

A. Employer/Employee Identification

Statement of Insurability Reference Guide

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. f 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: 8. Coverage or Change Being Requested (continued) Employee: Coverage Amount/Option in Force Coverage Amount/Option Applying for Significant Coverage Being Requested (continued) Employee: Coverage Amount/Option Significant Coverage Amount/Option Applying for Significant Coverage Amount/Option Significant Coverage A	(Note: Any missing information on this Request for Coverage will delay processing and the potential effective date.)		
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. f 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 (continued) Employees: Overage Election Current Coverage Amount/Option in Force Coverage Amount/Option Applying for Supplemental Term Life/AD&D* \$ / Option # Timely Late Change Change Supplemental Term Life/AD&D* \$ / Option # Timely Late Change Change Life \$ / Option # Timely Late Change Change Life \$ / Option # Timely Late Change Change Voluntary Disability Short Term S / Option # Timely Late Change Change Voluntary Disability Long Term S / Option # Timely Late Change Change Voluntary Disability Long Term S / Option # Timely Late Change Change Voluntary Disability Long Term S / Option # Timely Late Change Change Voluntary Disability Long Term S / Option # Timely Late Change Change Voluntary Disability Long Term S / Option # Timely Late Change CorePLUS Short Term Disability (Core only) S / Option # Timely Late Change Change CorePLUS Core Term Disability (Core only) S / Option # Timely Late Change Change CorePLUS Core Term Disability (Core only) S / Option # Timely Late Change Change CorePLUS Core Term Disability (Core only) S / Option # Timely Late Change Change CorePLUS Core Term Disability (Core only) S / Option # Timely Late Change Change Change CorePLUS Core Term Disability (Core only) S / Option # Timely Late Change Change Change Change Change Chan			2. Group Number:
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):	3. Employee Name (Last, First, Middle):		4. Gender:
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B. Coverage or Change Being Requested (continued)	15. Marital Status: Single Married Domestic Partner Civil Union		
B. Coverage or Change Being Requested (continued) Employee: Coverage Election Current Coverage Amount/Option in Force Basic Term Life/AD&D* Supplemental Term Life/AD&D* Supplementa	16. Annual Salary (Please contact your employer for assistance with amount per contract definition): \$/yr.		
Coverage Election Current Coverage Amount/Option in Force Coverage Amount/Option Applying for S	17. Email address where the Insurer may contact you:		
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Coverage Election		tea (continuea)	
Basic Term Life(AD&D* \$ Option # Late Change		Comment Comment of Comment (Continue in Continue in Co	Courses Assessed Detice Asset in the
Supplemental Term Life/AD&D* S			
Short Term Disability			☐ Timely ☐ Late ☐ Change
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Voluntary Term Life/AD&D*	•		☐ Timely ☐ Late ☐ Change
AD&D \$			☐ Timely ☐ Late ☐ Change
Voluntary Disability Long Term \$ /Option # S /Option # Late Change	□ Voluntary Term Life/AD&D*		AD&D \$/Option #
□ Voluntary Disability Short Term \$	☐ Voluntary Disability Short Term	\$/Option #	
Premier - 66 23% of Salary (Option 1) S100 max/week (Option 2) S200 max/week (Option 3) S350 max/week (Option 4) S350 max/week (Option 4) S350 max/week (Option 5) United Substitute Salary (Option 5) Salary (Option 6) Salary (Option 7) Salary (O	☐ Voluntary Disability Long Term		☐ Timely ☐ Late ☐ Change
Timely Late Change	Premier – 66 2/3% of Salary (Option 1) \$100 max/week (Option 2) \$200 max/week (Option 3) \$350 max/week (Option 4)		
CorePLUS Short Term Disability (Core only)	☐ Worksite Disability Short Term	\$/Option #	S/Option # ☐ Timely ☐ Late ☐ Change
Timely Late Change	☐ Worksite Disability Long Term	\$/Option #	S/Option# ☐ Timely ☐ Late ☐ Change
☐ Timely	☐ CorePLUS Short Term Disability (Core	only) \$/Option #	\$/Option # ☐ Timely ☐ Late ☐ Change
☐ Timely ☐ Late ☐ Change	☐ CorePLUS Long Term Disability (Core	only) \$/Option #	
CorePLUS Long Term Disability (PLUS) \$ /Option # \$ /Option #			☐ Timely ☐ Late ☐ Change
	☐ CorePLUS Long Term Disability (PLUS	S/Option #	
Insurability)	for Life Insurance and Statement of Insurability)		☐ 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 amount			☐ Timely ☐ Late ☐ Change

To accurately complete Statement of Insurability Form:

IMPORTANT: All sections of Statement of Insurability form must be completed. All incomplete forms will be returned.

Employer/Employee Identification Section

Any missing or inaccurate information will delay processing. Seek assistance from your employer for accurate salary and date of hire.

Coverage Election: Check the box(es) next to all current coverage and requested coverages.

Current Coverage Amount/Option in Force:

Indicate current volume(s) and/or plan option already in-force. (If you are requesting new coverage, write "none" in the current coverage column)

Coverage Amounts/Option Applying for: Indicate all new coverage/options you are applying for by indicating the new volume (i.e. \$50,000) and/or plan option number (i.e. 1, 2).

Check the reason for completing the Statement of Insurability form. (Timely = volume above the Guarantee Issue limit; Late = did not enroll when first eligible, Change = new volume/plan option desired)

Important: If you are applying for new Dependent coverage, each name and date of birth <u>MUST</u> be included in dependent information section of the Statement of Insurability.

Completed forms should be faxed to (888) 285-1565 or emailed to the Group Contact Center at

GroupContactCenter@oneamerica.com.