Request for Change – Group Insurance

American United Life Insurance Company®
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
(800) 553-5318 Telephone
(317) 285-1565 Fax

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)*