

**Voluntary Universal Life  
Waiver of Monthly Deductions Claim Form**



American United Life Insurance Company®  
Group Life Claims Department  
P.O. Box 368  
Indianapolis, IN 46206-0368  
Toll Free Number: 1-800-533-3522  
Local: 1-317-263-1874 or 1-317-263-1980

**INSTRUCTIONS - Please read carefully**

1. Waiver of Monthly Deductions claims must be furnished without expense to American United Life. Each question should be answered in full. American United Life reserves the right to obtain further information should it be necessary.
2. Please direct all Waiver of Monthly Deductions correspondence to the above address.

**OWNER'S INFORMATION**

Name of Owner \_\_\_\_\_ Policy Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Street Address, City, State & Zip \_\_\_\_\_  
Telephone Number (\_\_\_\_) \_\_\_\_\_  
Is claim due to an accident?  Yes  No Date of accident \_\_\_\_\_  
Where did the accident occur? \_\_\_\_\_  
Please give details of the accident \_\_\_\_\_  
Is claim due to an illness?  Yes  No When did the illness begin? \_\_\_\_\_  
State nature of illness \_\_\_\_\_  
Is this claim the result of a work related illness or injury?  Yes  No  
Have you had this condition before?  Yes  No If yes, please give dates. \_\_\_\_\_  
On what date were you first treated by a physician for this illness or injury? \_\_\_\_\_  
Please advise the physician's name and address. \_\_\_\_\_  
Were you hospitalized?  Yes  No Give from and to dates of hospitalization. \_\_\_\_\_  
Please advise the name and address of the hospital \_\_\_\_\_  
Please list the names and address of any other physicians who treated you for this illness or injury. \_\_\_\_\_

What was the first date you were prevented from working due to this illness or injury? \_\_\_\_\_  
Are you now working?  Yes  No Explain, giving date of return, hours worked and duties. \_\_\_\_\_  
If due to total disability, you are unable to work at this time, when do you expect to return? \_\_\_\_\_  
Have you applied for Social Security?  Yes  No Has Social Security been approved?  Yes  No  
If approved, please send a copy of your Social Security Award notice.  
If not approved, what is the status of your Social Security Benefit application? \_\_\_\_\_  
Have you retired?  Yes  No If yes, give date of retirement. \_\_\_\_\_  
Are you receiving disability retirement?  Yes  No Are you receiving a pension?  Yes  No  
Are you receiving any long term disability benefits?  Yes  No

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

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 to its legal representatives, consumer reporting agencies, or its other insurance support agencies. This authorization can be used for 2½ years 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.

\_\_\_\_\_  
*Owner's Signature*

\_\_\_\_\_  
*Date*

**EMPLOYER'S INFORMATION**

Employee's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Date Employed \_\_\_\_\_  
Describe duties of regular occupation \_\_\_\_\_  
Please submit a copy of the employees job description.  
Hours Worked \_\_\_\_\_ Annual Salary \_\_\_\_\_  
Present status of employee?  Active  Retired  Lay-Off  Leave of Absence  Pension  Other  
Explain, giving dates of any change of status \_\_\_\_\_

**EMPLOYER'S INFORMATION (continued)**

Average hours worked per week prior to onset of disability. \_\_\_\_\_

Date employee last worked. \_\_\_\_\_ Hour \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Reason for stopping work. \_\_\_\_\_

Is employee, or will this employee be eligible for a disability or retirement pension?  Yes  No

If yes, type:  Disability  Retirement  Other (explain) \_\_\_\_\_

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.

Policyholder \_\_\_\_\_ Policy No. \_\_\_\_\_ Telephone No. \_\_\_\_\_

Address, City, St., and Zip Code \_\_\_\_\_

Signed by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**ATTENDING PHYSICIAN'S INFORMATION**

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

ICD Code \_\_\_\_\_ Patients Height \_\_\_\_\_ Patients Weight \_\_\_\_\_

When did symptoms first appear or accident happen? \_\_\_\_\_

Date patient ceased work because of disability? \_\_\_\_\_

Has patient ever had the same or similar condition?  Yes  No If yes, state when and describe \_\_\_\_\_

Subjective symptoms of present condition \_\_\_\_\_

Objective findings of present condition \_\_\_\_\_

What are the results of current X-rays, E.K.G.s or any other special tests? \_\_\_\_\_

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

Is patient:  Ambulatory  Bed Confined  House Confined  Hospital Confined

Name and address of all treating physicians \_\_\_\_\_

Date of first visit \_\_\_\_\_ Date of last visit \_\_\_\_\_

Frequency of visits  Weekly  Monthly  Other (Specify) \_\_\_\_\_

Is patient:  Improved  Unimproved  Recovered  Retrogressed

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%)

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)

Is patient now totally disabled for  Own Occupation  Any Occupation

If not disabled, when will the patient be able to resume any work \_\_\_\_\_

If still disabled, when will the patient be able to resume any work? \_\_\_\_\_

Is patient a suitable candidate for a rehabilitation program?  Yes  No

Prognosis \_\_\_\_\_

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

Additional comments: \_\_\_\_\_

\_\_\_\_\_  
*Physician's Name and Title (please print)*

\_\_\_\_\_  
*Physician's Signature and Title*

\_\_\_\_\_  
*Board Certified Specialty*

\_\_\_\_\_  
*Street Address, City, State and Zip Code*

\_\_\_\_\_  
*Date*

(\_\_\_\_\_) \_\_\_\_\_  
*Telephone Number*

