Policyholder Statement for Waiver of Premium Claim

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: 1-317-285-7663
waiverclaims.employeebenefits@oneamerica.com

ONEAMERICA®

Section I – Employee Information

Policyholder Name: _____ Policyholder Number: _____

Employee Name: _____ Gender: ☐ Male ☐ Female

Employee 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: _____

Date Employee was last Physically/Actively at Work: _____

Date Active Pay Status Ceased: _____

Has Employee returned to work? ☐ Yes ☐ No If yes, date of return to work: _____

Returned to work: ☐ Full-Time ☐ Part-Time

Is the Employee returning in an accommodated job? ☐ Yes ☐ No

Was Employee given Application to Port or Convert Group Coverage? ☐ Yes ☐ No Date given: _____

Date through which premiums are paid for this employee: _____

Gross Annual Salary	Date of Last Salary Change	Employee is: *(check all that apply)*
$ _____	_____	☐ Hourly ☐ Executive ☐ Management ☐ Salaried / Non-exempt ☐ Salary/Exempt ☐ Bargaining ☐ Non-bargaining

Gross Annual Salary includes: ☐ Commissions ☐ Bonuses ☐ Overtime ☐ Based on W2 *(please attach last W2)*

Please indicate the type of retirement plan in which the Employee is/was enrolled:

☐ 401(k) ☐ 403(b) ☐ 457 ☐ Employer Sponsored Defined Benefit Plan ☐ Employer Sponsored Defined Contribution Plan

☐ Other: _____

Is this Employee receiving, or eligible for, an Employer Sponsored retirement plan benefit? ☐ Yes ☐ No

If yes, what date did/will they begin receiving the retirement plan benefit? _____

Is the Employee receiving, or eligible for, an Employer Sponsored disability retirement plan benefit? ☐ Yes ☐ No

If yes, what date did/will they begin receiving the plan benefit? _____

If yes, will the disability retirement plan benefit automatically roll over to a regular retirement plan benefit when the Employee reaches a certain age? ☐ Yes ☐ No At what age will the benefit roll to the regular retirement plan benefit? _____

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 _____

G-30615 6/18/18

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Employee Name: _____ Policyholder Name and Number: _____

Section II – Dependent Information

Identify all coverages and volume of coverage:

☐ Basic Dependent Term Life
☐ Spouse ☐ Child ☐ Family Class _____ Volume _____ Option # _____

☐ Basic Dependent AD&D
☐ Spouse ☐ Child ☐ Family Class _____ Volume _____ Option # _____

☐ Voluntary/Supplemental Dependent Life
☐ Spouse ☐ Child ☐ Family Class _____ Volume _____ Option # _____

☐ Voluntary/Supplemental Dependent AD&D
☐ Spouse ☐ Child ☐ Family Class _____ Volume _____ Option # _____

Spouse Name: _____ Spouse Social Security Number: _____

Spouse Date of Birth: _____ Effective Date of Insurance: _____

Was Evidence of Insurability required? ☐ Yes ☐ No

Dependent Children's Names and Dates of Birth: _____

_____

_____

_____

Date through which premiums are paid for dependent coverage: _____

Section III – Policyholder Information

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: 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.

☐ **I understand that premium must continue to be paid during the Waiver of Premium Elimination Period.**

Policyholder Name: _____ Policyholder Number: _____

Address: _____
City *State* *Zip Code*

Phone Number: _____ Fax Number: _____

Email Address: _____ Is this plan governed by ERISA? ☐ Yes ☐ No

Date: _____

_____ _____
Printed Name & Title of Authorized Representative of Policyholder *Signature of Authorized Representative*

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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.