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

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 continue paying premiums and keep existing insurance in force. Refer to the Group Policy/Certificate for guidelines and provisions to determine if coverage is portable.

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. Initial premium payment may be made via personal check, credit card, or money order.

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

SECTION 1: POLICYHOLDER INFORMATION				
Employer Name*			Group Number*	
Francisco Control Nove (Francis			Fundament Cantact Dhama	
Employer Contact Name/Email			Employer Contact Phone	
Original Effective Date of Coverage with Pol	icyholder*			
SECTION 2: EMPLOYEE INFORMATION Last Name*		First None +		N/L
Last Name"		First Name*		M.I.
Social Security Number*		Gender*		
,		☐ Female	☐ Male	
Date of Birth*	Email Address			
Street Address*				
City*	State*	Zip*	Phone*	
oney	State	216	THORE	
SECTION 3: REASON FOR REQUEST Indicat	e reason for portability r	request and provide the d	ate of change in eligibility/status (N	M/DD/YYYY)
Employment/Employment Contract Term	ination	☐ Reduction in Hou	ırs/Eligibility Status Change	
Date Last Physically/Actively At Work: _		Date of Status Cl	hange:	
☐ Termination of Group Policy		Disability		
Date of Policy Termination:		Date of Disability	<i>!</i> :	
☐ Retirement		☐ Permanent Layoff	f	
Date of Retirement:		Date of Layoff: _		
Other (Describe)		☐ Temporary Layof	f	
Date of Status Change:		Date of Layoff: _		

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SEC	TION 4: DEPENDEN	T INFORMATION						
con	nplete this section on tinue coverage for a ase attach a signed a	ny eligible dependeı	nt(s) you must contin	ue your associate	d Employee Co	verage. If more sp		
	First Name	Last Name	Relationship (ex: Spouse, Child)	Date of Birth	Gender	Full-Time Student	Disabled?	
					\square F \square M	☐ Yes ☐ No	☐ Yes ☐ N	lo
					□ F □ M	☐ Yes ☐ No	☐ Yes ☐ N	lo
					\square F \square M	☐ Yes ☐ No	☐ Yes ☐ N	lo
					\square F \square M	☐ Yes ☐ No	☐ Yes ☐ N	lo
Refe	er to the "Life rates a	nd calculating premi	um" section of the "P	ortability employe	e guide" when	completing this se	ction.	
The	TION 5: AMOUNT O amount of insurance y group policy terminate	ou purchase under the	Portability provision n			nce in place when	coverage under	
Terr	n Life/AD&D Portability is not ava In order to continue In order to continue	ilable to anyone age AD&D coverage, Ter	70 or older, unless of m Life coverage mus	t be continued.	•		ige.	
INS	TRUCTIONS FOR CO	MPLETING THIS SEC	TION					
1. 2. 3. 4. 5.	n Life/AD&D Select the desired bi Enter the coverage a Enter the monthly pro Enter the Frequency Multiply the monthly enter this amount in	mount requested in emium amount in Col Factor in Column D premium (Column C)	umn C	ctor (Column D) to	o calculate the	Total Premium An	nount Due;	
A) \$	SELECT BILL FREQUE	NCY FOR TERM LIFE	/AD&D					
l .	Quarterly - 4 paymer Frequency Factor = 3		Semi-Annually - Frequency Facto	2 payments/year; r = 6		ually - 1 payment/ uency Factor - 12	year;	

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TERM LIFE /AD&D						
(B)	(C	(;)	(D)	(E)		
Amount of Insurance	Mon	thly		Total		
(If Applicable)	Premium	Amount	Frequency Factor	Premium Amount		
Total Initial Premium	Payment Due	(Add all prem	nium amounts in Column E)	\$		
INFORMATION*						
ey order. Completing the fo	llowing inform	nation will init	tiate automatic premium de	ductions from the		
		Routing Num	nber			
		Account Typ	e			
			☐ Checking ☐ Savi	ngs		
	Amount of Insurance (If Applicable) Total Initial Premium INFORMATION* ormation only if electing ba ey order. Completing the fo	(B) (C Amount of Insurance Mon (If Applicable) Premium Total Initial Premium Payment Due INFORMATION* ormation only if electing bank draft option ey order. Completing the following inform	(B) (C) Amount of Insurance (If Applicable) Total Initial Premium Payment Due (Add all premint Insurance) INFORMATION* ormation only if electing bank draft option. Bank draft ey order. Completing the following information will initial premium due date will be determined upon policy Routing Num	(B) (C) (D) Amount of Insurance (If Applicable) Premium Amount Frequency Factor Total Initial Premium Payment Due (Add all premium amounts in Column E) INFORMATION* ormation only if electing bank draft option. Bank draft is not required. Payment calley order. Completing the following information will initiate automatic premium deep order. Completing the following information will initiate automatic premium deep order. Routing Number Routing Number		

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SECTION 7: 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:

		med as the Primary or Secondar	y Beneticiary	
F' . N		Relationship	D ((D) (.
First Name	Last Name	(ex: Spouse, Child)	Date of Birth	Percentage
			Total	
SECONDARY BENEFICIA	RY(S) If the Primary Benefic	iary(s) predeceases the insured	iotai	
	(1, 11 110 1111111, 1111111)	Relationship		
First Name	Last Name	(ex: Spouse, Child)	Date of Birth	Percentage
			Total	
	or consent below is not sig at no such interest exists.	ned by a person having such	an interest, then UneAme	rica snail be entitled to
pouse's signature and co	onsent (if applicable)¹:		Date:	
nd/or disability insurance	rica to continue the insura e contract issued by OneAi	nce coverage for which I am		able under the group life
nd accurate to the best o	of my knowledge and belief	insurance and any facts and f. I understand and agree that	other matters contained in t any insurance which sha	provide to OneAmerica this application are true
nd accurate to the best on tingent upon any state	of my knowledge and belied ments made to OneAmeric	insurance and any facts and	other matters contained in t any insurance which sha t.	provide to OneAmerica this application are trud Il be continued is
nd accurate to the best on ontingent upon any state understand and agree pre understand no continuat	of my knowledge and belied ments made to OneAmeric mium payment greater than ion of coverage under any	insurance and any facts and f. I understand and agree that a being complete and correct the amount of premium owed contract will be issued until to	other matters contained in t any insurance which sha t. will not result in additional c this application is received	provide to OneAmerica this application are trud Il be continued is overage under the contra , reviewed, and approve
nd accurate to the best on the ontingent upon any state understand and agree pre understand no continuat writing by OneAmerica.	of my knowledge and belied ments made to OneAmeric mium payment greater than ion of coverage under any If no coverage is issued a	insurance and any facts and f. I understand and agree that a being complete and correct the amount of premium owed contract will be issued until the total approved, I understand	other matters contained in t any insurance which shal t. will not result in additional c his application is received the premium deposit will b	provide to OneAmerica this application are trud Il be continued is overage under the contra , reviewed, and approve be refunded.
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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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