Group Statement of Insurability and Notice of Insurance Information Practices Packet

Products and financial services provided by
AMERICAN UNITED LIFE INSURANCE COMPANY® | *a* ONEAMERICA® *company*
One American Square, P.O. Box 368 | Indianapolis, Indiana 46206-0368 | 1-800-553-5318 | www.oneamerica.com

G-20790 (NC) 4/24/08

Statement of Insurability/
Change of Coverage Request

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
P.O. Box 6123
Indianapolis, IN 46206-6123
Attn: Group Division, Medical Underwriting
Support Unit

OneAmerica®

This form is to be used only by residents of Michigan and North Carolina. If you reside in another state, please contact your employer's AUL representative for the correct form.

Instructions for completing form for yourself or your dependents, if any.

If you are applying for:

1. An amount of coverage above the Guaranteed Issue amount.
   Complete Sections A, B and E. Sign and date under Section E and submit with a completed enrollment form. Detach and retain this notice page for your files.

2. Coverage as a Late Enrollee.
   Complete Sections A, C and E. Sign and date under Section E and submit with a completed enrollment form. Detach and retain this notice page for your files.

3. A change in current coverage.
   If change is an increase or addition to coverage, complete Sections A, D and E. If change is a decrease in coverage, complete Sections A and D. If you are making a change in your Voluntary Disability Coverage, complete Sections A, D and E. Sign and date under Section E. Detach and retain this notice page for your files.

Note: Any coverage applied for will not become effective until Evidence of Insurability is approved by AUL. AUL has the right to exclude one or more of your dependents, if any, from the dependent coverage based on Evidence of Insurability. AUL shall not be liable with respect to any change in coverage for any claim commencing prior to the date of approval of such change in coverage.

Notices Affecting Coverages

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in it's file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you contact MIB and seek a correction in accordance with procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

We or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Notice of Pre-existing Conditions Exclusion

If you receive treatment, service or incur expenses as a result of an injury or sickness prior to the effective date of approval, disability claims incurred after the date of approval may not be eligible due to the pre-existing conditions exclusion of the policy.

Fraud Notice

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.

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FORM COMPLETION INSTRUCTIONS:

1. Please print the entire document.
2. Please complete pages marked "Submit this page to AUL" at the bottom of the page.
3. Please seek assistance from your employer for salary and benefit elections.
4. Signatures for You and your dependents (if applicable) are required on this form.
5. Please make a copy of the completed pages for your records.
6. Please mail the completed pages to AUL at the address on the left.

A. General Employee Information

1. Name of Employer _____

Participating Unit number or Group Policy number as shown on first page of certificate G _____

2. Employee Name (Last, First, Middle): _____

Birth Place _____ DOB _____ Sex _____ Height _____ Weight _____

Complete Home Address (Including City, State, Zip) _____

Work Phone Number (_____) _____ Home Phone Number (_____) _____

Social Security Number _____

Annual Salary Amount $ _____ as defined by your AUL contract. Please contact your employer for assistance.

3. Complete only for those requesting coverage. If needed, please use a separate sheet of paper.

Spouse Name (Last, First, Middle)			Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle)	Relationship to You	Full-Time Student Y / N	Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle)	Relationship to You	Full-Time Student Y / N	Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle)	Relationship to You	Full-Time Student Y / N	Birth Place	DOB	Sex	Height	Weight

B. Amounts in Excess of Guaranteed Issue

Check all that apply:

Traditional Coverages: ☐ Basic Life/AD&D ☐ Supplemental Life/AD&D ☐ Dependent Life/AD&D ☐ LTD ☐ STD

Voluntary Coverages: ☐ Term Life/AD&D ☐ Dependent Life/AD&D ☐ LTD ☐ STD

C. Late Enrollment

Check all that apply:

Traditional Coverages: ☐ Basic Life/AD&D ☐ Supplemental Life/AD&D ☐ Dependent Life/AD&D ☐ LTD ☐ STD

Voluntary Coverages: ☐ Term Life/AD&D ☐ Dependent Life/AD&D ☐ LTD ☐ STD

D. Change of Coverage

Check all that apply:

☐ Voluntary Term Life Coverage from $ _____ to $ _____.
If coverage is a flat amount, coverage can only be increased or decreased in dollar increments. If coverage is a multiple of salary coverage can only be increased or decreased in multiples as offered by the employer. **No coverage can be less than the minimum or more than the maximum allowed by the employer.**

☐ Supplemental Term Life Coverage from $ _____ to $ _____.

☐ Dependent Life: Specify Coverage Type: ☐ Traditional Basic ☐ Voluntary Term

☐ Change coverage from plan _____ to plan _____ as offered by the employer.
Specify Dependent type: ☐ Spouse Only ☐ Children Only ☐ Spouse and Children

☐ Add Dependent: ☐ Spouse Only ☐ Children Only ☐ Spouse and Children

☐ Delete Dependent: ☐ Spouse Only ☐ Children Only ☐ Spouse and Children

☐ Disability Coverage from plan _____ to plan _____. (See enrollment form for plan information)

E. Medical Questions

1. Within the past 7 years, has any person proposed for insurance been diagnosed or treated by a physician or qualified professional, or tested positive for the presence of, or taken prescribed medicine for: (Please provide full details for any "yes" responses in Question 4.)

	Employee		Spouse/Child			Employee		Spouse/Child	
	Yes	No	Yes	No		Yes	No	Yes	No
a. Cancer					l. Neurological or Brain Disorder including Epilepsy or Paralysis				
b. Diabetes or other Glandular Disorders					m. Psychological/Emotional Disorder or Depression				
c. Chest Pain or Heart Attack					n. Lung or Respiratory Disorder/Disease				
d. Heart Disease or Disorder including Murmurs					o. Neuromuscular or Musculoskeletal Disorders including Arthritis and Back Disorders				
e. High Blood Pressure – If yes, provide last reading and date of reading in Question 4.					p. Skin or Lymph Gland Disorders				
f. Anemia or Blood Disorders					q. Eye, Ear, Nose and Throat Disorders				
g. Liver Disorder or Hepatitis					r. Acquired Immune Deficiency Syndrome (AIDS)				
h. Stomach and/or Intestinal Disorders					s. Any sexually transmitted disease				
i. Stroke									
j. Kidney/Bladder/Pancreatic Disease									
k. Prostate/Reproductive Organ Disorder									

2. Within the past 5 years, has any person proposed for insurance: (Please provide full details for any "yes" responses in Question 4.)

a. Taken or currently take any prescription medicine?				
b. Had an electrocardiogram, x-ray, blood study, urinalysis or any other diagnostic study?				
c. Been rejected, rated, postponed or modified for life insurance?				
d. Received or been instructed to seek treatment for use or abuse of alcohol or drugs?				
e. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates or any other habit forming drugs?				
f. Had any illness, injury, operation or treatment other than stated above?				

3. For Disability Only: Are you pregnant? ☐ Yes ☐ No If yes, expected delivery date _____

4. Describe details of "Yes" answers from Questions 1 and 2. If needed, use separate sheet of paper. Please list the letter version of the question where applicable, i.e. E.2.b.

Name	Ques. #	Date	Detail of injury, illness or disorder	Name/Address of Physician/Hospital

Authorization and Acknowledgment:

I authorize any physician, or medical practitioner, hospital and medical facility, insurance company, DMV, and the MIB to give to any company listed as a OneAmerica® company and its reinsurers any of the following about me or my dependents, if they are to be insured: facts about physical and mental health, medical care, advice or treatment; hobbies, other insurance, flying, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs, and tobacco. This authorization does not apply to the release of genetic screening or testing. Each person proposed for insurance may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the AIDS virus. All sources except the MIB may give these facts to any insurance support organization authorized by a OneAmerica® company to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date I signed the application. I can choose to be interviewed if an investigative consumer report is made. I or my authorized representative can receive a copy of this authorization form.

I represent that the statements and answers given on this form are true and complete to the best of my knowledge and belief. I understand and agree that any insurance which shall be issued is in consideration of these statements being complete and correct. I certify that the notices attached were read and understood prior to the completion of this form, and that I have retained these notices for my records.

Signature of Insured/Employee Date

Signature of Spouse/Eligible Child age 18 or over Date

Printed Name of Insured/Employee

American United Life Insurance Company®
a OneAmerica® *company*
One American Square
P.O. Box 6003
Indianapolis, IN 46206-6003
1-800-537-6442

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United Mutual Insurance Holding Company
a OneAmerica® *company*
101 North 10th Street
Fargo, ND 58102
1-800-437-4692

The State Life Insurance Company
a OneAmerica® *company*
P.O. Box 6062
Indianapolis, IN 46206

OneAmerica®

For general inquiries call: 1-877-999-9883

ALWAYS GIVE THIS DOCUMENT TO THE PROPOSED INSURED UPON HIS/HER SIGNING APPLICATION OR EVIDENCE OF INSURABILITY FORM

NOTICE OF INSURANCE INFORMATION PRACTICES

Thank you for your application for insurance. We are glad to have the chance to participate in your insurance program. This notice tells you about the underwriting process. It also tells how information is gathered to review your application. To issue a policy we need to obtain information about you. Some of it will come from you and some will come from other sources. We need it to see if you qualify for insurance. When signed, the Authorization and Acknowledgement will allow us to obtain this information. We will also be able to share it with others. We can share when necessary and as permitted by law. No unnecessary disclosures will be made. Information will be treated as confidential by us and by our reinsurers. It may have to be disclosed to others without your further consent. If permitted by law, you have the right to submit a written request for access to personal information obtained by the company as part of the application. That information must be reasonably locatable and retrievable. Within 30 days of said request, the company must respond by allowing you to see or pay to copy the requested personal information. We must also give you the source of the information. The individual may request correction of certain personal information. He may also request the amendment or deletion of certain personal information. Within 30 days of said request, the company will correct, amend or delete the requested personal information or notify the individual of its refusal to make such correction, amendment or deletion. A reason for said refusal will be given. If an individual disagrees with the refusal, the individual can file a concise statement with the company. That statement must detail what the individual believes is the correct information. It must also list the reasons why the individual disagrees with the refusal. This statement will remain in the individual's file. Any revisions made will be sent to those that have been provided such information within the past 2 years. It will also be sent to insurance support organizations that have received such information in the past 7 years, and any insurance support organization that furnished the personal information that has been corrected, amended or deleted. You have a right to get a copy of any investigative consumer report which is made. If you want to know more about our underwriting practices and your rights, please write to the Privacy Officer, OneAmerica Financial Partners Inc., P.O. Box 368, Indianapolis, Indiana 46206-0368.

MEDICAL INFORMATION BUREAU NOTICE

Your information will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to MIB which operates on an information exchange on behalf of its members. If you apply to an MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will give the company the information in its file.

If you request it, MIB will arrange disclosure of any such information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB. The federal Fair Credit Reporting Act allows you to seek a correction. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

We or our reinsurers, may also release information in our file. We may release to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FAIR CREDIT REPORTING ACT NOTICE

We may request an investigative consumer report. These reports contain information. That information can be about your character, general reputation, and mode of living. It can also be about your health, except as may be related directly or indirectly to your sexual orientation. The information may be obtained through interviews with you. We may also interview your neighbors, friends and others who know you. Upon request, we will give you the name and address of the consumer reporting firm so that you may request a copy of the report.

AUTHORIZATION AND ACKNOWLEDGMENT

I authorize many people and organizations to give information about me to any OneAmerica® company and its reinsurers. They include any physician, medical practitioner, hospital, medical facility, insurance company, DMV, and the MIB. They can also give this information about my dependents, if they are to be insured. That information includes facts about physical and mental health. It also includes facts about medical care, advice or treatment, and hobbies. They may also disclose information on other insurance, flying, and driving records (which is not limited to existing address), age, occupation, and income. Lastly, they may disclose information on the use of alcohol, drugs, and tobacco. Each person proposed for insurance may be asked to take a physical exam. Tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar. The tests may also include tests for cocaine or other drugs, cholesterol and nicotine. Where permitted by law, tests for antibodies to the AIDS virus may be conducted. All sources except the MIB may give these facts to any insurance support organization authorized to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date I signed the application. I can choose to be interviewed if an investigative consumer report is made. I or my authorized representative can receive a copy of this authorization form.