

Request for Change – Group Insurance

American United Life Insurance Company®
 a ONEAMERICA® financial partner
 One American Square, P.O. Box 6123
 Indianapolis, IN 46206-6123
 (800) 553-5318 Telephone
 (317) 285-1565 Fax



THIS FORM TO BE COMPLETED BY THE EMPLOYEE.

Please send the completed request to American United Life Insurance Company® at the address shown above.

Employer's Name: _____ Group Number: _____

Insured's Name: _____ Date of Birth: _____
First Middle Last

Insured's Social Security No.: _____

ADDITION OF DEPENDENTS' COVERAGE

I hereby request the addition of the following dependents for:

- Basic Life / AD&D Supplemental Life / AD&D Voluntary Term Life / AD&D

Note: Where an employee applies for dependent coverage more than 31 days after first acquiring dependents, or where he again applies for dependent coverage after previously elected to discontinue it, the coverage will not become effective until evidence of insurability is submitted on each eligible dependent and such evidence is approved by AUL.

Full Name	Relationship to Insured	Date of Birth	Reason	Date Acquired
			<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other _____	
			<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other _____	
			<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Other _____	

REQUEST FOR TERMINATION OF COVERAGE

I hereby request termination of the coverages listed below. All terminations will take place on or after the signature date, according to the terms of the certificate. I understand that if my insurance terminates, my dependent's insurance, if any, automatically terminates.

- | | | | |
|---|-----------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Basic Life / AD&D | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse | <input type="checkbox"/> Children |
| <input type="checkbox"/> Supplemental Life / AD&D | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse | <input type="checkbox"/> Children |
| <input type="checkbox"/> Voluntary Life | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse | <input type="checkbox"/> Children |
| <input type="checkbox"/> Voluntary AD&D | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse | <input type="checkbox"/> Children |
| <input type="checkbox"/> Short Term Disability | | | |
| <input type="checkbox"/> Long Term Disability | | | |
| <input type="checkbox"/> Voluntary Disability | <input type="checkbox"/> Short | <input type="checkbox"/> Medium | <input type="checkbox"/> Long |

Requested Termination Date

CHANGE OF NAME

I hereby request my name to be changed from: _____
First Middle Initial Last

Reason: _____ to: _____
First Middle Initial Last

 Date

 Signature of Insured (Required for all changes)