Group Enrollment Form

Products and financial services provided by
American United Life Insurance Company®
a ONEAMERICA® *company*
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
(800) 553-5318

ONEAMERICA®

Applicant's Full Legal Name:			Employment Status: ☒ Active ☐ Retired
	Applicant's State of Residence: Ohio	Applicant's Residential Zip Code:	Gender: ☐ Male ☐ Female
Date of Birth:	Marital Status: ☐ Single ☐ Married	Employer: **ESC of Lorain County**	
Employed Full-Time: ☒ Yes ☐ No	Hours worked per week:	Employer's City:	State: Ohio
	Are you authorized to work and reside in the US? ☐ Yes ☐ No		
Name of Primary Beneficiary		Relationship	SSN/Date of Birth
Name of Contingent Beneficiary		Relationship	SSN/Date of Birth

COVERAGE BEING APPLIED FOR: Apply for or decline each coverage listed below. Not checking either box will be considered a declination of that coverage.

Request Decline

[X] [ ] Term Life/AD&D

[ ] [ ] Voluntary Term Life $_____

[ ] *Voluntary Term Dependent Life Coverage

	[ ] Option 1	[ ] Option 2	[ ] Option 3	[ ] Option 4	[ ] Option ___ (EOI required)
Spouse	**$5,000**	**$10,000**	**$15,000**	**$20,000**	$_____
Child	**$2,500**	**$ 5,000**	**$ 7,500**	**$10,000**	$_____

*If spouse is included in dependent coverage: Name _____ Date of birth _____

NOTE: Coverage is only offered and available to eligible Dependents who are authorized to reside in the United States.

- I hereby apply for the group insurance coverage for which I and my dependents, if any, are eligible and available under AUL's policy. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by AUL.
- I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.
- The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the 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. Any insurance coverage or benefits are contingent upon any statements made to AUL as being complete and correct and 2. Benefits under any policy will be paid only if AUL decides in its discretion the applicant is entitled to them. The undersigned have read, understand, and retained the notices, limitations, and exclusions for his/her records.
- **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.**

Date: _____ **Signature of Applicant:** _____

MUST BE COMPLETED BY THE EMPLOYER

Group Policy #: 00610712-0164	Class # :	FT Hired Date:	Occupation:
SalaryMode: [ ] Hourly [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [X] Annually			