Group Enrollment Form

American United Life Insurance Company®
a OneAmerica® financial partner
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
(317) 285-1877

Employee's Full Name:		Status: ☐ Active ☐ Retired
Employee's Social Security Number:		Sex: ☐ Male ☐ Female
Employer:	Occupation:	Date of Birth:
Employed Full-Time: ☐ Yes ☐ No	Hours worked per week:	Marital Status: ☐ Single ☐ Married
Have you used tobacco in any form in the last 12 months? ☐ Yes ☐ No		

Beneficiary Designation (If none given, death benefits will be paid according to state statutes and contract language):

First Name	Last Name	Relationship to You	% of benefit
First (Primary) Beneficiary(ies)			
		TOTAL	**100%**
Second (Secondary) Beneficiary(ies)			
If percentages don't total 100% in the same class of beneficiaries, benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, death benefits will be distributed equally. **A separate form is available, if necessary, for more complex beneficiary designations.**		**TOTAL**	**100%**

COVERAGE BEING APPLIED FOR*: Request or decline all coverages listed below.

Request	Decline	
☐	☐	Basic Life
☐	☐	Basic AD&D
☐	☐	Basic Dependent Coverage Plan # _________ for ☐ Spouse only ☐ Children only ☐ Family
☐	☐	Supplemental Life $ ___________ or _________ times annual salary
☐	☐	Supplemental AD&D $ ___________ or _________ times annual salary
☐	☐	Voluntary Life $ ___________ or _________ times annual salary
☐	☐	Voluntary AD&D $ ___________ or _________ times annual salary
☐	☐	Voluntary Dependent Coverage Plan # _________ for ☐ Spouse only ☐ Children only ☐ Family
☐	☐	Short Term Disability
☐	☐	Long Term Disability
☐	☐	Voluntary Disability Short Term Plan # _________
☐	☐	Voluntary Disability Long Term Plan # _________
☐	☐	CorePLUS (Base and Supplemental) Disability STD Plan # _________
☐	☐	CorePLUS (Base and Supplemental) Disability LTD Plan # _________
☐	☐	CorePLUS (Base only) Disability STD
☐	☐	CorePLUS (Base only) Disability LTD

*If spouse included in dependent coverage, indicate spouse's name ___________________________ and date of birth ________________.
Voluntary Life/AD&D coverage selected cannot exceed 5 times the employee's annual salary.
Dependent coverage only available with employee coverage.

Basic AD&D and Voluntary AD&D coverage only available with Basic Life and Voluntary Life, respectively.