GROUP INSURANCE

Request for Coverage when Evidence of Insurability is Required, Statement of Insurability and Notice of Insurance Information Practices Packet

Products and financial services provided by
AMERICAN UNITED LIFE INSURANCE COMPANY® | *a* ONEAMERICA® *company*
One American Square, P.O. Box 368 | Indianapolis, Indiana 46206-0368 | 1-800-553-5318 | www.oneamerica.com

G-24650 (OH) 3/18/15

Request for Coverage when Evidence of Insurability is Required

(to be submitted with Statement of Insurability)

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®

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 through 4 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 4 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 through 4 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
P.O. Box 6123
Indianapolis, IN 46206-6123
1-888-285-1565 (Fax)
GroupContactCenter@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.

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OneAmerica®

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: ☐ Male ☐ 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: ☐ Single ☐ Married ☐ Domestic Partner ☐ 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
☐ Basic Term Life/AD&D*	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Supplemental Term Life/AD&D*	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Short Term Disability	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Long Term Disability	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Voluntary Term Life/AD&D*	Life $_____ /Option #_____ AD&D $_____ /Option #_____	Life $_____ /Option #_____ AD&D $_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Voluntary Disability Short Term	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Voluntary Disability Long Term	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ 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 #_____ ☐ Timely ☐ Late ☐ Change
☐ Worksite Disability Short Term	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Worksite Disability Long Term	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ CorePLUS Short Term Disability (Core only)	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ CorePLUS Long Term Disability (Core only)	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ CorePLUS Short Term Disability (PLUS)	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ CorePLUS Long Term Disability (PLUS)	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Whole Life (must also complete Application for Life Insurance and Statement of Insurability)	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Lump Sum Disability	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ 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.

B. Coverage or Change Being Requested (continued)

Dependent:

Coverage Election	Current Coverage Amount/Option in Force	Coverage Amount/Option Applying for
☐ Basic Dependent Life/AD&D ☐ Spouse ☐ Children ☐ Spouse and Children	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Supplemental Term Life/AD&D ☐ Spouse ☐ Children ☐ Spouse and Children	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ Change
☐ Voluntary Term Life/AD&D ☐ Spouse ☐ Children ☐ Spouse and Children	$_____ /Option #_____	$_____ /Option #_____ ☐ Timely ☐ Late ☐ 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

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- 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.

Statement of Insurability

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One American Square, P.O. Box 368
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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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Diabetes, thyroid, or other glandular disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Chest pain, angina, or heart attack; heart disease/disorder or murmur, peripheral vascular disease, elevated cholesterol or triglycerides?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. High blood pressure or hypertension?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Anemia, bleeding disorder, clotting disorder or other blood disease or disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Stomach or intestinal disorder, Crohn's, irritable bowel disorder, diverticulitis, GERD/reflux?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Stroke or transient ischemic attack (TIA)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Kidney, urinary bladder, gallbladder, pancreas, liver disorder or hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. Psychological, psychiatric, or emotional disorder, depression, anxiety, stress?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. Lung or respiratory disorder/disease, shortness of breath, asthma?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l. Neuromuscular, musculoskeletal disorders, lupus, arthritis, neck-, back-, knee- or foot disorders, other joint disorder, fibromyalgia, or chronic fatigue syndrome?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m. Skin or lymph node disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n. Eye, ear, nose, mouth, or throat disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or any immune deficiency related disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p. Prostate or testicular disorder, female reproductive organ disorder, or sexually transmitted disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section B: Health Questions *(continued)*

2. Within the past 5 years, has any applicant for insurance: ***(Circle information that applies in multi-part questions, and provide full details to any "yes" response in Section 4.)***

	Proposed Insured	Spouse	Children
a. Had a checkup or consultation with a physician or medical practitioner?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Been an inpatient or outpatient in a hospital, clinic, or medical facility or any similar entity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Taken in the past, or is currently taking, any prescription medicine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. Had an EKG, x-ray, blood study, urinalysis, treadmill, heart cath, MRI, CT scan, biopsy, or any other diagnostic testing? *(Does not apply to tests for AIDS or HIV)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed? *(Does not apply to tests for AIDS or HIV)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Made a claim or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition, and/or been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Received or been instructed to seek treatment for use or abuse of: ☐ Alcohol ☐ Drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates, inhalants, or any other habit-forming drug or substance, whether prescribed or non-prescribed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Had any surgical procedure for weight loss? If so what was date of surgery? _____ What was your pre-surgery weight? _____ lbs.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. Been rejected, declined, rated, postponed, or modified for life or disability insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. Had any illness, disease, injury, operation, or treatment other than stated above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. Currently, is any Applicant: ***(Provide details to any "yes" response in Section 4.)***

a. Pregnant? Expected delivery date: _____ *(List current or past complications or high risk issues, including but not limited to pregnancy related high blood pressure, diabetes multiple gestations, i.e., twins, etc in Section 4.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Has any applicant ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products? If Yes, provide detail below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name _____

1. ☐ Present ☐ Former
2. Type of nicotine or tobacco used: _____
3. When did the applicant quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year

If more than one applicant has used nicotine, provide full details in Section 4.

4. Describe details of each "yes" response from Questions 1-3. If needed, use separate sheet of paper.

Name	*Question No.*	*Details of injury, illness, or disorder*	*Date*	*Name of Physician, Hospital, or Other Provider*

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. I/we authorize American United Life Insurance Company® (AUL) and its reinsurers to make a brief report of my personal health information to MIB. 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
P.O. Box 2167
Fargo, ND 58107
1-800-437-4692

The State Life Insurance Company
a OneAmerica® company
P.O. Box 6062
Indianapolis, IN 46206
1-800-275-5101

OneAmerica®

Website: www.oneamerica.com

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

We or our reinsurers may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau. The MIB is a not-for-profit organization of insurance companies. It is an information exchange for its members. If you apply to an MIB member company for life or health insurance coverage, the MIB, upon request, will give the company the information in the MIB's file. This may include previously filed claims.

Upon receipt of a request from you, the MIB will give you any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction under the procedures in the federal Fair Credit Reporting Act. The address of the MIB is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We or our reinsurers may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim may be submitted. Information for consumers abut 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. I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB. 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.

American United Life Insurance Company®
Pioneer Mutual Life Insurance Company*
The State Life Insurance Company

Employee Authorization for the Release of Health-Related Information
(HIPAA-Compliant Form)

_____ _____
Name of Proposed Insured/Patient (Please type or print.) Date of Birth

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory, pharmacy or pharmacy benefit manager; medical facility; or other health care provider; insurance company; the MIB, Inc. (formerly known as Medical Information Bureau); or other organization or person that has provided payment, treatment or services to me or on my behalf within the past 10 years or has any records or knowledge of my health within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the partners of OneAmerica Financial Partners, Inc., as listed above. This includes information on the diagnosis or treatment of human immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.* I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that partners of OneAmerica® may:

1) underwrite my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
2) obtain reinsurance;
3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) administer coverage; and
5) conduct other legally permissible activities that relate to any coverage I have or have applied for with a OneAmerica financial partner.

This authorization shall remain in force for twenty-four (24) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Attention: Privacy Officer, OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206.

Please <u>DO NOT</u> send medical records, etc. to the Privacy Officer – this will delay the process because the Privacy Officer does not review records or handle billing.

I understand that a revocation is not effective to the extent that any of My Providers have already relied on this authorization to disclose information about me or to the extent that OneAmerica partners have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by any OneAmerica partner except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, OneAmerica partner companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Signature of Proposed Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

**A stock subsidiary of American United Mutual Insurance Holding Company.*

American United Life Insurance Company®
Pioneer Mutual Life Insurance Company*
The State Life Insurance Company

Spouse Authorization for the Release of Health-Related Information
(HIPAA-Compliant Form)

_____ _____
Name of Proposed Insured/Patient (Please type or print.) Date of Birth

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