Claimant's Statement – Death Claim

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
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

Check all that apply: ☐ **American United Life Insurance Company®** ☐ **Pioneer Mutual Life Insurance Company** ☐ **The State Life Insurance Company**

Hereinafter referred to as "the Company."

Please print all information with the exception of signatures.

Complete this side in full. The Company does not waive any right nor admit any claim by furnishing this form.

Instructions for Completing Claim Form

1. **If More Than one Beneficiary** – Each beneficiary must sign the claimant's statement or if more convenient, a separate statement may be completed and signed for each.
2. **Death Certificate** – One *certified* copy required including manner and cause of death.
3. **Estate As Beneficiary** – The claimant's statement should be completed and signed by the Executor or Administrator. The current certificate of appointment carrying a court certified stamp must be submitted.
4. **Minor Or Incompetent Beneficiary** – The claimant's statement should be completed and signed by the guardian of the *Estate* of the beneficiary. A current certificate of appointment carrying a court certified stamp must be submitted.
5. **Beneficiary Deceased** – If any of the beneficiaries named in the policy are deceased, a copy of the death certificate of such deceased beneficiary must accompany the completed claimant's statement.
6. **Trust Beneficiary** – If the designated beneficiary is a trust, the statement should be completed by the trustees and returned along with the current trust agreement and complete the enclosed Trust Affidavit.
7. **Assignment** – If a policy has been assigned, the assignee must join in the claim or release it's interest by separate letter.
8. **Consent To Transfer** – Some states have special inheritance or estate tax laws governing payment of insurance proceeds. If applicable, the company will advise the beneficiary of the requirements.

Notice to All Parties Completing This Form

This form must be signed by the person making claim. The company cannot pay any fees for legal documents or proofs of death required.

Policy Numbers(s) under which claim is being made: ____________________

Name of Insured: ____________________ Date of Birth: ____________________

Residence Address of Insured *(Street, City, State, Zip)*: ____________________ Date of Death: ____________________

Cause of Death: ____________________

Social Security Number of Deceased: ______/______/________

If Proceeds are Assigned to a Funeral Home, fill in this section.

Assignee's Name: ____________________

Assignee's Address *(Street, City, State, Zip)*: ____________________

Amount Assigned $ ____________________ *(Per Beneficiary)*

Mode of Settlement

☐ Lump Sum
☐ Settlement Option: ____________________
☐ Apply to Policy Number: ____________________
☐ SP Annuity Policy No. *(Attach Application)*: ____________________
☐ Inheritance Rollover to Existing Policy: ____________________
☐ IRA Spousal Rollover Policy No.: ____________________

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

LOST CONTRACT STATEMENT – Pursuant to the above contract, the certificate issued has been lost or destroyed, after diligent search has not been located, and 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.

____________________ *Signature*

____________________ *Date*

4-18357 5/06

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First Beneficiary

These statements are true and complete to the best of my knowledge. I understand that the furnishing of forms by the company does not constitute an admission that there is any insurance in force.

Name of Claimant *(beneficiary)*: ______________________ ______________________
Print Name *Signature of Beneficiary*

______________ ______________________________ (   ) ______________
Date of Birth *Address (City, State, Zip Code)* *Daytime Telephone No.*

The Internal Revenue Service requires that we obtain this information. Under present law we are required to seek each claimant's correct Taxpayer Identification Number. If you are an individual, your taxpayer number is your Social Security Number. If you do not provide us with this number you may be subject to a $50 penalty imposed by the Internal Revenue Service. Interest paid in the settlement of this claim may be subject to Federal Income Tax withholding at the rate of 20 percent unless we have your correct Social Security Number on file.

Under penalty of perjury, I certify that my Tax Identification Number is: _____/_____/______ or ______________
Soc. Sec. No. *Employer ID No.*

and that I am not subject to Backup Withholding for failure to report interest or dividends or because the Internal Revenue Service has notified me that I am no longer subject to Backup Withholding.

Second Beneficiary (if any)

These statements are true and complete to the best of my knowledge. I understand that the furnishing of forms by the company does not constitute an admission that there is any insurance in force.

Name of Claimant *(beneficiary)*: ______________________ ______________________
Print Name *Signature of Beneficiary*

______________ ______________________________ (   ) ______________
Date of Birth *Address (City, State, Zip Code)* *Daytime Telephone No.*

The Internal Revenue Service requires that we obtain this information. Under present law we are required to seek each claimant's correct Taxpayer Identification Number. If you are an individual, your taxpayer number is your Social Security Number. If you do not provide us with this number you may be subject to a $50 penalty imposed by the Internal Revenue Service. Interest paid in the settlement of this claim may be subject to Federal Income Tax withholding at the rate of 20 percent unless we have your correct Social Security Number on file.

Under penalty of perjury, I certify that my Tax Identification Number is: _____/_____/______ or ______________
Soc. Sec. No. *Employer ID No.*

and that I am not subject to Backup Withholding for failure to report interest or dividends or because the Internal Revenue Service has notified me that I am no longer subject to Backup Withholding.

State of ______________ County of ______________

On this _______ day of ______________, _______ personally appeared before me as the above

named claimant ______________________ of full legal age, who subscribed the foregoing statement before me and made oath that the answers are each and all complete and true.

(SEAL) My commission expires ____________ ______________________
Notary Public

If Producer signs in notary space, notarization not necessary.

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Medical Information

NOTE: Fill out this section and the authorization below **ONLY** when a policy was issued within two years of the date of death.

Show names and address of all doctors who treated the insured and all hospitals where he or she was confined during the last five years.

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

Authorization

Note: Sign Authorization.

I authorize any physician, medical professional, hospital, clinic, other medical care institution, pharmacy, employer, insurer, or insurance support organization to provide the Company, its reinsurers or any agent, attorney, insurance support organization or other authorized representative acting on their behalf, with information concerning medical care, advice, treatment or supplies provided.

______________________________ , my ______________________________
Deceased

who died *(Date)* ____________________. I specifically authorize the parties named above to provide information about drug and alcohol use and psychiatric history. I also authorize the release of employment related information regarding the deceased insured.

This information will be used in evaluating and administering my claim for benefits. A photocopy of this authorization will be as valid as the original. I know that I may receive a copy of this authorization.

This authorization will be valid for the duration of the claim, or one year after date signed.

____________________ ______________________________
Date *Signature of Claimant*

____
Witness

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

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Fraud Warnings *(For use in AR, 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 is guilty of a crime and may be subject to fines and confinement in prison.

Alaska, Oregon

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 representative 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 reward 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 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 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.

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.

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, Washington D.C.

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 and denial of insurance benefits.