# Huron–Erie School Employee Insurance Association
## Employee Application/Change Form

MMO Group Number: 569036 Section #: _____

DELTA Group Number: 1306 Section #: _____

MMO Effective date: _____ DELTA Effective date: _____

### EMPLOYEE INFORMATION

| Last Name: | First Name: | Middle Initial: | Hire Date: | Employment Status: |
|---|---|---|---|---|
| Address: | City: | State: | Zip: | Active ☐ |
| Home Phone: ( ) | Work Phone: ( ) | Male ☐ Female ☐ | Married ☐ Unmarried ☐ | Retired ☐ COBRA ☐ |

### B. COVERAGE INFORMATION

☐ New Enrollment — Reason : ☐ New Employee ☐ Rehired ☐ Open Enrollment ☐ Employment Eligibility Change Explain _____

☐ Change in Enrollment — Reason: ☐ Marriage: Date_____ ☐ Birth/Adoption: Date _____ ☐ Divorce/Death: Date _____ ☐ Open Enrollment ☐ Dependent Change: Date _____ ☐ Loss of coverage: Date _____ ☐ Other _____

### C. COVERAGE WAIVER

☐ Waive Enrollment — I do not want to be enrolled in: ☐ Medical /Drug ☐ Dental

### D. MEDICAL AND DENTAL ENROLLMENT

| Add | Drop | Relationship | Last Name | First Name, MI | Birth Date | Social Security No. | Gender Male | Gender Female | Benefit Selection Medical | Dental | Vision | Drug |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Employee | | | / / | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Spouse ** | | | / / | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Child ☐☐ Step | | | / / | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Child ☐☐ Step | | | / / | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Child ☐☐ Step | | | / / | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Child ☐☐ Step | | | / / | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | Child ☐☐ Step | | | / / | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Child over the dependent age limit applying due to a disability: Onset of Disability Date: Dependent's Name:

### E. PRIOR AND OTHER COVERAGE INFORMATION (including Medicare) YES NO

If yes, who was covered? ☐Employee ☐ Spouse ☐Dependent children Date coverage began ___/___/___ Date ended ___/___/___

### F. OTHER COVERAGE INFORMATION (including Medicare) ***ALL SPOUSES MUST COMPLETE A COB QUESTIONNAIRE***

| Policy holder Name(s): | Medical Ins. Co. Name: | ID or Policy Number | Other Coverage applies to: |
|---|---|---|---|
| | | | ☐ Employee ☐Med ☐Dental ☐Vision ☐Drug<br>☐ Spouse/DP ☐Med ☐Dental ☐Vision ☐Drug<br>☐ Child(ren) ☐Med ☐Dental ☐Vision ☐Drug |

**SIGNATURE REQUIRED ON BACK**

**G. MEDICAL PLANS: Please select the Plan you want (Put an X beside your choice.**

*Please see reverse side.*

**$500 Deductible Plan** ☐ **$750 Deductible Plan** ☐

**Premium Savings Plan** ☐ **Minimum Value Plan** ☐

**Terms and Conditions**

I hereby apply for the coverage indicated on this application:
I authorize: (1) payroll deduction(s) and remittance of any required contribution for my coverage to Medical Mutual, any affiliates or division of medical Mutual, and/or the sponsor of my group Health plan; (2) release of information, without limitation, from any medical/medically-related facility, prior health carrier, the Medical Information Bureau (MIB), government agency or person to Medical Mutual and/or any affiliates or division of Medical Mutual: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities; and/or credentialing purposes. I authorize Medical Mutual and/or the sponsor of my group health plan to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

My dependents and I understand and agree that any information obtained will not be release by Medical Mutual to any person or organization, except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any Application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. My revocation must be in writing. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application or a pending insurance action.

I understand and acknowledge that this authorization extends to all medical records, including records that may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.

**Signature**

I have read all of the statements contained in this Application and declare by signing this Application that I am an active, eligible, compensated, benefit-eligible employee of HESE and that the information I have provided is true and complete to the best of my knowledge.

**Employee Signature** _____ **Date signed** _____ ____ _____

Note: Any person who, with 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 is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

Rev 9/28/21

**REQUIRED DOCUMENTATION:**
**FOR SPOUSE:**

Copy of marriage certificate; and
Copy of either (1) front page of federal tax return (2) recent household document (recurring monthly bill, bank statement; and Completed Working Spouse Certificate Form (if applicable)

**FOR CHILDREN(Up to age 26 and disabled children)**

Copy of child's birth certificate/hospital birth record or adoption certificate, or court order For stepchildren only, the above documentation for a spouse

**SPOUSE ELIGIBILITY CERTIFICATION**
**[School District]**
**a member of Huron-Erie School Employee Insurance Association**
**THIS PAGE TO BE COMPLETED BY [SCHOOL DISTRICT] EMPLOYEE – PLEASE PRINT**

**DISTRICT EMPLOYEE INFORMATION:**

_____ _____
FULL NAME SOCIAL SECURITY NUMBER

**SPOUSE INFORMATION:**

_____ _____ _____
FULL NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

My Spouse is (check ***one***): _____ Not employed _____ Employed (including self-employed)
_____ Sole Proprietor _____ Employed by another HESE District (provide name)
Other HESE District _____
Name

_____ Retired _____ _____ Other _____
Date

If retired, Retirement Plan_____
Name

**IF YOUR SPOUSE IS NOT EMPLOYED OR IS A SOLE PROPRIETOR, STOP, sign below and return form. Otherwise, complete and have your spouse's employer/retirement plan, or your spouse if self-employed but not a sole proprietor, complete all applicable sections of this form.**

** Is group health insurance or prescription drug insurance available to your spouse through his/her employment (whether as a current employee or retiree) or retirement plan?*

_____ *YES* _____ *NO*

**Regardless of your answer, your spouse must have his/her employer/retirement plan, or your spouse himself/herself if self-employed but not a sole proprietor, complete the Employer/Retirement Plan information on the next page.**

The District requires that if your spouse is eligible to participate, as a current employee, self-employed individual (other than a sole proprietor) in a business or organization (e.g., partner, member), or retiree in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or any retirement plan, your spouse must enroll for coverage in such employer, business, organization, or retirement plan sponsored group insurance coverage(s). Any spouse who fails to enroll in any such group insurance coverage, as required by this Section, shall be ineligible for benefits under such group insurance coverage sponsored by the District. The information contained in this Certification will be utilized in making a determination regarding your spouse's eligibility to receive benefits through the District's group medical and prescription drug insurance coverage.

Please note it is your responsibility to advise the District immediately (and not later than 30 days after any change in eligibility) if your spouse becomes eligible to participate in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization or retirement plan after the date you submit this Certification. Upon becoming eligible, your spouse must enroll in such insurance(s) and upon such enrollment by your spouse, the District's group insurance will become the secondary payer of benefits according to the primary plan's coordination of benefits and participation rules. If you submit false information in this Certification or fail to timely advise the District of a change in your spouse's eligibility for employer (or business, organization or retirement plan) sponsored group health insurance and/or prescription drug insurance, and such false information or such failure by you results in the provision of benefits to which your spouse is not entitled, you will be personally liable for reimbursement of benefits and expenses, including attorneys' fees and costs. Any amount to be reimbursed by you may be deducted from the benefits to which you would otherwise be entitled. In addition, your spouse will be terminated immediately from group health insurance and/or prescription drug insurance coverage provided by the District. **If you submit false information in this Certification, you may be subject to disciplinary action by the District, up to and including termination of employment.**

**DISTRICT EMPLOYEE CERTIFICATION:**

**I HEREBY CERTIFY THAT THE ABOVE EMPLOYEE AND SPOUSE INFORMATION IS CORRECT,** and understand that, to ensure benefits are coordinated properly between plans, verification of the accuracy of information will be determined through audits. My spouse's employer/retirement plan and I may be contacted.

_____ _____
**EMPLOYEE'S SIGNATURE & DATE (Required)** **AREA CODE/PHONE NUMBER**

**EMPLOYEE'S FULL NAME (PRINTED):** _____

**THIS PAGE TO BE COMPLETED BY EMPLOYER/RETIREMENT PLAN OF SPOUSE OF [SCHOOL DISTRICT] EMPLOYEE**

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER/RETIREMENT PLAN NAME: _____

SPOUSE'S EMPLOYER/RETIREMENT PLAN MAILING ADDRESS: _____

_____

* Do you offer group health insurance and/or prescription drug insurance (including, but not limited to, insurance requiring employee premium contributions):

(a) To employees? _____ YES _____ NO (b) To retirees? _____ YES _____ NO

Is this spouse (your employee) eligible to participate? _____ YES _____ NO

If no, explain why:

_____

If no, did you pay this spouse (your employee) to waive coverage with you? _____ YES _____ NO

* How many hours per week does this spouse (your employee) regularly work with you? _____

**HEALTH INSURANCE PLAN INFORMATION**
(for the Plan in which this spouse/your employee is enrolled)

PLAN TYPE: ☐ Traditional, PPO or POS ☐ HMO ☐ HRA ☐ HSA

PLAN/GROUP # _____ EFFECTIVE DATE OF COVERAGE: _____

INSURANCE COMPANY/TPA NAME: _____

MAILING ADDRESS: _____

**SINGLE COVERAGE COST ONLY:**

MONTHLY EMPLOYER COST $_____ MONTHLY EMPLOYEE COST $_____ or _____%

**PRESCRIPTION DRUG PLAN INFORMATION** (If separate from Health Insurance)

PLAN/GROUP # _____ EFFECTIVE DATE OF COVERAGE: _____

INSURANCE COMPANY/PBM NAME: _____

MAILING ADDRESS: _____

**SINGLE COVERAGE COST ONLY:**

MONTHLY EMPLOYER COST $_____ MONTHLY EMPLOYEE COST $_____ or _____%

**EMPLOYER/RETIREMENT PLAN CERTIFICATION**
**I HEREBY CERTIFY THE ABOVE EMPLOYER/RETIREMENT PLAN INFORMATION IS CORRECT.**

_____ _____
**EMPLOYER/RETIREMENT PLAN SIGNATURE** **PRINTED NAME AND TITLE**

_____ _____
**AREA CODE/PHONE** **DATE**

(11-2021)

***ATTENTION [SCHOOL DISTRICT] EMPLOYEE: PLEASE RETURN THE COMPLETED CERTIFICATION TO THE TREASURER'S OFFICE.***

*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®

# Could your family meet its expenses if you or your spouse died unexpectedly?

24 million U.S. households (22 percent) have no life insurance protection at all.[1]

44 percent of all U.S. households (48 million) either don't own life insurance and believe they should, or own life insurance and believe they need more. Among those that already own some life insurance, 40 percent believe they don't have enough.[1]

Of households with insurance, approximately 12 percent would immediately have trouble meeting everyday living expenses, and another 15 percent would have difficulty keeping up with expenses after several months.[1]

Here is your opportunity to apply for voluntary group term life insurance coverage for you and your family, under a group life insurance policy issued to your employer by American United Life Insurance Company® (AUL), a OneAmerica® company. AUL's contract offers[2] :

- Convenience of payroll deduction
- Affordable premium rates
- Guaranteed issue amount of coverage[3]
- Accidental death and dismemberment benefits
- Waiver of premium benefit
- Accelerated life benefit
- Continuation of Insurance options and portability
- Guaranteed increase in benefit
- Family status change
- Additional AD&D benefits: Seat Belt, Air Bag, Repatriation, Child Higher Education, Child Care, Paralysis/Loss of Use, Severe Burns

---

1 LIMRA International (2005): Facts About Life 2005, (p.1)

2 This invitation to inquire allows eligible employees an opportunity to inquire further about group insurance coverage and is limited in its description of the losses for which benefits may be payable. The contract has exclusions, limitations, reduction of benefits, and terms under which the contract may be continued in force or discontinued. The contract may contain a waiting or elimination period between the effective date of the contract and the effective date of coverage, and between the date a loss occurs and the date benefits begin to be payable for the loss. Any payable benefit is based on a percentage of an insured's coverage earnings subject to AUL's approval, contract maximums, reduction by other income benefits and according to contract terms and conditions.

3 If an employee does not apply timely and/or applies for an amount greater than the guaranteed issue amount, coverage will not be available until after undergoing medical underwriting and receiving written approval from AUL.

*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®

# AUL's Group Voluntary Term Life and AD&D Insurance Coverage for Eligible Employees

| | |
|---|---|
| **Guaranteed issue amount: $150,000** | If you are eligible and you enroll timely, you will be able to apply for coverage up to the guaranteed issue amount without providing Evidence of Insurability. Any amount of coverage requested as a late enrollee or in excess of the guaranteed issue amount will first require medical underwriting and written approval by AUL. If approved, coverage will become effective on the date identified by AUL. |
| **Flexible choices** | You may apply for a flat benefit amount of group life insurance coverage in increments of $1,000, in a minimum amount of $10,000, and up to a maximum amount of $300,000. |
| **Accidental death and dismemberment (AD&D) benefits** | If approved for this benefit, additional life insurance benefits may be payable for you or a dependent(s) who have an accident which results in death or dismemberment as defined in the contract. |
| **Accidental death and dismemberment (AD&D) with seat belt and air bag benefit** | If approved for this benefit, after the employee and or his dependent(s) suffers a loss under the contract as a result of an automobile accident while properly wearing a seat belt and an air bag deploys properly, an additional amount may be payable under the contract. |
| **Guaranteed increase in benefit (GIB)** | If eligible, you may apply for an additional amount of coverage offered by AUL at each AUL approved scheduled enrollment period without providing Evidence of Insurability. You can increase your coverage annually by the greater of of 10% or $10,000. |
| **Family status change** | If eligible and a qualifying event has occured, you may apply for an additional amount of coverage for the event. |
| **Waiver of premium benefit** | If eligible under the insurance contract and approved for this benefit, AUL will waive premium payments for your coverage while you remain totally disabled. |
| **Accelerated life benefit** | If eligible for this benefit, you or your spouse may apply for payment of 25%, 50% or 75% of the amount of life insurance coverage. A benefit is also payable due to cognitive impairment or loss of ADL. |
| **Portability** | You may be eligible to apply for continuation of coverage should your coverage terminate. Approval for this benefit will extend your coverage for an additional period of time. |
| **Continuation of insurance** | You may be eligible to request continuance of insurance should you take a temporary leave of absence or if you are on temporary layoff. |
| **Eligible employees** | An eligible employee is a full-time employee legally authorized to work and reside in the US. If you are not actively at work on the contract effective date, group insurance coverage will not exist until you return to full-time active work. |
| **Evidence of insurability** | If you do not enroll timely, or if amounts of coverage greater than the guaranteed issue amount are requested, you will be required to provide a statement or proof of medical history. AUL will then review that information to determine if coverage can be approved. |
| **Suicide limitation** | The certificate of insurance contract contains a Suicide Limitation. This limitation may vary by state. |

## Premiums for Voluntary Term Life and matching ADD Coverage

# EMPLOYEE COVERAGE

**Guarantee Issue: $150,000**
**Use age as of 01/01 of the current year**

Premiums will be deducted once a **MONTH** for employees

| | 0 - 29 | 30 - 34 | 35 - 39 | 40 - 44 | 45 - 49 | 50 - 54 | 55 - 59 | 60 - 64 | 65 - 69 | 70+ |
|---|---|---|---|---|---|---|---|---|---|---|
| $10,000 | $0.75 | $0.75 | $0.95 | $1.35 | $1.95 | $3.25 | $5.25 | $6.95 | $10.45 | $24.15 |
| $20,000 | $1.50 | $1.50 | $1.90 | $2.70 | $3.90 | $6.50 | $10.50 | $13.90 | $20.90 | $48.30 |
| $25,000 | $1.88 | $1.88 | $2.38 | $3.38 | $4.88 | $8.13 | $13.13 | $17.38 | $26.13 | $60.38 |
| $30,000 | $2.25 | $2.25 | $2.85 | $4.05 | $5.85 | $9.75 | $15.75 | $20.85 | $31.35 | $72.45 |
| $40,000 | $3.00 | $3.00 | $3.80 | $5.40 | $7.80 | $13.00 | $21.00 | $27.80 | $41.80 | $96.60 |
| $50,000 | $3.75 | $3.75 | $4.75 | $6.75 | $9.75 | $16.25 | $26.25 | $34.75 | $52.25 | $120.75 |
| $60,000 | $4.50 | $4.50 | $5.70 | $8.10 | $11.70 | $19.50 | $31.50 | $41.70 | $62.70 | $144.90 |
| $70,000 | $5.25 | $5.25 | $6.65 | $9.45 | $13.65 | $22.75 | $36.75 | $48.65 | $73.15 | $169.05 |
| $75,000 | $5.63 | $5.63 | $7.13 | $10.13 | $14.63 | $24.38 | $39.38 | $52.13 | $78.38 | $181.13 |
| $80,000 | $6.00 | $6.00 | $7.60 | $10.80 | $15.60 | $26.00 | $42.00 | $55.60 | $83.60 | $193.20 |
| $90,000 | $6.75 | $6.75 | $8.55 | $12.15 | $17.55 | $29.25 | $47.25 | $62.55 | $94.05 | $217.35 |
| $100,000 | $7.50 | $7.50 | $9.50 | $13.50 | $19.50 | $32.50 | $52.50 | $69.50 | $104.50 | $241.50 |
| $110,000 | $8.25 | $8.25 | $10.45 | $14.85 | $21.45 | $35.75 | $57.75 | $76.45 | $114.95 | $265.65 |
| $120,000 | $9.00 | $9.00 | $11.40 | $16.20 | $23.40 | $39.00 | $63.00 | $83.40 | $125.40 | $289.80 |
| $125,000 | $9.38 | $9.38 | $11.88 | $16.88 | $24.38 | $40.63 | $65.63 | $86.88 | $130.63 | $301.88 |
| $130,000 | $9.75 | $9.75 | $12.35 | $17.55 | $25.35 | $42.25 | $68.25 | $90.35 | $135.85 | $313.95 |
| $135,000 | $10.13 | $10.13 | $12.83 | $18.23 | $26.33 | $43.88 | $70.88 | $93.83 | $141.08 | $326.03 |
| $140,000 | $10.50 | $10.50 | $13.30 | $18.90 | $27.30 | $45.50 | $73.50 | $97.30 | $146.30 | $338.10 |
| $150,000 | $11.25 | $11.25 | $14.25 | $20.25 | $29.25 | $48.75 | $78.75 | $104.25 | $156.75 | $362.25 |
| $175,000 | $13.13 | $13.13 | $16.63 | $23.63 | $34.13 | $56.88 | $91.88 | $121.63 | $182.88 | $422.63 |
| $200,000 | $15.00 | $15.00 | $19.00 | $27.00 | $39.00 | $65.00 | $105.00 | $139.00 | $209.00 | $483.00 |
| $250,000 | $18.75 | $18.75 | $23.75 | $33.75 | $48.75 | $81.25 | $131.25 | $170.75 | $261.25 | $603.75 |
| $300,000 | $22.50 | $22.50 | $28.50 | $40.50 | $58.50 | $97.50 | $157.50 | $208.50 | $313.50 | $724.50 |

*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®

# AUL's Group Voluntary Term Life Insurance Coverage Available to Eligible Dependents

## Amount of Coverage Offered

The amount of coverage for eligible dependents cannot exceed 100% of the employee's voluntary life insurance amount of coverage. Spouse and child(ren) coverage must be from the same option. Coverage is only offered and available to eligible Dependents who are authorized to reside in the United States. **The voluntary insurance coverage is distinct and separate from any insurance coverage you may receive from the school board.**

**Accelerated Life Benefit for Spouse**

**Suicide Limitation**

**Portability Option (If Employee continues coverage under this option)**

**Conversion Options**

## Eligible Dependents

Any coverage for a spouse or child(ren) cannot become effective before the employee's coverage is approved. If a spouse or child is confined in any medical facility, rehabilitation center, convalescent care facility, nursing home, or correctional facility on the date an employee's coverage is approved, that dependent coverage will not become effective until the spouse or child is released from such confinement and pursuant to the contract provisions.

## Dependent Voluntary Term Life Insurance Options[1]

| Dependent Type | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| Spouse | $5,000 | $10,000 | $15,000 | $20,000 |
| Dependent Child(ren) - live birth to age 26 | $2,500 | $5,000 | $7,500 | $10,000 |
| **MONTHLY Dependent Group Voluntary Term Life Insurance Premiums[1]** | | | | |
| Family | $2.00 | $4.00 | $6.00 | $8.00 |

* Age and Definition of Child(ren) may vary by state.

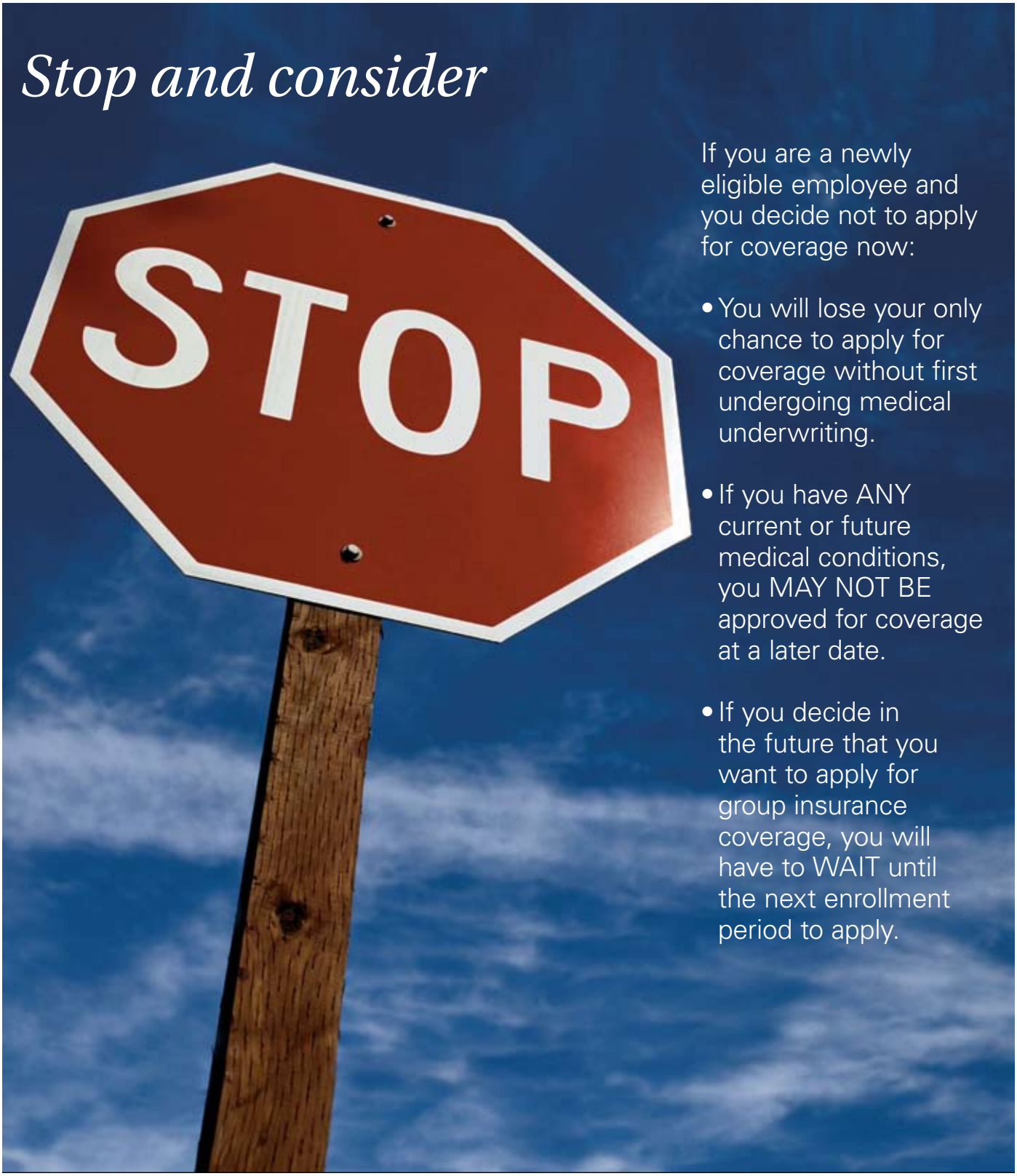
[1]Coverage for child(ren) and spouses does terminate when they are no longer classified as dependents.

*Rev. 04/07*

ONEAMERICA®

*Employee Benefits*

# *Stop and consider*




If you are a newly eligible employee and you decide not to apply for coverage now:

- You will lose your only chance to apply for coverage without first undergoing medical underwriting.
- If you have ANY current or future medical conditions, you MAY NOT BE approved for coverage at a later date.
- If you decide in the future that you want to apply for group insurance coverage, you will have to WAIT until the next enrollment period to apply.

*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 | (317) 285-1877 | www.oneamerica.com*

G-17963 11/2/07

# Group Enrollment Form

GRADYBENEFITS

*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: | Applicant's Residential Zip Code: | Gender: ☐ Male ☐ Female |
| Date of Birth: | Marital Status: ☐ Single ☐ Married | Employer: | |
| Employed Full-Time: ☒ Yes ☐ No | Hours worked per week: | Employer's City: | State: |
| | 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/AD&D $_____

[ ] *Voluntary Term Dependent Life Coverage

| | [ ] Option 1 | [ ] Option 2 | [ ] Option 3 | [ ] Option 4 |
|---|---|---|---|---|
| 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 | Class # : | FT Hired Date: | Occupation: |
| Salary | Mode: [ ] Hourly [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [X] Annually | | |

# Notices and Limitations for Group Life and Disability Insurance Products

*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*
*www.oneamerica.com*

ONEAMERICA®

## Eligibility for Coverage [1]:

An eligible Employee is a full-time Employee legally authorized to work and reside in the United States. Eligible Employees cannot be considered a part-time, temporary or seasonal Employee. If any eligible Employee is not Actively at Work on the contract Effective Date, group insurance coverage for that Employee will not exist until he/she returns to full-time active work. After the initial enrollment period, an Employee may apply for coverage under another available AUL coverage option during an AUL approved scheduled enrollment period. However, any amount of coverage requested will then require satisfactory Evidence of Insurability prior to approval.

## (The Following Paragraph Applies to Life Coverages Only.)

Any coverage for a spouse or children cannot become effective before the Employee's coverage is approved. If a spouse or child is confined in a medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility on the date an employee's coverage is approved, that dependent coverage will not become effective until the spouse or child is released from such confinement and pursuant to the contract provisions. Before coverage for any incapacitated Dependent child older than the normal termination age can be considered, the Employee must apply in writing to AUL before or on the Employee's Effective Date of coverage.

## Community Property Notice:

The laws of some community property states may not allow an Employee to name a beneficiary other than his/her spouse without the spouse's written consent. Community property states currently include Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington, and Wisconsin. If AUL has not previously received written notice of a community property interest, then AUL shall be entitled to rely upon its good faith that no such interest exists. AUL assumes no responsibility of inquiry regarding such interest and, in consideration of acknowledgement of this designation, the insured person, for himself/herself and his/her estate, heirs, successors and assigns, agrees to indemnify AUL and hold it harmless from the consequences of acknowledging this beneficiary designation.

## Effective Date and Claims Payment Notice:

No insurance coverage shall exist or become effective until approved in writing by American United Life Insurance Company® (AUL) at its Indianapolis, Indiana home office. Coverage continues while required premiums are paid and the Employer receives coverage under the AUL group insurance contract. Premium rates do increase upon reaching certain age brackets, according to contract terms, and are subject to change. AUL shall not be liable or responsible for any loss incurred prior to the effective date of coverage for any insured. Any benefit payable under the contract is based on a percentage of an Employee's covered earnings subject to AUL's approval, contract maximums, contract reductions, and according to contract terms and conditions.

## Arbitration Notice, if Applicable [2]:

**Coverage under the group insurance contract for which you have applied may include a binding or nonbinding arbitration agreement. The arbitration agreement requires that any disagreement related to this contract must first be resolved by arbitration and not in a court of law. The results of the arbitration can be final and binding on you and the insurance company. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties. When you accept coverage under this insurance contract you agree to first resolve any disagreement related to the contract by arbitration instead of a trial in court including a trial by jury (note that some states may not allow mandatory arbitration). Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator often cannot be reviewed in court by a judge and jury.**

## Required Notices Regarding Certain Contract Limitations [3] and Exclusions [4]

## Life Limitations/Exclusions:

## Suicide Limitation, if Applicable, Except for Washington Residents:

If any insured approved for coverage, commits suicide, while sane or insane:[5] 1) within two years[6] from the effective date of this policy, the benefits payable will be limited to the premiums paid; or 2) two or more years after the effective date of this policy, but within two years of the effective date of an increase in the amount of coverage previously obtained, the benefits payable will be limited to the coverage obtained prior to the effective date of the increase, if any, plus the premiums paid for the increased coverage.

1 Any coverage offered by AUL prior to and after the Effective Date of coverage is contingent upon information and documents received by AUL being accurate and reliable.
2 Contracts covering insureds residing in KS, LA, MO, MT, NE, OK and SD do not have arbitration provisions. Contracts covering insureds residing in AR, CA, CT, FL, ME, NJ, NM, VA, WA, WV and WY do not have binding arbitration provisions. Contracts covering insureds in KY and NH do not allow any type of arbitration in Life Insurance and Annuity contracts. Contracts in TX do not include an arbitration provision.
3 Limitations may vary by state.
4 The policy has exclusions, limitations, reduction of benefits, and terms under which the policy may be continued in force or discontinued. The policy may contain a waiting or elimination period between the effective date of the policy and the effective date of coverage, and a time period between the date a loss occurs and the date benefits begin to be payable for the loss.
5 In Colorado suicide/attempted suicide while insane does not apply.
6 1 year for insureds residing in Colorado and North Dakota; 1 year suicide for insureds in Missouri may apply.



G-14320 (05 Prudent) 03/24/2010

## Accelerated Life Benefit, if Applicable:

Certain insured individuals diagnosed with a terminal condition may be eligible to request payment of an Accelerated Life Benefit under the group life insurance contract. A terminal condition is an injury or sickness that despite appropriate medical care is reasonably expected to result in the Person's death within a specified time frame following the date of the Accelerated Life Benefit payment, as determined by AUL. After payment of Accelerated Life Benefits, the amount of the Person's life insurance payable at death to the Person's beneficiary will equal the amount of the Person's life insurance if no Accelerated Life Benefit payment had been made minus the amount of the Accelerated Life Benefit payment minus an interest charge.

The Accelerated Life Benefit offered under the contract may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as the Person's life expectancy at the time benefits are accelerated or whether the Person uses the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Life Benefits qualify for favorable tax treatment, the benefits will be excludable from the Person's income and not subject to federal taxation. Tax laws relating to Accelerated Life Benefits are complex. The Person is advised to consult with a qualified tax advisor about circumstances under which he/she could receive Accelerated Life Benefits excludable from income under federal law.

Receipt of Accelerated Life Benefits may affect a Person's, his/her spouse's, or his/her family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. The Person is advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect a Person's, his/her spouse's, or his/her family's eligibility for public assistance.

## Disability Limitations/Exclusions:

## Pre-existing Condition Limitation:

Certain disabilities are not covered if the cause of the disability is traceable to a condition existing prior to the insured's effective date of coverage. A pre-existing condition is any condition for which an ordinarily prudent person would ordinarily have done any of the following at any time, during the period of time stated in the contract, whether or not that condition is diagnosed at all or is misdiagnosed during that period of time: a) received medical treatment or consultation; b) taken or were prescribed drugs or medicine; or c) received care or services, including diagnostic measures. Insureds must also be treatment-free for a time-frame specified in some contracts following the individual effective date of coverage.

## Fraud Notice:

**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.**

**In OHIO any person who, with 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 is guilty of insurance fraud.**

# Call Your ComPsych® GuidanceResources® program anytime for confidential assistance.

Call: **855.387.9727**
Go online: **guidanceresources.com**
TDD: 800.697.0353
Your company Web ID: **ONEAMERICA3**

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Your GuidanceResources program provides support, resources and information for personal and work-life issues. The program is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

## Confidential Counseling

*3 Session Plan*

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 3 sessions per issue per year) and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

## Financial Information and Resources

*Discover your best options.*

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

## Legal Support and Resources

*Expert info when you need it.*

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

## Work-Life Solutions

*Delegate your "to-do" list.*

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

## GuidanceResources® Online

*Knowledge at your fingertips.*

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

## Free Online Will Preparation

*Get peace of mind.*

EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify your wishes for your property
- Provide funeral and burial instructions

**Program starts January 1, 2016.**

ONEAMERICA®

*OneAmerica is the marketing name for American United Life Insurance Company(R) (AUL). AUL markets ComPsych services. ComPsych Corporation is not an affiliate of AUL and is not a OneAmerica company.*



## Your ComPsych® GuidanceResources® Program

CALL ANYTIME
Call: **855.387.9727**
TDD: 800.697.0353
Online: **guidanceresources.com**
Your company Web ID: **ONEAMERICA3**

# *Travel Assistance Services*

## provided by Europ Assistance USA

Emergencies can happen away from home – now there are certain services available when you travel. When an emergency occurs, especially when traveling, you need help that is fast and simple.

With a phone call to Europ Assistance USA (EA USA)[1], covered persons have access to worldwide 24-hour medical and transportation services when traveling, business or personal, 100 or more miles away from home during a covered trip at no additional premium cost to the covered policyholder.[2]

### What is a covered person?

A covered person[2] is an individual who receives coverage under a covered policyholder's AUL group life insurance contract and the individual's spouse, domestic partner and children. The Travel Assistance benefit applies to covered persons who are traveling 100 miles or more away from home during a covered trip.

### What is a covered trip?

A covered trip is defined as a business or pleasure trip of not more than 90 days in length. EA USA offers and administers the program and services in most countries.[3]

EA USA can also provide Pre-Trip Assistance services to help prepare and plan for a covered person's trip.


For more information on the services offered under EA USA's Travel Assistance program, an EA USA representative can be contacted at 1-866-294-2469 or via e-mail at *OPS@europassistance-usa.com.*

**1.** *EA USA is neither affiliated nor under common control with OneAmerica or AUL, and AUL only markets the EA USA program.*

**2.** *A covered person does not include an individual who has been approved for continuation of insurance or portability benefits, an individual insured under AUL's 2+ Protector contract or an individual insured under AUL's Voluntary Universal Life insurance contract. The program and services are not offered or available to individuals who are not covered persons and may be terminated or discontinued at any time.*

**3.** *However, conditions and events such as force majeure, war, natural disasters or political instability may occur or exist that render assistance and services difficult or impossible in some areas. Therefore, availability of services cannot always be guaranteed or offered.*





*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 | (317) 285-1877 | www.oneamerica.com*

G-21420 07/12/11

Covered persons have access to numerous travel assistance services[4] offered by EA USA, and these services are further outlined in EA USA's brochure.[5] For more information, please visit EA USA's Website at *www.europassistance-usa.com*.

**Should a covered person desire to utilize the travel assistance services of EA USA, the covered person will first need to do the following:**

1. From the United States and Canada, call an EA USA representative at the dedicated toll-free line at 1-866-294-2469.

2. From other locations, please call collect at +1 240 330 1509. Provide contact name and phone number of the covered policyholder.

3. Allow EA USA to verify the covered person's eligibility.

Travel emergencies can happen any time, EA USA is there.

**4.** *Neither EA USA nor AUL shall have responsibility for the nature, content or quality of any medical advice or legal counsel given by any medical professional or attorney, nor shall EA USA or AUL be liable for the negligence or other wrongful acts or omissions of any healthcare or legal professionals providing direct services to covered persons.*

**5.** *Eligibility must always first be verified by EA USA through the covered policyholder's designated contact.*



*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 | (317) 285-1877 | www.oneamerica.com*

G-21420 07/12/11