American United Life Insurance Company® Group Enrollment/Change Form

Employee's Name:		Status: ❒ Active ❒ Retired
Employee's Social Security Number:		Sex: ❒ Male ❒ Female
Address:	City/State/Zip:	Telephone No.:
Employer:	Occupation:	Date of Birth:
Employed Full-Time: ❒ Yes ❒ No	Hours worked per week:	Marital Status: ❒ Single ❒ Married

Beneficiary Designation (If none given, death benefits will be paid according to state statutes and contract language):

First Name	Last Name	Relationship to You	% of benefit
If percentages don't total 100%, death benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, death benefits will be distributed equally. A separate form is available, if necessary, for more complex beneficiary designations, including naming a secondary beneficiary.			Total 100%

COVERAGE BEING APPLIED FOR:

[X] Basic Life/AD&D

Request	**Decline**	
[ ]	[ ]	Voluntary Life/AD&D $ ________
[ ]	[ ]	Voluntary Dependent Coverage Plan # ______ for [ ] Spouse only [ ] Children only [ ] Family

* If spouse included in dependent coverage, indicate spouse's name __________________________ and date of birth ____________.

Voluntary Life/ADD coverage selected cannot exceed 5 times the employee's annual salary.
Dependent coverage only available with employee coverage.

I have read the Notices, Limitations and Exclusions prior to the completion of this statement. I understand them and have retained a copy. I hereby apply for the benefit for which I and my dependents, if any, are eligible. I authorize my employer to take deductions for this insurance from my earnings, including any premium increases due to age bracket or salary changes, if applicable. I understand I have the right to revoke this deduction authorization at any time on written notice. I understand if I or my dependents, if any, request an amount that exceeds my employer's guaranteed issue amount, the excess amount will be subject to Evidence of Insurability and approval by AUL.

I understand if I decline any of the above coverages, enrollment of the coverage at a later date will require Evidence of Insurability at my own expense.

Fraud Notice <u>(DOES NOT APPLY TO RESIDENTS OF VA)</u>: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of the crime of insurance fraud as determined by a court of competent jurisdiction.

Date:________________ Signature of Employee (Please sign in ink):____

To be completed by the Employer

Group Policy #	Effective Date:	Class:	Coverage Amt.:	Date of Hire:
Action: ❒ New Enrollment ❒ Benefit Increase ❒ Benefit Decrease ❒ Name Change ❒ Address Change ❒ Beneficiary Change ❒ Other				
Salary: $ ________________ Mode: ❒ Hourly ❒ Weekly ❒ Bi-Weekly ❒ Semi-Monthly ❒ Monthly ❒ Annually				

MAIL TO: CBA BENEFIT SERVICES

73 EAST WILSON BRIDGE RD., SUITE B-6
WORTHINGTON, OH 43085

Notices:

Actively at Work Notice:

If an Employee is not Actively at Work, as defined in the policy, on the date personal insurance would otherwise become effective, the Individual Effective Date of Insurance is the date the Employee returns to full-time Active Work. However, an Employee not Actively at Work may have limited coverage if Continuity of Coverage is provided. If Dependent coverage is elected and a Dependent is confined in a hospital, convalescent care facility, or nursing home on the date Dependent Insurance would otherwise become effective for that Dependent, the Individual Effective Date of Insurance for that Dependent is the date following the Dependent's final discharge from the hospital, convalescent care facility, or nursing home. On the Effective Date of Coverage, the Employee must make written request to AUL for coverage to be considered for any incapacitated Child beyond normal termination age.

Community Property Notice:

If you reside in a community property state, it may be unlawful to name someone other than your spouse as your beneficiary, without your spouse's consent. Community property states include but may not be limited to: AZ, CA, ID, LA, NM, NV, TX, WA and WI.

Effective Date and Claims Payment Notice:

No coverage shall become effective until approved by the Home Office of American United Life which is located in Indianapolis, Indiana. In addition, the company shall not be liable for any claim prior to the effective date of the employee's or his dependents' coverage, if any.

Limitations/Exclusions:

Accidental Death and Dismemberment **:

The insurance does not cover any loss resulting directly or indirectly from: 1) suicide or attempted suicide, whether sane or insane; 2) air travel as a crew member; 3) participation in a riot or from war or any act of war, whether declared or undeclared; 4) commission of an assault or felony; 5) the voluntary taking of: a) a prescription drug in a manner other than as prescribed by a physician; b) any other federally or state controlled substance in an unlawful manner; c) non-prescription medicine, in a manner other than as indicated in the printed instructions; or d) poison; 6) the voluntary inhaling of gas (unless due to occupational accident); 7) sickness other than infection occurring as a result of accidental injury; and for Voluntary ADD coverage only; 8) participation in hang gliding, bungee jumping, automobile racing, motorcycle racing, skydiving, rock climbing or mountain climbing.

** Wording may vary by state.