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

OneAmerica®

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
			☐ Marriage ☐ Birth ☐ Adoption ☐ Other_____	
			☐ Marriage ☐ Birth ☐ Adoption ☐ Other_____	
			☐ Marriage ☐ Birth ☐ Adoption ☐ 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.

					Requested Termination Date
☐ Basic Life / AD&D	☐ Employee	☐ Spouse	☐ Children		_____
☐ Supplemental Life / AD&D	☐ Employee	☐ Spouse	☐ Children		_____
☐ Voluntary Life	☐ Employee	☐ Spouse	☐ Children		_____
☐ Voluntary AD&D	☐ Employee	☐ Spouse	☐ Children		_____
☐ Short Term Disability					_____
☐ Long Term Disability					_____
☐ Voluntary Disability	☐ Short	☐ Medium	☐ Long		_____

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)*