Group Enrollment Form

Vance County Government

American United Life Insurance Company®
a ONEAMERICA® *company*
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
1-800-553-5318
www.employeebenefits.aul.com

ONEAMERICA®

Applicant's Full Legal Name:			Employment Status: ☐ Active ☐ Retired
Applicant's Social Security Number:	Date of Birth:	Marital Status: ☐Single ☐Married	Gender: ☐ Male ☐ Female
Applicant's Street Address:		Applicant's City:	
Applicant's State of Residence:		Applicant's Residential Zip Code:	
Applicant's Telephone Number: (*normal business hours*): ( ) -	Applicant's E-Mail Address:	Employed Full-Time: ☐ Yes ☐ No	Hours worked per week:
		Are you authorized to work and reside in the US? ☐ Yes ☐ No	

COVERAGE BEING APPLIED FOR: Apply for each desired coverage listed below. Not checking a box or boxes will be considered a declination of that coverage.

Request	Decline			
☐	☐	Worksite Short Term Disability	0/7 Day Elimination Period/13-week Duration	Not to exceed: $ _____ of Monthly Benefit

Request Decline (You may choose only one of the options below)

☐	☐	Worksite Disability Long Term	Option 1	$500 Monthly Maximum Benefit
☐	☐	Worksite Disability Long Term	Option 2	$1,000 Monthly Maximum Benefit
☐	☐	Worksite Disability Long Term	Option 3	$1,500 Monthly Maximum Benefit
☐	☐	Worksite Disability Long Term	Option 4	$2,000 Monthly Maximum Benefit

- I hereby apply for the requested group life and/or disability insurance coverage for which I and my dependents, if any, are eligible and available under AUL's policy, I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by AUL.
- I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.
- The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. **The undersigned understands and agrees 1. any insurance coverage or benefit are contingent upon any statements made to AUL as being complete and correct and 2. benefits under any group life or disability insurance policy will be paid only if AUL, or its third party administrator, DRMS, decides, in its discretion, the applicant is entitled to them. The undersigned have read, understand, and retained the notices, limitations, and exclusions for his/her records.**
- 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.

Signature of Applicant: _____ **Date:** _____

MUST BE COMPLETED BY THE EMPLOYER	Group Policy#: 614869	Class#:	Employer: Vance County Government	Employer's City: Henderson	Employer's State: NC
	Salary: $	Mode: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually		Date Hired Full-Time:	Occupation:

RGO #180