐ Right	Comments _____
Repetitive motion	☐ Left	☐ Right	Comments _____

8. MENTAL HEALTH ABILITY (if applicable)
What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

9. RETURN TO WORK PLAN

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

b. The date you released patient to return to work: _____ (Mo. Day Year) ☐ Full-time ☐ Reduced hours Number of hours: _____

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*

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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 statement of 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

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 or a denial of insurance benefits.

PLEASE RETURN COMPLETED FORM TO YOUR PATIENT/THE EMPLOYEE

American United Life Insurance Company®
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