Group Enrollment Form

American United Life Insurance Company®
a ONEAMERICA® *company*
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
(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 State of Residence:	Applicant's Residential Zip Code:	Employer: College of Central Florida	
Applicant's Telephone Number: (normal business hours): ( ) -	Applicant's E-mail Address:		Employed Full-Time: ☐ Yes ☐ No
		Are you authorized to work and reside in the US? ☐ Yes ☐ No	

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

	Benefit Amount / Option Requested		
Worksite Short Term Disability	Option_____	☐ Elect	☐ Decline
Worksite Long Term Disability	Option_____	☐ Elect	☐ Decline

- 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 have read, understand, and retained the notices, limitations, and exclusions for his/her records.
- 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.

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

MUST BE COMPLETED BY THE EMPLOYER	Group Policy #: 00601730-0000-000	Class # :	Employer: College of Central Florida	Occupation:	Employer's State: FL
	Salary: Mode: [ ] Hourly [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Annually F/T Requirements (hours, days, weeks, etc.):			Date Hired Full Time:	