# Disability Insurance Claim Packet

OneAmerica® Financial

**American United Life Insurance Company®** a OneAmerica Financial® company
One American Square, P.O. Box 7003, Indianapolis, IN 46207-7003 • 1-855-517-6365 • Fax 1-844-287-9499 • *disability.claims@oneamerica.com*

## Instructions - Please Read Carefully and Submit All Required Information

We offer five options for filing a disability claim:

1. Call our disability claims team at 1-855-517-6365 *(Spanish available)*. A claims representative is available to assist you between 8 am and 6 pm ET, Monday through Friday. When calling, you should have the following information readily available: Employee's personal information *(including social security number)*, Employer's Name, Group Policyholder number, Employee's hire date, contact information for doctors, hospitals or clinics treating the Employee, and dates of treatment. You should also have information regarding a worker's compensation or state disability claim if one has been or will be filed.

   If you do not wish to call the disability claims team, please complete the following forms and send the forms and supporting documentation to us by:

2. Online Claim Form:

   Complete and submit your disability claim form, found at *www.employeebenefits.aul.com* in the Disability section of the Forms tab. This will automate the submission process.

3. Email to *disability.claims@oneamerica.com*;
4. Fax to 1-844-287-9499; or
5. Mail forms to:

   American United Life Insurance Company®
   P.O. Box 7003
   Indianapolis, IN 46207

If you have any questions when completing the claim forms, please call a claims representative at 1-855-517-6365.

## Disability Insurance Claim Filing Instructions

All questions should be answered fully and accurately before a decision on benefit entitlement can be made. All forms should be completed as follows:

**Employee Statement for Disability Insurance Claim Form** – The Employee should complete this form.

**Policyholder Statement for Disability Insurance Claim Form** – The Policyholder *(Employer)* should complete in full and submit the following information:

- Enrollment forms, requests for increase or decrease in coverage amount, approval of Evidence of Insurability, and/or enrollment information from the Policyholder's electronic enrollment system.
- Most recent W-2 if salary is based on W-2.
- Employee's current job description.
- If coverage is Voluntary/Employee Contributes to premium, please include proof of enrollment and copy of paycheck stub for year of disability and prior year.

**Attending Physician Statement for Disability Claim** – The primary medical provider treating the Employee for the conditions related to this injury or sickness should complete this form. A list of current medications should be attached to the form.

**Authorization for Release of Information** – The Employee should read, sign, and date this form. This form is required for us to obtain additional documentation to support this claim.

**Direct Deposit Authorization Agreement** – This form should be completed by the Employee if he/she wishes to have disability payments deposited into his/her bank account. Banking information specified on the form should be attached.

It is the responsibility of you and your Employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.



G-28203 (PKT) 5/19/26

# Employee Statement for Disability Insurance Claim Form

Claim is being filed for: ☐ Short-Term Disability ☐ Long-Term Disability

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**If the claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.**

## Employee Information – To Be Completed By Employee *(please print)*

| | | | |
|---|---|---|---|
| **1.** Employee Name | | | **2.** Social Security Number |
| **3.** Height | **4.** Weight | **5.** Gender ☐ Male ☐ Female | **6.** Date of Birth |
| **7.** Street/Box/Apt. Address | City | State | ZIP Code |
| **8.** Phone Number | **9.** Email | | |
| **10.** Employer Name | | | **11.** Employer Phone Number |
| **12.** Employer Address | City | State | ZIP Code |

**13.** Occupation ☐ Hourly ☐ Salaried ☐ Executive ☐ Management ☐ Union ☐ Other _____

**14.** List Occupation Duties

| | | |
|---|---|---|
| **15.** Date of Accident or First Symptoms | **16.** Date Last Physically/Actively at Work | **17.** Anticipated Date Last Worked *(if still working)* |

**18.** Reason Unable to Work *(check one)*
☐ Accidental Injury ☐ Illness ☐ Pregnancy ☐ Motor Vehicle Accident (MVA)

If Related to MVA, Provide Attorney Name and Phone Number

| | | |
|---|---|---|
| **19.** Have you returned to work? ☐ Yes ☐ No | If YES, Date Returned ☐ Full-Time ☐ Part-Time | If NO, Date Expected to Return ☐ Full-Time ☐ Part-Time ☐ Unknown |

**20.** Describe in detail, when, where, and how accidental injury occurred, or nature of disability and first symptoms.

| | | |
|---|---|---|
| **21.** Is your accidental injury or illness related to your occupation? ☐ Yes ☐ No | If YES, Explain | |
| **22.** Have you filed a Worker's Compensation Claim? ☐ Yes ☐ No | If NO, do you intend to? ☐ Yes ☐ No | If NO, Explain |

**23.** When were you first treated for your accidental injury or illness?

| | | |
|---|---|---|
| Hospital | Address/Phone Number | Date(s) |
| Doctor | Address/Phone Number | Date(s) |

**24.** Date of Next Office Visit

| Employee Name | Employer Name | Employer Policy Number |
|---|---|---|
| | | |

**Employee Information – To Be Completed By Employee *(please print) (continued)***

**25.** Have you ever had same or similar condition in the past?

☐ Yes ☐ No

If YES, Provide Name and Address of Hospital/Doctor Below

| Hospital | Address/Phone Number | Date(s) |
|---|---|---|
| | | |
| Doctor | Address/Phone Number | Date(s) |
| | | |

| **26.** Are you receiving any of the following? *(now or in the future)* *(check each benefit you are receiving)* | Gross Amount | Begin Date | End Date |
|---|---|---|---|
| ☐ Worker's Compensation | $ | | |
| ☐ Social Security/Veteran's Administration | $ | | |
| ☐ State Disability *(provide state)* _____ | $ | | |
| ☐ Paid Family Medical Leave | $ | | |
| ☐ Vacation/PTO/Salary Continuance | $ | | |
| ☐ Sick Pay | $ | | |
| ☐ Short-Term Disability | $ | | |
| ☐ Unemployment | $ | | |
| ☐ Other *(Retirement Income)* | $ | | |
| ☐ Auto Insurance Wage Replacement | $ | | |

| **27.** Marital Status<br>☐ Single ☐ Married ☐ Divorced ☐ Widowed | **28.** Spouse Name | **29.** Spouse Date of Birth |
|---|---|---|
| | | |

**30.** List Children Under Age 25 *(Names and Dates of Birth)*

**Tax Withholding**

If benefits are approved, do you want federal income taxes withheld from your payments? *(if your benefits are non-taxable, taxes will not be withheld)*

☐ Yes ☐ No

If YES,

☐ Short-Term Disability *(weekly minimum $20)* $ _____

☐ Long-Term Disability *(monthly minimum $88)* $ _____

**Employer self-funded plans have mandatory withholding requirements based on IRS Publication 15-A without a W-4.**

**Signature**

The undersigned represents 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 that any insurance coverage or benefits are contingent upon any statements made to AUL or its third party administrator as being complete and correct. 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*.

| Employee Signature | Date |
|---|---|
| | |

| Employee Printed Name |
|---|
| |

# Policyholder Statement for Disability Insurance Claim Form

OneAmerica® Financial

Claim is being filed for: ☐ Short-Term Disability ☐ Long-Term Disability ☐ Maternity

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**If the claim form is not completed in full, determination of benefits will be delayed until all required information has been received. Write "NA" in non-applicable sections.**

## Policyholder Information – To Be Completed By Employer *(please print)*

| **1.** Policyholder Company Name | **2.** Policy Number | **3.** Policy Class of Covered Employee |
|---|---|---|
| | | |

## Employee Information – To Be Completed By Employer *(please print)*

| **4.** Employee Name | **5.** Social Security Number | **6.** Date of Birth |
|---|---|---|
| | | |

| **7.** Street/Box/Apt. Address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

| **8.** Phone Number | **9.** Date of Hire | **10.** Occupation *(include job description)* |
|---|---|---|
| | | |

| **11.** Original Short-Term Disability Coverage Effective Date ☐ No Coverage | **12.** Original Long-Term Disability Coverage Effective Date ☐ No Coverage |
|---|---|
| | |

| **13.** How many months per year does Employee work? | **14.** Employee Work Location |
|---|---|
| | |

**15**. Regular Work Schedule *(check all that apply)*
☐ Full-Time ☐ Part-Time ☐ Exempt ☐ Non-Exempt ☐ Seasonal ☐ Shift Work

**16.** Regular Scheduled Weekly Hours

**17.** Regular Workdays *(check all that apply)*
☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

**18.** What was work schedule at time last worked? *(includes a reduced work schedule, if applicable)*
Number of Days Per Week _____ Number of Hours Per Week _____

| **19.** Date Last Physically/Actively at Work | **20.** Hours Worked That Day | **21.** Anticipated Date Last Worked *(if still working)* |
|---|---|---|
| | | |

| **22.** Has Employee Returned to Work? ☐ Yes ☐ No | If YES, Date Returned ☐ Full-Time ☐ Part-Time |
|---|---|
| | |

| **23.** Was Employee at work when disability began? ☐ Yes ☐ No | If NO, Select Status | If NO, Date Status Began |
|---|---|---|
| | ☐ Terminated ☐ Family Medical Leave (FML)<br>☐ Laid Off ☐ Leave of Absence<br>☐ Resigned ☐ Sick Leave<br>☐ Vacation/PTO ☐ Other _____ | |

**24** How is Employee paid? *(check one)*
☐ Hourly $ _____ *(hourly rate)* ☐ Salary ☐ Commission ☐ Other _____

**25.** How often is Employee paid? *(check one)* ***(if earnings vary, provide pay stubs supporting earnings as defined in the policy)***
☐ Weekly $ _____ ☐ Bi-Weekly $ _____
☐ Semi-Monthly $ _____ ☐ Monthly $ _____
☐ Annually $ _____ *Please provide earnings amount as of date last worked.*

**26.** Based on the policy definition of earnings, does Employee receive any of the following? *(check all that apply)* ***(provide supporting payroll documentation)***
☐ Bonus $ _____ ☐ Commission $ _____ ☐ Overtime $ _____
☐ W-2 $ _____ ***(if applicable, provide W-2(s) and year-end pay stub(s) for period(s) indicated in the policy)***
☐ Pre-Tax ☐ Post-Tax

| **27.** Date of Last Salary Increase | **28.** On the job injury or illness? ☐ Yes ☐ No If YES, include initial injury/illness report |
|---|---|
| | |

**Employee Information – To Be Completed By Employer *(please print) (continued)***

| **29.** Employee is Eligible for: *(now or in the future)* | Yes | No | Unknown | If YES, Weekly or Monthly Gross Amount | Frequency | Provider Name/Address | Date Benefits Begin | Date Benefits End |
|---|---|---|---|---|---|---|---|---|
| Salary Continuation | ☐ | ☐ | ☐ | $ | | | | |
| Disability Pension | ☐ | ☐ | ☐ | $ | | | | |
| Retirement Pension | ☐ | ☐ | ☐ | $ | | | | |
| State Disability If YES, list state _____ | ☐ | ☐ | ☐ | $ | | | | |
| Unemployment | ☐ | ☐ | ☐ | $ | | | | |
| Social Security | ☐ | ☐ | ☐ | $ | | | | |
| Paid Family Medical Leave | ☐ | ☐ | ☐ | $ | | | | |
| Vacation/PTO | ☐ | ☐ | ☐ | $ | | | | |
| Sick Pay | ☐ | ☐ | ☐ | $ | | | | |
| Workers' Compensation | ☐ | ☐ | ☐ | $ | | | | |
| Has Workers' Comp. claim been filed? | ☐ | ☐ | ☐ | If Worker's Compensation has been denied, submit copy of denial with this claim. | | | | |

**30.** Are the Employee's current wages exempt from FICA?

☐ Yes ☐ No

**Please complete the below premium questions. If not fully completed, this claim will be taxed at 100%.**

**31.** Percentage of Employee/Employer contributions to premium for this disability coverage: *(if assistance is needed in determining the percentage, refer to the **Employer Disability Taxability Calculation Tool** at https://www.employeebenefits.aul.com/public/index.html#forms)*

**Short-Term Disability *(if the premium is a dollar amount, it should be converted to a percentage)***

Employee: ☐ 100% ☐ Other _____ % Are Employee Contributions: ☐ Pre-Tax Deduction ☐ Post-Tax Deduction

Employer: ☐ 100% ☐ Other _____ %

**Long-Term Disability *(if the premium is a dollar amount, it should be converted to a percentage)***

Employee: ☐ 100% ☐ Other _____ % Are Employee Contributions: ☐ Pre-Tax Deduction ☐ Post-Tax Deduction

Employer: ☐ 100% ☐ Other _____ %

***If the plan is either a 2004-55 plan with a post-tax deduction or a gross-up, please complete as Employee paid post-tax for that plan type.***

**32.** If coverage is Voluntary/Employee Contributes to premium, please include proof of enrollment and copy of paycheck stub *(year of disability and prior year)*.

**Signature**

The undersigned represents 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 that any insurance coverage or benefits are contingent upon any statements made to AUL or its third party administrator as being complete and correct. 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*

| Authorized Employer Representative Signature *(the above statements are true and complete to the best of my knowledge)* | |
|---|---|
| Authorized Employer Representative Printed Name | Date |
| Employer Phone Number | Employer Email |

| Employer Street Address | City or Town | State | ZIP Code |
|---|---|---|---|

**A Job Description is required.**

# Attending Physician Statement for Disability Claim

OneAmerica Financial

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## Patient Information – To Be Completed By Physician

| | | | |
|---|---|---|---|
| **1.** Patient Name | | **2.** Employer Name | |
| **3.** Height | **4.** Weight | **5.** Blood Pressure *(last visit)* | **6.** Date of Birth |

**7.** Reason Patient Is/Was Unable to Work *(check one)*
☐ Injury ☐ Illness ☐ Pregnancy

**8.** Primary Diagnosis *(include complications and International Classification of Diseases (10th revision) (ICD 10))*

**9.** Secondary Diagnosis *(include complications and ICD 10)*

**For Routine Pregnancy, Complete Items 10-16 *(then skip to item 33)***

| | | | |
|---|---|---|---|
| **10.** Last Menstrual Period (LMP) Date | **11.** Expected Date of Delivery | **12.** Date First Treated | **13.** Date Last Treated |
| **14.** Date of Delivery | **15.** Type of Delivery | **16.** List Any Complications | |

**For All Conditions Except Routine Pregnancy, Complete the Following Items**

| | | |
|---|---|---|
| **17.** Date symptoms first appeared or accident happened? | **18.** Date patient was advised to stop working? | **19.** Is condition due to injury or illness arising out of patient's employment? ☐ Yes ☐ No |
| **20.** Has patient ever had same or similar condition? ☐ Yes ☐ No | If YES, State When and Describe | |

| | | | |
|---|---|---|---|
| **21.** Date of First Visit | **22.** Date of Last Visit | **23.** Date of Next Office Visit | **24.** Frequency of Visits |

| | |
|---|---|
| **25.** Objective Findings *(x-rays, EKG's, lab data and clinical findings)* | **26.** Subjective Symptoms |

**27.** Nature of Treatment *(surgery, medications, etc.; provide medication dosage and frequency)*

| | |
|---|---|
| **28.** Names and Addresses of Patient's Other Physicians | **29.** Name of Physician You Referred This Patient To |

| | | |
|---|---|---|
| **30.** Has patient been hospitalized? ☐ Yes ☐ No | If YES, Beginning and Ending Dates | If YES, Provide Name and Address |

**31.** Please provide us with your patient's current restrictions and limitations. Restrictions are defined as the actions that your patient should not be doing. Limitations are defined as the actions that your patient cannot do. We use this information to better understand your patient's current functional capacity. Responses of "no work" or "totally disabled" may not assist us in completing our review in a timely manner.

| | |
|---|---|
| **32.** Has maximum medical improvement been achieved? ☐ Yes ☐ No | If NO, when do you expect a fundamental change? ☐ 1-2 weeks ☐ 3-4 weeks ☐ 5-6 weeks ☐ More than 6 weeks |



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| Employee Name | Employer Name | Employer Policy Number |
|---|---|---|
| | | |

**For All Conditions Except Routine Pregnancy, Complete the Following Items *(continued)***

| **33.** Has patient been released to return to work? ☐ Yes ☐ No | If YES, Date Released ☐ Full-Time ☐ Part-Time | If NO, Anticipated Return to Work Date |
|---|---|---|
| | | |

**34.** Current Functional Ability

a. In an 8 hour work 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 Work Activity | 10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours. |
| _____ Hrs. | Light Work 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 Work Activity | 50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing. |
| _____ Hrs. | Heavy Work Activity | 100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking and standing. |

**Signature**

The undersigned Attending Physician represents and warrants any information or documents provided to American United Life Insurance Company® (AUL®) by this Attending Physician 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*.

| Attending Physician Signature | Date |
|---|---|
| | |

| Attending Physician Printed Name |
|---|
| |

| Degree/Specialty |
|---|
| |

| Phone Number | Fax Number | Tax ID Number |
|---|---|---|
| | | |

| Office Address | City/Town | State | ZIP Code |
|---|---|---|---|
| | | | |

# State Fraud Warning Notices

Revised on 11/5/25

OneAmerica® Financial

**American United Life Insurance Company®** a OneAmerica Financial® company

**General Fraud Warning:** 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.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**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.

**Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, West Virginia:** 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.

**California: For your protection, California law requires the following to appear on this form:** Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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, 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:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim containing 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.

**Hawaii:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**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, Virginia, 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:** 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, as provided in RSA 638:20.

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

**Ohio:** 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 is guilty of insurance fraud.

**Oklahoma: WARNING:** 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.

**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 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.

**Texas:** Any person who knowingly presents a 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.

**Vermont:** Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

# Authorization for Release of Information – HIPAA Compliant

Excluding Psychotherapy Notes

OneAmerica® Financial

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| Claimant Printed Name | Date of Birth | Claim Number |
|---|---|---|
| Claimant Address | | |
| City | State | ZIP Code |
| Employer Name | | Employer Policy Number |

## Persons and Records Covered

I authorize the following people and organizations to disclose my medical records, financial/employment records, and other protected health information:

**Medical Sources:** Health plans; doctors and other health care professionals; hospitals; clinics; laboratories; pharmacies and pharmacy benefit managers; medical facilities; any insurance company; and any organization or person that has provided treatment, services, or payment to me or on my behalf, or that has records or knowledge of my health.

**Non-Medical Sources:** The Social Security Administration; any consumer reporting agency; any employer; and state/federal agencies holding records regarding my FICA earnings, Workers' Compensation, State Disability, pension, credit, or employment history *(together, "Providers")*.

**Disclose this information to:** American United Life Insurance Company® (AUL®) and its reinsurers.
**You also authorize AUL to redisclose this information to:** Medical, investigative, financial, and vocational specialists or entities; and Service providers under written confidentiality agreements.

Recipients may use or disclose the information only for the purposes in Section 3 and as permitted by law.

This authorization may include information about HIV and sexually transmitted diseases, mental health information other than psychotherapy notes, and alcohol, drug, and tobacco use. **Psychotherapy notes are not authorized. This authorization does not permit disclosure of records from a federally assisted substance use disorder program protected by 42 C.F.R. Part 2**.

## Category-Specific Consents

Some states require an opt-in consent to release the categories below. If you live in, or any of your Providers is located in, such a state, check the applicable box or boxes. If no such requirement applies, this authorization in Section 1 permits disclosure of those categories even if the boxes below are not checked. If you do not want AUL to obtain a category in any state, draw a line through that category.

☐ HIV test results and HIV-related information *(and sexually transmitted disease information where treated similarly by state law)*.

☐ Mental health information other than psychotherapy notes.

## Purpose of Disclosure

AUL and the recipients listed above will use this information to:

1. evaluate and adjudicate my current disability claim and any other claim or coverage I have with AUL;
2. determine eligibility for benefits and assess vocational rehabilitation or ability to work;
3. conduct business analytics, report aggregate claims information, and perform risk management; and
4. conduct other legally permissible activities that relate to my claim. We will not redisclose where further disclosure is prohibited by law, including state laws protecting HIV/STD and mental-health information.

## Method of Disclosure

I authorize disclosure on paper and, where permitted by law, electronically. A copy of this authorization is as valid as the original.

## Expiration and Revocation

This authorization remains in force for **two (2) years** from the date signed, unless a shorter period is required by applicable law. For disclosures of District of Columbia mental health information, this authorization expires no later than 365 days from the date signed.

I may revoke this authorization at any time by writing to: **Privacy Officer, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206.**

Revocation will not be effective to the extent Providers have already relied on this authorization. Upon request, I or my authorized representative will receive a copy of this authorization.

## Rights and Important Notices

I may inspect or obtain a copy of the records disclosed, subject to applicable law. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA.

I understand that AUL cannot condition the payment of a claim on my signing this authorization. However, failure to sign may impair the ability of AUL to evaluate my claim and lack of information may be a basis for denying benefits.

## Signature

Claimant or Personal Representative Printed Name

| Claimant or Personal Representative Signature | Date *(mm/dd/yyyy)* |
|---|---|

Role *(check one)*

☐ Claimant ☐ Personal Representative

If Personal Representative, Authority *(check one and describe if "Other")*

☐ Power of Attorney ☐ Guardian ☐ Executor ☐ Other _____

Verification of Authority Attached or On File

☐ Yes ☐ No

As of the date of last revision, the following states require specific, affirmative consent:

- HIV or HIV-related information *(and, where applicable, sexually transmitted disease information)*: AZ, CA, CO, CT, DC, DE, FL, IL, IN, IA, ME, NH, NJ, OH, OR, PA, RI, VT, WA, WI, NV.
- Mental health information other than psychotherapy notes: IA, IL, MD, TX, DC. *(DC authorizations expire after 365 days.)* This list is provided for convenience and is maintained by AUL. State laws change. Providers may require their own state forms or notices.

# Direct Deposit Authorization Agreement

OneAmerica Financial

**American United Life Insurance Company®** a OneAmerica Financial® company
One American Square, P.O. Box 7003, Indianapolis, IN 46207-7003 • 1-855-517-6365 • Fax 1-844-287-9499 • *disability.claims@oneamerica.com*

☐ New Direct Deposit ☐ Change to Current Direct Deposit ☐ Cancel Direct Deposit

**Please Print**

| Name | Social Security Number |
|---|---|
| | |

**Account Information**

Type of Account

☐ Checking ☐ Savings *(American United Life Insurance Company® (AUL) will only deposit to one account.)*

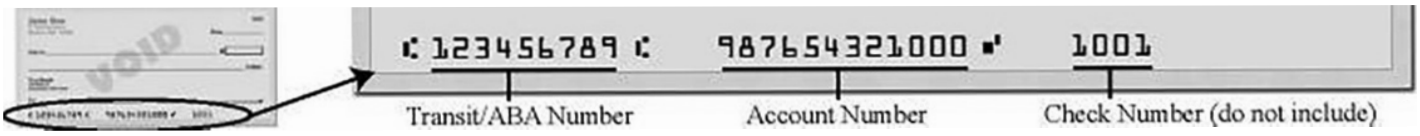
Name of Financial Institution

Financial Institution Street Address

| City | State | ZIP Code |
|---|---|---|
| | | |

| Transit/ABA Number | Account Number | Check Number<br>Do Not Include |
|---|---|---|
| | | |

Checking Account information can be found at the bottom of your check. Savings Account information can be obtained from your financial institution.




**Authorization**

I authorize American United Life Insurance Company® (AUL) to electronically deposit all payments due me into the account identified above. I discharge and release AUL from further liability for any payments so deposited to my account. I authorize AUL to pursue corrections, if necessary, to any amounts credited to my account in error. AUL will notify me of the error and amount of overpayment.

Any such payments shall be returned to AUL by the Financial Institution if funds are available in my account or shall be returned to AUL by me, my legal representative, my estate or my heirs if the funds in my account are not sufficient to make the required correction.

I understand that AUL may terminate this electronic fund transfer at any time and for any reason and may make payments by check instead. I also understand that I may revoke this authorization at any time by written request which will be effective when received and acknowledged by AUL at its Home Office.

| Signature | Date |
|---|---|
| | |



G-28291 5/22/25

# California Notice

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In the state of California, the following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

**California Insurance Code 790.03**

**(h)** Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

**(i)** Canceling or refusing to renew a policy in violation of Section 676.10.

**(j)** Holding oneself out as representing, constituting or otherwise providing services on behalf of the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code without a valid agreement with the California Health Benefit Exchange to engage in those activities.

In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, *www.insurance.ca.gov* or by calling the department's consumer information line at 1-800-927-HELP (4357). You may also obtain a copy of this law and these regulations free of charge from this insurer.