



Statement of Insurability Reference Guide

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: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> 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)

Employee:	Coverage Election	Current Coverage Amount/Option in Force	Coverage Amount/Option Applying for
<input type="checkbox"/>	Basic Term Life/AD&D*	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Supplemental Term Life/AD&D*	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Short Term Disability	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Long Term Disability	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Voluntary Term Life/AD&D*	Life \$ _____ /Option # _____ AD&D \$ _____ /Option # _____	Life \$ _____ /Option # _____ AD&D \$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Voluntary Disability Short Term	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Voluntary Disability Long Term	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	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 # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Worksite Disability Short Term	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Worksite Disability Long Term	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	CorePLUS Short Term Disability (Core only)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	CorePLUS Long Term Disability (Core only)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	CorePLUS Short Term Disability (PLUS)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	CorePLUS Long Term Disability (PLUS)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Whole Life (must also complete Application for Life Insurance and Statement of Insurability)	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> Change
<input type="checkbox"/>	Lump Sum Disability	\$ _____ /Option # _____	\$ _____ /Option # _____ <input type="checkbox"/> Timely <input type="checkbox"/> Late <input type="checkbox"/> 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.

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 **MUST** 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.