

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



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 form 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 Term Life Insurance

Follow completion directions beginning on page 2.

Statement of Insurability for Group Term Life 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 additional voluntary 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 additional 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 additional 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 amount you are requesting must be completely filled out. Seek assistance from your employer, if needed.

Employer Name		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.)			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married (includes domestic partnership/civil union as determined by state law and certificate)				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Height ft. in.		Weight 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.)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Reason for Statement of Insurability (see instructions and check applicable) <input type="checkbox"/> Initial Enrollment/New Hire (for use when employees and/or spouse are first eligible and are requesting an amount of insurance that exceeds the guaranteed issue amount as listed in your certificate) <input type="checkbox"/> Increase to Existing Coverage (for employees and/or spouse requesting to increase existing benefits) <input type="checkbox"/> Late Enrollment (for employees and/or spouse requesting to join the plan after their initial eligibility period)				

B. Employee Coverage Information (continued)**Coverage Applied For**

Current Amount: If there is an existing amount of coverage in effect prior to this request, please enter it as the current amount
 If the applicant is a New Hire/Newly Eligible, the guaranteed issue amount should be entered as the current amount
 If the applicant is a late enrollee, please enter "\$0" as the current amount

Additional Amount Requested: Enter the benefit amount being requested for purchase

Total Amount if Approved: Enter the sum of the current coverage and the additional amount being requested

Employee Life Coverage	Basic Term Life	Voluntary Term Life
Current Amount	\$	\$
Additional Amount Requested	\$	\$
Total Amount if Approved	\$	\$

C. Spouse Coverage Information

(to be completed ONLY if Dependent Spouse Life Coverage is requested)

First Name		Middle Initial	Last Name	
Mailing Address		City	State	ZIP Code
Email			Home or Cell Phone Number	
Date of Birth	Place of Birth (City, State, or Country if outside the U.S.)		Social Security Number	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married (includes domestic partnership/civil union as determined by state law and certificate)				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Height ft. in.		Weight 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.)? <input type="checkbox"/> Yes <input type="checkbox"/> No				

The employee and their spouse may complete the same form or separate forms. Both the employee and their spouse must sign and date their form.

Dependent Spouse Life Coverage (includes domestic partnership/civil union as determined by state and certificate)	Basic Term Life	Voluntary Term Life
Current Amount	\$	\$
Additional Amount Requested	\$	\$
Total Amount if Approved	\$	\$

D. Underwriting Information

Please provide the contact information of your primary care physician:

For Employee	For Spouse
Physician Name	Physician Name
Phone Number	Phone Number
Address (<i>city, state, ZIP code</i>)	Address (<i>city, state, ZIP code</i>)

In the past ten (10) years:	Employee	Spouse
1. Have you or any person requesting coverage been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

In the past ten (10) years, have you or any person requesting coverage been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:	Employee	Spouse
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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Cancer, leukemia, tumor, neoplasm, nodule or polyp (<i>excluding nasal polyp</i>), pre-cancerous condition, or dysplastic nevi?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 gastrointestinal disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Disorder of the kidney, bladder (<i>excluding healed bladder infections</i>), urinary system, prostate gland (<i>including elevated PSA</i>), or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

In the past five (5) years, have you or any person requesting coverage been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:	Employee	Spouse
7. Asthma, bronchitis, sleep apnea, cystic fibrosis; or any lung or respiratory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Headaches, epilepsy, seizures, memory loss, intellectual disability, multiple sclerosis, muscular dystrophy; or any brain or neurological disorder; chronic infection, or chronic fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Skin disorders including, psoriasis, rosacea, vitiligo, lupus, cellulitis, impetigo, actinic keratosis, carbuncle, anaphylaxis, hives, eczema, or dermatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Anxiety, depression; or any mood, emotional, mental, or nervous disorder; post-traumatic stress disorder, or schizophrenia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Employee Spouse

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 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 Yes No
14. Consulted a medical professional for anything other than the conditions previously identified in this Underwriting Information Section? Yes No 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 Yes No
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 Yes No
17. Had any screening or diagnostic tests with abnormal results for cancer or heart/circulatory disorders? Yes No 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 #	Applicant Name	Date of Onset (mm/yy)	Date Last Seen (mm/yy)	Fully Recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Diagnosis/Condition

Treatment	Medication	Dosage
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Medical Provider Name, Complete Address, and Phone Number Same as Primary Care Physician Listed Above

Question #	Applicant Name	Date of Onset (mm/yy)	Date Last Seen (mm/yy)	Fully Recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Diagnosis/Condition

Treatment	Medication	Dosage
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Medical Provider Name, Complete Address, and Phone Number Same as Primary Care Physician Listed Above

In the past five (5) years, have you or any person requesting coverage: **Employee** **Spouse**

18. Been off work for more than five consecutive days due to an illness or injury? . Yes No Yes No

19. Had any life or health insurance declined, postponed, or modified; or had a waiver or extra premium added? Yes No Yes No

20. Received payment for disability, illness, or injury? Yes No 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 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 #	Applicant Name	Full Details to Include Dates

In the past three (3) years, have you or any person requesting coverage: **Employee** **Spouse**

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

Applicant Name	Medication	Dosage	Date First Prescribed	Date Last Taken
Diagnosis/Condition				
Prescriber Name, Complete Address, and Phone Number <input type="checkbox"/> Same as Primary Care Physician Listed Above				

Applicant Name	Medication	Dosage	Date First Prescribed	Date Last Taken
Diagnosis/Condition				
Prescriber Name, Complete Address, and Phone Number <input type="checkbox"/> Same as Primary Care Physician Listed Above				

Applicant Name	Medication	Dosage	Date First Prescribed	Date Last Taken
Diagnosis/Condition				
Prescriber Name, Complete Address, and Phone Number <input type="checkbox"/> Same as Primary Care Physician Listed Above				

23. Are you or is any person requesting coverage currently pregnant?..... Yes No Yes No
 If YES, expected due date _____

24. Have you or has any person requesting coverage 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 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 (we) 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 (us): 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 (we) authorize AUL and its reinsurers to make a brief report of my (our) personal health information to MIB. This authorization will be valid for 24 months from the date shown below. I (we) understand that I (we) 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 (we) can choose to be interviewed and to receive a copy of the report upon request.

Requests for coverage not offered by or under the AUL 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 approval should be discontinued and will not be a substitute for the AUL 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 (our) 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 (our) 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)

Requesting Insured/Employee Signature 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
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Spouse Signature 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
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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