

Statement of Insurability/ Change of Coverage Request

American United Life Insurance Company®
P.O. Box 6123
Indianapolis, IN 46206-6123
Attn: Group Division, Medical Underwriting
Support Unit



This form is to be used only by residents of California. If you reside in another state, please contact your employer's AUL representative for the correct form.

Instructions for completing form for yourself or your dependents, if any.

If you are applying for:

1. An amount of coverage above the Guaranteed Issue amount.

Complete Sections A, B and E. Sign and date under Section E and submit with a completed enrollment form. Detach and retain this notice page for your files.

2. Coverage as a Late Enrollee.

Complete Sections A, C and E. Sign and date under Section E and submit with a completed enrollment form. Detach and retain this notice page for your files.

3. A change in current coverage.

If change is an increase or addition to coverage, complete Sections A, D and E. If change is a decrease in coverage, complete Sections A and D. If you are making a change in your Voluntary Disability Coverage, complete Sections A, D and E. Sign and date under Section E. Detach and retain this notice page for your files.

Note: Any coverage applied for will not become effective until Evidence of Insurability is approved by AUL. AUL has the right to exclude one or more of your dependents, if any, from the dependent coverage based on Evidence of Insurability. AUL shall not be liable with respect to any change in coverage for any claim commencing prior to the date of approval of such change in coverage.

Notices Affecting Coverages

Notice of Insurance Information Practices

Thank you for your request for insurance. We are glad to have the chance to participate in your insurance program. This notice tells you about the underwriting process. It also tells you how information is gathered to review your request.

To properly underwrite and administer your insurance coverage we need to obtain information about you. Some of that information will come from you and some will come from other sources. We need this information to see if you qualify for insurance. When signed, the Authorization will allow us to obtain this information and to share it with others when necessary. No unnecessary disclosures will be made. Information will be treated as confidential by us and by our reinsurers. However, in some cases, information may have to be disclosed to others without your further consent.

You have the right to review and to correct this information, and you have the right to get a copy of any investigative consumer report which is made. If you want to know more about our underwriting practices and your rights, please write to: Group Department, American United Life, Post Office Box 368, Indianapolis, Indiana 46206-0368.

Medical Information Bureau Notice

We or our reinsurers may make a brief report to the Medical Information Bureau (MIB) if allowed by state law. The MIB is a nonprofit organization of life insurance companies. It is an information exchange for its members. If you apply to a MIB member company for life or health insurance, or file a claim with such a company, the MIB, upon request, will give the company the information in the MIB's file.

Upon receipt of a request from you, the MIB will give you any information it may have in your file. If you question the accuracy of information it may have in your file, you may contact the MIB and seek a correction under the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB is Post Office Box 105, Essex Stations, Boston, Massachusetts 02112. The phone number is (617) 426-3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim may be submitted.

Fair Credit Reporting Act Notice

We may request an investigative consumer report. These reports contain information about your character, general reputation, personal characteristics, mode of living and health. The information may be obtained through interviews with you, your employer, neighbors, friends and others who know you. Upon request, we will disclose to you whether or not such a report was made. Upon request, we will give you the name and address of the consumer reporting firm so that you may request a copy of the report.

Notice of Pre-existing Conditions Exclusion

If you receive treatment, service or incur expenses as a result of an injury or sickness prior to the effective date of approval, disability claims incurred after the date of approval may not be eligible due to the pre-existing conditions exclusion of the policy.

Fraud Notice

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 may be guilty of the crime of insurance fraud as determined by a court of competent jurisdiction.

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FORM COMPLETION INSTRUCTIONS:

1. Please print the entire document.
2. Please complete pages marked "Submit this page to AUL" at the bottom of the page.
3. Please seek assistance from your employer for salary and benefit elections.
4. Signatures for You and your dependents (if applicable) are required on this form.
5. Please make a copy of the completed pages for your records.
6. Please mail the completed pages to AUL at the address on the left.

A. General Employee Information

1. Name of Employer _____
Participating Unit number or Group Policy number as shown on first page of certificate G _____
2. Employee Name (Last, First, Middle): _____
Birth Place _____ DOB _____ Sex _____ Height _____ Weight _____
Complete Home Address (Including City, State, Zip) _____
Work Phone Number (_____) _____ Home Phone Number (_____) _____
Social Security Number _____
Annual Salary Amount \$ _____ as defined by your AUL contract. Please contact your employer for assistance.

3. Complete only for those requesting coverage. If needed, please use a separate sheet of paper.

Spouse Name (Last, First, Middle)			Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle)	Relationship to You	Full-Time Student Y / N	Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle)	Relationship to You	Full-Time Student Y / N	Birth Place	DOB	Sex	Height	Weight
Dependent Name (Last, First, Middle)	Relationship to You	Full-Time Student Y / N	Birth Place	DOB	Sex	Height	Weight

B. Amounts in Excess of Guaranteed Issue

Check all that apply:

- Traditional Coverages: Basic Life/AD&D Supplemental Life/AD&D Dependent Life/AD&D LTD STD
Voluntary Coverages: Term Life/AD&D Dependent Life/AD&D LTD STD

C. Late Enrollment

Check all that apply:

- Traditional Coverages: Basic Life/AD&D Supplemental Life/AD&D Dependent Life/AD&D LTD STD
Voluntary Coverages: Term Life/AD&D Dependent Life/AD&D LTD STD

D. Change of Coverage

Check all that apply:

- Voluntary Term Life Coverage from \$ _____ to \$ _____.
If coverage is a flat amount, coverage can only be increased or decreased in dollar increments. If coverage is a multiple of salary coverage can only be increased or decreased in multiples as offered by the employer. **No coverage can be less than the minimum or more than the maximum allowed by the employer.**
- Supplemental Term Life Coverage from \$ _____ to \$ _____.
 Dependent Life: Specify Coverage Type: Traditional Basic Voluntary Term
 Change coverage from plan _____ to plan _____ as offered by the employer.
Specify Dependent type: Spouse Only Children Only Spouse and Children
 Add Dependent: Spouse Only Children Only Spouse and Children
 Delete Dependent: Spouse Only Children Only Spouse and Children
 Disability Coverage from plan _____ to plan _____. (See enrollment form for plan information)

E. Medical Questions

1. Within the past 7 years, has any person proposed for insurance been diagnosed or treated by a physician or qualified professional, or tested positive for the presence of, or taken prescribed medicine for: (Please provide full details for any "yes" responses in Question 4.)

	Employee		Spouse/Child			Employee		Spouse/Child	
	Yes	No	Yes	No		Yes	No	Yes	No
a. Cancer					l. Neurological or Brain Disorder including Epilepsy or Paralysis				
b. Diabetes or other Glandular Disorders					m. Psychological/Emotional Disorder or Depression				
c. Chest Pain or Heart Attack					n. Lung or Respiratory Disorder/Disease				
d. Heart Disease or Disorder including Murmurs					o. Neuromuscular or Musculoskeletal Disorders including Arthritis and Back Disorders				
e. High Blood Pressure – If yes, provide last reading and date of reading in Question 4.					p. Skin or Lymph Gland Disorders				
f. Anemia					q. Eye, Ear, Nose and Throat Disease				
g. Liver Disorder or Hepatitis					r. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?				
h. Stomach and/or Intestinal Disorders					s. Any immune deficiency related disorders? (not including HIV status)				
i. Stroke					t. Any sexually transmitted disease? (not including HIV status)				
j. Kidney/Bladder/Pancreatic Disease									
k. Prostate/Female Organ Disorder									

2. Within the past 5 years, has any person proposed for insurance: (Please provide full details for any "yes" responses in Question 4.)

a. Taken or currently take any prescription medicine? If yes, state medicine and the reason for using it in question 4.				
b. Had an electrocardiogram, x-ray, blood study (not including HIV status), urinalysis or any other diagnostic study (not including HIV status)?				
c. Been rejected, rated, postponed or modified for life insurance?				
d. Received or been instructed to seek treatment for use or abuse of alcohol or drugs?				
e. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates or any other habit forming drugs?				
f. Had any illness, injury, operation or treatment other than stated above?				

3. For Disability Only: Are you pregnant? Yes No If yes, expected delivery date _____

4. Describe details of "Yes" answers from Questions 1 and 2. If needed, use separate sheet of paper. Please list the letter version of the question where applicable, i.e. E.2.b.

Name	Ques. #	Date	Detail of injury, illness or disorder	Name/Address of Physician/Hospital

Authorization and Acknowledgment: I authorize any physician, medical practitioner, hospital, medical facility, insurance company, and the MIB to give to American United Life Insurance Company® and its reinsurers any of the following about me: facts about physical and mental health; medical care, advice or treatment; and other characteristics, including the use of alcohol, drugs and tobacco. This authorization does not apply to the release of genetic screening or testing. 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 AIDS virus. 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 if I am eligible for insurance. A photocopy of this form shall be as valid as the original. I understand that I or my authorized representative has a right to receive a copy of this authorization. This authorization will be valid for 24 months from the date shown below. I can choose to be interviewed if an investigative consumer report is made.

I represent that the statements and answers given on this form are true and complete to the best of my knowledge and belief. I understand and agree that any insurance which shall be issued is in consideration of these statements being complete and correct. I certify that the notices attached were read and understood prior to the completion of this form, and that I have retained these notices for my records.

Signature of Insured/Employee _____ Date _____

Signature of Spouse/Eligible Child age 18 or over _____ Date _____

Printed Name of Insured/Employee _____