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

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
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 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*: Voluntary Life and AD&D coverage cannot exceed 5 times employee's annual salary or $500,000, whichever is less. Request or decline all coverages listed below.

Request	Decline	
☐	☐	Voluntary Life $ ____________ or __________ times annual salary
☐	☐	Voluntary AD&D $ ____________ or __________ times annual salary
☐	☐	Voluntary Dependent Coverage Plan # __________ for ☐ Spouse only ☐ Children only ☐ Family

*If spouse included in dependent coverage, indicate spouse's name ____________________________ and date of birth ________________.
Dependent coverage only available with employee coverage.

Voluntary AD&D coverage only available with Voluntary Life coverage.

I have read the Notices, Limitations and Exclusions G-14320, prior to the completion of this statement. I understand them and have retained a copy. I hereby apply for the benefit for which I and my dependents, if any, are eligible. I authorize my employer to take deductions for this insurance from my earnings, including any premium increases due to age bracket or salary changes, if applicable. I understand I have the right to revoke this deduction authorization at any time on written notice. I understand if I or my dependents, if any, request an amount that exceeds my employer's guaranteed issue amount, the excess amount will be subject to Evidence of Insurability and approval by AUL.

I understand if I decline any or all of the above coverages, enrollment at a later date will require Evidence of Insurability at my own expense.

Fraud Notice: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of the crime of insurance fraud as determined by a court of competent jurisdiction. In FL, 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. In NJ or VA, any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties. In LA, PA or TN, any person who knowingly and with intent to defraud any insurance company or 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 person to criminal and civil penalties. In WA, a person who knowingly makes a false or misleading statement or impersonation, or who willfully fails to reveal a material fact in or relative to an application for insurance, to an insurer, is guilty of a gross misdemeanor.

Date: ______________________ Signature of Employee: ____

In Michigan only:
Signature(s) of Dependent Spouse and Child(ren) over age 18 ____

____ Date ______________________

Group Policy #:	Class by Coverage:	Date Hired Full-Time:
Salary: $ ____________	Mode: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually	