Application to Port Group Insurance

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 6123
Indianapolis, IN 46206
1-800-553-5318
Fax: 1-317-285-7542
www.employeebenefits.aul.com

OneAmerica®

Continuing Insurance After Coverage Termination

If coverage under an American United Life Insurance Company® (AUL) Group Insurance contract terminates, in some contracts eligible insureds may be able to continue paying premiums and keep existing insurance in force. Refer to the Group Policy/Certificate for guidelines and provisions to determine if coverage is portable.

Eligible insureds have 91 days from the date coverage terminates under the contract to apply and pay the required premium to AUL. Applications received after 91 days from the date coverage terminates under the group contract will be denied and any unearned premium remitted will be refunded. AUL will review the information provided to determine eligibility to continue existing coverage. Initial premium payment may be made via personal check, credit card, or money order.

Refer to the "Guide to completing application" when completing this form. Please print clearly. Required fields are marked with an asterisk (*).

SECTION 1: POLICYHOLDER INFORMATION	
Employer Name* Mohawk ESV, Inc.	Group Number* 00616239
Contact Name/Email	Contact Phone

SECTION 2: EMPLOYEE INFORMATION		
Last Name*	First Name*	M.I.
Social Security Number*	Gender* ☐ Female ☐ Male	

Date of Birth*	Email Address		
Street Address*			
City*	State*	Zip*	Phone*
Original Effective Date of Coverage with Policyholder*			

SECTION 3: REASON FOR REQUEST ***Indicate reason for portability request and provide the date of change in eligibility/status (MM/DD/YYYY)***

☐ Employment/Employment Contract Termination
Date Last Physically/Actively At Work: _____

☐ Termination of Group Policy
Date of Policy Termination: _____

☐ Retirement
Date of Retirement: _____

☐ Other (Describe)
Date of Status Change: _____

☐ Reduction in Hours/Eligibility Status Change
Date of Status Change: _____

☐ Disability
Date of Disability: _____

☐ Permanent Layoff
Date of Layoff: _____

☐ Temporary Layoff
Date of Layoff: _____

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 6123
Indianapolis, IN 46206
1-800-553-5318
Fax: 1-317-285-7542
www.employeebenefits.aul.com

OneAmerica®

SECTION 4: DEPENDENT INFORMATION

Complete this section only if you are requesting Portability of existing eligible Dependent Spouse and/or Child coverage. In order to continue coverage for any eligible dependent(s) you must continue your associated Employee Coverage. If more space is needed, please attach a signed and dated addendum page to this application to include all information outlined below.

First Name	Last Name	Relationship *(ex: Spouse, Child)*	Date of Birth	Gender	Full-Time Student	Disabled?
				☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No
				☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No
				☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No
				☐ F ☐ M	☐ Yes ☐ No	☐ Yes ☐ No

Refer to the "Rates and Calculating Premium" section of the "Guide to completing application" when completing this section.

SECTION 5: AMOUNT OF INSURANCE, PREMIUM CALCULATION AND PAYMENT OPTIONS

The amount of insurance you purchase under the Portability provision may not exceed the amount of insurance in place when coverage under the group policy terminated and is subject to the following:

Term Life/AD&D

- Portability is not available to anyone age 70 or older.
- If applicable, in order to continue AD&D coverage, Term Life coverage must be continued.
- If applicable, in order to continue coverage for any eligible dependent(s) you must continue your associated Employee Coverage.

INSTRUCTIONS FOR COMPLETING THIS SECTION

Term Life/AD&D

1. Select the desired bill frequency (A)
2. Enter the coverage amount requested in Column B
3. Enter the monthly premium amount in Column C
4. Enter the Frequency Factor in Column D
5. Multiply the monthly premium (Column C) by the Frequency Factor (Column D) to calculate the Total Premium Amount Due; enter this amount in Column E

A) SELECT BILL FREQUENCY FOR TERM LIFE/AD&D

☐ **Quarterly -** 4 payments/year; Frequency Factor = 3	☐ **Semi-Annually -** 2 payments/year; Frequency Factor = 6	☐ **Annually -** 1 payment/year; Frequency Factor - 12

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
One American Square, P.O. Box 6123
Indianapolis, IN 46206
1-800-553-5318
Fax: 1-317-285-7542
www.employeebenefits.aul.com

OneAmerica®

TERM LIFE /AD&D				
	(B)	**(C)**	**(D)**	**(E)**
Coverage Type	**Amount of Insurance** *(If Applicable)*	**Monthly Premium Amount**	**Frequency Factor**	**Total Premium Amount**
Employee Basic Term Life & AD&D				
Employee Voluntary Term Life				
Voluntary Spouse Term Life				
Voluntary Child Term Life				
Total Initial Premium Payment Due (Add all premium amounts in Column E)				**$**

SECTION 6: BANK DRAFT INFORMATION*

Complete the following information *only* if electing bank draft option. Bank draft is not required. Payment can be made via check, credit card, or money order. Completing the following information will initiate automatic premium deductions from the account indicated below. The premium due date will be determined upon policy issue date, and will be included with the initial premium statement.

Account Number	Routing Number
	Account Type ☐ Checking ☐ Savings

Application to Port Group Insurance

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® *company*
One American Square, P.O. Box 6123
Indianapolis, IN 46206
1-800-553-5318
Fax: 1-317-285-7542
www.employeebenefits.aul.com

OneAmerica®

SECTION 7: BENEFICIARY INFORMATION

If more space is needed, please attach a signed and dated addendum page to this application to include all information outlined below. This beneficiary designation supersedes and cancels all prior beneficiary designations by the insured person. Subject to the provisions of the policy, applicable laws, and the rights of any valid assignee of record with OneAmerica, it is requested the beneficiary of any policy proceeds payable at the death of the Insured Person be as follows:

PRIMARY BENEFICIARY(S) ***The insured cannot be named as the Primary or Secondary Beneficiary***

First Name	Last Name	Relationship *(ex: Spouse, Child)*	Date of Birth	Percentage
			Total	

SECONDARY BENEFICIARY(S) ***If the Primary Beneficiary(s) predeceases the insured***

First Name	Last Name	Relationship *(ex: Spouse, Child)*	Date of Birth	Percentage
			Total	

Lack of Notice of Community Property Interest: If OneAmerica has not previously received written notice of a community property interest and if the space for consent below is not signed by a person having such an interest, then OneAmerica shall be entitled to rely upon its good faith that no such interest exists.

Spouse's signature and consent *(if applicable)*[1]: _____ Date: _____

I hereby apply to OneAmerica to continue the insurance coverage for which I am eligible and which is available under the group life and/or disability insurance contract issued by OneAmerica. I represent that any information or documents I provide to OneAmerica prior to and after the date of application to continue insurance and any facts and other matters contained in this application are true and accurate to the best of my knowledge and belief. I understand and agree that any insurance which shall be continued is contingent upon any statements made to OneAmerica being complete and correct.

I understand and agree premium payment greater than the amount of premium owed will not result in additional coverage under the contract.

I understand no continuation of coverage under any contract will be issued until this application is received, reviewed, and approved in writing by OneAmerica. If no coverage is issued and/or approved, I understand the premium deposit will be refunded.

I understand and agree that any dependent who was previously excluded from coverage is not eligible for continuation/portability of life insurance.

I understand and agree that I may not continue coverage in an amount that exceeds valid coverage in force at the time coverage terminated under the group policy.

I understand the ability to continue coverage under the contract is contingent upon, but is not limited to, the following conditions:

1) I must remit a fully completed, signed and dated application and all required premium directly to OneAmerica within 91 days from the date my coverage under the group policy terminated; and,
2) Failure to pay the correct amount of premium timely will terminate the insurance under the contract at the end of the period for which the premium has been paid.

I understand and agree any coverage or benefit under any contract will be approved only if OneAmerica decides in its discretion that I am entitled to it. I have read, understood, and retained for my records the notices, limitations, and exclusions.

Signature of Employee: _____ Date: _____

[1] Spouse's signature is needed only if Insured/Beneficiary lives in a community property state which currently include AZ, CA, ID, LA, NM, NV, TX, WA and WI.