Group Enrollment Form

American United Life Insurance Company®
a ONEAMERICA FINANCIAL® *company*
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
(800) 553-5318
www.employeebenefits.aul.com

OneAmerica® Financial

Applicant's Full Legal Name:			Employment Status: Active Retired
Applicant's Social Security Number:	Date of Birth:	Marital Status Single Married	Gender: Male Female
Applicant's State of Residence:	Applicant's Residential Zip Code:	Employer: Plan Sponsor: Small Business Association of Michigan	
Applicant's Phone Number:	Applicant's E-mail Address:		Employed Full Time: Yes No
Are you authorized to work and reside in the US? Yes No			

COVERAGE BEING APPLIED FOR: Apply for or decline each coverage listed below. Not checking a box or boxes will be considered a declination of that coverage

Short Term Disability	Elect		
Long Term Disability	Elect		
Voluntary Short Term Disability	Elect	Option _____	Decline
Voluntary Long Term Disability	Elect	Option _____	Decline
Basic Term Life & AD&D	Elect		
Employee Voluntary Term Life & AD&D	Elect	Amount $_____	Decline
Spouse Voluntary Term Life & AD&D	Elect	Amount $_____	Decline
Child Voluntary Term Life & AD&D	Elect	Option _____	Decline

*If spouse is included in dependent coverage: Name _____ Date of Birth: _____

For AUL Term Life Coverages, identify your Beneficiary Designation to ensure proceeds can be paid according to your wishes.

Name of Primary Beneficiary:	Percentage:	Relationship:	SSN: Date of Birth:
Name of Contingent Beneficiary:	Percentage:	Relationship:	SSN: Date of Birth:

- I hereby apply for the requested group life and/or disability insurance coverage for which I and my dependents, if any, are eligible and available under AUL's policy. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by AUL.
- I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.
- The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the 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 any insurance coverage or benefit are contingent upon any statements made to AUL as being complete and correct. The undersigned have read, understand, and retained the notices, limitations, and exclusions for his/her records.
- 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.

Signature of Applicant: _____ Date: _____

Signature of Dependent Spouse: _____ Date: _____

Signature(s) of Dependent Child(ren) over age 18: _____ Date: _____

MUST BE COMPLETED BY THE EMPLOYER

Group Policy #: _____ **Employer:** _____ **Employer State:** MI

Plan Sponsor: Small Business Association of Michigan

Occupation: _____ **Date of Hire:** _____ **F/T Requirement: Hours Worked Per Week:** _____

Salary: $_____ **Mode:** **Hourly** **Weekly** **Bi-Weekly** **Semi-Monthly** **Monthly** **Annually**