American United Life Insurance Company® Voluntary Term Life 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



Employer: Occupation: Date of Birth: Employed Full-Time: Yes No Hours worked per week: Marital Status: Single Married If applicable to coverage, 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 beneficiary (Primary) Beneficiary(ies) Second (Secondary) Beneficiary(ies) Total 100% If percentages don't total 100% in the same class of beneficiaries, benefits will be paid on a pro- rate 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 heneficiary	Employee's Full Name:		Status: Active	Status: Active Retired	
Employed Full-Time: Yes No	Employee's Social Security Number:		Sex: ☐ Male ☐ Fema	Sex: Male Female	
Second Secondary Beneficiary	Employer:	Occupation:	Date of Birth:	Date of Birth:	
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Date Date Date Hired Full-Time:	Voluntary AD&D coverage only available with have read the Notices, Limitations and hereby apply for the benefit for which I may earnings, including any premium incrededuction authorization at any time on whe waranteed issue amount, the excess amounderstand if I decline any or all of the raud Notice: Any person who, with a pplication or files a claim containing court of competent jurisdiction. In the statement of claim or an application egree. In NJ or VA, any person who subject to criminal and civil penaltie ompany or other person files an apponceals, for the purpose of mislead which is a crime and subjects such possible ading statement or impersonation insurer, is guilty of a gross mister. Michigan only:	e with Voluntary Life coverage. Exclusions G-14320, prior to the completion of the and my dependents, if any, are eligible. I authorize asses due to age bracket or salary changes, if appritten notice. I understand if I or my dependents, yount will be subject to Evidence of Insurability and above coverages, enrollment at a later date will not the intent to defraud or knowing that he is far a false or deceptive statement may be guiffle, any person who knowingly and with intercontaining any false, incomplete, or mislead includes any false or misleading information. In LA, PA or TN, any person who knowing hilication for insurance or statement of claiming, information concerning any fact material person to criminal and civil penalties. In WA on, or who willfully fails to reveal a material lemeanor. Ignature of Employee:	is statement. I understand them and have my employer to take deductions for to blicable. I understand I have the right to if any, request an amount that exceeds and approval by AUL. require Evidence of Insurability at my overcilitating a fraud against an insure lity of the crime of insurance fraud and to injure, defraud, or deceive any ling information is guilty of a felony in on any application for an insurantly and with intent to defraud any in containing any materially false infolentially thereto commits a fraudulent insurantly and reson who knowingly makes a fact in or relative to an application	ve retained a copy this insurance from the revoke this my employer's who expense. or, submits an as determined by insurer files a y of the third ce policy is surance ormation or trance act, false or in for insurance,	
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