Group Life Insurance Claim Packet

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 7106
Indianapolis, IN 46207-7106
1-800-553-3522
Fax 317-285-7666
lifeclaims.employeebenefits@oneamerica.com

ONEAMERICA®

Instructions - Please Read Carefully and Submit All Required Information

This form is to be completed by the Employer.

We offer five options for filing a life claim. The following information may be sent to us via:

1. Online Claim Submission:
   Complete and submit your life claim form, found at *www.employeebenefits.aul.com* in the Life section of the Forms tab. This will automate the submission process.
2. Fax to 317-285-7666
3. Email to *lifeclaims.employeebenefits@oneamerica.com*
4. Mail forms to: Employee Benefits Life Claims Department
   American United Life Insurance Company
   PO Box 7106
   Indianapolis, IN 46207-7106
5. Overnight forms to: Employee Benefits Life Claims Department
   American United Life Insurance Company
   250 W. North Street
   Indianapolis, IN 46202

If you have any questions when completing the claim forms, please call a claims representative at 1-800-553-3522.

Group Life Insurance Claim Form

All questions should be answered fully and accurately to avoid delays in claim processing. Forms should be completed as follows:

The Authorized Representative of the Employer should:

1. Submit all forms within the timeframe specified in the policy.
2. The below supporting documentation is required to complete this process:
   a. Copy of each Beneficiary designation signed by the Employee or copy of the Beneficiary designation from an electronic enrollment system.

      NOTE: A maximum of eight Beneficiaries may be added. If additional Beneficiaries are named, you may attach a separate sheet listing any additional Beneficiaries.

   b. If applicable, submit all forms requesting or changing group life insurance coverage. This includes, but is not limited to, enrollment form, proof of enrollment from an electronic enrollment system, request to decrease coverage, request to increase coverage, and all Guaranteed Increase in Benefit (GIB) forms.
   c. Employee's most recent W-2 if salary is based on W-2.
3. The below supporting documentation may be attached if available *(These items are required to process the claim benefit.)*:
   a. Copy of the certified Death Certificate.
   b. If Dependent claim and Dependent is full-time student:
      1. Documentation from the educational institution of full-time student status.
      2. Copy of Employee's most recent federal tax return.
   c. If the Beneficiary is a Trust or Estate:
      1. Trust/Estate Document
      2. IRS Form SS-4 for verification of Tax ID Number
4. Please provide any additional comments, notes, or attachments that may be applicable or relevant to the claim.

Authorization for the Release of Protected Health Information (PHI) of a Deceased Individual

As the Employer, please provide this form to the Personal Representative or the person who had the legal authority to make medical decisions for the deceased. The Personal Representative should complete, sign, and return the form to American United Life Insurance Company.®

OneAmerica prides itself on being there when our customers need us most, and we are pleased to offer a beneficiary guide entitled *Day by Day*, which assists families in managing life after loss. The guide and Frequently Asked Questions (FAQs) regarding Employee Benefits life insurance claims can be found on our website *www.oneamerica.com/claims*.

G-23774 7/5/23

Group Life Insurance Claim Form

Notice of claim for:

☐ Employee ☐ Dependent

TO BE COMPLETED BY EMPLOYER

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Section I - Employee Information

Employer Name Prime Inc.		Employer Policy Number 621679	
Employee Name		Gender ☐ Male ☐ Female	
Employee Street Address	City	State	ZIP Code
Employee Daytime Phone Number	Employee Social Security Number	Employee Date of Birth	
Employee Full Time Hire Date	Number of Hours Worked Per Week	Effective Date of Employee Insurance	
Was Evidence of Insurability Required? ☐ Yes ☐ No	Employee Occupation	Employee Class	
Date Employee was Last Physically/Actively at Work		Date Active Pay Status Ceased	
Did employment cease prior to death? ☐ Yes ☐ No	Was Employee given Application to Port or Convert Group Coverage? ☐ Yes ☐ No If YES, date given		
How was Notice of Portability or Conversion given?		Date through which premiums are paid for this Employee	
Gross Annual Salary $	Date of Last Salary Change	Gross Annual Salary Includes ☐ Commissions ☐ Bonuses ☐ Overtime ☐ Based on W-2	

Employee Is *(check all that apply)*

☐ Hourly ☐ Executive ☐ Management ☐ Salaried/Non-Exempt ☐ Salary/Exempt ☐ Bargaining ☐ Non-Bargaining

Indicate Reason(s) for Date Last Physically/Actively at Work *(please select all that apply)*

☐ Termination of Employment Date _____

☐ Reduction of Hours Date _____

☐ Layoff: ☐ Permanent ☐ Temporary Layoff Date _____

☐ Retirement: Date of Retirement _____

☐ Disability: Date of Disability _____

☐ Entered Active Military Service: Date Entered _____

☐ FMLA Type: ☐ Self ☐ Family

FMLA Begin Date _____ FMLA End Date _____

☐ Leave of Absence

Reason for Leave of Absence _____

Date Leave of Absence Began _____

☐ Illness/Injury: Date of Illness/Injury _____

☐ Other _____

For Union Groups Only

Is the coverage through a Union Group? ☐ Yes ☐ No	Date all dues and assessments were paid for this Employee
Was member in good standing on coverage effective date? ☐ Yes ☐ No	Was member in good standing at his (or Dependent's) Date of Death? ☐ Yes ☐ No

Employee Name	Employer Name/Policy Number

Section I - Employee Information *(continued)*

Employee Date of Death

Identify all coverage, classes and volume of coverage for the Employee. This information is required for claim processing:

- ☐ Basic Term Life Class _____ Volume _____
- ☐ Basic AD&D Class _____ Volume _____
- ☐ Voluntary Term Life Class _____ Volume _____
- ☐ Voluntary AD&D Class _____ Volume _____
- ☐ Supplemental Life Class _____ Volume _____
- ☐ Supplemental AD&D Class _____ Volume _____

Section II – Dependent Information

Dependent Information *(please complete the entire claim form if claim is for a Dependent)*

Name of Dependent		Relationship to the Employee	
Dependent's Date of Birth	Dependent's Social Security Number	Marital Status of Dependent ☐ Single ☐ Married	Is Dependent a Full-Time Student? ☐ Yes ☐ No

If Dependent Child is over 19 and a full-time student, please send documentation from the educational institution of full-time student status and a copy of the Employee's most recent federal tax return.

Effective Date of Dependent Insurance	Was Evidence of Insurability Required? ☐ Yes ☐ No
Date through which premiums are paid for this Dependent	Dependent's Date of Death

Identify All Coverages and Volume of Coverage

- ☐ Basic Dependent Term Life
  Dependent: ☐ Spouse ☐ Child Class _____ Volume _____ Option # _____
- ☐ Basic Dependent AD&D
  Dependent: ☐ Spouse ☐ Child Class _____ Volume _____ Option # _____
- ☐ Voluntary/Supplemental Dependent Life
  Dependent: ☐ Spouse ☐ Child Class _____ Volume _____ Option # _____
- ☐ Voluntary/Supplemental Dependent AD&D
  Dependent: ☐ Spouse ☐ Child Class _____ Volume _____ Option # _____

Section III – Beneficiary Contact Information

Individual Beneficiary Contact Information

A maximum of eight Beneficiaries may be added. If additional Beneficiaries are named, please attach a separate sheet listing remaining Beneficiaries contact information. In addition to providing the information for each Beneficiary, you must also submit a copy of each Beneficiary designation signed by the Employee or copy of the Beneficiary designation from electronic enrollment system.

Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address	City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email	

Employee Name	Employer Name/Policy Number

Section III – Beneficiary Contact Information *(continued)*

Individual Beneficiary Contact Information

Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address	City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email	
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address	City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email	
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address	City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email	
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address	City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email	
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address	City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email	
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address	City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email	
Beneficiary Name		Beneficiary Social Security Number	Beneficiary Date of Birth
Beneficiary Mailing Address	City	State	ZIP Code
Beneficiary Daytime Phone Number		Beneficiary Email	

Employee Name	Employer Name/Policy Number

Section III – Beneficiary Contact Information *(continued)*

Trust/Estate Beneficiary Contact Information *(complete this section if an Estate or Trust is the named Beneficiary)*

Please attach the Trust/Estate Document and IRS Form SS-4 for verification of Tax ID Number.

Trust/Estate Name	Trust /Estate Tax ID Number	Trustee/Estate Personal Representative	
Trustee/Estate Personal Representative Mailing Address	City	State	ZIP Code
Trustee/Estate Personal Representative Daytime Phone Number	Trustee/Estate Personal Representative Email		

Contact Information for Employee Claim

☐ No Beneficiary designation on file.

If no Beneficiary has been designated on an American United Life Insurance Company® (AUL) form or a prior Carrier form for the same coverage, please indicate the name and contact information for the person who supplied the copy of the certified Death Certificate. Check the "No Beneficiary designation on file" box. AUL will contact this person with instructions concerning what additional information is required to determine the proper payee. If no Beneficiary has been named and an Estate has been or will be established, please provide Estate information.

Contact Name			
Street Address	City	State	ZIP Code
Daytime Phone Number	Relationship to Deceased	Email	

Section IV – Additional Information
(please provide any additional comments, notes, or attachments that may be applicable or relevant to the claim)

Section V – Employer Information

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: 1) any insurance coverage or benefits are contingent upon any statements made to AUL as being complete and correct, and 2) benefits under any policy will be paid only if AUL determines the applicant is entitled to them. The undersigned has read, understands, and has retained the notices, limitations, and exclusions for his/her records and the Discretionary Authority & Fraud Warnings on the following pages.

Employer	Employer Policy Number		
Street Address	City	State	ZIP Code
Phone Number	Fax Number	Email	
Is this plan governed by ERISA? ☐ Yes ☐ No	Printed Name & Title of Authorized Representative of the Employer		
Signature of Authorized Representative of the Employer		Date	

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, and denial of insurance benefits.

Discretionary Authority

Products and financial services provided by American United Life Insurance Company® a OneAmerica® company

ONEAMERICA®

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 designated third party administrator.

Such discretionary authority shall not apply in the following states for life and disability as indicated:

Life:

1. Alaska
2. California
3. Colorado
4. District of Columbia
5. Kentucky
6. Michigan
7. New Hampshire
8. New Jersey
9. New York
10. Oklahoma
11. Oregon
12. Rhode Island
13. South Dakota
14. Texas
15. Utah
16. Vermont
17. Washington

Disability:

1. Alaska
2. Arkansas
3. California
4. Colorado
5. District of Columbia
6. Hawaii
7. Illinois
8. Kentucky
9. Maine
10. Maryland
11. Michigan
12. Minnesota
13. Missouri
14. Montana
15. Nevada
16. New Hampshire
17. New Jersey
18. New Mexico
19. New York
20. Oklahoma
21. Oregon
22. Rhode Island
23. South Dakota
24. Texas
25. Utah
26. Vermont
27. Washington

G-25673 (Packet) 2/13/20

Authorization for the Release of Protected Health Information (PHI) of a Deceased Individual

HIPAA-Compliant Form

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As the Employer, please provide this form to the Personal Representative or the person who had the legal authority to make medical decisions for the deceased. The Personal Representative should complete, sign, and return the form to American United Life Insurance Company.®

Employee Name	Deceased Name
Your Relationship to Deceased	Deceased Date of Birth
Group Policyholder Number	Claim Number

I hereby attest that I am the Personal Representative for the deceased, and I am therefore legally authorized by a court or by state law to act on behalf of the deceased individual or his or her estate. I authorize any employer; health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy; pharmacy benefit manager; medical facility; other health care provider; insurance company; insurance support organization; the MIB, Inc. *(formerly known as Medical Information Bureau)*; or other organization or person that has provided payment, treatment, or services to the deceased or on his/her behalf within the past 10 years or has any records or knowledge of the deceased's health within the past 10 years *(the "Providers")* to disclose the deceased's entire medical record, prescription history, supplies provided with any other protected health information concerning the deceased to any company listed as a OneAmerica® company *("the Company")*, its reinsurers or any agent, attorney, insurance support organization or other authorized representative acting on their behalf. This includes information on the diagnosis or treatment of human immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and psychiatric history, as well as the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of the deceased's personal health information to MIB.

By my signature below, I acknowledge that any agreements the deceased made to restrict his/her protected health information do not apply to this authorization and I instruct his/her Providers to release and disclose his/her entire medical record without restriction.

This protected health information will be used in evaluating and administering my claim for benefit. The authorization will be valid for the duration of the claim or one year after the date it is signed. A photocopy of this authorization will be as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the Privacy Manager, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206. ***(Do NOT send this form, medical records, etc. to the Privacy Manager.)*** I understand that a revocation is not effective to the extent that any of the deceased's Providers have already relied on this authorization to disclose information about the deceased or to the extent that the Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but that it will not be redisclosed by the Company except as authorized by me or as required by law.

Personal Representative Signature	Date

10-15857 (EBLIFE) 4/20/23

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OneAmerica®

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.