

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

American United Life Insurance Company®
a ONEAMERICA® financial partner
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
(800) 553-5318
(317) 285-1565 Fax



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 if insured under AUL's GC2525 or GC2526 Voluntary Term Life Contracts.

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.

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 Florida, 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 New Jersey and Virginia, any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties. In Louisiana, Pennsylvania, and Tennessee, 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 Washington, 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.

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 _____

Date Group coverage terminates for the applicant _____

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 _____