

**Statement of Claim For  
Waiver of Premium Group Life Insurance**

American United Life Insurance Company®  
Group Life Waiver Department  
P.O. Box 368  
Indianapolis, IN 46206-0368  
1-800-553-3522  
Fax: 317-285-7666



**EMPLOYER'S STATEMENT**

**POLICY NUMBER** \_\_\_\_\_

**PLEASE SUBMIT A COPY OF THE EMPLOYEE'S JOB DESCRIPTION AND ALL ENROLLMENT CARDS.**

Employee's Name \_\_\_\_\_ Member No. or  
Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Occupation \_\_\_\_\_  
Hours worked per week \_\_\_\_\_ Date Employed \_\_\_\_\_ Effective Date of Insurance \_\_\_\_\_  
Was Evidence of Insurability Required?  Yes  No Date last premium payment was made for employee \_\_\_\_\_  
Amount of Insurance: Basic Volume \$ \_\_\_\_\_ Voluntary Volume \$ \_\_\_\_\_ Supplemental Volume \$ \_\_\_\_\_  
Date employee ceased active work \_\_\_\_\_ Annual Salary at that time \$ \_\_\_\_\_  Hourly  Salary  
Reason for ceasing work \_\_\_\_\_  
Please provide dates of any change of status \_\_\_\_\_  
Is employee, or will this employee be eligible for a disability or employer paid pension?  Yes  No  
If yes, please provide type and date of eligibility \_\_\_\_\_  
I hereby certify that the employee described herein is insured as stated and that this claim is full and true to the best of my knowledge and belief.  
Policyholder \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Authorized Person's Name and Title *(please print)*

Authorized Person's Signature

**EMPLOYEE'S STATEMENT**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_  
State nature of illness/injury \_\_\_\_\_  
Have you had this or a similar condition before?  Yes  No If yes, please advise the first date of treatment. \_\_\_\_\_  
Please list the name and address of any other physician who has treated you for this condition. \_\_\_\_\_  
When was your last date worked? \_\_\_\_\_ When do you expect to return? \_\_\_\_\_  
Since you last worked have you worked for any employer in any capacity?  Yes  No  
Have Social Security Disability Benefits been awarded?  Yes  No If yes, please attach a copy of your Social Security Award notice.  
If no, what is the status of your Social Security Disability application? \_\_\_\_\_  
Are you receiving a disability retirement?  Yes  No OR an Employer Paid Pension?  Yes  No If yes, please explain. \_\_\_\_\_  
Are you receiving any long term disability benefits?  Yes  No If yes, what is the name of the carrier? \_\_\_\_\_  
Fraud 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 may be guilty of the crime of insurance fraud as determined by a court of competent jurisdiction. In Florida, any person who knowingly and with intent to injure files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. In New Jersey and Virginia, any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties. In Louisiana, Pennsylvania or Tennessee, 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 person to criminal and civil penalties. In Washington, a person who knowingly makes a false or misleading statement or impersonation, or who willfully fails to reveal a material fact in or relative to an application for insurance, to an insurer, is guilty of a gross misdemeanor.  
I certify that the information furnished by me in support of this claim is true and correct.  
I give you my permission to give American United Life Insurance Company® any information about me necessary for determining eligibility for insurance, determining eligibility for benefits, detecting or preventing fraud or misrepresentations. The word "you" refers to any organization or person that has records or knowledge about me or my medical history, mental or physical condition, diagnosis, treatment or prognosis. This includes my employer, any provider of health care, another insurance company, consumer reporting agencies and other insurance support agencies. This information may also be given by American United Life Insurance Company® to its legal representatives, consumer reporting agencies, or its other insurance support agencies. This authorization can be used for 24 months from the date below. I know I can receive a copy of this authorization. I agree that a copy of this authorization may be considered as valid as the original.  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**ATTENDING PHYSICIAN'S STATEMENT**

Return to: American United Life Insurance Company®  
Group Life Waiver Department  
P.O. Box 368  
Indianapolis, IN 46206-0368  
1-800-553-3522  
Fax: 317-285-7666

Name of Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Patient's Height \_\_\_\_\_ Patient's Weight \_\_\_\_\_

Date patient became disabled due to present illness or injury \_\_\_\_\_

Diagnosis (including complications) \_\_\_\_\_

Objective findings (including current x-rays, EKG's, biopsy or any other special tests) \_\_\_\_\_

Subjective symptoms \_\_\_\_\_

Date of first visit \_\_\_\_\_ List all dates of service \_\_\_\_\_

Frequency of visits \_\_\_\_\_ Nature of treatment (including surgery date and medications prescribed, if any) \_\_\_\_\_

Has patient  Recovered?  Unchanged?  Improved?  Retrogressed?

Is patient ambulatory?  Yes  No If yes, give a description? \_\_\_\_\_

Names and address of other treating physicians for this condition \_\_\_\_\_

List any restrictions, limitations, therapy \_\_\_\_\_

Mental/Nervous Impairments (if applicable):

a. Please list your findings according to the DSM-III multiaxial classification. \_\_\_\_\_

b. Axis IV findings, please describe: \_\_\_\_\_

- Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
- Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Functional capacity (American Heart Association):

- Class 1 (No limitation)  Class 2 (Slight limitation)
- Class 3 (Marked limitation)  Class 4 (Complete limitation)

Physical Impairments (As defined in Federal Dictionary of Occupational Titles):

- Class 1 - No limitation of functional capacity; capable of heavy work\*. No restrictions. (0-10%)
- Class 2 - Medium manual activity\*. (15-30%)
- Class 3 - Slight limitation of functional capacity; capable of light work\*. (35-55%)
- Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary\*) activity. (60-70%)
- Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary\*) activity. (75-100%)

Remarks: \_\_\_\_\_

When could trial employment commence?  Full-time  Part-time Month/Day/Year \_\_\_\_\_

Name (Attending Physician) Print \_\_\_\_\_

Board Certified Specialty \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature \_\_\_\_\_ Tax I.D. No. \_\_\_\_\_ Date \_\_\_\_\_