

State: Arkansas Filing Company: American United Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: Group Cover Page
Project Name/Number: /

Filing at a Glance

Company: American United Life Insurance Company
Product Name: Group Cover Page
State: Arkansas
TOI: H11G Group Health - Disability Income
Sub-TOI: H11G.004 Other
Filing Type: Form
Date Submitted: 07/19/2012
SERFF Tr Num: AULD-128586450
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num: G-23985 - HEALTH

Implementation: On Approval
Date Requested:
Author(s): Angie Neville, Cathy Strong
Reviewer(s): Donna Lambert (primary)
Disposition Date: 07/19/2012
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: American United Life Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.004 Other
Product Name: Group Cover Page
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General Information

Project Name: Status of Filing in Domicile: Authorized
Project Number: Date Approved in Domicile: 06/07/2012
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 07/19/2012
State Status Changed: 07/19/2012 Deemer Date:
Created By: Angie Neville Submitted By: Angie Neville
Corresponding Filing Tracking Number:

Filing Description:
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1940

RE:American United Life Insurance Company - NAIC #60895
Group Term Life and Disability Income Insurance
Forms: Request for Coverage when Evidence of Insurability is Required
and Fraud Notices (Life filing under SERFF, AULD-128535408)
Form No.: G-23985 and G-22373

Dear Commissioner Bradford:

The following forms are attached for approval:

- 1)Form G-23985, Request for Coverage when Evidence of Insurability is Required; and
2)Form G-22373, Fraud Notices.

Each of these forms will be used with both the Group Term Life and Group Disability products of American United Life Insurance Company (AUL) on file with your Department. These forms are new and do not replace any existing forms.

These forms will be used at enrollment, along with form G-23223-EOI previously approved by your Department on October 10, 2011 under SERFF Filing No. AULD-127685512, to medically underwrite individuals who apply for:

- an amount of coverage above the Guaranteed Issue amount;
·coverage as a Late Enrollee; or
·a change in coverage (except that a decrease in coverage does not require the completion of the Medical Questions in Form G-23223-EOI).

A copy of Form G-23223-EOI has been attached for informational purposes only.

Variable language has been marked with brackets to allow for flexibility. If this language is changed, it will never be less favorable than your state's laws allow.

This form will also be issued in conjunction with form I-19080, AUL's Notice of Insurance Information Practices form, which

State: Arkansas Filing Company: American United Life Insurance Company
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was previously approved by your Department on August 1, 2007 under SERFF Filing No. AULD-125243079. A copy of this form is also attached for informational purposes only.

Please acknowledge approval of this form via SERFF.

Should you have any questions concerning this filing, please call me at 1-877-285-7660, ext. 1943 or e-mail me at productcompliance.corporatecompliance@oneamerica.com. Thank you for your assistance with this filing.

Sincerely,

Catherine S. Strong
Sr. Contract Analyst
Corporate Contracts and Compliance

Company and Contact

Filing Contact Information

Cathy Strong, Sr. Contract Analyst Cathy.Strong@OneAmerica.com
One American Square 317-285-1943 [Phone]
Indianapolis, IN 46206 317-285-5510 [FAX]

Filing Company Information

American United Life Insurance CoCode: 60895 State of Domicile: Indiana
Company Group Code: 619 Company Type:
One American Square Group Name: State ID Number:
P.O. Box 7127 FEIN Number: 35-0145825
Indianapolis, IN 46206
(877) 285-7660 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: \$50.00 per form
Per Company: No

Table with 4 columns: Company, Amount, Date Processed, Transaction #. Row 1: American United Life Insurance Company, \$100.00, 07/19/2012, 61027404

SERFF Tracking #:	AULD-128586450	State Tracking #:		Company Tracking #:	G-23985 - HEALTH
State:	Arkansas	Filing Company:	American United Life Insurance Company		
TOI/Sub-TOI:	H11G Group Health - Disability Income/H11G.004 Other				
Product Name:	Group Cover Page				
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	07/19/2012	07/19/2012

SERFF Tracking #:	AULD-128586450	State Tracking #:		Company Tracking #:	G-23985 - HEALTH
State:	Arkansas	Filing Company:	American United Life Insurance Company		
TOI/Sub-TOI:	H11G Group Health - Disability Income/H11G.004 Other				
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Disposition

Disposition Date: 07/19/2012

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Accepted for Informational Purposes	Yes
Supporting Document	Notice of Practices	Accepted for Informational Purposes	Yes
Supporting Document	Statement of Variables	Approved	Yes
Form	Request for Coverage when Evidence of Insurability is Required	Approved	Yes
Form	Fraud Notice	Approved	Yes

SERFF Tracking #:	AULD-128586450	State Tracking #:		Company Tracking #:	G-23985 - HEALTH
State:	Arkansas	Filing Company:	American United Life Insurance Company		
TOI/Sub-TOI:	H11G Group Health - Disability Income/H11G.004 Other				
Product Name:	Group Cover Page				
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Form Schedule

Lead Form Number: G-23985							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1	Approved 07/19/2012	G-23985	AEF	Request for Coverage when Evidence of Insurability is Required	Initial:	50.200	G-23985 (Bracketed).pdf
2	Approved 07/19/2012	G-22373	NOC	Fraud Notice	Initial:	48.300	G-22373 Fraud Notice.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

**Request for Coverage when
Evidence of Insurability is Required**
(to be submitted with Statement of Insurability)

American United Life Insurance Company®
a ONEAMERICA® company
One American Square
P.O. Box 6123
Indianapolis, IN 46206-6123
(800) 553-5318



Please read the following instructions for completing this form for coverage on yourself or your dependents, if any, for an amount of coverage above the Guaranteed Issue Amount, for coverage as a Late Enrollee, or for a change (increase or decrease) in current coverage:

1. Please **fully and accurately complete** pages 2 and 3 and the separate Statement of Insurability form. **Seek assistance** from your employer for salary definition and coverage options. Incomplete information will result in a delay of processing and, if approved, the date coverage can begin.
2. **Your Signature and date** are required on page 3 of this Request for Coverage. **Signatures and dates** are required on the separate Statement of Insurability form for you and your dependents (if applying for dependent coverage).
3. **Retain** a copy of all pages for your reference and records.
4. Please **mail, fax, or email** completed, signed, and dated pages 2 and 3 and the separate Statement of Insurability form to American United Life Insurance Company® ("Insurer") at the address below:

American United Life Insurance Company®
Attn: Employee Benefits Division, Medical Underwriting Support Unit
P.O. Box 6123
Indianapolis, IN 46206-6123
317-285-7694 (Fax)
MedicalUnderwritingSupport.Grp@OneAmerica.com

Note: Any coverage applied for which requires evidence of insurability will not become effective unless approved and an effective date is assigned by the Insurer, regardless of whether payroll deductions have begun or premium has been submitted to the Insurer. The Insurer has the right to decline coverage for any applicant based on unsatisfactory evidence of insurability. The Insurer is not liable for any loss commencing prior to the date of approval of coverage or change in coverage.

Notices Affecting Coverages

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FORMS FOR THE INSURED'S GROUP INSURANCE.

Please read the notices attached to the Enrollment Form and the insurance contract issued to your employer. If you did not receive a copy of either form, your employer can provide a copy of your Enrollment Form and/or a copy of the employer's insurance contract following written request. Omissions or misstatements in this Request for Coverage, the Enrollment Form and/or Statement of Insurability form may cause an otherwise valid claim to be denied. Carefully check the forms and write to the Insurer within **10 calendar days** of submitting this Request for Coverage if any information communicated to the Insurer changes or is not correct and complete. Any insurance coverage will be issued on the basis that the answers to all questions and any other information submitted to the Insurer is correct and complete.

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.

**Request for Coverage when
Evidence of Insurability is Required**
(to be submitted with Statement of Insurability)

American United Life Insurance Company®
a ONEAMERICA® company
One American Square
P.O. Box 6123
Indianapolis, IN 46206-6123
(800) 553-5318



A. Employer/Employee Identification

(Note: Any missing information on this Request for Coverage will delay processing and the potential effective date.)

1. Name of Employer:		2. Group Number:	
3. Employee Name (Last, First, Middle):		4. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Home Address:		City:	State: Zip:
6. Date of Birth:	7. Occupation:		8. State/Country of Birth:
9. Home Phone:	10. Work Phone:	11. Cell Phone:	
12. Social Security Number:	13. Date of hire with above employer:	14. # of hours worked per week:	
15. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil Union			
16. Annual Salary (Please contact your employer for assistance with amount per contract definition): \$ _____ / yr.			
17. Email address where the Insurer may contact you:			

B. Coverage or Change Being Requested

Check all coverages or changes being requested and provide full and complete information regarding coverage amount(s)/option(s) being requested, as well as current coverage amount(s)/option(s) in force. Consult your employer for assistance with coverage amounts, class, option numbers, elimination periods, salary multiples, or percentages being requested. Requests for Coverage not offered under the Insurer's contract will not be approved. Coverage can not be less than the minimum or more than the maximum amount allowed under the contract. Payroll deductions or premium payments greater than the amount owed will not result in additional coverage. Payroll deductions prior to the Insurer's approval should be discontinued and will not be a substitute for the Insurer's approval of coverage.

Timely applications for amounts in excess of Guaranteed Issue Amount, as well as late applications and changes in coverage require completion of the Statement of Insurability form. "Coverage Amount Applying for" includes the Current Coverage Amount plus the amount of the desired increase, i.e., if \$100,000 is the Current Coverage Amount and you're asking for \$50,000 additional. "Coverage Amount Applying for" should be shown as \$150,000.

Timely applications are those made at time of first initial enrollment. Late applications or change requests are those made outside of the first initial enrollment.

B. Coverage or Change Being Requested (continued)

Employee:

Coverage Election	Current Coverage Amount/Option in Force	Coverage Amount/Option Applying for
<input type="checkbox"/> Basic Term Life/AD&D*	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Supplemental Term Life/AD&D*	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Short Term Disability	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Long Term Disability	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Voluntary Term Life/AD&D*	Life \$ _____ /Option # _____ AD&D \$ _____ /Option # _____	Life \$ _____ /Option # _____ AD&D \$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Voluntary Disability Short Term	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Voluntary Disability Long Term	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Voluntary Disability Short Term Premier – 66 2/3% of Salary (Option 1) \$100 max/week (Option 2) \$200 max/week (Option 3) \$350 max/week (Option 4) \$500 max/week (Option 5)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> CorePLUS Short Term Disability (Core only)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> CorePLUS Long Term Disability (Core only)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> CorePLUS Short Term Disability (PLUS)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> CorePLUS Long Term Disability (PLUS)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Whole Life (must also complete Application for Life Insurance and Statement of Insurability)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Lump Sum Disability	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change

*AD&D amounts are available only if AUL is offering this Option. Unless otherwise offered by AUL in the contract, the coverage amounts for Voluntary Life/AD&D will mirror each other.

Dependent:

Coverage Election	Current Coverage Amount/Option in Force	Coverage Amount/Option Applying for
<input type="checkbox"/> Basic Dependent Life/AD&D <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Spouse and Children	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Supplemental Term Life/AD&D <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Spouse and Children	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/> Voluntary Term Life/AD&D <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Spouse and Children	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change

The undersigned: 1) represents that the information provided herein is true and complete to the best of my knowledge and belief; 2) certifies the information in this Request for Coverage form, the Enrollment form and the Statement of Insurability form was read and understood prior to the completion of this form; 3) has retained a copy of the notices and materials supplied by the Insurer for my records; and 4) has retained a copy of this form, as well as any other documents provided to or by the Insurer related to this Request for Coverage.

Signature of Insured/Employee

Date

Printed Name of Insured/Employee

Fraud Notices

American United Life Insurance Company®
a ONEAMERICA® company
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
1-800-553-5318
www.oneamerica.com



- 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.
- **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- **District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- **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.
- **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
- **Louisiana and Rhode Island:** 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 is guilty of a crime and may be subject to fines and confinement in prison.
- **Maine:** Any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties may include imprisonment, fines or denial of insurance benefits.
- **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance or knowingly or willfully fails to provide material information in connection with the person's eligibility or continued eligibility for benefits under a disability insurance policy, is guilty of a crime and may be subject to fines and confinement in prison.
- **New Jersey:** Any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties.
- **New Mexico:** 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 is guilty of a crime and may be subject to civil fines and criminal penalties.
- **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.
- **Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- **Pennsylvania:** 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.
- **Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SERFF Tracking #:	AULD-128586450	State Tracking #:		Company Tracking #:	G-23985 - HEALTH
State:	Arkansas	Filing Company:	American United Life Insurance Company		
TOI/Sub-TOI:	H11G Group Health - Disability Income/H11G.004 Other				
Product Name:	Group Cover Page				
Project Name/Number:	/				

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	07/19/2012
Comments:			
Attachment(s):			
READCERT.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Accepted for Informational Purposes	07/19/2012
Comments:			
Attachment(s):			
G-23223-EOI.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Notice of Practices	Accepted for Informational Purposes	07/19/2012
Comments:			
Attachment(s):			
I-19080.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables	Approved	07/19/2012
Comments:			
Attachment(s):			
Statement of Variables - G-22373 Fraud Notices.pdf			
Statement of Variables - G-23985.pdf			

CERTIFICATE OF READABILITY

I, Jay B. Williams, Vice President and Director of Compliance of American United Life Insurance Company, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements.

FORMS

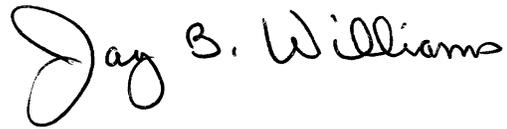
READABILITY SCORE

G-23985

50.2

G-22373

48.3

A handwritten signature in black ink that reads "Jay B. Williams". The signature is written in a cursive style with a large, stylized initial "J".

July 12, 2012

Jay B. Williams
Vice President and Chief Compliance Officer

Statement of Insurability

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
 1-800-553-5318



Section A: Proposed Insured (complete Statement of Insurability)

Proposed Insured Name: _____
 Driver's License Number _____ State where Issued _____
 Height _____ ft. _____ in. Weight _____ lbs. Gained Lost _____ lbs. In Past Year

**Spouse and/or Child(ren) must complete Statement of Insurability if required for Group Coverage.
 Whole Life Insurance Coverage not available for Spouse/Children.**

Spouse/Partner Name (Last, First, Middle) _____ Gender M F Birth Date _____ Birth Place _____
 Driver's License # _____ State where Issued _____
 Height _____ Weight _____ Authorized to Reside in U.S. Yes No

Child Name (Last, First) _____ Relationship to You _____ Full-Time Student Yes No
 Gender M F Birth Date _____ Birth Place _____
 Height _____ Weight _____ Authorized to Reside in U.S. Yes No

Child Name (Last, First) _____ Relationship to You _____ Full-Time Student Yes No
 Gender M F Birth Date _____ Birth Place _____
 Height _____ Weight _____ Authorized to Reside in U.S. Yes No

Child Name (Last, First) _____ Relationship to You _____ Full-Time Student Yes No
 Gender M F Birth Date _____ Birth Place _____
 Height _____ Weight _____ Authorized to Reside in U.S. Yes No

Child Name (Last, First) _____ Relationship to You _____ Full-Time Student Yes No
 Gender M F Birth Date _____ Birth Place _____
 Height _____ Weight _____ Authorized to Reside in U.S. Yes No

Underwriting Information

Section B: Health Questions

1. Within the past 7 years, has any applicant for insurance been diagnosed or treated by a physician or medical professional, tested positive for the presence of, or taken prescribed medicine for the following: (Circle conditions that apply in multi-condition questions, and provide full details to any "yes" response in Section 4.)

	Proposed Insured	Spouse	Children
a. Cancer, malignancy, or tumor of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes, thyroid, or other glandular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chest pain, angina, or heart attack; heart disease/disorder or murmur, peripheral vascular disease, elevated cholesterol or triglycerides?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. High blood pressure or hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Anemia, bleeding disorder, clotting disorder or other blood disease or disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Neurological or brain disorder, seizures, epilepsy, paralysis, multiple sclerosis, ALS or Lou Gehrig's disease, Parkinson's disease, Alzheimer's, other forms of dementia/cognitive disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Stomach or intestinal disorder, Crohn's, irritable bowel disorder, diverticulitis, GERD/reflux?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Kidney, urinary bladder, gallbladder, pancreas, liver disorder or hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Psychological, psychiatric, or emotional disorder, depression, anxiety, stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Lung or respiratory disorder/disease, shortness of breath, asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Neuromuscular, musculoskeletal disorders, lupus, arthritis, neck-, back-, knee- or foot disorders, other joint disorder, fibromyalgia, or chronic fatigue syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Skin or lymph node disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Eye, ear, nose, mouth, or throat disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or any immune deficiency related disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. Prostate or testicular disorder, female reproductive organ disorder, or sexually transmitted disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Authorization and Acknowledgement

I/we authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about me (and my spouse and/or my dependents, if they are to be insured): facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. **This authorization does not authorize the release of genetic screening or testing results.** All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date shown below. In Arizona, this authorization is limited to 180-days for disclosure of HIV-related information. I/we understand that any person requesting to be insured may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made, I/we can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my/our knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) I/we certify that all notices contained herein were read and understood prior to my/our completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgment.

Signatures

Signature of Proposed Insured / Employee *Mo. / Day / Year*

Printed Name of Proposed Insured / Employee

Signature of Spouse / Partner *Mo. / Day / Year*

Printed Name of Spouse / Partner

Signature of Dependent Child Age 18+ *Mo. / Day / Year*

Printed Name of Dependent Child Age 18+

American United Life
Insurance Company®
a ONEAMERICA® company
One American Square
P.O. Box 6003
Indianapolis, IN 46206-6003
1-800-537-6442

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United
Mutual Insurance Holding Company
a ONEAMERICA® company
101 North 10th Street
Fargo, ND 58102
1-800-437-4692

The State Life
Insurance Company
a ONEAMERICA® company
P.O. Box 6062
Indianapolis, IN 46206



For general inquiries call: 1-877-999-9883

**ALWAYS GIVE THIS DOCUMENT
TO THE PROPOSED INSURED UPON HIS/HER SIGNING APPLICATION
OR EVIDENCE OF INSURABILITY FORM**

NOTICE OF INSURANCE INFORMATION PRACTICES

Thank you for your application for insurance. We are glad to have the chance to participate in your insurance program. This notice tells you about the underwriting process. It also tells how information is gathered to review your application. To issue an insurance policy we need to obtain information about you. Some of the information will come from you and some will come from other sources. We need this information to see if you qualify for insurance. When signed, the Authorization and Acknowledgement will allow us to obtain the information and to share it with others when necessary and as permitted by law. No unnecessary disclosures will be made. Information will be treated as confidential by us and by our reinsurers. However, in some cases, information may have to be disclosed to others without your further consent. If permitted by law and after proper identification, you have the right to submit a written request for access to personal information obtained by the company as part of the application for insurance and which is reasonably locatable and retrievable. Within thirty (30) days of the request, the company must respond by allowing you to see, in person, or by copy (a copying charge may be assessed) the requested personal information and by giving you the source(s) of the information. The individual may request correction, amendment or deletion of certain personal information. Within thirty (30) days of said request, the company will correct, amend or delete the requested personal information (and contact the individual of such in writing) or notify the individual of its refusal to make such correction, amendment or deletion and the reason for said refusal. If an individual disagrees with the refusal, the individual can file a concise statement as to what the individual believes is the correct information and the reasons why the individual disagrees with the refusal. This statement will remain in the individual's file. Any revisions made will be sent to those parties that have been provided such information within the past 2 years, insurance support organizations that have received such information in the past 7 years, and any insurance support organization that furnished the personal information that has been corrected, amended or deleted. You have a right to get a copy of any investigative consumer report which is made. If you want to know more about our underwriting practices and your rights, please write to the Privacy Officer, OneAmerica Financial Partners Inc., P.O. Box 368, Indianapolis, Indiana 46206-0368.

MEDICAL INFORMATION BUREAU NOTICE

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We or our reinsurers may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

FAIR CREDIT REPORTING ACT NOTICE

We may request an investigative consumer report. These reports contain information about your character, general reputation, mode of living and health except as may be related directly or indirectly to your sexual orientation. The information may be obtained through interviews with you, your neighbors, friends and others who know you. Upon request, we will give you the name and address of the consumer reporting firm so that you may request a copy of the report.

AUTHORIZATION AND ACKNOWLEDGMENT

I authorize any physician, or medical practitioner, hospital and medical facility, insurance company, DMV, and the MIB to give to any company listed as a OneAmerica® company and its reinsurers any of the following about me or my dependents, if they are to be insured: facts about physical and mental health, medical care, advice or treatment; hobbies, other insurance, flying, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs, and tobacco. Each person proposed for insurance may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the AIDS virus. All sources except the MIB may give these facts to any insurance support organization authorized by a OneAmerica® company to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date I signed the application. I can choose to be interviewed if an investigative consumer report is made. I or my authorized representative can receive a copy of this authorization form.

STATEMENT OF VARIABLES
G-22373

FORM NUMBER	SECTION TITLE	PROVISION/ DESCRIPTION	BRACKETED VARIABLES EXPLANATION
G-22373	Fraud Notices	Company address/phone number	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
"		OneAmerica (logo)	Bracketed for ease in updating the logo in case it is changed.
"	"	Fraud Notice	Bracketed to allow state variations of fraud language as necessary, per state law. State specific language is supplied by the individual states.

STATEMENT OF VARIABLES
G-23985

FORM NUMBER	SECTION TITLE	BRACKETED VARIABLES EXPLANATION
G-23985	Company address/phone number (heading on pages 1 and 2)	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
“	Company address/phone number/ website	Bracketed for ease in updating as need arises should there be a change in the company address, phone number or website
“	Notices Affecting Coverages	10 days is standard. Range is 5 – 30 days. Bracketed for ease in making company procedural changes and/or state required variations
“	Employer/Employee Identification	Bracketed for ease in updating as need arises should there be a change in the information required from the employee.
“	Fraud Notice	Bracketed to allow state variations of fraud language as necessary, per state law. State specific language is supplied by the individual states.
“	Group Product and Plan Information – Requested Products	Bracketed for ease in updating as need arises. The first column would be updated whenever there is a change in products offered – the change could be in a product name or it could be a new product that has been filed and approved by the state. The second column contains the amount of coverage or the plan option an employee currently has and the last column contains the amount of coverage or plan option that the employee is applying for. The amounts/options in the second and third columns would vary by employee. Any amount or option in column 2 would be within the range of the approved product. Any amount or option in column 3 would require underwriting approval.