Voluntary Term Life & Voluntary Disability
Election to Continue
Coverage After Termination

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

AUL
a OneAmerica® financial partner

Name of Insured _____ ☐ Male ☐ Female

Insured's Date of Birth _____ Social Security Number _____

Participating Unit or Group Policy Number as shown on first page of current certificate G _____

Have you smoked cigarettes or cigars, used a pipe or smokeless tobacco or chewed tobacco in the past 12 months? ☐ Yes ☐ No Daytime Phone Number (_____) _____

Current home address for billing purposes:

_____
Street Address *City* *State* *Zip Code*

I hereby apply to American United Life Insurance Company® (AUL) as a former employee of _____ to continue my insurance coverage for benefits for which I am eligible. I represent that the statements and answers given above are true and complete to the best of my knowledge and belief. I understand and agree that any insurance, which shall be continued, is in consideration of these statements being complete and correct.

I understand this completed form must be received in the Home Office of AUL within 31 days of coverage termination.

I understand that semi-annual or annual premium statements will be mailed to my home address and payment must be remitted to AUL within 30 days of receipt in order to keep this coverage in force.

I understand that I may terminate this coverage at any time by giving AUL at least 31 days prior written notice. AUL may terminate this coverage at any time by giving me at least 31 days prior written notice.*
*may vary by state

For Voluntary Term Life Coverage:

Check the box for each coverage you wish and are eligible to continue.
☐ Voluntary Life ☐ Voluntary AD&D ☐ Voluntary Dependent Life ☐ Voluntary Dependent AD&D

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%

Voluntary AD&D coverage is only available if continuing Voluntary Life coverage.

Voluntary Dependent coverage is only available if continuing Voluntary coverage for former employee. Evidence of Insurability will be required for any requested amounts of coverage greater than the amounts of coverage in force at this time of continuation or for any coverage being added at the time of continuation. (See Statement of Insurability form.)

I understand and agree that any Dependent who was previously excluded from coverage is not eligible for any benefits under this continuation of coverage.

For Voluntary Disability Coverage:

Check the box for each coverage you wish to continue.

☐ Voluntary Short Term Disability Coverage ☐ Voluntary Long Term Disability Coverage

I understand that if I have a claim during the time my coverage is continued, the maximum benefit duration will be the lesser of: 1) the maximum benefit duration in effect immediately prior to my termination, or 2) two years. In addition, I understand that any claim I have may be subject to the pre-existing conditions exclusion.

I certify that I have read the above prior to completion of this statement, and that I have retained a copy for my records.

Signature of Employee _____ Date _____

TO BE COMPLETED BY THE GROUP PLAN ADMINISTRATOR

Group Policy/Participating Unit Number _____

Name of Group Policyholder/Participating Unit _____

Original effective date of group coverage for applicant _____

Last date applicant was actively at work _____

Circle the reason for the termination of this applicant's coverage:

1. Termination of Group Policy (as long as coverage is not obtained with another carrier in 31 days)
2. Termination of employment
3. Attainment of limiting age
4. Reduction of hours
5. Not actively at work (waiver of premium)
6. Other _____

Choose all the coverages that are applicable and provide the amount of coverage:

☐ Voluntary Life Amount _____ ☐ Employee Class # _____

☐ Voluntary AD&D Amount _____ ☐ Number of Dependent Children _____

☐ Voluntary Dependent Life Amount: (Spouse) _____ (Child) _____

☐ Voluntary Dependent AD&D Amount: (Spouse) _____ (Child) _____

☐ Dependent Class _____ ☐ Dependent Plan # _____ ☐ Spouse's Date of Birth _____

☐ Voluntary Short Term Disability: Salary Amount _____ Salary Mode _____ Class _____ Plan # _____

☐ Voluntary Long Term Disability: Salary Amount _____ Salary Mode _____ Class _____ Plan # _____

Signature of Plan Administrator _____ Date _____

For Home Office Use Only

This request to continue coverage has been reviewed by the Group Department of AUL, and has been approved by:

Name _____ Date _____