

## Disability Claim

Products and financial services provided by  
American United Life Insurance Company®  
a ONEAMERICA® company  
c/o Custom Disability Solutions  
600 Sable Oaks Drive, Suite 200  
South Portland, ME 04106  
Fax: 1-844-287-9499  
Toll Free Phone: 1-855-517-6365



### Disability Claim Filing Instructions INSTRUCTIONS – PLEASE READ CAREFULLY

#### Have you...

1. Completed the **Employee's Statement** in full?
2. Had your treating physician complete the **Attending Physician's Statement** and return to you?
3. Had your employer complete the **Policyholder's Statement** and return it 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 form is available, list your Gross Monthly Earnings for the past 12 months just prior to the date of disability and last paycheck
  - Your current job description
  - If coverage is summary billed, a copy of your enrollment form
4. Read, signed and dated the **Authorization for Release of Information?**

If you have questions when completing this form, please call an American United Life Insurance Company® representative at 1-855-517-6365.

Completed forms and communications should be sent to:

American United Life Insurance Company®  
c/o Custom Disability Solutions  
600 Sable Oaks Drive, Suite 200  
South Portland, ME 04106

Or

Fax: 1-844-287-9499

Or

[OneAmerica.claims@customdisability.com](mailto:OneAmerica.claims@customdisability.com)

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



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	\$ _____	_____	_____	<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"/>

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 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 that any insurance coverage or benefits are contingent upon any statements made to AUL as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

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

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

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**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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**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**

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**Oregon**

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**Virginia**

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## Discretionary Authority

*Products and financial services provided by  
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Toll Free Phone: 1-855-517-6365*



The following discretionary authority rights shall apply to all policies except the states below:

**DISCRETIONARY AUTHORITY:** Benefits under the policy will be paid only if American United Life Insurance Company® (AUL) (or its third party administrator) decides in its discretion the claimant is entitled to them. Except for the functions the policy explicitly reserves to the Participating Unit or Trustee, AUL (or its third party administrator) reserves the right to: 1) manage the policy and administer claims under it; and 2) interpret the provisions and resolve any questions arising under it.

AUL's (or its third party administrator's) authority includes, but is not limited to, the right to:

- 1) establish and enforce procedures for administering the policy and claims under it;
- 2) determine participants' eligibility for coverage and entitlement to benefits;
- 3) determine what information it reasonably requires to make such decisions; and
- 4) resolve all matters when a claim review is requested.

Any decision that AUL (or its third party administrator) makes, in the exercise of its authority, will be conclusive and final subject to any rights under applicable laws such as the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its third party administrator, Disability Reinsurance Management Services, Inc.

Such discretionary authority shall not apply in the following states:

1. Arkansas
2. Alaska
3. California
4. Colorado
5. Hawaii
6. Kentucky
7. Illinois
8. Maine
9. Montana
10. Michigan
11. New Jersey
12. New York
13. Oregon
14. South Dakota
15. Texas
16. Vermont
17. Washington
18. Non-ERISA governed policies in New Hampshire and Utah

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Toll Free Phone: 1-855-517-6365



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 Custom Disability Solutions (CDS), 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 CDS, 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 Disability Reinsurance Management Services, Inc., employed by or representing CDS, 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 CDS in writing of my revocation. However, such revocation is not effective to the extent that CDS 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 CDS' 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 CDS 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 CDS 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: \_\_\_\_\_

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

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**Policyholder's Statement For Disability Claim**

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 South Portland, ME 04106  
 Fax: 1-844-287-9499  
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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"/>
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<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 or its third party administrator 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



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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	Frequently	Continuously
	0% to 33%	33% to 66%	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. _____
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 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 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**



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a ONEAMERICA® company  
Fax: 1-844-287-9499  
Toll Free Phone: 1-855-517-6365*

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