Group Statement of Insurability and Notice of Insurance Information Practices Packet
Instructions for completing form for yourself or your dependents, if any.

If you are applying for:

1. An amount of coverage above the Guaranteed Issue amount.
   Complete Sections A, B and E. Sign and date under Section E and submit with a completed enrollment form. Detach and retain this notice page for your files.

2. Coverage as a Late Enrollee.
   Complete Sections A, C and E. Sign and date under Section E and submit with a completed enrollment form. Detach and retain this notice page for your files.

3. A change in current coverage.
   If change is an increase or addition to coverage, complete Sections A, D and E. If change is a decrease in coverage, complete Sections A and D. If you are making a change in your Voluntary Disability Coverage, complete Sections A, D and E. Sign and date under Section E. Detach and retain this notice page for your files.

Note: Any coverage applied for will not become effective until Evidence of Insurability is approved by AUL. AUL has the right to exclude one or more of your dependents, if any, from the dependent coverage based on Evidence of Insurability. AUL shall not be liable with respect to any change in coverage for any claim commencing prior to the date of approval of such change in coverage.

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We or our reinsurers may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

Notice of Pre-existing Conditions Exclusion

If you receive treatment, service or incur expenses as a result of an injury or sickness prior to the effective date of approval, disability claims incurred after the date of approval may not be eligible due to the pre-existing conditions exclusion of the policy.
Statement of Insurability/Change of Coverage Request

FORM COMPLETION INSTRUCTIONS:
1. Please print the entire document.
2. Please complete pages marked "Submit this page to AUL" at the bottom of the page.
3. Please seek assistance from your employer for salary and benefit elections.
4. Signatures for you and your dependents (if applicable) are required on this form.
5. Please make a copy of the completed pages for your records.
6. Please mail the completed pages to AUL at the address on the left.

A. General Employee Information

1. Name of Employer

   Participating Unit number or Group Policy number as shown on first page of certificate G

2. Employee Name (Last, First, Middle):

   Birth Place ___________________ DOB ____________ Sex ___________ Height ___________ Weight ___________

   Complete Home Address (Including City, State, Zip) ____________________________

   Work Phone Number (_______) ___________________________ Home Phone Number (_______) ___________________________

   Social Security Number ___________________________

   Annual Salary Amount $________________ as defined by your AUL contract. Please contact your employer for assistance.

3. Complete only for those requesting coverage. If needed, please use a separate sheet of paper.

<table>
<thead>
<tr>
<th>Spouse Name (Last, First, Middle)</th>
<th>Relationship to You</th>
<th>Full-Time Student Y/N</th>
<th>Birth Place</th>
<th>DOB</th>
<th>Sex</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Name (Last, First, Middle)</td>
<td>Relationship to You</td>
<td>Full-Time Student Y/N</td>
<td>Birth Place</td>
<td>DOB</td>
<td>Sex</td>
<td>Height</td>
<td>Weight</td>
</tr>
<tr>
<td>Dependent Name (Last, First, Middle)</td>
<td>Relationship to You</td>
<td>Full-Time Student Y/N</td>
<td>Birth Place</td>
<td>DOB</td>
<td>Sex</td>
<td>Height</td>
<td>Weight</td>
</tr>
</tbody>
</table>

B. Amounts in Excess of Guaranteed Issue

Check all coverages that apply, and indicate total amounts and/or plan desired:

Traditional: ☐ Basic Life/AD&D ☐ Supplemental Life/AD&D ☐ Dependent Life/AD&D ☐ LTD ☐ STD

Voluntary: ☐ Term Life ☐ AD&D* ☐ Dependent Life/AD&D ☐ LTD ☐ STD

C. Late Enrollment

Check all coverages that apply, and indicate total amounts and/or plan desired:

Traditional: ☐ Basic Life/AD&D ☐ Supplemental Life/AD&D ☐ Dependent Life/AD&D ☐ LTD ☐ STD

Voluntary: ☐ Term Life ☐ AD&D* ☐ Dependent Life/AD&D ☐ LTD ☐ STD

D. Change of Coverage

Check all that apply:

☐ Voluntary Term Life Coverage from $_________ to $_________. ☐ Voluntary AD&D* coverage from $_________ to $_________.

If coverage is a flat amount, coverage can only be increased or decreased in dollar increments. If coverage is a multiple of salary coverage can only be increased or decreased in multiples as offered by the employer. No coverage can be less than the minimum or more than the maximum allowed by the employer.

☐ Supplemental Term Life Coverage from $_________ to $_________.

☐ Dependent Life: Specify Coverage Type: ☐ Traditional Basic ☐ Voluntary Term

☐ Change coverage from plan ___________ to plan ___________ as offered by the employer.

   Specify Dependent type: ☐ Spouse Only ☐ Children Only ☐ Spouse and Children

☐ Add Dependent: ☐ Spouse Only ☐ Children Only ☐ Spouse and Children

☐ Delete Dependent: ☐ Spouse Only ☐ Children Only ☐ Spouse and Children

☐ Disability Coverage from plan ___________/$_________ to plan ___________/$_________. (See enrollment form for plan information)

*Voluntary AD&D in an amount different from the Voluntary Life amount is available only if this mixed option is chosen by the Employer; otherwise, AD&D will default to match the Voluntary Life amount.

(Submit this page to AUL)

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NOTICE OF INSURANCE INFORMATION PRACTICES

Thank you for your application for insurance. We are glad to have the chance to participate in your insurance program. This notice tells you about the underwriting process. It also tells how information is gathered to review your application. To issue an insurance policy we need to obtain information about you. Some of the information will come from you and some will come from other sources. We need this information to see if you qualify for insurance. When signed, the Authorization and Acknowledgement will allow us to obtain the information and to share it with others when necessary and as permitted by law. No unnecessary disclosures will be made. Information will be treated as confidential by us and by our reinsurers. However, in some cases, information may have to be disclosed to others without your further consent. If permitted by law and after proper identification, you have the right to submit a written request for access to personal information obtained by the company as part of the application for insurance and which is reasonably locatable and retrievable. Within thirty (30) days of the request, the company must respond by allowing you to see, in person, or by copy (a copying charge may be assessed) the requested personal information and by giving you the source(s) of the information. The individual may request correction, amendment or deletion of certain personal information. Within thirty (30) days of said request, the company will correct, amend or delete the requested personal information (and contact the individual of such in writing) or notify the individual of its refusal to make such correction, amendment or deletion and the reason for said refusal. If an individual disagrees with the refusal, the individual can file a concise statement as to what the individual believes is the correct information and the reasons why the individual disagrees with the refusal. This statement will remain in the individual’s file. Any revisions made will be sent to those parties that have been provided such information within the past 2 years, insurance support organizations that have received such information in the past 7 years, and any insurance support organization that furnished the personal information that has been corrected, amended or deleted. You have a right to get a copy of any investigative consumer report which is made. If you want to know more about our underwriting practices and your rights, please write to the Privacy Officer, OneAmerica Financial Partners Inc., P.O. Box 368, Indianapolis, Indiana 46208-0368.

MEDICAL INFORMATION BUREAU NOTICE

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FAIR CREDIT REPORTING ACT NOTICE

We may request an investigative consumer report. These reports contain information about your character, general reputation, mode of living and health except as may be related directly or indirectly to your sexual orientation. The information may be obtained through interviews with you, your neighbors, friends and others who know you. Upon request, we will give you the name and address of the consumer reporting firm so that you may request a copy of the report.

AUTHORIZATION AND ACKNOWLEDGMENT

I authorize any physician, or medical practitioner, hospital and medical facility, insurance company, DMV, and the MIB to give to any company listed as a OneAmerica® company and its reinsurers any of the following about me or my dependents, if they are to be insured: facts about physical and mental health, medical care, advice or treatment; hobbies, other insurance, flying, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs, and tobacco. Each person proposed for insurance may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the AIDS virus. All sources except the MIB may give these facts to any insurance support organization authorized by a OneAmerica® company to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date I signed the application. I can choose to be interviewed if an investigative consumer report is made. I or my authorized representative can receive a copy of this authorization form.