American United Life Insurance Company®

Group Enrollment Form

AUL
a OneAmerica™ financial partner

Employee's Name:		Status: ☒ Active ☐ Retired
Employee's Social Security Number:		Gender:
Employer: SOUTHEAST LOCAL	Occupation:	Date of Birth:
Employed Full-Time: ☒ Yes ☐ No	Hours worked per week: 40	Marital Status: ☐ Single ☐ Married

Employee's 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
If percentages don't total 100%, death 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, including naming a secondary beneficiary.			Total 100%

COVERAGE BEING APPLIED FOR: You **must** request or decline all coverages listed below.

Request **Decline**

[ ] [ ] Voluntary Employee Life Benefit $ _____

[ ] [ ] Voluntary Dependent Coverage Plan # _____ for [ ] Spouse only [ ] Children only [ ] Family

If spouse included in dependent coverage, indicate spouse's name _____ and date of birth _____.

Voluntary Life coverage selected cannot exceed 5 times the employee's annual base salary.

Dependent coverage only available with employee 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 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 of the above coverages, enrollment of the coverage at a later date will require Evidence of Insurability at my own expense.

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.

Date:_____ Signature of Employee:_____

To be completed by the Employer

Group Policy #: 606016	Class by Coverage:	Date Hired Full-Time:
Salary Mode: [ ] Hourly [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [X] Annually Reported salary must match definition determined for employee's class.		