

What you need to know:

- **Are you eligible?** Benefits are available to employees who are actively at work on the effective date of coverage and working the minimum number of hours per week stated in the contract.
- **Your premiums and benefits may vary.** Actual premiums and benefit amounts will be calculated by OneAmerica and may change upon reaching certain ages, according to contract terms, and are subject to change. Volumes and benefit amounts shown may be subject to reductions due to age.
- **Enroll timely for guaranteed issue coverage.** You may be eligible for coverage without having to answer any health questions if you enroll during the initial enrollment period when benefits are first offered by OneAmerica®, or if you enroll as a newly hired employee within 31 days after any applicable waiting period.
- **Enrolling later requires approval.** If you decline coverage now, you will lose your only chance to apply for group insurance coverage without having to first undergo medical underwriting. If you decide to enroll later, you will need to submit a Statement of Insurability form for review. OneAmerica will then decide to approve or deny your coverage based on your health history. You may not be approved for any type of coverage at a later date if you have any current or future medical conditions.

What you need to do:

- **Carefully review the contents of this packet.** Enclosed is personal information about the benefits offered to you by OneAmerica on behalf of your employer. This is your opportunity to learn more about group insurance from OneAmerica, but it is not a complete explanation of benefits. For more information, consult the contract about exclusions, limitations, reduction of benefits, and terms under which the contract may be continued in force or discontinued.
- **Review the Notices and Limitations.** Visit www.employeebenefits.aul.com to find the Notices and Limitations, G-14320 (05 NonPrudent) 12/28/12. Go to Forms, Policy/Employee Admin, and Notices and Limitations.
- **Submit your enrollment form.** Please return your completed enrollment form to your employer.

Note: Products issued and underwritten by American United Life Insurance Company® (AUL), a OneAmerica company. Not available in all states or may vary by state.

Group Enrollment Form

American United Life Insurance Company®
 a ONEAMERICA® company
 One American Square, P.O. Box 6123
 Indianapolis, IN 46206-6123
 (800) 553-5318
 www.employeefits.aul.com



Applicant's Full Legal Name:		Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Applicant's Social Security Number:	Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Applicant's State of Residence:	Applicant's Residential Zip Code:	Employer:	
Applicant's Telephone Number: (normal business hours): () -	Applicant's E-mail Address:	Employed Full-Time: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you authorized to work and reside in the US? <input type="checkbox"/> Yes <input type="checkbox"/> No			

COVERAGE BEING APPLIED FOR: Apply for or decline each coverage listed below. Not checking a box or boxes will be considered a declination of that coverage.

Benefit Amount / Option Requested

Worksite Short Term Disability	Option _____	<input type="checkbox"/> Elect	<input type="checkbox"/> Decline
Worksite Long Term Disability	Option _____	<input type="checkbox"/> Elect	<input type="checkbox"/> Decline
Employee Voluntary Term Life & AD&D	<input type="checkbox"/> \$ _____		<input type="checkbox"/> Decline
Spouse Voluntary Term Life	<input type="checkbox"/> \$ _____		<input type="checkbox"/> Decline
Child Voluntary Term Life	Option _____	<input type="checkbox"/> Elect	<input type="checkbox"/> Decline

*If spouse is included in dependent coverage: Name _____ Date of birth _____.

NOTE: Coverage is only offered and available to eligible Dependents who are authorized to reside in the United States.

For AUL Term Life Coverages, identify your Beneficiary Designation to ensure proceeds can be paid according to your wishes.

Name of Primary Beneficiary:	Percentage:	Relationship:	SSN/Date of Birth:
Name of Contingent Beneficiary:	Percentage:	Relationship:	SSN/Date of Birth:

- I hereby apply for the requested group life and/or disability insurance coverage for which I and my dependents, if any, are eligible and available under AUL's policy. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by AUL.
 - I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.
 - 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 1. any insurance coverage or benefit are contingent upon any statements made to AUL as being complete and correct and 2. benefits under any group life or disability insurance policy will be paid only if AUL or its third party administrator decides in its discretion the applicant is entitled to them. The undersigned have read, understand, and retained the notices, limitations, and exclusions for his/her records.**
- 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.

Signature of Applicant: _____ **Date:** _____

MUST BE COMPLETED BY THE EMPLOYER	Group Policy #:	Class # :	Employer:	Occupation:	Employer's State:
	Salary: _____ Mode: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually				Date Hired Full Time:
F/T Requirements (hours, days, weeks, etc.): _____					