Application to Convert Group Insurance

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 6123
Indianapolis, IN 46206
1-800-553-5318
Fax: 1-317-285-7542
www.employeebenefits.aul.com

OneAmerica®

Continuing Insurance After Coverage Termination

If coverage under an American United Life Insurance Company® (AUL) Group Insurance contract terminates, in some contracts eligible insureds may be able to convert to Individual insurance. Refer to the Group Policy/Certificate for guidelines and provisions to determine if coverage is eligible for conversion.

Eligible insureds have 31 days from the date coverage terminates under the contract to apply and pay the required premium to AUL. Incomplete submissions and/or applications received after 31 days from the date coverage terminates under the group contract will be denied and any unearned premium remitted will be refunded. AUL will review the information provided to determine eligibility to continue existing coverage.

Refer to the "Conversion employee guide" when completing this form. Please print clearly. Required fields are marked with an asterisk (*).

SECTION 1: POLICYHOLDER INFORMATION

Employer Name*	Group Number*
Employer Contact Name/Email	Employer Contact Phone
Original Effective Date of Coverage with Policyholder*	

SECTION 2: EMPLOYEE INFORMATION

Employee Last Name*	Employee First Name*
Employee Social Security Number*	Date Application was Provided*

SECTION 3: PROPOSED INSURED INFORMATION

Last Name*	First Name*	M.I.
Social Security Number*	Gender* ☐ Female ☐ Male	Relationship to Employee* ☐ Self ☐ Spouse ☐ Child
Date of Birth*	Email Address	
Street Address*		
City*	State*	Zip*	Phone*
U.S. Citizen* ☐ Yes ☐ No *(If No, give details and attach copy of visa)*		
During the last 12 months, has the applicant used any nicotine (including substitutes such as gum, patch, e-cigarettes, etc.) and/or tobacco products? ☐ Yes ☐ No		

POLICY OWNER INFORMATION* ***If other than Proposed Insured***

Last Name	First Name	Age
Social Security Number	Relationship	
Street Address*		
City*	State*	Zip*

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SECTION 4: REASON FOR REQUEST *Indicate reason for conversion request and provide the date of change in eligibility/status (MM/DD/YYYY)*

- ☐ Employment/Employment Contract Termination
  Date Last Physically/Actively At Work: _____
- ☐ Termination of Group Policy
  Date of Policy Termination: _____
- ☐ Retirement
  Date of Retirement: _____
- ☐ Other (Describe)
  Date of Status Change: _____
- ☐ Reduction in Hours/Eligibility Status Change
  Date of Status Change: _____
- ☐ Disability
  Date of Disability: _____
- ☐ Permanent Layoff
  Date of Layoff: _____
- ☐ Temporary Layoff
  Date of Layoff: _____

SECTION 5: NONFORFEITURE INFORMATION

Automatic Premium Loan (APL) If not declined, APL will be applied if applicable ☐ Decline
Automatic Premium Loan allows you to borrow against any accumulated cash value from your policy to pay a premium and help prevent a lapse in your policy. There is no cost for this option.

Refer to the "Guide to completing application" for dividend option descriptions.

SECTION 6: DIVIDENDS *Dividends to be used as follows*

- ☐ Cash
- ☐ Reduce Premiums *(Can only be selected if premium is paid annually)*
- ☐ Accumulated at Interest
- ☐ Paid-Up Additions

Refer to the "Life rates and calculating premium" section of the "Conversion employee guide" when completing this section.

SECTION 7: COVERAGE TYPE, AMOUNT OF INSURANCE, EFFECTIVE DATE, AND PAYMENT OPTIONS

The amount of life insurance you purchase under the Conversion privilege may not exceed the amount of insurance in place when coverage under the group policy terminated and is subject to the following:

Life Insurance

- Group coverage will be converted to an individual Life insurance Legacy Policy, underwritten and insured by AUL.
- Any coverage under the individual life insurance policy is based on the amount existing and available under the group life insurance contract and must be a minimum of $2,000, subject to AUL's approval, contract maximums, and according to contract terms and conditions.
- Converted coverage becomes effective the first day following the expiration of the application period.
- Any coverage otherwise effective the 29th, 30th, 31st will be made effective the first of the next following month.

LIFE INSURANCE - INSTRUCTIONS FOR COMPLETING THIS SECTION

1. Select the desired bill frequency (A)
2. Enter the coverage amount requested (B)
3. Enter the total Life premium include with the Application (C)

A) SELECT BILL FREQUENCY FOR LIFE

- ☐ **Monthly/Automatic Payment Plan (APP) -** Note: 3 months' premium must be included with the conversion application. Subsequent premium payments will be drafted on a monthly basis from the account listed in Section 8.
- ☐ **Semi-Annually -** 2 premium payments per year
- ☐ **Annually -** 1 premium payment per year

Amount of Insurance (B)	Total Life Premium Included with Application (C)
$	$

SECTION 8: AUTOMATIC PAYMENT PLAN (APP) INFORMATION

Complete the following information *only* if electing "APP" (bank draft) option in Section 7.

Account Number	Routing Number
Monthly Deduction Day *(1st through 28th)*	Account Type ☐ Checking ☐ Savings

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SECTION 9: BENEFICIARY INFORMATION

If more space is needed, please attach a signed and dated addendum page to this application to include all information outlined below. This beneficiary designation supersedes and cancels all prior beneficiary designations by the insured person. Subject to the provisions of the policy, applicable laws, and the rights of any valid assignee of record with OneAmerica, it is requested the beneficiary of any policy proceeds payable at the death of the Insured Person be as follows:

PRIMARY BENEFICIARY(S) ***The insured cannot be named as the Primary or Secondary Beneficiary***

First Name	Last Name	Relationship *(ex: Spouse, Child)*	Date of Birth	Percentage
			Total	

SECONDARY BENEFICIARY(S) ***If the Primary Beneficiary(s) predeceases the insured***

First Name	Last Name	Relationship *(ex: Spouse, Child)*	Date of Birth	Percentage
			Total	

Lack of Notice of Community Property Interest: If OneAmerica has not previously received written notice of a community property interest and if the space for consent below is not signed by a person having such an interest, then OneAmerica shall be entitled to rely upon its good faith that no such interest exists.

Spouse's signature and consent *(if applicable)*[1]: _____ Date: _____

I hereby apply to OneAmerica to convert the insurance coverage for which I am eligible and which is available under the group life insurance contract issued by OneAmerica. I represent that any information or documents I provide to OneAmerica prior to and after the date of application to continue insurance 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 converted is contingent upon any statements made to OneAmerica being complete and correct.

I understand and agree premium payment greater than the amount of premium owed will not result in additional coverage under the contract.

I understand no conversion of coverage under any contract will be issued until this application is received, reviewed, and approved in writing by OneAmerica. If no coverage is issued and/or approved, I understand the premium deposit will be refunded.

I understand and agree that any dependent who was previously excluded from coverage is not eligible for conversion of life insurance.

I understand and agree that I may not continue convert in an amount that exceeds valid coverage in force at the time coverage terminated under the group policy.

I understand the ability to convert coverage under the contract is contingent upon, but is not limited to, the following conditions:

1) I must remit a fully completed, signed and dated application and all required premium directly to OneAmerica within 31 days from the date my coverage under the group policy 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 any coverage or benefit under any contract will be approved only if OneAmerica decides in its discretion that I am entitled to it. I have read, understood, and retained for my records the notices, limitations, and exclusions.

Signature of Proposed Insured: _____ Date: _____

Signature of Owner or Employee if other than Proposed Insured: _____ Date: _____

[1] Spouse's signature is needed only if Insured/Beneficiary lives in a community property state which currently include AZ, CA, ID, LA, NM, NV, TX, WA and WI.

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