Statement of Insurability for Group Term Life Insurance Coverage

American United Life Insurance Company® (AUL)

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 6123
Indianapolis IN 46206-6123
1-800-553-5318

ONEAMERICA®

A. Employer/Employee Identification

(Note: Any missing information will delay processing and the potential effective date.)

1. Name of Employer:		2. Group Number:
3. Employee Name *(Last, First, Middle)*:		4. Gender: ☐ Male ☐ Female
5. Home Address: City: State: Zip:		
6. Date of Birth:	7. Occupation:	8. Date of Hire with above Employer:
9. Phone Number:	10. ☐ Work ☐ Home ☐ Cell	11. Social Security Number:
12. Marital Status: ☐ Single ☐ Married	13. Email Address:	

14. Annual Salary *(Please contact your employer for assistance with amount per contract definition)*: $_____ / yr.

15. Height: _____ ft. _____ in. Weight: _____ lbs.

16. During the last 12 months, have you ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products? ☐ Yes ☐ No

B. Coverage or Change Being Requested

Timely applications for amounts in excess of Guaranteed Issue Amount, late applications, and requests for changes in coverage require completion of this form. Timely applications are those made at time of first initial enrollment or at time of a Family Status Change. Late applications or change requests are those made outside of the first initial enrollment or a Family Status Change.

Check all coverages or changes being requested and provide full and complete information regarding coverage amount(s)/option(s) being requested, as well as current coverage amount(s)/option(s) currently in force. Consult your employer for assistance with coverage amounts, class, option numbers, or salary multiples. Requests for coverage not offered under AUL's contract will not be approved. Coverage cannot be less than the minimum or more than the maximum amount allowed under the contract. Payroll deductions or premium payments greater than the amount owed will not result in additional coverage. Payroll deductions that occur prior to AUL's approval should be discontinued and will not be a substitute for AUL's approval of coverage.

"Coverage Amount/Option Applying for" includes the Current Coverage Amount plus the amount of the desired increase. For example, if $100,000 is the Current Coverage Amount and an additional $50,000 of coverage is being requested, the full amount of $150,000 should be listed under "Coverage Amount/Option Applying for".

Employee Request for Coverage:

Coverage Election	*Current Coverage Amount/Option in Force*	*Coverage Amount/Option Applying for*
☐ Basic Term Life/AD&D* Class # _____	$_____ / Option #_____ Salary Multiple _____	$_____ / Option #_____ Salary Multiple _____ ☐ Timely ☐ Late ☐ Change
☐ Voluntary (Supplemental) Term Life/AD&D* Class # _____	$_____ / Option #_____ Salary Multiple _____	$_____ / Option #_____ Salary Multiple _____ ☐ Timely ☐ Late ☐ Change

*AD&D amounts are available only if AUL is offering this option. Unless otherwise offered by AUL in the contract, the Life/AD&D will be the same amount for each.

B. Coverage or Change Being Requested (continued)

Request for Coverage of Dependent (spouse)
Must be completed if required for Group Coverage

Spouse Name *(Last, First, Middle)*: _____ Gender: ☐ M ☐ F Date of Birth: _____

Social Security Number: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

Email Address: _____ Tobacco Use:** ☐ Yes ☐ No

**During the last 12 months, has any nicotine *(including substitutes such as gum, patch, etc.)* and/or tobacco products ever been used?

Dependent Coverage Election	*Current Coverage Amount/Option in Force*	*Coverage Amount/Option Applying for*
☐ Basic Dependent Life/AD&D* ☐ Spouse	$_____ / Option #_____	$_____ / Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Voluntary (Supplemental) Term Life/AD&D* ☐ Spouse	$_____ / Option #_____	$_____ / Option #_____ ☐ Timely ☐ Late ☐ Change

*AD&D amounts are available only if AUL is offering this option. Unless otherwise offered by AUL in the contract, the Life/AD&D will be the same amount for each.

UNDERWRITING INFORMATION:

C. Health Questions

	Employee	Spouse
1. Has any person proposed for insurance ever been diagnosed by a member of the medical profession as having or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the last 7 years has any person proposed for insurance been diagnosed by a member of the medical profession as having, or been treated for:		
a. ALS *(Amyotrophic Lateral Sclerosis)*	☐ Yes ☐ No	☐ Yes ☐ No
b. Cancer *(Excluding Basal Cell Carcinoma)*	☐ Yes ☐ No	☐ Yes ☐ No
c. Cardiomyopathy	☐ Yes ☐ No	☐ Yes ☐ No
d. Cirrhosis	☐ Yes ☐ No	☐ Yes ☐ No
e. Clotting Disorder	☐ Yes ☐ No	☐ Yes ☐ No
f. COPD *(Chronic Obstructive Pulmonary Disease)* / Emphysema	☐ Yes ☐ No	☐ Yes ☐ No
g. Chron's Disease / Ulcerative Colitis	☐ Yes ☐ No	☐ Yes ☐ No
h. Diabetes, Type 1 *(Insulin Dependent)*	☐ Yes ☐ No	☐ Yes ☐ No
i. Heart Attack	☐ Yes ☐ No	☐ Yes ☐ No
j. Heart Disease, including with surgery *(Stent / Bypass)*	☐ Yes ☐ No	☐ Yes ☐ No
k. Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No
l. Lupus	☐ Yes ☐ No	☐ Yes ☐ No
m. Heart Disease / Murmur	☐ Yes ☐ No	☐ Yes ☐ No
n. Mental or Nervous Disorder *(Excluding Anxiety / Mild Depression)*	☐ Yes ☐ No	☐ Yes ☐ No
o. Organ Transplant	☐ Yes ☐ No	☐ Yes ☐ No
p. Pancreatitis	☐ Yes ☐ No	☐ Yes ☐ No
q. Paralysis	☐ Yes ☐ No	☐ Yes ☐ No
r. Parkinson's	☐ Yes ☐ No	☐ Yes ☐ No
s. PVD *(Peripheral Vascular Disease)*	☐ Yes ☐ No	☐ Yes ☐ No
t. Seizures / Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No
u. Stroke	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the last 5 years has any person proposed for insurance been diagnosed by a member of the medical profession as having, or been treated for:		
a. Anemia	☐ Yes ☐ No	☐ Yes ☐ No
b. Anxiety	☐ Yes ☐ No	☐ Yes ☐ No
c. Asthma	☐ Yes ☐ No	☐ Yes ☐ No
d. Depression	☐ Yes ☐ No	☐ Yes ☐ No
e. Diabetes, Type 2	☐ Yes ☐ No	☐ Yes ☐ No
f. Diverticulitis	☐ Yes ☐ No	☐ Yes ☐ No
g. Fibromyalgia / Chronic Pain Syndrome	☐ Yes ☐ No	☐ Yes ☐ No
h. GERD *(Gastroesophageal Reflux Disease)* / Irritable Bowel Syndrome	☐ Yes ☐ No	☐ Yes ☐ No
i. High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
j. Hyperlipidemia *(Elevated Cholesterol / Triglycerides)*	☐ Yes ☐ No	☐ Yes ☐ No
k. Kidney / Bladder Disorder	☐ Yes ☐ No	☐ Yes ☐ No
l. Lung Disorder	☐ Yes ☐ No	☐ Yes ☐ No
m. TIA *(Transient Ischemic Attack)*	☐ Yes ☐ No	☐ Yes ☐ No
n. Tumor	☐ Yes ☐ No	☐ Yes ☐ No

UNDERWRITING INFORMATION:

C. Health Questions (continued)

4. Describe details of each "Yes" response from Questions 2 and 3.

Name	*Question Number*	*Diagnosis and Treatment Details*	*Date(s)*	*Name of Physician, Hospital, or Other Provider*

5. Are you or your dependent currently taking prescribed or non-prescribed medications or have you or your dependent taken any in the last 12 months? ☐ Yes ☐ No

   If "Yes", please list below:

Name	*Name of Medication*	*Date(s) in Use*	*Date Prescribed, Name and Address of Prescriber (if applicable)*

6. Have you or your dependent been treated, examined, or advised by a member of the medical profession regarding any illness, disease, or injury not listed above in the last 5 years? *(Wellness exams can be excluded.)* ☐ Yes ☐ No

7. Have you or your dependent been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery, or diagnostic test in the last 5 years, except those tests related to the Human Immunodeficiency Virus (AIDS virus)? ☐ Yes ☐ No

8. Have you or your dependent ever had life insurance declined, postponed, rated, or had reinstatement refused? ☐ Yes ☐ No

9. Have you or your dependent missed more than 5 consecutive days of active work, been unable to attend school or perform the normal activities of like age, or been confined at home in the past 6 months? ☐ Yes ☐ No

10. Have you or your dependent ever received medical treatment or counseling for, or been advised by a member of the medical profession to discontinue the use of alcohol? ☐ Yes ☐ No

11. Have you or your dependent ever received medical treatment or counseling for, or been advised by a member of the medical profession to discontinue the use of prescribed or non-prescribed drugs? ☐ Yes ☐ No

12. Provide full details to each "Yes" response in questions 6-11:

Name	*Question Number*	*Full Details*

If additional space is needed for full responses to Questions 4, 5, and 12, please attach that information to this form.

Fraud Warning

FRAUD WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization and Acknowledgement

I (we) authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmacy or pharmacy benefit manager, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about me (us): facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. **This authorization does not authorize the release of genetic screening or testing results.** All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. I (we) authorize American United Life Insurance Company (AUL) and its reinsurers to make a brief report of my/our personal health information to MIB. This authorization will be valid for 24 months from the date shown below. I (we) understand that I (we) may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made, I (we) can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my (our) knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) I (we) certify that all notices contained herein were read and understood prior to my/our completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgement.

Signatures

Signature of Proposed Insured/Employee *Mo./Day/Year*	*Signature of Spouse/Partner* *Mo./Day/Year*
Printed Name of Proposed Insured/Employee	*Printed Name of Spouse/Partner*