

Application to Continue or Convert Group Insurance Coverage Packet



Products and financial services provided by
AMERICAN UNITED LIFE INSURANCE COMPANY® | *a ONEAMERICA® company*
One American Square, P.O. Box 6123 | Indianapolis, Indiana 46206-6123 | 1-800-553-5318 | www.oneamerica.com

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Continuing Insurance After Coverage Termination

If coverage under American United Life Insurance Company® (AUL) Group Insurance contract terminates, eligible insureds may be able to continue paying premiums and keep existing insurance in force. Eligible insureds have 31 days from the date coverage terminates under the contract to apply in writing to AUL. *Eligible insureds will not be eligible to apply at a later date to continue this coverage.*

Section I - You should complete Section I making certain you apply for all the coverages you want to continue. By indicating your desire you are completing Section 1 to continue this application process and receive additional instructions and premium rate information.

Section II - Your Employer should complete Section II. The Employer should indicate all coverages you had at the time your coverage terminated.

AUL will review the information provided and then determine your eligibility for continuing coverage. Once AUL has established your eligibility for continuing coverage, additional application instructions and premium rate information will be provided.

Important Information

- Voluntary (premium paid by Employee) AD&D insurance coverage can only be continued when Voluntary Life insurance coverage is continued.
- Voluntary Dependent Life insurance coverage can only be continued under the Continuation and/or Portability Privilege when Voluntary Life insurance coverage is continued.
- AUL shall have the right and discretion to determine the type of coverage, the benefits offered, and the amount of the coverage continued under the contract. The coverage and benefit options may differ from those under your current contract.

Continuation of Group Disability Insurance

- In order to apply for the Conversion or Portability Privilege in AUL's Group Disability insurance contract, eligible insureds must have been insured under the group contract for at least 12 consecutive months.
- If the insured is approved for benefits under the Conversion or Portability Privilege, coverage under that disability insurance contract is for only **12 months**.
- If the insured is approved for benefits under the Portability Privilege, the maximum benefit duration for any payable claim under that contract is the lesser of:
 - 1) the maximum benefit duration in effect immediately prior to termination of coverage under the prior group disability insurance contract; or
 - 2) two years.
- If the insured is approved for benefits under the Conversion or Portability Privilege, any claim under that contract is subject to limitations and exclusions, such as a pre-existing condition exclusion.
- The Conversion and Portability benefits are not available to an individual who:
 - ◆ no longer belongs to a class eligible for coverage under the contract
 - ◆ has retired
 - ◆ fails to pay any required premium
 - ◆ is or becomes insured for any other group disability insurance within 31 days after termination under AUL's contract
 - ◆ is disabled under the terms of the contract
 - ◆ is on a leave of absence
 - ◆ was insured under a contract that terminated.

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Section I – TO BE COMPLETED BY EMPLOYEE

Employee Name: _____ Policyholder Name and Number: _____

Date of Birth: _____ Social Security Number: _____ Gender: Male Female

Employee Address: _____

City: _____ State: _____ Zip: _____

Employee Phone Number: _____

Employee Email Address: _____

Were you disabled at the time coverage terminated? Yes No

If yes, have you applied for: Life Insurance Waiver of Premium Benefit Short Term Disability Benefits
 Long Term Disability Benefits

1. Conversion of Life Insurance

If you wish to begin the application process to convert your existing group life insurance to an individual life insurance policy, the attached Application for Conversion Policy will need to be completed and returned within 31 days of termination of insurance.

Please note, a separate application is required for EACH person wishing to convert existing group life insurance to an individual policy.

2. Continuation of Voluntary Life Insurance

Under the Continuation and/or Portability Privilege in the Group Voluntary Life Insurance contract, eligible insureds can apply to continue existing coverage. If you wish to apply for the Continuation and/or Portability Privilege benefit, check the box next to the coverage for which you are currently insured. Not checking any box will be considered a declination of the Continuation and/or Portability Privilege benefit.

- Voluntary Life Voluntary AD&D
 Voluntary Dependent Life Voluntary Dependent AD&D

Have you smoked cigarettes or cigars, used a pipe or smokeless tobacco, or chewed tobacco in the past 12 months?

Yes No

Dependents for which you are applying to continue the coverage under the Continuation and/or Portability Privilege in the Group Voluntary Life Insurance contract:

Name	Relationship	Date of Birth	FullTime Student	Disabled
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have any of the above dependents smoked cigarettes or cigars, used a pipe or smokeless tobacco, or chewed tobacco in the past 12 months? Yes No If yes, list those individuals: _____

Section I – TO BE COMPLETED BY EMPLOYEE (continued)

Employee Name: _____ Policyholder Name and Number: _____

If applying to continue life insurance coverage under the Continuation and/or Portability Privilege, please complete the Beneficiary Designation below:

PRIMARY BENEFICIARY(S)

<i>Name</i>	<i>Relationship</i>	<i>Address</i>	<i>DOB</i>	<i>SSN</i>	<i>Percentage</i>
Total¹					0.00

CONTINGENT BENEFICIARY(S) IF THE PRIMARY BENEFICIARY(S) PREDECEASES YOU

<i>Name</i>	<i>Relationship</i>	<i>Address</i>	<i>DOB</i>	<i>SSN</i>	<i>Percentage</i>
Total¹					0.00

This beneficiary designation supersedes and cancels all prior beneficiary designations by the Insured person for the coverages indicated.

Lack of Notice of Community Property Interest: If AUL has not previously received written notice of a community property interest and if the space for consent below is not signed by a person having such an interest, then AUL shall be entitled to rely upon its good faith that no such interest exists.

Spouse's signature and consent (*if applicable*):² _____ Date _____

¹ Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

² Spouse's signature is needed only if Insured/Beneficiary lives in a community property state which currently include AZ, CA, ID, LA, NM, NV, TX, WA and WI.

Section I – TO BE COMPLETED BY EMPLOYEE (continued)

Employee Name: _____ Policyholder Name and Number: _____

3. Conversion of Long Term Disability Insurance

If coverage under the Group Long Term Disability (LTD) insurance contract terminates due to employment ending, eligible insureds can apply to convert the coverage and pay premiums directly to AUL.

If you wish to apply to convert the LTD coverage, check the following box. Not checking the box will be considered a declination of the Conversion Privilege benefit.

Traditional Long Term Disability

4. Portability Privilege of Voluntary Disability Insurance

If coverage under the Group Voluntary Disability insurance contract terminates, eligible insureds can apply to continue the coverage and pay premiums directly to AUL.

If you wish to apply to continue the Voluntary Disability coverage, select each coverage you wish to continue. Not checking either box will be considered a declination of the Portability Privilege benefit.

Voluntary Short Term Disability Voluntary Long Term Disability

-
- I hereby apply to AUL to continue the insurance coverage for which I am eligible and which is available under the group life and/or disability insurance contract issued to the above policyholder number ("contract"). I represent that any information or documents I provide to AUL prior to and after the date of the application to continue insurance and any facts and other matters contained in this application are true and accurate to the best of my knowledge and belief. I understand and agree that any insurance, which shall be continued, is contingent upon any statements made to AUL as being complete and correct.
 - I understand premium payment greater than the amount of premium owed will not result in additional coverage under the contract.
 - I understand no continuation of coverage under any contract will be effective until this application is received, reviewed, and approved in writing by AUL. If no coverage is issued and/or approved, I understand the premium deposit will be refunded.
 - I understand and agree that any Dependent who was previously excluded from coverage is not eligible for Continuation of Coverage of life insurance.
 - I understand the ability to continue coverage under the contract is contingent upon, but is not limited to, the following conditions:
 - 1) I must remit required amount of premium plus any administration fee directly to AUL, within 31 days of the date my coverage terminated
 - 2) Failure to pay the correct amount of premium timely will terminate the insurance under the contract at the end of the period for which the premium has been paid.
 - I understand and agree any coverage or benefit under any contract will only be approved if AUL decides in its discretion that I am entitled to them. I have read, understood, and retained for my records the notices, limitations, and exclusions.

Signature of Employee: _____ Date: _____

**Application to Continue or Convert
Group Insurance Coverage**

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Section II – TO BE COMPLETED BY EMPLOYER

Please attach copies of the Group Enrollment Form(s), GIB Election Form(s) and/or Life Event Benefit Form(s).

Policyholder Name: _____ Policyholder Number: _____

Employee Name: _____

Employee Hire Date: _____

Effective Date of Employee's Insurance: _____

Was Evidence of Insurability Required? _____

Number of Hours Worked Per Week ____ Hours	Gross Monthly Salary (prior to the employee's last date worked) \$ _____	Please Indicate How the Employee is Paid (check all that apply)		
		<input type="checkbox"/> Hourly	<input type="checkbox"/> Salaried	<input type="checkbox"/> Other _____
		<input type="checkbox"/> Includes Commissions	<input type="checkbox"/> Includes Bonuses	

Date Employee was last Physically/Actively at Work: _____

Employee occupation: _____

Date through which premiums are paid: _____

Date Employee was given Application to Continue or Convert Group Insurance Coverage form: _____

Is/was the Employee on an approved Leave of Absence: Yes No

If Yes, what type of Leave of Absence: _____

Indicate reason for coverage termination

<p>For Life Insurance Coverage:</p> <p><input type="checkbox"/> 1. Termination of contract and coverage has not or will not be obtained with another carrier within 31 days</p> <p><input type="checkbox"/> 2. Termination of Employment</p> <p><input type="checkbox"/> 3. Reduction of Hours</p> <p><input type="checkbox"/> 4. Reduction of Life Insurance Amount</p> <p><input type="checkbox"/> 5. Divorce from Insured</p> <p><input type="checkbox"/> 6. Layoff <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary</p> <p><input type="checkbox"/> 7. Death of Insured</p> <p><input type="checkbox"/> 8. Attainment of Limiting Age (Employee)</p> <p><input type="checkbox"/> 9. Attainment of Limiting Age (Spouse)</p> <p><input type="checkbox"/> 10. Attainment of Limiting Age, Full Time Employment or Marriage of Dependent Child</p> <p><input type="checkbox"/> 11. Retirement: Date of Retirement _____</p> <p><input type="checkbox"/> 12. Disability: Date of Disability _____</p> <p><input type="checkbox"/> 13. Enter Active Military Service: Date Entered _____</p> <p><input type="checkbox"/> 14. Other: _____</p>	<p>For Disability Insurance Coverage:</p> <p><input type="checkbox"/> 1. Termination of contract and coverage has not or will not be obtained with another carrier within 31 days</p> <p><input type="checkbox"/> 2. Termination of Employment</p> <p><input type="checkbox"/> 3. Reduction of Hours</p> <p><input type="checkbox"/> 4. Retirement: Date of Retirement _____</p> <p><input type="checkbox"/> 5. Enter Active Military Service: Date Entered _____</p> <p><input type="checkbox"/> 6. Layoff <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary</p> <p><input type="checkbox"/> 7. Disability: Date of Disability _____</p> <p><input type="checkbox"/> 8. Other: _____</p>
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Section II – TO BE COMPLETED BY EMPLOYER (continued)

Employee Name: _____ Policyholder Name and Number: _____

Identify all existing coverages and amounts of those coverages:			
<input type="checkbox"/> Basic Term Life	Class _____	Volume _____	
<input type="checkbox"/> Basic Dependent Term Life	Class _____	Volume _____	Plan # _____
<input type="checkbox"/> Voluntary Life	Class _____	Volume _____	Plan # _____
<input type="checkbox"/> Voluntary AD&D	Class _____	Volume _____	Plan # _____
<input type="checkbox"/> Voluntary Dependent Life	Class _____	Volume _____	Plan # _____
<input type="checkbox"/> Voluntary Dependent AD&D	Class _____	Volume _____	Plan # _____
<input type="checkbox"/> Supplemental Life	Class _____	Volume _____	Plan # _____
<input type="checkbox"/> Traditional Long Term Disability	Class _____		
<input type="checkbox"/> Voluntary Short Term Disability	Class _____		Plan # _____
<input type="checkbox"/> Voluntary Long Term Disability	Class _____		Plan # _____

The undersigned represents that any information or documents provided to AUL prior to and after the date of the application for insurance and any 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 benefit is contingent upon any statement 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, understood, and retained for the company's records the notices, limitations, and exclusions.

Signed By: _____ Date: _____

Title: _____ Phone Number: _____

Email Address: _____

Fraud Warnings *(For use in AR, DC, LA, NM, TX and WV)*

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.

Alaska, Oregon

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or representative of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or reward payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana, Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland, Rhode Island

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire, Ohio

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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Part I

1. Employee's Name _____
(Print Name - Do Not Use Initials) (Social Security Number)
 2. Applicant's Full Name _____
(Social Security Number)
 3. Address to which communications are to be sent _____
(Number or Box) (Street or R.F.D.) (City) (State) (Zip Code)
 4. Applicant's Telephone Number (_____) _____
 5. Applicant's Date of Birth _____
(Month) (Day) (Year)
 6. Is Applicant a U.S. citizen? _____
 7. Applicant's e-mail address _____
 8. Plan of Insurance Legacy
 9. Amount of Insurance requested \$ _____
 10. Premium Payment Method: Annually Semi-Annually Automatic Payment Plan (APP)
 If APP is chosen, please complete the following:
 Add this Premium to Existing APP for Policy # _____
 Start a New Draft from the Following Account: Checking Savings
 Account Number _____ Routing Number _____
 (Attach a blank, voided check from this account for routing information.)
 Monthly Deduction Day (1st thru 28th) _____
 Home Office Use Only: App Control Number _____
 11. I Do Do Not Wish the premium loan provision to be automatic (If not completed, APL will be applied if applicable.)
 12. Dividends To Be Used As Follows:
 Cash (Opt. 1) Accumulate at Interest (Opt. 2)
 Reduce Premiums (Opt. 3) Paid-Up Additions (Opt. 4) Other _____
 13. Beneficiary of the proceeds owed on date of insured's death:
 Primary: _____
(Name) (Relationship) (Age) (Social Security Number) (% of Benefits)

(Name) (Relationship) (Age) (Social Security Number) (% of Benefits)
 Contingent, If No Primary Beneficiary Is Living:

(Name) (Relationship) (Age) (Social Security Number) (% of Benefits)
- Beneficiaries shall share equally unless a different percentage is specified.
14. (A) Owner, (if other than insured, give name, relationship, age): _____
 _____ (B) _____
(Social Security Number)
 15. Has the proposed insured ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products?
 If yes, provide detail below Yes No
 a. Present Former
 b. Type of nicotine or tobacco used: _____
 c. When did you quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year

I represent that I have read and understand all the statements given in this application and they are true and complete to the best of my knowledge and belief. It is agreed that: a. the statements given to this application and any amendments to it or made to AUL will be the basis of any insurance issued; b. no representative or group policyholder has the authority to make or alter any contract for AUL; c. AUL may indicate changes in an endorsement to this application for administrative purposes only, and I must agree in writing to any other changes in this application (not applicable in NJ, PA, or WV); d. if AUL approves this application different from that applied for as to option, amount, age, classification or benefits, no insurance will take effect until (1) the policy is delivered to and accepted by me and (2) the full first premium is paid and (3) to the best of the applicant's knowledge, the health and insurability of any proposed insured has not changed since the application date.

I certify that I have read, or had read to me, the completed application and I realize that any false statement or misrepresentation therein may result in loss of coverage under the policy.

Amount of Deposit Paid With Application \$ _____ Date _____

I understand the deposit shall be held and applied toward the first premium owed from the effective date of any policy issued and accepted as part of said application. There shall be no coverage under the insurance applied for until a policy is issued and accepted. If no policy is issued and/or accepted, I understand the deposit will be refunded.

(Signature of Employee)

(Signature of Applicant if other than Employee)

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Delaware, Idaho, Indiana, Oklahoma

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Maryland, Rhode Island

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New Hampshire, Ohio

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud

New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

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