Group Insurance – Proofs of Death

American United Life Insurance Company®
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
Toll-Free (800) 553-3522
Fax (317) 285-1033

***Instructions** – Please read carefully*

1) Proofs of Death must be furnished without expense to the Company. Each question should be answered in full. The Company reserves the right to obtain further information should it be necessary.
2) A certified death certificate is required. If not available, the Physician's Statement on the reverse side of the form may be completed by the Insured's attending Physician.
3) If the policy has provision for Accidental Death Benefits and accidental death is involved, attach newspaper account of accident. If the policy has a seat belt benefit, attach a copy of the police accident report in addition to the newspaper article.
4) When proceeds are payable to the Estate or Executors or Administrators of the Insured, or to a minor or mentally incompetent person, such Executor, Administrator, Guardian or Conservator must file an official certificate of his appointments with the Proofs of Death.
5) Enclose the insured's enrollment card.
6) Please direct all Proofs of Death correspondence to: ***Group Claims Department,*** American United Life Insurance Company®, P.O. Box 368, Indianapolis, Indiana 46206-0368.

Policyholder's Statement

1. Name Of Employee ______________________ Date of Birth ______________
2. Address ______________________ Social Security No. or Member No. ______________
   No. Street City State Zip
3. Date Of Employment ______________ Was Evidence of Insurability Required ______________
   Job Title ______________ Hours Worked Per Week ______________ Class ______________
   Effective Date Of Insurance: Life ______________ Supp ______________ Contributory? ______________
4. Amount Of Insurance Claim ______________ ______________ ______________ ______________ ______________
   Life AD&D Seat Belt Supplemental Voluntary
5. Salary ______________ Date Of Death ______________ Date To Which Premiums Were Paid ______________
6. Last Day Deceased Physically At Work ______________ If Employment Ceased Prior to Death, Give Date ______________ Reason: ______________

For Union Groups Only:
A. Was member in good standing at issue of his insurance? ☐ Yes ☐ No
B. Was member in good standing at his date of death? ☐ Yes ☐ No
C. Date to which full dues and assessments were paid ______________

Beneficiary Information - ALL information MUST be given before claim can be considered.

I certify that the information furnished in support of this claim is true and correct.

First Name	*Last Name*	*Birthdate*	*Social Security Number*	*Address*

Benefit Proceeds Should Be Forwarded To: ☐ Policyholder For Delivery ☐ Directly To Beneficiary
☐ ______________

This is to certify that the foregoing statements are true to the best of my knowledge and belief.

The Laws of some states require us to furnish you with the following notice: 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 the criminal act of insurance fraud.

Employer (Policyholder) ______________ Policy Number ______________
Address ______________ Phone No. ______________
No. Street City State Zip
Date ______________ , ______________ By ______________
Printed Name and Signature of Authorized Representative (required)

Proofs of Death – Physician's Statement

1. (A) Deceased's Name In Full ____________________

   (B) Residence At Death ____________________

   (C) Age At Death __________ Occupation ____________________

   ____

2. (A) Date Of Death ____________________

   (B) Place Of Death ____________________

   ____

3. (A) Immediate Cause Of Death ____________________

   ____

   (B) Contributory Cause Of Death Or Any Chronic Ailments ____________________

   ____

   (C) Date Of Last Attendance ____________________

   (D) The Deceased Was Totally Disabled And Unable To Work At His Usual Occupation From ____________________

   (E) Was Death Due To Suicide, Homicide or Accident? __________ If so, which? __________

   Describe Briefly ____________________

   ____

   ____

I hereby certify that the above answers are full and true to the best of my knowledge and belief.

Date __________ Signature ____________________ M.D.

Address ____________________

____