Application to Continue/Port Group Insurance Disability Coverage or One Lump Sum Coverage Only

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
1-317-285-1877

ONEAMERICA®

If coverage under an American United Life Insurance Company (AUL) Group Disability Income Insurance contract ("Contract") terminates, in some Contracts, eligible insureds have 31 days from the date their disability income insurance coverage terminates under the Contract issued to the Group Policyholder as identified in Section II of this Application ("Application") to apply, in writing to AUL, to continue their coverage under the Portability Privilege section of their Contract. *Eligible insureds will not be eligible to apply at a later date to continue this coverage.*

Section I – You should complete Section I, making certain you apply for all the coverages you want to continue. By completing Section I, you are indicating your desire to continue this application process and receive additional instructions and premium rate information.

Section II – Your Employer should complete Section II. The Employer should indicate all coverages you had at the time your coverage terminated.

AUL will review the information provided and then determine your eligibility for continuing coverage. Once AUL has established your eligibility for continuing coverage, additional application instructions and premium rate information will be provided.

- In order to apply for the Portability Privilege in AUL's Contract, eligible insureds must have been insured under the Contract for the number of months as specified in the Portability Privilege provision of the Contract.
- If the insured is approved for continued coverage under the Portability Privilege, coverage under the Contract is for only the period of time as specified in the Portability Privilege provision of the Contract.
- If the insured is approved for continued coverage under the Portability Privilege, the maximum benefit duration for any payable claim under the Contract is stated in the Portability Privilege provision of the Contract.
- If the insured is approved for benefits under the Portability Privilege, any claim under the Contract is subject to limitations and exclusions, such as a pre-existing condition exclusion.
- The Portability benefits are not available to an individual who:
  1. no longer belongs to a class eligible for coverage under the Contract;
  2. has retired;
  3. fails to pay any required premium;
  4. is or becomes insured for any other similar group disability income insurance within 31 days after termination under the Contract
  5. is disabled under the terms of the Contract;
  6. is on a leave of absence; or
  7. was insured under a contract that terminated.

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Section I – To Be Completed by Employee		
Employee Name:	Policyholder Name/Number:	
Date of Birth:	Social Security Number:	Gender:
Employee Address:		
City:	State:	Zip
Employee Phone Number:	Employee Email Address:	

Were you disabled at the time coverage terminated? ☐ Yes ☐ No

If you wish to apply to continue the disability income coverage, select each coverage you wish to continue. Not checking a box will be considered a declination of the Portability Privilege Benefit.

Voluntary/Worksite Short Term Disability ☐ Yes ☐ No

Voluntary/Worksite Long Term Disability ☐ Yes ☐ No

One Lump Sum ☐ Yes ☐ No

Acknowledgments

- I hereby apply to AUL to continue the insurance coverage for which I am eligible and which is available under the Contract. I represent that any information or documents I provide to AUL prior to and after the date of this Application and any facts and other matters contained in this Application are true and accurate to the best of my knowledge and belief. I understand and agree that any insurance, which shall be continued, is contingent upon any statements made to AUL as being complete and correct.
- I understand premium payment greater than the amount of premium owed will not result in additional coverage under the Contract.
- I understand no continuation of coverage under the Contract will be effective until this Application is received, reviewed, and approved in writing by AUL. If no coverage is issued and/or approved, I understand that any premium deposit remitted will be refunded.
- I understand the ability to continue coverage under the Contract is contingent upon, but is not limited to, the following conditions:
  1. I must remit the required amount of premium plus any administration fee directly to AUL, within 31 days of the date my coverage terminated; and
  2. Failure to pay the correct amount of premium timely will terminate the insurance under the Contract at the end of the period for which the premium has been paid.
- I understand and agree that any coverage or benefit under the Contract will be approved only if AUL decides in its discretion that I am entitled to it. I have read, understood, and retained for my records the notices, limitations, and exclusions of AUL.

Signature	
Signature of Employee:	Date:

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Section II – To Be Completed by Employer	
Policyholder Name:	Policyholder Number:
Employee Name:	
Employee Hire Date:	Number of Hours Worked Per Week:
Effective Date of Employee Insurance:	Employee's Annual Salary (prior to the employee's last date worked):
Date Employee as last Physically/Actively at Work:	Last Day of Coverage through which Premiums are Paid:

Indicate reason for coverage termination. Please choose only one of the following options:

☐ Termination of Employment ☐ Reduction in Hours
☐ Termination of Group Policy ☐ Permanent Layoff
☐ Temporary Layoff ☐ Disability
☐ Leave of Absence ☐ Retirement
☐ Other If Other, please describe. _____

Identify all existing coverages under the following plans:

Voluntary/Worksite Short Term Disability ☐ Yes ☐ No Plan # _____
Voluntary/Worksite Long Term Disability ☐ Yes ☐ No Plan # _____
One Lump Sum ☐ Yes ☐ No Volume _____

Acknowledgments

The undersigned represents that any information or documents provided to AUL prior to and after the date of the application for insurance and any facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.

The undersigned understands and agrees:

1. If required under state law, Employee is designated as a person acting on behalf of the Employer to remit the required premium payments to AUL for the sole purpose of Employee continuing/porting group insurance coverage under the Contract.
2. Any insurance coverage or benefit is contingent upon any statement made to AUL as being complete and correct; and
3. Benefits under the Contract will be paid only if AUL decides in its discretion the applicant is entitled to them.

The undersigned has read, understood, and retained for his records the notices, limitations, and exclusions of AUL.

Signature	
Signed By:	Date:
Title:	Phone Number:
Email Address:	

G-32370 10/29/19