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 (VT) 5/2/08

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 Vermont. 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 5.)

	Employee		Spouse/Child			Employee		Spouse/Child	
	Yes	No	Yes	No		Yes	No	Yes	No
a. Cancer					k. Prostate/Female Organ Disorder				
b. Diabetes or other Glandular Disorders					l. Neurological or Brain Disorder including Epilepsy or Paralysis				
c. Chest Pain or Heart Attack									
d. Heart Disease or Disorder including Murmurs					m. Psychological/Emotional Disorder or Depression				
e. High Blood Pressure – If yes, provide last reading and date of reading in Question 5.					n. Lung or Respiratory Disorder/Disease				
f. Anemia or Blood Disorders (not including HIV-related disorders)					o. Neuromuscular or Musculoskeletal Disorders including Arthritis and Back Disorders				
g. Liver Disorder or Hepatitis									
h. Stomach and/or Intestinal Disorders					p. Skin or Lymph Gland Disorders				
i. Stroke					q. Eye, Ear, Nose and Throat Disorders				
j. Kidney/Bladder/Pancreatic Disease					r. Any sexually transmitted disease				

2. Within the past 7 years, has any person proposed for insurance been diagnosed or treated by a medical physician, medical doctor or doctor of osteopathy for Acquired Immune Deficiency Syndrome (AIDS) or any immune deficiency related disorders? Employee ☐ Yes ☐ No Spouse/Child ☐ Yes ☐ No

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

a. Taken or currently take any prescription medicine?				
b. Had an electrocardiogram, x-ray, blood study, urinalysis or any other diagnostic study? (not including HIV-related tests)				
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?				

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

5. Describe details of "Yes" answers from Questions 1, 2 and 3. 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, medical practitioner, hospital, medical facility, insurance company, and the MIB to give to AUL and its reinsurers any of the following about me: facts about physical and mental health; medical care, advice or treatment; and other characteristics, including the use of alcohol, drugs and tobacco. All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. **(This authorization excludes previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC.)** This authorization does not apply to the release of genetic screening or testing. I 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. This data will be used to determine if I am eligible 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 shown below. I can choose to be interviewed if an investigative consumer report is made.

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 an insurance policy we need to obtain information about you. Some of the information will come from you and some will come from other sources. We need this information to see if you qualify for insurance. When signed, the Authorization and Acknowledgement will allow us to obtain the information and to share it with others 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. However, in some cases, information may have to be disclosed to others without your further consent. If permitted by law and after proper identification, you have the right to submit a written request for access to personal information obtained by the company as part of the application for insurance and which is reasonably locatable and retrievable. Within thirty (30) days of the request, the company must respond by allowing you to see, in person, or by copy (a copying charge may be assessed) the requested personal information and by giving you the source(s) of the information. The individual may request correction, amendment or deletion of certain personal information. Within thirty (30) days of said request, the company will correct, amend or delete the requested personal information (and contact the individual of such in writing) or notify the individual of its refusal to make such correction, amendment or deletion and the reason for said refusal. If an individual disagrees with the refusal, the individual can file a concise statement as to what the individual believes is the correct information and 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 parties that have been provided such information within the past 2 years, 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

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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.

FAIR CREDIT REPORTING ACT NOTICE

We may request an investigative consumer report. These reports contain information about your character, general reputation, mode of living and health except as may be related directly or indirectly to your sexual orientation. The information may be obtained through interviews with you, 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 (we) 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. 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 and nicotine. This Authorization **EXCLUDES** the release of ANY information relating to previously administered tests for **HIV Antibodies, HIV Virus, T-Cell Counts, AIDS, or ARC** by the applicant's family physician, regular physician, attending physician or any other licensed medical physician, care giver, health care professional, hospital, clinic, medical facility, federal Veteran's Administration program, the Medical Information Bureau (MIB), employer, consumer reporting agency, any other insurance company, or any other person or entity that may be possessed of such information. In **ADDITION**, this Authorization **EXCLUDES** the release of any new testing results, from tests required by the Insurance Company in connection with this Application, to any outside, non-affiliated company or to any other person or entity not under specific contract with the Insurance Company to perform underwriting services in connection with this Application. 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.