Claimant's Statement – Death Claim

American United Life Insurance Company®
a OneAmerica® *company*
One American Square
P.O. Box 6008
Indianapolis, IN 46206-6008
1-800-833-5569

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United Mutual Insurance Holding Company
a OneAmerica® *company*
P.O. Box 6008
Indianapolis, IN 46206-6008
1-800-833-5569

The State Life Insurance Company®
a OneAmerica® *company*
P.O. Box 6008
Indianapolis, IN 46206
1-800-833-5569

LIFE INSURANCE CLAIMS PACKET

INSTRUCTIONS

- A certified copy of the death certificate must be submitted. The certified copy of the death certificate should include the cause and manner of death. If claim is submitted via fax or email, the certified copy of the death certificate must be mailed. Only one copy of the death certificate is required.
- Each beneficiary should complete a separate **"Claimant's Statement – Death Claim"** form
- Please include all applicable policy numbers on the claim form
- If a beneficiary has predeceased the insured, a certified copy of the beneficiary's death certificate is required
- ***Estate as Beneficiary*** –The **"Claimant's Statement – Death Claim"** form should be completed and signed by the Executor or Administrator of the Estate. The certificate of appointment issued by the court, carrying a court certified stamp, must also be submitted along with the tax identification number for the Estate
- ***Trust as Beneficiary*** –The **"Claimant's Statement – Death Claim"** form should be completed by the current Trustee of the Trust. The enclosed "Trust Affidavit" should be completed and returned along trust tax identification number. A copy of the entire Trust document and all amendments should be provided
- ***Minor or Incompetent Adult as Beneficiary*** –The **"Claimant's Statement – Death Claim"** form should be completed by the Guardian of the Estate of the minor or incompetent adult. The court appointment documents with a court certified stamp must also be submitted along with the tax identification number for the estate.
- ***Unnamed Children as Beneficiary*** –The **"Surviving Children Affidavit"** should be completed if the beneficiary is "Children" or any variation of, and each child is not specifically named

If you have any questions when completing the enclosed forms, please call the Claims Department at 1-800-833-5569.

Completed forms and communication should be sent to:
OneAmerica Claims Department
P.O. Box 6008
Indianapolis, IN 46206-6008
Or
Fax 1-317-285-1344
Or
Claims.ind@oneamerica.com

Overnight Mail Address:
OneAmerica
250 W. North Street
Attn: Claims Department
Indianapolis, IN 46202

FOR ILLINOIS RESIDENTS ONLY

Common Names of Reference – Please provide a list of any names and/or abbreviations the insured(s) may have used. This includes last name, maiden name, middle name, religious name, baptismal name, nicknames and/or common names of reference

Claims not processed within 30 days of receipt of proof of loss will begin to accrue interest at the rate of 10% from the date of death through the date proceeds are paid

Notice of Availability of the Department of Insurance:

Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 Michigan Ave., 19th floor, Chicago, IL 60603, and in Springfield, at 320 W. Washington Street, Springfield IL 62767. They may also be reached at 1-312-814-2420, 1-217-782-4515 or http://insurance.illinois.gov/.

Life Insurance and Annuity Beneficiary Distribution Options

Annuitization of Benefits Available on Life Insurance and Annuity Death Proceeds

Fixed Period Annuity

Annuity is payable for a specific period of time. If the payee dies prior to the end of the specific period of time chosen, the remaining payments may be paid to the contingent payee.

Certain and Life Annuity

Annuity is payable as long as the payee lives. The payments are guaranteed for a number of payments (according to the specific period of time chosen.) If the payee dies after the guaranteed number of payments are paid, no additional payments are due. If the payee dies prior to the guaranteed number of payments being paid, the remaining number of guaranteed payments may be paid to a contingent payee appointed by the payee.

Life with Installment Refund Annuity

Annuity is payable as long as the payee lives. The payments are based on the initial premium. If any initial premium amount remains unpaid after the payee's death, the remainder will be paid to the contingent payee.

Note: Not all options may be available in all products or there may be other options; see your policy or contract for complete details.

Settlement/Distribution Available on Annuity Death Proceeds

Distribution Based on Life Expectancy

This distribution requires a new application for an inherited contract. This option is only available when the benefit amount equals or exceeds $25,000. A new contract will be issued and payments will be based on the life expectancy of the beneficiary.

Five Year Deferral

This option is only available if: (1) the Owner died before April 1 following the year the Owner attained age 70½ for qualified funds; or, (2) the policy is a nonqualified deferred annuity. Under this option, the payee's entire interest in the policy must be distributed by the end of the calendar year which contains the fifth anniversary of the date of the Owner's death for qualified annuities, or by the fifth anniversary of the date of the Owner's death for nonqualified annuities. Under this option, distribution will be made to the payee through requested withdrawals.

Inheritance Rollover to Existing Policy

Available to spouse only. Spouse must be the sole beneficiary. The spouse becomes the owner and annuitant of the current annuity contract. The existing contract will remain in force with the original effective date and no death benefit distribution will occur.

IRA Spousal Rollover

Available to spouse only. The death proceeds will be placed into an existing IRA owned by the spouse. The IRA must be able to accept new premium. Distribution may be made to a OneAmerica® company IRA or an IRA held by another company. If the IRA is held by another company, the spouse must provide approved transfer documents with the claim.

I-29534 07/11/17

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OneAmerica®

Check all that apply:

☐ **American United Life Insurance Company®**
☐ **The State Life Insurance Company**
☐ **Pioneer Mutual Life Insurance Company**
☐ **Golden Rule Insurance Company**
Administered by The State Life Insurance Company
1-800-275-5101

Hereinafter referred to as "the Company."

Please print all information with the exception of signatures.

Section I – Insured's Information

Insured Name: _____ Insured Social Security Number: _____

Policy Number(s): 618499

Claim Number(s): _____

Insured's Date of Birth: _____ Insured's Date of Death: _____

Insured's Address: _____
Address *City* *State* *Zip Code*

Cause of Death: _____

Section II – Beneficiary Information

If there are multiple beneficiaries under the above policy number(s), each beneficiary must complete a "Claimant's Statement – Death Claim" form. Only one copy of the death certificate is required.

Beneficiary Name: _____

Relationship to Insured: _____

Beneficiary Social Security Number: _____

Beneficiary Date of Birth: _____

Beneficiary Mailing Address:

_____
Address *City* *State* *Zip Code*

Beneficiary Daytime Phone Number: _____

Beneficiary Email Address: _____

Section III – Trust/Estate Beneficiary *Complete this section if the Beneficiary is a trust or estate.*

Please attach the Trust/Estate Document and IRS Form SS-4 for verification of Tax ID Number. If the beneficiary is a trust, please complete the enclosed Trust Affidavit.

Trust or Estate Name: _____

Trust or Estate Tax ID Number: _____

Trustee or Estate Personal Representative: _____

Trustee or Estate Personal Representative Mailing Address:

_____
Address *City* *State* *Zip Code*

Trustee or Estate Personal Representative Daytime Phone Number: _____

Trustee or Estate Personal Representative Email Address: _____

4-18357 5/18/17

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Section IV – Settlement/Distribution Options

A ☐ **Benefit Payment in a Lump Sum**

Any distribution above $50,000 will be distributed via a Benefit Plus Account (BPA). The BPA is a draft account which functions similar to an interest-bearing checking account, and the beneficiary has immediate access to the funds. The Benefits Plus Account is not available for contracts issued in or residents of the following states: AK, CA, CT, FL, IL, KS, KY, MD, MN, NC, ND, NH, NJ, NY or RI.

☐ I elect to **opt out** of receiving a Benefit Plus Account. I elect to receive a lump sum check.

B ☐ **Annuitization of Benefit *(Choose one of the following options)*:**

☐ Option 1 – Fixed Period annuity for _____ (3-20) years. *(Fixed period cannot exceed beneficiary's life expectancy using the single life expectancy table in 26 CFR 1.401(a)(9)-9 Q&A-1.)*

☐ Option 2 – Certain and Life annuity. The certain period is to be _____ (3-20) years. Periodic payments are to continue for my life. Upon my death prior to the end of the certain period, periodic payments are to continue to my contingent payee in the same amount for the remainder of the certain period. *(Certain period cannot exceed beneficiary's life expectancy using the single life expectancy table in 26 CFR 1.401(a)(9)-9 Q&A-1.)*

☐ Option 3 – Installment Refund Annuity. Periodic payments are to continue for my life. If, at my death, the sum of the income payments previously made to me is less than my benefit applied under this option, periodic payments of the same amount shall be continued to my contingent payee until the total of all the periodic payments equals the total benefit applied under this option.

☐ Option 4 – Other option as stated in the policy. Please indicate option: _____

Contingent Payee ***Complete if Option B was chosen above.***

Contingent Payee: Person(s) who are to receive any remaining fixed period payments, certain period payments or installment refund payments at my death if I choose to annuitize my benefit. *(Submit supplement if space is insufficient)* **For Option B only.**

First Contingent Payee(s)

Full Name	Relationship to Insured	% of Benefit	SSN or Tax ID# *(Required)*	DOB or Date of Trust
1.				
2.				
3.				

If naming a Corporation or Trust:

Full Name of Corporation/Trust | *Full Name of Corporate Office/Title* | *State of Incorporation*

Second Contingent Payee(s) ***(If all First Contingent Payees are deceased)***

Full Name	Relationship to Insured	% of Benefit	SSN or Tax ID# *(Required)*	DOB or Date of Trust
1.				
2.				
3.				

If naming a Corporation or Trust:

Full Name of Corporation/Trust | *Full Name of Corporate Office/Title* | *State of Incorporation*

Claimant's Statement – Death Claim

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OneAmerica®

Section V – Medical Information

Complete this section and the authorization below **ONLY** when a policy was issued or reinstated within two years of the date of death.

Please list names and addresses of all doctors who treated the insured and all hospitals where he or she was confined during the last five years. If additional space is needed, please attach information to this claim form.

Name	*Address*	*Date Treated*	*Disease or Condition*

Section VI – Authorization

Note: Sign Authorization.

Name of Deceased | *Your Relationship to Deceased* | *Date of Death*

I authorize any employer; health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy; pharmacy benefit manager; medical facility; other health care provider; insurance company; insurance support organization; the MIB, Inc. (formerly known as Medical Information Bureau); or other organization or person that has provided payment, treatment or services to the deceased or on his/her behalf within the past 10 years or has any records or knowledge of the deceased's health within the past 10 years (the "Providers") to disclose the deceased's entire medical record, prescription history, supplies provided with any other protected health information concerning the deceased to the Company, its reinsurers or any agent, attorney, insurance support organization or other authorized representative acting on their behalf. This includes information on the diagnosis or treatment of human immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and psychiatric history, as well as the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. I authorize any company listed as a OneAmerica® company and its reinsurers to make a brief report of the deceased's personal health information to MIB.

By my signature below, I acknowledge that any agreements the deceased made to restrict his/her protected health information do not apply to this authorization and I instruct his/her Providers to release and disclose his/her entire medical record without restriction.

This protected health information will be used in evaluating and administering my claim for benefit. The authorization will be valid for the duration of the claim or one year after the date it is signed. A photocopy of this authorization will be as valid as the original.

I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the Privacy Manager, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206. **(Do not send this form, medical records, etc. to the Privacy Manager.)** I understand that a revocation is not effective to the extent that any of the deceased's Providers have already relied on this authorization to disclose information about the deceased or to the extent that the Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but that it will not be redisclosed by the Company except as authorized by me or as required by law.

Date | *Signature of First Beneficiary*

Date | *Signature of Second Beneficiary*

Witness

The Company reserves the right to require further information or proof if deemed necessary.

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Section VII – Substitute W-9 Certification

I (we) certify, under penalty of perjury that 1) the number(s) shown on this form is my (our) correct taxpayer identification number(s), or I (we) am (are) waiting for a number to be issued to me (us); and 2) I (we) am (are) not subject to backup withholding because: a) I (we) am/are exempt from backup withholding or b) I (we) have not been notified by the Internal Revenue Service that I (we) am (are) subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me (us) that I (we) am/are no longer subject to backup withholding; and 3) I (we) am (are) a U.S. citizen or other U.S. person (as defined in Form W-9 located at www.irs.gov); and I (we) am (are) not subject to FATCA reporting because (I) am (we) are a U.S. person and the account is located within the United States.

☐ Check this box if you have been notified by the IRS that you are currently subject to withholding because of under reporting interest or dividends on your tax return.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATION REQUIRED TO AVOID BACKUP WITHHOLDING.

Section VIII – Signature

Please return the original policy to the Company.

☐ Place an X in the box if unable to locate the policy.

LOST CONTRACT STATEMENT – Pursuant to the above contract, the certificate issued has been lost or destroyed after diligent search and has not been located. This certificate has not been pledged or assigned in anyway whatsoever. I further state that if said certificate should be found at anytime that I will immediately return it to the Company.

My signature below indicates that I understand and agree that:

(a) Any annuity issued or pattern of death benefit payments made will be based on the statements I made on this election form;

(b) No representative has the authority to make, alter or waive any contract provisions on the Company's behalf;

(c) My taxpayer identification number is correct;

Further, if I have elected an option other than a lump sum distribution, I understand and agree that

(a) My distribution will be placed in an annuity contract ("Contract").

(b) The Contract cannot accept additional premium contributions.

(c) The Contract cannot be commingled with other policies to which I have contributed as an active participant.

(d) There may be surrender charges for distributions as set forth in the Contract.

_____ _____

Beneficiary Signature *Date*

4-18357 5/18/17

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 or a denial of insurance benefits.

Trust Affidavit

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☐ **Golden Rule Insurance Company**
Administered by The State Life Insurance Company
1-800-275-5101

Hereinafter referred to as "the Company."

Please print all information with the exception of signatures.

Policy Number(s) 618499 Insured's Name _____

I, _____ , affirm that the _____

Agreement executed by _____ on _____ is in full force and effect

and has not been amended, modified, or revoked, and the current Trustee(s) is/are:

I understand that the Company will rely on the statements that I have made in this affidavit.

_____ _____
Current Trustee Printed *Current Trustee Printed*

Date: _____ By: _____
Trustee Signature

County of: _____ Subscribed and sworn before me

State of: _____ this _____ day of _____ , _____

at _____
Location

_____ _____
Notary Name *Notary Signature*

4-18358 3/30/17

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

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Colorado
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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 or a denial of insurance benefits.

4-18358 3/30/17

Surviving Children Affidavit

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☐ **Golden Rule Insurance Company –**
Administered by the State Life Insurance Company
1-800-275-5101

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Please print all information with the exception of signatures.

Policy Number(s) 618499 Insured's Name _____

This form must be completed by a disinterested party with actual personal knowledge of the facts stated below. A disinterested party is not a beneficiary under said policy nor a direct heir or relative.

RE: STATE OF _____

COUNTY OF _____

_____, age _____, residing at _____

_____ being duly sworn, on oath, deposes and says that I was

acquainted with the late _____ who died on the _____ day of _____ (*Month*), _____ (*Year*)

and with the family;

THAT _____ was united in marriage with _____;

THAT _____ children were born of that marriage, namely: _____

_____

THAT _____, wife/husband, predeceased _____

THAT _____ is survived by _____ children, namely:

Name	Birth Date	Address

THAT to the best of my knowledge and belief, no other children were born of the said marriage.

THAT this affidavit is made to establish and identify the survivors of _____.

_____
Affiant Signature

Subscribed and sworn before me this _____ day of _____, _____

in _____ *(location)*

_____ _____
Notary Name *Notary Signature*

My Commission Expires _____ County _____

4-18353 3/30/17

Fraud Warnings *(For use in AL, AR, DC, LA, NM, TX and WV)*

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Delaware, Idaho, Indiana, Oklahoma
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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
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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 or a denial of insurance benefits.

4-18353 3/30/17

American United Life Insurance Company®
a OneAmerica® *company*
P.O. Box 6008
Indianapolis, IN 46206-6008
1-800-833-5569

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United Mutual Insurance Holding Company
a OneAmerica® *company*
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The State Life Insurance Company®
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Indianapolis, IN 46206
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OneAmerica®

In the state of California, the following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

California Insurance Code 790.03

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

(i) Canceling or refusing to renew a policy in violation of Section 676.10.

(j) Holding oneself out as representing, constituting or otherwise providing services on behalf of the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code without a valid agreement with the California Health Benefit Exchange to engage in those activities.

In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov or by calling the department's consumer information line at 1-800-927-HELP (4357). You may also obtain a copy of this law and these regulations free of charge from this insurer.