

Group Enrollment Form

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
 (800) 553-5318



Applicant's Full Legal Name:		Applicant's State of Residence:	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired
Applicant's Social Security Number:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Employer: BRILLION PUBLIC SCHOOLS	
Employer's City:	State:	Employed Full-Time: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hours worked per week:
Have you used tobacco in any form in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you authorized to work and reside in the US? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Primary Beneficiary		Relationship	DOB
Name of Contingent Beneficiary		Relationship	DOB

COVERAGE BEING APPLIED FOR*: Apply for or decline each coverage listed below. Not checking either box will be considered a declination of that coverage.

Request	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Life ___\$25,000 ___\$50,000 ___\$100,000 ___\$150,000* ___\$250,000*
		*Evidence of Insurability Required for \$150,000 and \$250,000
<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Dependent Life Coverage Plan # _____
		*Evidence of Insurability Required for Plan 4 and Plan 5

*If spouse is included in dependent coverage: Name _____ Date of birth _____ Spouse's Life/AD&D volume _____

- I hereby apply for the group insurance coverage for which I and my dependents, if any, are eligible and available under AUL's policy. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by AUL.
- I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.
- The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. The undersigned understands and agrees 1. any insurance coverage or benefits are contingent upon any statements made to AUL as being complete and correct and 2. benefits under any policy will be paid only if AUL decides in its discretion the applicant is entitled to them. The undersigned have read, understand, and retained the notices, limitations, and exclusions for his/her records.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant: _____ Date: _____

TO BE COMPLETED BY THE EMPLOYER

Group Policy#: 00005000-9800-001	Class#:	Date Hired Full Time:	Occupation:
Salary: \$	Mode: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		