

**Group Enrollment Form**

Mail completed form to:

**PIBT** | PRINTING INDUSTRIES  
BENEFIT TRUST

5800 S. Eastern Ave., Suite 400 • Los Angeles, CA 90040 • License #0747420  
Phone (323) 728-9500 • Outside Southern Cal: (800) 449-4898  
Fax (323) 722-7386 • Outside Southern Cal: (866) 559-0355  
www.piasc.org • www.piasd.org • www.pinc.org • www.piag.org

American United Life Insurance Company®  
a ONEAMERICA® financial partner  
One American Square, P.O. Box 1623  
Indianapolis, IN 46206-1623  
(317) 285-1877



Employee's Full Name:		Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Employee's Social Security Number:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer:	Occupation:	Date of Birth:	
Employed Full-Time: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hours worked per week:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Have you used tobacco in any form in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Beneficiary Designation (If none given, death benefits will be paid according to state statutes and contract language):			
<b>First Name</b>	<b>Last Name</b>	<b>Relationship to You</b>	<b>% of benefit</b>
First (Primary) Beneficiary(ies)			
		<b>TOTAL</b>	<b>100%</b>
Second (Secondary) Beneficiary(ies)			
If percentages don't total 100% in the same class of beneficiaries, benefits will be paid on a prorata basis, according to the percentages shown. If no percentages are shown, death benefits will be distributed equally. <b>A separate form is available, if necessary, for more complex beneficiary designations.</b>		<b>TOTAL</b>	<b>100%</b>

**COVERAGE BEING APPLIED FOR\*:** Request or decline all coverages listed below.

Request Decline

- [ ] [ ] Voluntary Life \$\_\_\_\_\_ (increments of \$25,000)  
 [ ] [ ] Voluntary Dependent Coverage for  Spouse only  Children only  Family  
 Spouse Coverage \$\_\_\_\_\_ (increments of \$5,000)

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

Voluntary Life coverage selected cannot exceed 10 times the employee's annual base salary.

Dependent coverage only available with employee coverage.

*I have read the Notices, Limitations and Exclusions G-14320, prior to the completion of this statement. I understand them and have retained a copy. I hereby apply for 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 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:** 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. In FL, any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. In NJ or VA, any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties. In LA, PA, or TN, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. In WA, a person who knowingly makes a false or misleading statement or impersonation, or who willfully fails to reveal a material fact in or relative to an application for insurance, to an insurer, is guilty of a gross misdemeanor.

Date: \_\_\_\_\_ Signature of Employee: \_\_\_\_\_

In community property states, if the spouse is not the designated beneficiary, the signature of the spouse is required. Community property states include, but may not be limited to, AZ, CA, ID, LA, NM, NV, TX, WA & WI.

Signature of Spouse: \_\_\_\_\_ Date: \_\_\_\_\_

In Michigan only:

Signature(s) of Dependent Spouse and Child(ren) over age 18 \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY THE EMPLOYER**

Group Policy #: <b>35713</b>	Class by Coverage: <b>Class 2</b>	Date Hired Full-Time:
Salary: \$      Mode: <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually		