Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106
Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

OneAmerica®

Maternity Disability Claim
Filing Instructions
INSTRUCTIONS – PLEASE READ CAREFULLY

Employee's Statement for Maternity Claim:

- The employee must complete the Employee's Statement in full, sign and date
- Read, sign and date the AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA-COMPLIANT) form

Policyholder's Statement for Maternity Claim:

- The employer must complete the Policyholder's Statement in full, sign and date

If you have questions when completing this form, please call an American United Life Insurance Company® representative at 1-855-517-6365.

Completed forms and communications should be sent to:

American United Life Insurance Company®
c/o Custom Disability Solutions
600 Sable Oaks Drive, Suite 200
South Portland, ME 04106

Or

Fax: 1-844-287-9499

Or

OneAmerica.claims@customdisability.com

All portions of these forms must be completed in order to expedite your claim.

Employee's Statement For Maternity Claims

TO BE COMPLETED BY THE EMPLOYEE

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OneAmerica®

(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

Notice of Claim for: ☐ **Short Term Disability Benefits** ☐ **Long Term Disability Benefits**

NAME OF EMPLOYEE				EMPLOYEE'S SOCIAL SECURITY
EMPLOYEE'S ADDRESS	STREET & NUMBER	CITY	STATE	ZIP
TELEPHONE NUMBER	CELL PHONE NUMBER	DATE OF BIRTH		
HOW MANY HOURS WERE YOU REGULARLY WORKING PER WEEK WITH YOUR PRESENT EMPLOYER? _____ hrs. Authorized to work/reside in US? ☐ Yes ☐ No	GROSS ANNUAL WAGES: (During the 12 months just prior to your disability – for this employer only) $_____	PLEASE INDICATE HOW YOU ARE PAID (Check all that apply): ☐ Hourly ☐ Salaried ☐ Other _____ ☐ Includes commissions ☐ Includes bonuses		
NAME OF EMPLOYER Northeast Kansas Education Service Center DBA Keystone Learning Services	EMPLOYER'S TELEPHONE NUMBER	GROUP POLICY NUMBER 618499		
EMPLOYER'S ADDRESS	STREET & NUMBER	CITY	STATE	ZIP
YOUR OCCUPATION & TITLE	ESSENTIAL DUTIES OF YOUR JOB AT THE TIME OF DISABILITY			
DATE YOU LAST WORKED BECAUSE OF DISABILITY:	DATE YOU RETURNED TO WORK ON A PART-TIME BASIS:	DATE YOU RETURNED TO WORK ON A FULL-TIME BASIS:	DATE FIRST TREATED FOR YOUR PREGNANCY:	

PRIMARY CARE PHYSICIAN'S:	OB/GYN PHYSICIAN'S:	OTHER PROVIDER'S:
NAME: _____	NAME: _____	NAME: _____
ADDRESS: _____	ADDRESS: _____	ADDRESS: _____
_____	_____	_____
PHONE: _____	PHONE: _____	PHONE: _____
FAX: _____	FAX: _____	FAX: _____

IF "HOSPITAL CONFINED," GIVE DATES OF CONFINEMENT: FROM _____ THROUGH _____

HOSPITAL: _____
Name Street Address City State Zip

HOSPITAL PHONE NUMBER: _____

ARE THERE ANY COMPLICATIONS EXPERIENCED WITH YOUR CURRENT PREGNANCY? IF YES, PLEASE EXPLAIN IN DETAIL:	HAVE YOU EXPERIENCED ANY COMPLICATIONS WITH ANY PAST PREGNANCY? IF YES, PLEASE EXPLAIN IN DETAIL:
DATE OF LAST MENSTRUAL PERIOD (LMP): _____	ACTUAL DATE OF DELIVERY: _____
EXPECTED DATE OF DELIVERY:	☐ VAGINAL ☐ C-SECTION

Employee's Statement For Maternity Claims

TO BE COMPLETED BY THE EMPLOYEE

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(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

NAME OF EMPLOYER Northeast Kansas Education Service Center DBA Keystone Learning Services GROUP POLICY NUMBER 618499

NAME OF EMPLOYEE _____

As a result of this disability, are you, your spouse or any of your dependent children receiving amounts from any of the following?

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
☐	☐	Sick Pay, Vacation, PTO	$_____	_____	_____	☐	☐
☐	☐	Salary Continuance	$_____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$_____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$_____	_____	_____	☐	☐
☐	☐	No Fault	$_____	_____	_____	☐	☐
☐	☐	Unemployment Compensation Disability	$_____	_____	_____	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$_____	_____	_____	☐	☐
☐	☐	Retirement Income (normal, early, or disability)	$_____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$_____	_____	_____	☐	☐
☐	☐	Other (describe) _____	$_____	_____	_____	☐	☐

HAVE YOU APPLIED, OR DO YOU PLAN TO APPLY FOR BENEFITS DESCRIBED ABOVE? ☐ YES ☐ NO

TYPE _____ DATE APPLICATION FILED _____

TYPE _____ DATE APPLICATION FILED _____

IF YOUR REQUEST FOR BENEFITS IS APPROVED, DO YOU WANT US TO WITHHOLD FEDERAL INCOME TAXES?
☐ YES ☐ NO IF YES, COMPLETE, SIGN, AND ATTACH W-4S. ($88 MINIMUM PER MONTH)

The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees that any insurance coverage or benefits are contingent upon any statements made to AUL as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

Signature of Employee _____ Date _____

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.

Discretionary Authority

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Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

The following discretionary authority rights shall apply to all policies except the states below:

DISCRETIONARY AUTHORITY: Benefits under the policy will be paid only if American United Life Insurance Company® (AUL) (or its third party administrator) decides in its discretion the claimant is entitled to them. Except for the functions the policy explicitly reserves to the Participating Unit or Trustee, AUL (or its third party administrator) reserves the right to: 1) manage the policy and administer claims under it; and 2) interpret the provisions and resolve any questions arising under it.

AUL's (or its third party administrator's) authority includes, but is not limited to, the right to:
1) establish and enforce procedures for administering the policy and claims under it;
2) determine participants' eligibility for coverage and entitlement to benefits;
3) determine what information it reasonably requires to make such decisions; and
4) resolve all matters when a claim review is requested.

Any decision that AUL (or its third party administrator) makes, in the exercise of its authority, will be conclusive and final subject to any rights under applicable laws such as the Employee Retirement Income Security Act (ERISA). This provision applies only where the interpretation of the policy is governed by ERISA. AUL may delegate some or all of its rights under this Discretionary Authority provision to another person or entity, and AUL hereby desires to share with and delegate rights under this provision to its third party administrator, Disability Reinsurance Management Services, Inc.

Such discretionary authority shall not apply in the following states:

1. Arkansas
2. Alaska
3. California
4. Colorado
5. Hawaii
6. Kentucky
7. Illinois
8. Maine
9. Montana
10. Michigan
11. New Jersey
12. New York
13. Oregon
14. South Dakota
15. Texas
16. Vermont
17. Washington
18. Non-ERISA governed policies in New Hampshire and Utah

Maternity Disability Claim

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Toll Free Phone: 1-855-517-6365

OneAmerica®

Name of Employer Northeast Kansas Education Service Center DBA Keystone Learning Services Group Policy Number 618499

AUTHORIZATION FOR RELEASE OF INFORMATION (excluding psychotherapy notes)
(HIPAA-COMPLIANT)
(to be signed and dated by the insured/claimant)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, the Social Security Administration, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of Custom Disability Solutions (CDS), American United Life Insurance Company® (AUL) and AUL's reinsurer(s) *excluding psychotherapy notes* and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and, where permitted by law, **HIV/AIDS** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by CDS, AUL, AUL's reinsurer(s) and the above-described representatives to evaluate and adjudicate my current disability claim, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, including Disability Reinsurance Management Services, Inc., employed by or representing CDS, AUL or AUL's reinsurer(s) to assist with the evaluation and adjudication of my current disability claim or another disability claim insured by AUL and/or to report aggregate claims information to AUL. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I have the right to revoke this authorization by notifying CDS in writing of my revocation. However, such revocation is not effective to the extent that CDS and/or AUL have relied previously upon this authorization for the use or disclosure of my protected health information. I understand that AUL cannot condition the payment of a claim on my signing this authorization. However, I understand that my revocation of or my failure to sign this authorization may impair CDS' and AUL's ability to evaluate my current disability claim and that a lack of required information may be a basis for denying that current disability claim for benefits.

If you reside in **California, Connecticut, Maine, or Massachusetts: This authorization excludes the release of information and test results about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant or employee-claimant (for self-insured business) is required each time results are released.

***If you reside in **Vermont:** This authorization EXCLUDES the release of any information and test results about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING CDS to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and CDS shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

Claimant Name:_____ Date of Birth: _____

Claimant Signature (or Authorized Representative): _____ Date: _____

Description of Personal Representative's Authority (if applicable): _____
(*If signed by authorized representative, attach verification of identity.)

Claim ID: _____

Policyholder's Statement For Maternity Claims

TO BE COMPLETED BY THE POLICYHOLDER

(TO AVOID DELAY, ALL QUESTIONS MUST BE ANSWERED)

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Fax: 1-844-287-9499
Toll Free Phone: 1-855-517-6365

OneAmerica®

Notice of Claim for: ☐ **Short Term Disability Benefits** ☐ **Long Term Disability Benefits**

NAME OF EMPLOYER Northeast Kansas Education Service Center DBA Kansas Learning Services			GROUP POLICY NUMBER 618499
NAME OF EMPLOYEE			EMPLOYEE TELEPHONE NUMBER
EMPLOYEE ADDRESS (City, State, Zip Code)			
OCCUPATION			INSURANCE CLASS
DATE EMPLOYED	DATE INSURED	DATE LAST WORKED	REASON FOR STOPPING WORK ☐ Disability ☐ Dismissed ☐ Resigned ☐ Layoff ☐ Retired ☐ Family Medical Leave of Absence ☐ Other Leave of Absence ☐ Other Reason _____

DATE RETURNED TO WORK ☐ FULL-TIME ☐ PART-TIME	IF PART-TIME, NUMBER OF HOURS WORKED PER WEEK	IF EMPLOYEE HAS NOT RETURNED TO WORK, ESTIMATED RETURN TO WORK DATE	DATE EMPLOYMENT TERMINATED	DATE DISABILITY INSURANCE TERMINATED

ACTUAL NUMBER OF HOURS WORKED PER WEEK _____ hrs.	GROSS MONTHLY SALARY: (Provide salary last reported and approved by AUL in writing.) $_____ / Hourly Rate _____	PLEASE INDICATE HOW THE EMPLOYEE IS PAID (check all that apply): ☐ Hourly ☐ Salaried ☐ Other_____ ☐ Includes commissions ☐ Includes bonuses

IS EMPLOYEE SUBJECT TO FICA TAX? ☐ YES ☐ NO
IF "YES", IS EMPLOYEE SUBJECT TO ☐ FULL FICA TAX? ☐ MEDICARE PORTION ONLY?

PERCENTAGE OF EMPLOYEE/EMPLOYER CONTRIBUTION TO PREMIUM FOR THIS DISABILITY PLAN
EMPLOYEE ☐ 100% ☐ OTHER _____% IS EMPLOYEE CONTRIBUTION: ☐ PRE-TAX DEDUCTION?
EMPLOYER ☐ 100% ☐ OTHER _____% ☐ AFTER-TAX DEDUCTION?

EMPLOYEE ELIGIBLE FOR:

YES	NO	TYPE	AMOUNT	DATE BEGAN	DATE TERM.	PAID WEEKLY	PAID MONTHLY
☐	☐	Sick Pay, Vacation, PTO	$_____	_____	_____	☐	☐
☐	☐	Salary Continuance Benefits	$_____	_____	_____	☐	☐
☐	☐	Workers' Compensation	$_____	_____	_____	☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan	$_____	_____	_____	☐	☐
☐	☐	No Fault	$_____	_____	_____	☐	☐
☐	☐	Unemployment Compensation Disability	$_____	_____	_____	☐	☐
☐	☐	Social Security Benefits (disability or retirement)	$_____	_____	_____	☐	☐
☐	☐	Retirement Income (normal, early, or disability)	$_____	_____	_____	☐	☐
☐	☐	Other STD/LTD Benefits	$_____	_____	_____	☐	☐
☐	☐	Other (describe) _____	$_____	_____	_____	☐	☐

The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees that any insurance coverage or benefits are contingent upon any statements made to AUL as being completed and correct. The undersigned acknowledges reading and understanding the state specific fraud statements and the Discretionary Authority statements on the following pages.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

_____ _____
Name of Policyholder (Company) *Print Name & Title of Official Representative*

_____ _____
Mailing Address of Policyholder (Company) *Signature* *Date* *Telephone Number*

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

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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.

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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.

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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

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Virginia

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Discretionary Authority

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Such discretionary authority shall not apply in the following states:

1. Arkansas
2. Alaska
3. California
4. Colorado
5. Hawaii
6. Kentucky
7. Illinois
8. Maine
9. Montana
10. Michigan
11. New Jersey
12. New York
13. Oregon
14. South Dakota
15. Texas
16. Vermont
17. Washington
18. Non-ERISA governed policies in New Hampshire and Utah

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