Disability Statement of Insurability Packet

OneAmerica® Financial

American United Life Insurance Company® a OneAmerica Financial® company
One American Square, P.O. Box 368, Indianapolis, IN 46206-0368 • 1-317-285-1877

SMALL BUSINESS Association of MICHIGAN

Instructions - Please Read Carefully and Submit All Required Information

This form is to be completed by the Employee, then provided to the Employer for submission to Small Business Association of Michigan per the directions below.

All group and traditional life and disability business forms should be submitted to Small Business Association of Michigan (SBAM), and the SBAM Member Care team will forward to the appropriate party at OneAmerica Financial.® Submit to:

1. Email to *membercare@sbam.org*
2. Mail forms to: Small Business Association of Michigan
   101 S. Washington Square, Suite 900
   Lansing, MI 48933
3. Overnight forms to: Small Business Association of Michigan
   101 S. Washington Square, Suite 900
   Lansing, MI 48933

If you have any questions when completing this form, please contact the SBAM Member Care Team at *membercare@sbam.org* or 1-877-949-7226.

Statement of Insurability for Group Disability Insurance Coverage

Follow completion directions beginning on page 2.

G-38463 (SBAM) 12/4/25

Statement of Insurability for Group Disability Insurance Coverage

OneAmerica Financial

American United Life Insurance Company® a OneAmerica Financial® company
One American Square, P.O. Box 6123, Indianapolis, IN 46206-6123 • 1-800-553-5318

This form is used to provide information, including medical evidence, for coverage when applicable. Information gathered will not affect the guaranteed issue amount of coverage outlined in your plan.

NOTE: This form is not enrolling you in a benefit. It is used to gather the information needed to underwrite the coverage you are requesting. Any coverage applied for which requires evidence of insurability will not become effective unless approved and an effective date is assigned by the American United Life Insurance Company.®

Incomplete forms may delay the decision to offer the coverage you're requesting. All fields on this form must be filled out unless they are marked optional.

A. Employer Plan Information

Employer and employee information along with the coverage you are requesting must be completely filled out. Seek assistance from your employer, if needed.

Name of Employer	Group Number

Date of Hire	Occupation

Class Number *(optional)*	Option Number *(optional)*	Benefits Eligible Salary *(per contract definition)*

B. Employee Coverage Information

First Name	Middle Initial	Last Name

Mailing Address	City	State	ZIP Code

Email	Home or Cell Phone Number	Social Security Number

Date of Birth	Place of Birth *(City and State, or Country if born outside of the U.S.)*

Gender	Height	Weight
☐ Male ☐ Female	ft. in.	lbs.

During the last 12 months, have you used any nicotine and/or tobacco products such as smoking cigarettes, pipes or cigars, using snuff, chewing tobacco, or a nicotine delivery device *(patch, gum, vaping, e-cigarettes, hookah, etc.)*?

☐ Yes ☐ No

Reason for Statement of Insurability *(see instructions and check applicable)*

- ☐ Initial Enrollment/New Hire *(for use when employees are first eligible and are requesting an amount of insurance that exceeds the guaranteed issue amount as listed in your certificate)*
- ☐ Increase to Existing Coverage *(for employees requesting to increase existing benefits)*
- ☐ Late Enrollment *(for employees requesting to join the plan after their initial eligibility period)*

Employee Disability Coverage

☐ Short-Term Disability ☐ Long-Term Disability ☐ Lump Sum Disability

C. Underwriting Information

Please provide the contact information of your primary care physician:

Physician Name		Phone Number
City	State	ZIP Code

In the past ten (10) years:

1. Have you been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?..... ☐ Yes ☐ No

In the past ten (10) years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

2. Amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease), chronic obstructive pulmonary disease (COPD), emphysema, diabetes type I (insulin dependent), any form of hepatitis other than hepatitis A, heart attack, heart valve disease or disorder, paralysis, Parkinson's disease, stroke, cardiomyopathy, cirrhosis, organ transplant, or PVD (Peripheral Vascular Disease)?..... ☐ Yes ☐ No
3. Transient ischemic attack (TIA), high blood pressure, irregular heartbeat, heart murmur, aneurysm, angina, elevated cholesterol, or any blood, anemia, heart or blood vessel disorder?... ☐ Yes ☐ No
4. Cancer, leukemia, tumor, neoplasm, nodule or polyp *(excluding nasal polyp)*, pre-cancerous condition, or dysplastic nevi?..... ☐ Yes ☐ No
5. Diabetes type II, hepatitis A, or other disorder of the liver or pancreas; thyroid, pituitary or other endocrine disorder; ulcer, colitis or Crohn's disease; irritable bowel syndrome, diverticulitis, or other astrointestinal disorder?..... ☐ Yes ☐ No
6. Disorder of the kidney, bladder *(excluding healed bladder infections), urinary system, prostate gland (including elevated PSA)*, or reproductive organs?..... ☐ Yes ☐ No

In the past five (5) years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

7. Asthma, bronchitis, sleep apnea, cystic fibrosis; or any lung or respiratory disorder?..... ☐ Yes ☐ No
8. Arthritis, rheumatism, or gout; back, neck, or disc disorder; disorder of the knee, muscles, joints, or bones; systemic lupus erythematosus, connective tissue disease, or fibromyalgia? ..... ☐ Yes ☐ No
9. Headaches, epilepsy, seizures, memory loss, intellectual disability, multiple sclerosis, muscular dystrophy; or any brain or neurological disorder; chronic infection, or chronic fatigue?..... ☐ Yes ☐ No
10. Skin disorders including, psoriasis, rosacea, vitiligo, lupus, cellulitis, impetigo, actinic keratosis, carbuncle, anaphylaxis, hives, eczema, or dermatitis?..... ☐ Yes ☐ No
11. Anxiety, depression; or any mood, emotional, mental, or nervous disorder; post-traumatic stress disorder, or schizophrenia? ..... ☐ Yes ☐ No
12. Disorder of the eyes, ears, nose or throat *(excluding myopia, astigmatism or healed ear infections)*; retinal detachment or hemorrhage; iritis, uveitis, chronic sinusitis, Meniere's Disease, chronic vertigo, or tinnitus?..... ☐ Yes ☐ No
13. Blood, pus or sugar in the urine; chest pain, shortness of breath, enlarged glands or lymph nodes; night sweats or unintentional weight loss?..... ☐ Yes ☐ No
14. Consulted a medical professional for anything other than the conditions previously identified in this Underwriting Information Section? ..... ☐ Yes ☐ No
15. Been advised to have, or have scheduled, a consultation, surgery, or test that has not been completed or that has been completed but has resulted in symptoms for which you have not consulted a medical professional? ..... ☐ Yes ☐ No

In the past five (5) years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: ***(continued)***

16. Been advised to reduce your consumption of alcohol or to seek counseling for the use of alcohol or drugs; or used cocaine, narcotics, barbiturates, amphetamines, hallucinogens, or other drugs, except as prescribed by a physician; or been arrested in connection with alcohol or drugs; or received treatment in connection with alcohol or drugs? .... ☐ Yes ☐ No
17. Had any screening or diagnostic tests with abnormal results for cancer or heart/circulatory disorders? .... ☐ Yes ☐ No

Provide full details for any YES answers to questions 3-17:
(if additional space is needed, please attach, sign, and date an additional sheet including all required information)

Question #	Date of Onset *(mm/yy)*	Date Last Seen *(mm/yy)*	Fully Recovered? ☐ Yes ☐ No
Diagnosis/Condition			
Treatment	Medication	Dosage	
Name, Complete Address, and Phone Number of Medical Provider ☐ Same as Primary Care Physician Listed Above			

Question #	Date of Onset *(mm/yy)*	Date Last Seen *(mm/yy)*	Fully Recovered? ☐ Yes ☐ No
Diagnosis/Condition			
Treatment	Medication	Dosage	
Name, Complete Address, and Phone Number of Medical Provider ☐ Same as Primary Care Physician Listed Above			

Question #	Date of Onset *(mm/yy)*	Date Last Seen *(mm/yy)*	Fully Recovered? ☐ Yes ☐ No
Diagnosis/Condition			
Treatment	Medication	Dosage	
Name, Complete Address, and Phone Number of Medical Provider ☐ Same as Primary Care Physician Listed Above			

In the past five (5) years, have you:

18. Been off work for more than five consecutive days due to an illness or injury? .... ☐ Yes ☐ No
19. Had any life or health insurance declined, postponed, or modified; or had a waiver or extra premium added? .... ☐ Yes ☐ No
20. Received payment for disability, illness, or injury? .... ☐ Yes ☐ No
21. Pled guilty to, pled no contest to, or been convicted of a felony; or been convicted of a major moving violation, including DUI, reckless driving, and driving to endanger; or had your driver's license suspended? .... ☐ Yes ☐ No

Provide full details for any YES answers to questions 18-21:
(if additional space is needed, please attach, sign, and date an additional sheet including all required information)

Question Number	Full Details to Include Dates

In the past three (3) years, have you:

22. Been prescribed or advised to take any medication by a medical professional not already listed above? ☐ Yes ☐ No

Provide full details for YES answer to question 22:
(if additional space is needed, please attach, sign, and date an additional sheet including all required information)

Medication	Dosage	Date First Prescribed	Date Last Taken
Diagnosis/Condition			
Name, Complete Address, and Phone Number of Prescriber ☐ Same as Primary Care Physician Listed Above			
Medication	Dosage	Date First Prescribed	Date Last Taken
Diagnosis/Condition			
Name, Complete Address, and Phone Number of Prescriber ☐ Same as Primary Care Physician Listed Above			
Medication	Dosage	Date First Prescribed	Date Last Taken
Diagnosis/Condition			
Name, Complete Address, and Phone Number of Prescriber ☐ Same as Primary Care Physician Listed Above			

23. Are you currently pregnant? ☐ Yes ☐ No
    If YES, expected due date _____
24. Have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for complications related to pregnancy? ☐ Yes ☐ No
    If YES, provide full details _____

Fraud Warning

Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization and Acknowledgement

I authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmacy or pharmacy benefit manager, pharmaceutical databases, DMV and the MIB, LLC (MIB) to give to American United Life Insurance Company (AUL) and its reinsurers any of the following information about me: facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, 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 authorize the release of genetic screening or testing results. All sources except the MIB may give these facts to any insurance support organization authorized by AUL 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. I authorize AUL and its reinsurers to make a brief report of my personal health information to MIB. This authorization will be valid for 24 months from the date shown below. I understand that 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 Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

Requests for coverage not offered by or under AUL's contract will not be approved. Coverage cannot be less than the minimum or more than the maximum amount allowed under the contract. Payroll deductions or premium payments greater than the amount owed will not result in additional coverage. Payroll deductions that occur prior to AUL's approval should be discontinued and will not be a substitute for AUL's approval of coverage. Any coverage applied for which requires evidence of insurability will not become effective unless approved and an effective date is assigned by AUL.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct; 3) certifies that all notices contained herein were read and understood prior to my completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; 5) has received the Notice of Insurance Information Practices, the MIB Notice, and this Authorization and Acknowledgement; and 6) understands that any false or otherwise erroneous statements or answers given on this form could result in revocation of coverage if coverage is approved prior to discovering the false or otherwise erroneous information.

Signatures *(if this form is not signed and dated, it will be returned for signature)*

Signature of Requesting Insured/Employee	☐ I consent to receive follow-up questions about this form via email. *(if not checked, US mail will be used)*
Date of Signature	City/State Where Signed

Mail, fax, or email this completed, signed, and dated form to:

American United Life Insurance Company
Attn: Employee Benefits Division
P.O. Box 6123
Indianapolis, IN 46206-6123
Fax: 1-888-285-1565
ebcontactcenter@oneamerica.com