

**Group Life Insurance –
Request For Accelerated Life Benefit**

American United Life Insurance Company®
Group Life Claims Department
P.O. Box 368
Indianapolis, IN 46206-0368
Toll Free Number (800) 553-3522



INSTRUCTIONS – PLEASE READ CAREFULLY

1. This form is to be completed by the Employee, Employer and Attending Physician without expense to American United Life Insurance Company®.
2. Each question should be answered in full. American United Life reserves the right to obtain further information should it be necessary.
3. Please attach a copy of the Employee's Enrollment Form.
4. Please direct all correspondence regarding Accelerated Life Benefit to American United Life Insurance Company®, Group Life Claims Department, P.O. Box 368, Indianapolis, Indiana 46206-0368.

EMPLOYEE'S STATEMENT

1. Employer's Name _____ Policy Number _____
2. Name of Employee _____
3. Employee's Social Security # _____
4. Claim is being made for Self Spouse Spouse's Name _____
If spouse, please provide spouse's Social Security # _____
5. Home Address _____
6. Daytime Telephone Number _____
7. Amount of Request: Employee Basic (select one) _____ 25% or _____ 50%.
 Employee Supplemental (select one) _____ 25% or _____ 50%.
 When Spouse and Employee are insured under the same policy, the Spouse amount is 50%.
 When Spouse is insured under a separate policy (select one) _____ 25% or _____ 50%.

Receipt of an Accelerated Life Benefit will reduce your death benefit. Also, receipt of an Accelerated Life Benefit payment may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. Acceptance of an Accelerated Life Benefit may be taxable and assistance should be sought from your personal tax advisor.

THE FOLLOWING FRAUD NOTICE DOES NOT APPLY TO RESIDENTS OF VA.

Fraud notice: Any person who, with the 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: any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties. In 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 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: the purpose of evaluating and administering claims for benefits, detecting or preventing fraud or misrepresentation. 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, reinsurers, consumer reporting agencies and other insurance support agencies. This information may also be given by American United Life Insurance Company® to its legal representative, reinsurers, consumer reporting agencies and other insurance support agencies. This information can be used for the duration of the claim but not to exceed two years from the date signed. 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 of Employee

Date

Signature of Spouse (if claim is for spouse)

Date

If you reside in a community property state, spousal consent and signature is required. Community property states include but are not limited to: AZ, CA, ID, LA, NM, NV, TX, WA, WI.

Signature of Spouse

Date

ATTENDING PHYSICIAN'S STATEMENT

Your patient is requesting an Accelerated Life Benefit payment on his/her life insurance policy. Please complete the following questions so that we may determine eligibility.

1. Please provide all current diagnoses.
2. Please indicate the patient's prognosis.
3. Is the patient totally disabled from any occupation?
4. With continuance of appropriate medical care is the patient's life expectancy twelve (12) months or less?
5. Please indicate any other details that would aid us with our determination.
6. Please provide the names and address of any other treating physicians.

Physician's Name (Please Print)

Title

Physician's Signature

Date

Address

Telephone Number _____

EMPLOYER'S STATEMENT

1. Employee's Name _____ Date of Birth _____ Member # or Social Security # _____
2. Occupation (*describe duties*) _____ Hours Worked _____
3. Date Employed _____ Effective Date of Insurance _____
4. Was Evidence of Insurability Required? _____ Amount of Insurance \$ _____ Employee Class _____
5. Date last premium payment was made for employee _____
6. Present Status of Employee: Active Retired Lay-Off Leave of Absence Other
7. Explain giving dates of any change of status _____
8. Average hours worked per week prior to onset of disability _____
9. Date Employee last worked _____ Hour _____ A.M. P.M. Annual Salary at that time \$ _____
10. Reason for Stopping Work _____
11. Nature of Employee's Disability _____

We hereby certify that the employee described herein is insured as stated and that this claim is full and true to the best of our knowledge and belief.

Policy holder _____ Policy No. _____ Phone No. _____

Address _____

City _____ State _____ Zip Code _____

Title _____ Date _____

Signature of Authorized Representative