Statement of Insurability

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
1-800-553-5318

ONEAMERICA®

Section A: Proposed Insured *(complete Statement of Insurability)*

Proposed Insured Name: _____

Driver's License Number _____ State where Issued _____

Height _____ ft. _____ in. Weight _____ lbs. ☐ Gained ☐ Lost _____ lbs. In Past Year

Underwriting Information

Section B: Health Questions

1. Within the past 7 years, has any applicant for insurance been diagnosed or treated by a physician or medical professional, tested positive for the presence of, or taken prescribed medicine for the following: *(Circle conditions that apply in multi-condition questions, and provide full details to any "yes" response in Section 4.)*

	Proposed Insured
a. Cancer, malignancy, or tumor of any kind?	☐ Yes ☐ No
b. Diabetes, thyroid, or other glandular disorder?	☐ Yes ☐ No
c. Chest pain, angina, or heart attack; heart disease/disorder or murmur, peripheral vascular disease, elevated cholesterol or triglycerides?	☐ Yes ☐ No
d. High blood pressure or hypertension?	☐ Yes ☐ No
e. Anemia, bleeding disorder, clotting disorder or other blood disease or disorders?	☐ Yes ☐ No
f. Neurological or brain disorder, seizures, epilepsy, paralysis, multiple sclerosis, ALS or Lou Gehrig's disease, Parkinson's disease, Alzheimer's, other forms of dementia/cognitive disorders?	☐ Yes ☐ No
g. Stomach or intestinal disorder, Crohn's, irritable bowel disorder, diverticulitis, GERD/reflux?	☐ Yes ☐ No
h. Stroke or transient ischemic attack (TIA)?	☐ Yes ☐ No
i. Kidney, urinary bladder, gallbladder, pancreas, liver disorder or hepatitis?	☐ Yes ☐ No
j. Psychological, psychiatric, or emotional disorder, depression, anxiety, stress?	☐ Yes ☐ No
k. Lung or respiratory disorder/disease, shortness of breath, asthma?	☐ Yes ☐ No
l. Neuromuscular, musculoskeletal disorders, lupus, arthritis, neck-, back-, knee- or foot disorders, other joint disorder, fibromyalgia, or chronic fatigue syndrome?	☐ Yes ☐ No
m. Skin or lymph node disorders?	☐ Yes ☐ No
n. Eye, ear, nose, mouth, or throat disorders?	☐ Yes ☐ No
o. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or any immune deficiency related disorders?	☐ Yes ☐ No
p. Prostate or testicular disorder, female reproductive organ disorder, or sexually transmitted disease?	☐ Yes ☐ No

Section B: Health Questions *(continued)*

2. Within the past 5 years, has any applicant for insurance: ***(Circle information that applies in multi-part questions, and provide full details to any "yes" response in Section 4.)***

	Proposed Insured
a. Had a checkup or consultation with a physician or medical practitioner?	☐ Yes ☐ No
b. Been an inpatient or outpatient in a hospital, clinic, or medical facility or any similar entity?	☐ Yes ☐ No
c. Taken in the past, or is currently taking, any prescription medicine?	☐ Yes ☐ No
d. Had an EKG, x-ray, blood study, urinalysis, treadmill, heart cath, MRI, CT scan, biopsy, or any other diagnostic testing?	☐ Yes ☐ No
e. Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?	☐ Yes ☐ No
f. Made a claim or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition, and/or been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home?	☐ Yes ☐ No
g. Received or been instructed to seek treatment for use or abuse of: ☐ Alcohol ☐ Drugs?	☐ Yes ☐ No
h. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates, inhalants, or any other habit-forming drug or substance, whether prescribed or non-prescribed?	☐ Yes ☐ No
i. Had any surgical procedure for weight loss? If so what was date of surgery? _____ What was your pre-surgery weight? _____ lbs.	☐ Yes ☐ No
j. Been rejected, declined, rated, postponed, or modified for life or disability insurance?	☐ Yes ☐ No
k. Had any illness, disease, injury, operation, or treatment other than stated above?	☐ Yes ☐ No

3. Currently, is any Applicant: ***(Provide details to any "yes" response in Section 4.)***

a. Pregnant? Expected delivery date: _____ (List current or past complications or high risk issues, including but not limited to pregnancy related high blood pressure, diabetes multiple gestations, i.e., twins, etc in Section 4.)	☐ Yes ☐ No
b. Has any applicant ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products? If Yes, provide detail below.	☐ Yes ☐ No

Name _____

1. ☐ Present ☐ Former
2. Type of nicotine or tobacco used: _____
3. When did the applicant quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year

4. Describe details of each "yes" response from Questions 1-3. If needed, use separate sheet of paper.

Name	*Question No.*	*Details of injury, illness, or disorder*	*Date*	*Name of Physician, Hospital, or Other Provider*

Authorization and Acknowledgement

I authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about me: facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. **This authorization does not authorize the release of genetic screening or testing results.** All sources except the MIB may give these facts to any insurance support organization authorized by AUL 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. I authorize American United Life Insurance Company (AUL) and its reinsurers to make a brief report of my personal health information to MIB. This authorization will be valid for 24 months from the date shown below. In Arizona, this authorization is limited to 180-days for disclosure of HIV-related information. I understand that any person requesting to be insured 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 Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) I certify that all notices contained herein, were read and understood prior to my completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgment.

Signatures

Signature of Proposed Insured/Employee	*Mo./Day/ Year*	*Printed Name of Proposed Insured/Employee*