Policyholder Change Request Form for AUL Group Insurance Policyholders

Products and financial services provided by
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a OneAmerica® company
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1-800-553-5318 Fax: 1-888-285-1299
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OneAmerica®

Policyholder's Full Legal Name:	Federal Tax ID #:	Policyholder #:
Policyholder's Physical Address:		State of Domicile:

Date of Incorporation/Existence:	Administrative Contact Person:	Email Address:

☐ **CHANGE OF POLICYHOLDER NAME REQUEST** Attach copy of Articles of Amendment or Certificate of Assumed Business Name filed with Secretary of State, Policyholder Resolution showing change of name, and IRS Form W-9

Previous Name:	New Name:	Federal Tax ID #:	Effective Date of Change	Reason for Change:

☐ **CHANGE OF POLICYHOLDER AND ASSIGNMENT/TRANSFER OF COVERAGE REQUEST**

Has the current policyholder been involved with any bankruptcy, merger, dissolution, majority change in ownership, cessation of business operations, policyholder assignment, transfer of assets, transfer of employees to another entity, etc? ☐ Yes ☐ No	If **yes**, name the entity considered to be the "employer" by the IRS.	
Does the current policyholder wish to assign and/or transfer any AUL group insurance policies to an entity not currently insured with AUL? ☐ Yes ☐ No	If **yes**, the attached Policyholder Assignment Form for AUL Group Insurance Policyholders must be completed and returned.	
Will any individuals have coverage added or terminated following the change? ☐ Yes ☐ No	If **yes**, a current census must be submitted.	
Will there be any change to the policyholder's SIC code? ☐ Yes ☐ No	If **yes**, indicate new SIC Code.	
Will any subsidiaries or affiliates be added or deleted? ☐ Yes ☐ No If **yes**, indicate additions or deletions and include a current census.	Additions:	Deletions:

☐ **CHANGE OF POLICYHOLDER ADDRESS REQUEST**

New Physical Address:	City/State/Zip:	Date of Change	Reason for Change:
New Billing Address:	City/State/Zip:	Date of Change	Reason for Change:

☐ **CHANGE OF POLICYHOLDER CONTACT INFORMATION REQUEST**

New Administrative Contact Person:	New Phone #:	Date of Change	Email Address:
New Billing Contact Person:	New Phone #:	Date of Change	Email Address:

☐ **CHANGE OF POLICYHOLDER AGENT OF RECORD REQUEST**

New Agent of Record and Producer:	New Agent of Record Address:	New Agent of Record Phone #:	Date of Change:

- If any change to the contract(s) is requested, AUL must receive this form from an authorized representative of the policyholder stating the change desired and the effective date. If necessary, the policy and/or certificates may need to be reissued by AUL.
- The undersigned hereby requests changes to the policyholder information shown in AUL's records. The policyholder understands receipt of any coverage following any bankruptcy, merger, dissolution, majority change in ownership, cessation of business operations, policyholder assignment, transfer of assets, transfer of employees to another entity, etc first requires underwriting and written approval by AUL.
- The undersigned agrees to the terms, conditions, guidelines, and responsibilities outlined in the Administration Guide and to pay the amount of premium required for the coverage approved by AUL, including any premium increases due to age bracket or changes when applicable. Premium payments greater than the amount of premium owed, for individuals not approved for coverage, and for entities not approved for coverage 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 has read, understands, and retained the notices, limitations, and exclusions for the undersigned's 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 Authorized Representative: _____ Date: _____

Printed Name: _____ Title/Position: _____

TO BE COMPLETED BY AUL	Approval Date:	By:	Printed: