

Statement of Claim for Acceleration of Payment for Long-Term Care Benefits

OneAmerica[®]
Financial

American United Life Insurance Company[®] a OneAmerica Financial[®] company

One American Square, P.O. Box 7106, Indianapolis, IN 46207-7106 • 1-800-553-3522 • Fax 1-317-285-7666 • lifecclaims.employeebenefits@oneamerica.com

Submit the fully completed and signed Claim Form and signed HIPAA form to American United Life Insurance Company[®] (AUL[®]) using the contact information above.

Statement of Insured (to be completed by Insured or Legal Representative)				
Policyholder Number		Policyholder/Employee Name		
Employee Social Security Number	Employee Date of Birth	Employee Gender	Employee Marital Status	
Address		City	State	ZIP Code
Phone Number	Email			
Insured Name		Insured Social Security Number	Insured Date of Birth	
Address		City	State	ZIP Code
☐ I hereby apply for payment of the qualified facility monthly benefit and have enclosed a copy of the medical provider's invoice showing dates and services rendered:				
Qualified Facility Name		Phone Number	Date Confinement Began	
Qualified Facility Address		City	State	ZIP Code
Hospice Facility Name		Phone Number	Date Outpatient Hospice Care Began	
Hospice Facility Address		City	State	ZIP Code
Physician Name		Phone Number	Date Treatment Began	
Physician Address		City	State	ZIP Code
Describe Physical Impairment				
Describe Cognitive Impairment				
Identify Any Loss of Ability to Perform Activities of Daily Living (select all that apply) ☐ Bathing ☐ Toileting ☐ Mobility ☐ Dressing ☐ Eating ☐ Continence				

Statement of Insured (to be completed by Insured or Legal Representative) (continued)

☐ I hereby apply for payment of the home care benefit and have enclosed a copy of the home care agency's invoice showing dates and services rendered:

Home Care Agency Name	Phone Number	Date Home Care Began
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Home Care Agency Address	City	State	ZIP Code
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Describe Physical Impairment

Describe Cognitive Impairment

Identify Any Loss of Ability to Perform Activities of Daily Living (*select all that apply*)

☐ Bathing ☐ Toileting ☐ Mobility ☐ Dressing ☐ Eating ☐ Continence

Signature

- I hereby apply for the acceleration of payment for long-term care benefits under the group life insurance coverage for which I am eligible and are available under AUL group life insurance policy.
- **The undersigned acknowledges and understands receipt of any benefit payment may be taxable and assistance should be sought from a qualified, personal tax advisor.**
- The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for benefits 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 and the state specific fraud statements attached, on the Forms page at employeebenefits.aul.com, or here: *State Fraud Warning Notices*.

Insured or Legal Representative Printed Name	Phone Number	Relationship to Insured
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Insured or Legal Representative Signature	Date
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Insured or Legal Representative Email

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Your patient is requesting payment of a benefit from their life insurance policy. The following medical information is needed to determine if benefits are owed. The completed and signed form with supporting medical records should be submitted to AUL using the contact information above.

Any expense associated with completion of this form is the claimant's responsibility and will not be reimbursed by AUL.

Attending Physician Statement (to be completed by Attending Physician)			
Patient Name		Social Security Number	Date of Birth
1. History			
Date Symptoms First Appeared		Date Patient Ceased Work	
2. Present Medical Condition			
Subjective Symptoms			
Objective Findings (include results of current X-rays, E.K.G.s, or any other special tests)			
Is Patient ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined			
Date Patient was Confined		Date Patient Received Hospice Care	Date Home Care Began
3. Diagnosis			
4. Treatment			
Date of First Visit to Your Office		Date of Last Visit to Your Office	
Frequency of Visits to Your Office ☐ Weekly ☐ Monthly ☐ Other _____		Date You Last Examined Patient	
5. If Patient is Confined in a Qualifying Facility (i.e. Nursing Facility, Custodial Care Facility, or Hospice Facility)			
Facility Name			Phone Number
Facility Address	City	State	ZIP Code

Attending Physician Statement (to be completed by Attending Physician)**6. If Patient is Receiving Home Health Care**

Frequency of Visits

Health Care Agency Name

Phone Number

Health Care Agency Address

City

State

ZIP Code

Reason(s) Confinement or Home Health Care is Required *(select all that apply)*☐ Physical Impairment ☐ Cognitive ImpairmentIdentify Any Loss of Ability to Perform Activities of Daily Living *(select all that apply)*☐ Bathing ☐ Toileting ☐ Mobility ☐ Dressing ☐ Eating ☐ Continence**7. Prognosis****Signature**

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. The undersigned acknowledges reading and understanding the state specific fraud statements attached, on the Forms page at employeebenefits.aul.com, or here: *State Fraud Warning Notices*.

Physician Printed Name

Specialty

Physician Address

City

State

ZIP Code

Phone Number

Fax Number

Tax ID Number

Physician Signature *(no signature stamps, please)*

Date