Voluntary Term Life/Voluntary Disability 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	
☐	☐	Voluntary Life $ __________ or ________ times annual salary
☐	☐	Voluntary AD&D $ __________ or ________ times annual salary
☐	☐	Voluntary Dependent Coverage Plan # ________ for ☐ Spouse only ☐ Children only ☐ Family
☐	☐	Voluntary Disability Short Term Plan # ________
☐	☐	Voluntary Disability Long Term Plan # ________

*If spouse included in dependent coverage, indicate spouse's name ______________________ and date of birth ______________.
Voluntary Life & AD&D coverage cannot exceed 5 times the employee's annual salary or $500,000, whichever is less.
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 of the coverage at a later date will require Evidence of Insurability at my own expense.