# Group Request for Change Form for the State of Indiana Employees

*Products and financial services provided by*
*American United Life Insurance Company®*
*a* ONEAMERICA® *company*
*One American Square, P.O. Box 368*
*Indianapolis, IN 46206-0368*
*(800) 673-3216*
*www.employeebenefits.aul.com*

ONEAMERICA®

| Applicant's Full Legal Name: | | Social Security Number: | Agency Number: |
|---|---|---|---|
| Applicant's Mailing Address: ☐ Check if this is a new address | | | Phone Number: |
| Date of Birth: | Marital Status: ☐ Single ☐ Married | Gender: ☐ Male ☐ Female | Email Address: |
| Employed Full-Time: ☐ Yes ☐ No (Minimum $37^{1/2}$ hours weekly) | | Gross Salary: ☐ Biweekly $_____ | ☐ Monthly $_____ |

REQUEST TO DISCONTINUE LIFE INSURANCE

☐ I am requesting to discontinue my basic life insurance. I understand all supplemental and dependent life insurance currently in force will also be discontinued.
☐ I am requesting to discontinue my supplemental life insurance. I understand all dependent life insurance currently in force will also be discontinued.
☐ I am requesting to discontinue my dependent life insurance.

REQUEST CHANGE OF NAME

| | Effective Date of Change | Reason for Change |
|---|---|---|
| Previous Name of Employee *(Last, First, M.I.)* | | |
| Name of Employee Changed to *(Last, First, M.I.)* | | |
| Previous Name of Dependent *(Last, First, M.I.)* | | |
| Name of Dependent Changed to *(Last, First, M.I.)* | | |

REQUEST TO ADD OR DELETE DEPENDENTS

I am requesitng to add/delete the following dependents under my exisitng dependent life insurance.

| Full name of dependent *(Last, First, M.I.)* | Relationship to You | Date of Birth | Date of Attainment | Full time student |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

- 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 AUL | Approval Date: | By: | |
|---|---|---|---|