



## D. Participation and Investment Options Contributions

I elect to make contributions to be allocated as indicated on the Investment Option Election Form.

I hereby authorize my employer to reduce my compensation by \_\_\_\_% OR \$\_\_\_\_ as a pre-tax contribution and/or by \_\_\_\_% OR \$\_\_\_\_ as a Roth after-tax deferral and/or by \_\_\_\_% OR \$\_\_\_\_ per \_\_\_\_\_ as an after-tax deferral to the Plan.

I elect NOT to make contributions. I understand that I may be entitled to employer contributions or forfeiture reallocations, if applicable, as permitted by the plan. **Note:** Plan provisions may not allow you to elect not to contribute. Please refer to your Summary Plan Description (SPD) or contact your plan administrator for additional information.

This election applies to compensation earned until changed by me through OneAmerica TeleServe® (1-800-249-6269), the Internet ([www.accountservices.aui.com](http://www.accountservices.aui.com)), or by paper form. The effective date of this election will be determined by my employer and is dependent upon plan document provisions. Apply any contributions received on my behalf as indicated on the Investment Option Election Form.

## E. Acknowledgement and Authorization

**I acknowledge that I have read and understand the provisions and restrictions and confirm receipt of the current prospectus, if applicable, as described in Participant Enrollment Provisions and Restrictions (R-20340).** I agree that the above information and statements contained in Participant Enrollment Provisions and Restrictions (R-20340) are true and correct to the best of my knowledge and belief and are made a basis for my application.

**Under penalties of perjury, by signing below, I hereby certify (1) that the Social Security or Taxpayer I.D. Number above is correct and (2) that I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report interest and dividends, or (b) the Internal Revenue Service (IRS) has notified me that I am no longer subject to backup withholding.**

**The IRS does not require your consent to any portions of this document other than certifications required to avoid backup withholding.**

For voluntary plans and/or residents of Florida, does this annuity replace any existing insurance or annuity?

Yes  No **If yes, submit any required replacement forms.**

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date





**C. Investment Elections** — See Participant Enrollment Provisions and Restrictions (R-20340) prior to proceeding

Investment Name	Internal Code	Investment Category	Election Percentage
Russell LifePoints® Bal Strat	PS	Balanced	<input type="text"/> <input type="text"/> <input type="text"/> %
TIAA-CREF Large-Cap Value Idex	5D	Large-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
State Street Equity 500 Index	X2	Large-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
TIAA-CREF Growth & Income	5A	Large-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
TIAA-CREF Social Choice Equity	5E	Large-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Amer Fds Grwth Fund Of America	8E	Large-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
TIAA-CREF Large-Cap Gro Index	5C	Large-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Goldman Sachs Mid Value	93	Mid-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Columbia Mid Cap Index	CA	Mid-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Prudential Jenn MidCap Growth	JC	Mid-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
DFA US Targeted Value	XM	Small-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Goldman Sachs Small Value	95	Small-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Columbia Small Cap Index	CB	Small-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
BlackRock SmallCap Growth Eqty	BF	Small-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Vanguard VIF Small Comp Growth	V4	Small-Cap Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
DFA Emerging Markets Value	XH	Foreign Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
DFA Intl Value	XL	Foreign Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Amer Fds EuroPacific Growth	8B	Foreign Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %

R-20089



**C. Investment Elections — See Participant Enrollment Provisions and Restrictions (R-20340) prior to proceeding**

Investment Name	Internal Code	Investment Category	Election Percentage
TIAA-CREF Intl Equity Index	5B	Foreign Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Amer Fds Capital World Gro&Inc	8A	World Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
DFA Global Equity	XK	World Stocks	<input type="text"/> <input type="text"/> <input type="text"/> %
Goldman Sachs Tech Tollkeeper	97	Specialty	<input type="text"/> <input type="text"/> <input type="text"/> %
Prudential Jenn Natural Resrcs	JD	Specialty	<input type="text"/> <input type="text"/> <input type="text"/> %
AmCent LIVESTRONG 2015	ZO	Managed Asset Allocation	<input type="text"/> <input type="text"/> <input type="text"/> %
AmCent LIVESTRONG 2025	ZQ	Managed Asset Allocation	<input type="text"/> <input type="text"/> <input type="text"/> %
AmCent LIVESTRONG 2035	ZS	Managed Asset Allocation	<input type="text"/> <input type="text"/> <input type="text"/> %
AmCent LIVESTRONG 2045	ZU	Managed Asset Allocation	<input type="text"/> <input type="text"/> <input type="text"/> %
AmCent LIVESTRONG Income	ZW	Managed Asset Allocation	<input type="text"/> <input type="text"/> <input type="text"/> %
<b>Totals:</b>			<b>100%</b>



**D. Acknowledgement and Authorization**

*Must be completed if not attached to Participant Enrollment Form (R-20087 or R-20088)*

I acknowledge that I have read and understand the provisions and restrictions and confirm receipt of the current prospectus, if applicable, as described in Participant Enrollment Provisions and Restrictions (R-20340). I agree that the information contained in Sections A and B of this form are true and correct to best of my knowledge and belief and are made a basis for my application. I further understand that contributions received after the date this form is processed will be invested according to the elections indicated in Section C.

**Under penalties of perjury, by signing below,** I hereby certify (1) that the Social Security or Taxpayer I.D. Number above is correct and (2) that I am not subject to backup withholding because (a) I have not been notified that I am subject to backup withholding as a result of a failure to report interest and dividends, or (b) the Internal Revenue Service (IRS) has notified me that I am no longer subject to backup withholding.

**The IRS does not require your consent to any portions of this document other than certifications required to avoid backup withholding.**

\_\_\_\_\_  
*Participant Signature*

\_\_\_\_\_  
*Date*



## Participant Enrollment Provisions and Restrictions

Products and financial services provided by  
American United Life Insurance Company®  
a OneAmerica® company  
One American Square, P.O. Box 6011  
Indianapolis, IN 46206-6011  
1-800-249-6269



### CONTRIBUTION ALLOCATION AND ACKNOWLEDGEMENT

Contributions, other than those directed to the AUL Fixed Interest Account, the Liquid Interest Fund, Guaranteed Interest Fund, or the AUL Stable Value Account, will be allocated to the variable account of the AUL American Unit Trust. The variable account is divided into investment accounts. Each investment account invests exclusively in shares of a specific mutual fund, a mutual fund portfolio or a pooled separate account. The investment return and principal value of the investment accounts will fluctuate, so that when redeemed, units may be worth more or less than the original cost.

A current Statement of Additional Information for the AUL American Unit Trust and the OneAmerica Series Fund, Inc. and for any other Mutual Fund being purchased by the Unit Trust for your variable annuity is available at [www.oneamerica.com](http://www.oneamerica.com).

**By signing the Participant Enrollment Form**, you acknowledge that if you do not complete and include the Investment Option Election Form with this enrollment, you are directing AUL Retirement Services to apply any contributions received on your behalf to the default investment option for the plan. You further acknowledge that these elections will take effect when this form is processed at AUL's Corporate Office. Contributions received after the date your form is processed will be invested according to the elections indicated on the Participant Enrollment Form or Investment Option Election Form until changed by you. It is your responsibility to use the transfer feature through OneAmerica TeleServe® (1-800-249-6269) or to log into your secure retirement services account ([www.accountservices.aul.com](http://www.accountservices.aul.com)) to re-direct any defaulted contributions (for which you can direct), if applicable, made to your account into other investment options available for the plan. If you have not already done so, you will need to register and select a password for account access.

### TRANSFER RESTRICTIONS

All or part of your account value may be transferred between the available investment accounts at any time during the accumulation period, but no more frequently than once per day. You can initiate a transfer through OneAmerica TeleServe® (1-800-249-6269), or by registering for and then logging into your secure account at [www.accountservices.aul.com](http://www.accountservices.aul.com).

#### 90-day Fixed Interest Account (FIA) Transfer Restriction

One hundred percent (100%) may be transferred from the Fixed Interest Account at any time. However, once a transfer has been made from your Fixed Interest Account, transfers back into the Fixed Interest Account are allowed only after 90 days have elapsed since your last transfer from the Fixed Interest Account.

### PROSPECTUS RECEIPT CONFIRMATION

For registered contracts, this material must be preceded by or accompanied by a current prospectus. **By signing the Participant Enrollment Form**, you acknowledge receipt of a current electronic prospectus or a paper version of the prospectus, of the OneAmerica Series Fund, Inc., the AUL American Unit Trust and for any other Mutual Fund being purchased by the Unit Trust for your variable annuity account or variable insurance portfolio. If an electronic copy of the prospectus was received, you further acknowledge that you have access to a CD-ROM drive in order to view the prospectus. Payment and values provided by the contract when based on investment performance of the Unit Trust are variable and are not guaranteed as to unit value. For 403(b) or 401/403(b) plans, you further acknowledge that you understand the restrictions on distributions from a 403(b) tax deferred annuity as set out in Section 403(b)(11) of the Internal Revenue Code and in the current AUL American Unit Trust Prospectus. For 457 or 401/457 plans, you further acknowledge that you understand the restrictions on distributions from a 457 deferred compensation plan as set out in Section 457 of the Internal Revenue Code and in the current AUL American Unit Trust Prospectus.

## CATCH-UP CONTRIBUTIONS

**By signing the Participant Enrollment Form**, if allowed by your plan, you understand that if you are eligible to make catch-up contributions, any of your elective deferrals that exceed either the elective deferral dollar limit (the Internal Revenue Code (Code) section 402(g) limit), the annual additions limit (the Code section 415 limit), the plan's deferral limit, or the Actual Deferral Percentage (ADP) limit shall be treated as catch-up contributions, up to the applicable catch-up contributions limit for the calendar year.

Furthermore, you understand that for any calendar year you have made elective deferrals to a retirement plan sponsored by an unrelated employer as well as to this plan, you are responsible for determining if you have exceeded the Code section 402(g) limit in effect for such taxable (calendar) year.

**ADDITIONAL PLAN SPECIFIC PROVISIONS OR LIMITATIONS MAY APPLY. PLEASE REFER TO YOUR SUMMARY PLAN DESCRIPTION (SPD) OR CONTACT YOUR PLAN ADMINISTRATOR FOR ASSISTANCE.**

## STATE NOTIFICATION

### State Specific Fraud Warning Notices for Retirement Services

#### Contract Applications

**All States Not Listed Below:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment or fines, denial of insurance and civil damages. Any insurance company or representative of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

**District of Columbia, Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Florida:** 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.

**Georgia, Vermont:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil fines and criminal penalties.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Tennessee, Virginia, Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal civil penalties.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

## Participant Beneficiary and Pre-Retirement Death Benefit Designations

Products and financial services provided by  
American United Life Insurance Company®  
a ONEAMERICA® company  
One American Square, P.O. Box 6011  
Indianapolis, IN 46206-6011  
1-800-249-6269



### Instructions For Participants

1. Read carefully the "Information for Plan Participant" section of this form. Keep in mind that plan documents may differ in their definitions concerning items such as the revocability of spousal consent, the minimum percentages for a qualified pre-retirement survivor annuity (QPSA) and other significant matters. Consult your plan administrator for details. This form assumes that your plan document provides for a qualified pre-retirement survivor annuity of 100% of your vested account balance.
2. If you wish to designate a beneficiary in accordance with the information referenced above, complete the "Beneficiary Designation" section. If you are participating in a voluntary TDA or IRA, this is the only section required to be completed.
3. If you wish to designate a form of pre-retirement death benefit other than a life annuity in accordance with the information referenced above, complete the "Pre-Retirement Death Benefit" section.
4. If you have completed either of the sections described above, you must complete the "Participant Certification" section, or your spouse must complete the "Spousal Consent and Waiver" section, depending upon your individual circumstances. The spousal consent and waiver must be witnessed by a plan representative or a notary public.
5. Sign and date the form at the bottom of the last page.
6. Keep a copy of this form for your records, and return the original to your plan administrator.

### Information For Plan Administrator

Any plan participant who wishes to designate a beneficiary other than his or her spouse or who wishes to elect a form of pre-retirement death benefit other than a life annuity must do so in writing and must obtain the spouse's consent, also in writing. If the participant is unmarried or cannot locate the spouse, the participant must also attest to that circumstance in writing.

This form has been provided to assist you in your obligation to maintain the written records described above. Retain the original form, and provide the participant with a copy. Make sure the participant initials any corrections. You may witness the spouse's consent and waiver, or you may accept a spousal signature which has been witnessed by a notary public. If the participant affirms that he or she is not married or that the spouse cannot be located, Treasury Regulation § 1.401(a)-20, Q&A-27, provides that "if it is established to the satisfaction of a plan representative that there is no spouse or that the spouse cannot be located, spousal consent to waive the QJSA or the QPSA is not required." Therefore, if the participant states that the spouse cannot be located, you will want to take further action, other than relying upon the participant's statement, such as attempting to contact the spouse at the last known address or telephone number. You may wish to attach documentation of such an attempt to this form.

## Information For Plan Participant

### Beneficiary Designation

If you are married, federal law requires that death benefits from the plan be paid to your spouse to ensure that your spouse receives income from the plan even if you die before you retire. However, you and your spouse may elect to have death benefits paid to someone else. To do this, your spouse must sign the "Spousal Consent and Waiver" section of this form. If you are not married, or if your spouse cannot be located, you must complete the "Participant Certification" section of this form.

If your marital status changes (through death, divorce or marriage), review your beneficiary designation to be sure it meets these requirements; if your name changes, notify your plan administrator.

### Notice of Qualified Pre-Retirement Survivor Annuity (QPSA)

As required by the Retirement Equity Act of 1984, your plan provides that a QPSA be paid to the spouse of a married participant in the event that the participant's death occurs before the benefit under the plan becomes payable. A portion of the value of your vested account balance at death (between 50% and 100%, according to your plan) is used to provide a monthly payment to your spouse for life. This form of benefit is a "life annuity." This form assumes that your plan provides for a QPSA of 100% of your vested account balance at death.

You may elect a form of distribution other than a QPSA if your plan allows. However, in order for such an election to be effective, it must be in writing and must include the consent of your spouse, witnessed by the plan administrator or a notary public. The plan may provide that any such election may be revoked at any time (see "Spousal Consent and Waiver" section), thereby reinstating the QPSA. You may choose to decline automatic QPSA coverage, but only under certain circumstances, as described below.

The period during which you may elect to decline automatic QPSA coverage starts on the latest of:

1. the first day of the plan year in which you attain age 35; or,
2. the date on which you first become a participant; or,
3. the date on which you are first married.

Your election period ends at the earlier of:

1. your death; or,
2. your annuity starting date.

However, if you separate from service of the plan sponsor prior to attaining age 35, the election period begins on your separation from service.

Note: If you are under age 35, you also may elect (with appropriate written spousal consent) to decline automatic QPSA coverage. This election expires at the beginning of the plan year in which you attain age 35, unless you then renew the election and the spousal consent. If you are under age 35 and you want to make this election, you must:

1. notify the plan administrator,
2. secure written spousal consent, and
3. during the plan year in which you attain age 34, complete this form again if you wish to renew your election so that it extends beyond the first day of the plan year in which you attain age 35.

### Trust Information

If your beneficiary is a trust, there shall be no obligation to inquire into the terms of the trust, and payment of the proceeds as provided in the designation will be a full discharge from all liability. If, before payment of the proceeds is made, satisfactory proof is presented that the trust has been revoked or is not in effect at your death, the proceeds shall be paid to the next class of beneficiary or to your estate if there is no such beneficiary. If the trust has been created by a will but fails to come into existence for any reason, the proceeds shall be paid to the next class of beneficiary or to your estate, if there is no such beneficiary.

If your beneficiary is to be a living trust, provide the name and location of the trustee and the name and date of the trust agreement.

### Community Property Information

If there has been no previous written notice of community property interest and the space for the consent of your spouse is not completed, then anyone acting on the information contained herein shall be entitled to rely on his/her good faith belief that no such interest exists. By signing this form, you agree to indemnify and hold any such person harmless from the consequences of his/her action.

This indemnification shall apply to any later payment to a named beneficiary even though:

1. you have not obtained the consent of a former spouse having a community interest; or,
2. you and your spouse subsequently divorce; or,
3. your spouse dies after the date of execution of this designation; or,
4. you and your spouse subsequently sever your interest in the community.



**Pre-Retirement Death Benefit**

Complete this section to elect a form of pre-retirement death benefit other than a life annuity. The reverse side of this form must also be completed.

Pay all pre-retirement death benefits from the plan as selected below (if no option is selected, the form of benefit is a life annuity).

- Option 1 – Lump Sum.
- Option 2 – Certain and Life Annuity. (Select a period.) The period certain is to be \_\_\_\_ 5 \_\_\_\_ 10 \_\_\_\_ 15 years. Monthly payments are to continue for the life of my beneficiary. If my beneficiary should die before the end of the certain period, monthly payments are to continue to my second beneficiary in the same amount for the remainder of the period.
- Option 3 – Discretionary. The form of benefit shall be elected by my beneficiary upon my death.

**Participant Certification**

Complete this section if you are unmarried or cannot locate your spouse, and if:

1. you have designated a beneficiary other than your spouse; or,
2. you have elected a pre-retirement death benefit other than a life annuity.

Check the applicable statement:

- I certify that I am unmarried at this time. I understand the beneficiary designation and/or pre-retirement death benefit election made in this form shall become invalid if I am married at the time of my death unless my spouse has consented in writing to the designations made herein.
- I certify that I am married, but my spouse cannot be located to sign this waiver.

**Participant Signature**

My signature here certifies: that I am designating the beneficiary(ies) defined in "Beneficiary Designation" section (if completed); that I am electing a form of pre-retirement death benefit other than a life annuity in "Pre-Retirement Death Benefit" section (if completed); that I am either unmarried or my spouse cannot be located (as indicated in "Participant Certification" section) if the spousal consent and waiver has not been completed; and that I agree to indemnify and hold harmless from the consequences of his/her action anyone acting on the information contained herein.

\_\_\_\_\_  
*Participant Signature*

\_\_\_\_\_  
*Date*

**Spousal Consent and Waiver**

Your spouse must sign the following consent and waiver if:

1. you have designated a beneficiary other than your spouse; or,
2. you have elected a pre-retirement death benefit other than a life annuity.

Your spouse's signature must be witnessed by a plan representative or by a notary public.

I hereby consent to the beneficiary designation and/or election to decline QPSA coverage under the plan. I understand that, but for this consent and waiver, should the participant die before his or her benefit commencement date under the plan, I would be entitled to receive a surviving spouse's benefit in the form of a lifetime annuity. I have been provided with all information that I may have requested from the plan administrator as to the economic effect of my consent and waiver. I understand fully the consequences of this action on my part and the loss of benefits that I may experience if I survive the participant. I have participated in the participant's decision to designate a beneficiary other than me and/or to decline coverage under the QPSA form of benefit.

I understand that, if the plan gives me the right to revoke this consent and waiver, I may do so by delivering to the plan administrator a written revocation of this consent and waiver, prior to the death of my spouse. Upon the death of my spouse, the consent and waiver contained herein, if not previously revoked, shall be irrevocable.

\_\_\_\_\_  
*Spouse Signature*

\_\_\_\_\_  
*Date*

Witnessed by:

\_\_\_\_\_  
*Plan Representative Signature*

\_\_\_\_\_  
*Date*

IF NOT WITNESSED BY PLAN REPRESENTATIVE, NOTARY PUBLIC MUST WITNESS.

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Notary Public \_\_\_\_\_

County of Residence: \_\_\_\_\_ My Commission Expires: \_\_\_\_\_

**Salary Deferral Agreement**

Products and financial services provided by  
American United Life Insurance Company®  
a ONEAMERICA® company  
One American Square, P.O. Box 6011  
Indianapolis, IN 46206-6011  
1-800-249-6269



EMPLOYEE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

**IT IS HEREBY AGREED by the parties to this Agreement as shown below:**

I. The compensation to be paid by the Employer to the Participant shall be reduced by an amount equal to \_\_\_\_\_% OR \$\_\_\_\_\_ of such compensation as a pre-tax deferral to the plan and/or by \_\_\_\_\_% OR \$\_\_\_\_\_ as a Roth after-tax deferral to the plan. The effective date of this agreement will be determined by my employer and is dependent upon plan document provisions.

**Please refer to your Summary Plan Description (SPD) for deferral limits permitted by your plan or speak with your plan representative.**

II. The Participant releases any and all rights, present and future, to receive from the Employer payment of the amounts resulting from the salary deferral selected in I. in any form except the right of the Participant upon termination of this Agreement or upon termination of employment by a reason other than death to personally receive all or any part of such amounts for which service has been rendered but which have not been transmitted to the life insurance company or companies.

III. This Agreement shall continue indefinitely until amended or terminated by due notice by the Participant to the Employer, subject to the conditions in IV. and V.

IV. If the Participant terminates employment with the Employer, this Agreement shall automatically terminate.

V. If the Employer terminates the program pursuant to which this Agreement is made, this Agreement shall automatically terminate and the procedures described in II. shall be followed.

VI. The Participant agrees that the Employer shall have no liability whatsoever for any loss suffered by the Participant

(a) with regard to his or her selection of a life insurance company contract or of mutual fund shares purchased in a separate account, or

(b) by reason of the Employer's transmittal of contributions.

VII. The Participant understands that

(a) the purpose of the Employer in executing this Agreement is to provide the Participant with an opportunity to benefit from the elective salary deferral provisions of the Internal Revenue Code (as amended) of the United States;

(b) the Employer is not providing tax or investment advice to the Participant that he or she participate in a program described above;

(c) the Employer does not warrant any particular tax consequences to the Participant;

(d) contribution limits may not exceed 100% of pay, the elective deferral limit (the Internal Revenue Code (code) Section 402(g) limit), or the plan's deferral limit and

(e) if allowed by the plan, in the calendar year that the Participant attains age 50, the Participant may make an additional catch-up contribution to plan. Please refer to your Summary Plan Description (SPD) or speak with your plan representative.

IN WITNESS WHEREOF, this Agreement has been executed by and on behalf of the parties hereto.

EMPLOYEE SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

PLAN ADMINISTRATOR: \_\_\_\_\_

DATE: \_\_\_\_\_

# 403(b) Incoming Transfer of Assets Request

Original Form Required for Processing

Products and financial services provided by  
American United Life Insurance Company®  
a ONEAMERICA® company  
One American Square, P.O. Box 6011  
Indianapolis, IN 46206-6011  
1-800-249-6269



To initiate a transfer or exchange of 403(b) assets to American United Life Insurance Company® (AUL) from your current carrier/custodian, please complete this form and forward to AUL at the above address.

Please note, your carrier/custodian may require additional forms to process your transfer request. In order to expedite your transfer or exchange, please contact your current carrier/custodian to obtain any additional forms necessary to process your request.

## Section I. To Be Completed By Plan Participant – Information About You

Your Name: \_\_\_\_\_ Your E-mail Address: \_\_\_\_\_  
Your Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Your Mailing Address: \_\_\_\_\_  
City, State, and Zip: \_\_\_\_\_  
Daytime Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Evening Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
AUL Plan Name: \_\_\_\_\_ AUL Plan Number: \_\_\_\_\_

## Section II. To Be Completed By Plan Participant – Current Carrier/Custodian Information

Current Carrier/Custodian Name: \_\_\_\_\_  
Account Number: \_\_\_\_\_  
Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City, State, and Zip: \_\_\_\_\_  
Requested Amount: \_\_\_\_\_ % or \$ \_\_\_\_\_

12/31/86 balance: \$ \_\_\_\_\_  
The 12/31/86 balance is requested to ensure that any required minimum distribution (RMD) is not calculated on contributions prior to 12/31/86. If we don't have this information, more might be distributed through the RMD than is necessary.

12/31/88 balance: \$ \_\_\_\_\_  
The pre 12/31/88 balance is requested to calculate a hardship distribution accurately by removing amounts contributed prior to 12/31/88.

Please select one option:

- 403(b) Exchange (within the same Employer's plan)  
 403(b) Plan Transfer (from one Employer's plan to a different Employer's plan)

Please Note: This form should not be used to initiate a rollover from a 403(b) Plan. If you are no longer employed with the employer sponsoring the transferring plan, please visit the Rollover Center at [www.oneamerica.com](http://www.oneamerica.com) for the Rollovers and Direct Transfers form.

## Section III. To Be Completed By Participant's Spouse (if applicable)\*

\*Please check with the current carrier/custodian to determine if this section is required.

Participant:

- Married  Not Married  I hereby certify that my spouse cannot be located.

Spousal Consent:

I hereby consent to the transfer/exchange of the account(s) specified. I understand by doing so I am giving up all rights to benefits under the applicable policy/contract(s).

\_\_\_\_\_  
Spouse's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse's Signature Witnessed by Notary Public or Plan Administrator

\_\_\_\_\_  
Date

**Section IV. Instructions To Current Carrier/Custodian**

Please send check along with a copy of this form to:

**American United Life Insurance Company®**

**Regular Mail:  
5391 Reliable Parkway  
Chicago, IL 60686-0053**

**Express Mail:  
One American Square  
Indianapolis, IN 46282**

I affirm that American United Life Insurance Company® (AUL) is either approved under the employer's plan or has entered into an information-sharing agreement with the employer, and that the transferred amounts will be invested in a product that has been approved by the employer and meets the requirements of Internal Revenue Code §403(b). This transaction is intended to qualify as a transfer or exchange and therefore not constitute actual or constructive receipt for Federal income tax purposes.

\_\_\_\_\_  
**AUL Authorized Signer's Name**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**AUL Authorized Signature**

\_\_\_\_\_  
**Date**

**Section V. To Be Completed By Plan Participant – Your Approval**

I authorize this transfer/exchange and certify that the information provided above is complete and accurate to the best of my knowledge. In addition, I certify that AUL is eligible to accept this transfer/exchange on my behalf.

\_\_\_\_\_  
**Your Signature**

\_\_\_\_\_  
**Date**

**Section VI. To Be Completed By Your Employer – Employer Approval**

I certify that the information provided above is complete and accurate to the best of my knowledge and the request complies with the transfer provisions required by the final 403(b) Regulations effective September 25, 2007. A written information-sharing agreement has been or will be established with each product vendor or provider involved in the transfer in order to ensure that certain compliance requirements, such as eligibility status, loans and hardship distributions, are satisfied. This transfer will not result in a reduction of benefit, and the distribution limitations applicable to the recipient plan and contract are as restrictive as those applicable to the distributing plan and contract. Please send check, along with a copy of this form, directly to American United Life Insurance Company®, as indicated in Section IV above.

\_\_\_\_\_  
**Employer Designated Representative Signature**

\_\_\_\_\_  
**Date**

**Rollovers and Direct Transfers**  
(For ALL Rollovers and 457(b)/IRA Transfers)

Products and financial services provided by  
American United Life Insurance Company®  
a ONEAMERICA® company  
One American Square, P.O. Box 6011  
Indianapolis, IN 46206-6011  
Questions? 1-800-348-6229, prompt #2



To initiate a rollover or transfer to American United Life Insurance Company® (AUL), a OneAmerica® company, from your current carrier/custodian, please complete this form and forward to AUL at the above address. Please confirm with your current employer that rollovers are permitted in your plan.

**Please note, your carrier/custodian may require additional forms to process your rollover/transfer request. In order to expedite your rollover/transfer, please contact your current carrier/custodian to obtain any additional forms necessary to process your request.**

**Participant Information**

Participant Name: \_\_\_\_\_ AUL Plan Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**Section I: To Be Completed By Plan Participant**  
*Please complete either the Rollover or Account Transfer section*

**Rollover**

<b>Rollover From</b> <i>(Please check one box, if applicable)</i>	<b>Rollover To</b> <i>(Please check one box, if applicable)</i>
<input type="checkbox"/> 401(a)/401(k) qualified plan	<input type="checkbox"/> 401(a)/401(k) qualified plan
<input type="checkbox"/> 403(b)/TDA plan	<input type="checkbox"/> 403(b)/TDA plan
<input type="checkbox"/> Governmental 457(b)/DCP plan	<input type="checkbox"/> Governmental 457(b)/DCP plan
<input type="checkbox"/> Traditional (Regular) IRA, Rollover IRA, or SEP IRA <i>(After-tax IRA money must transfer to another IRA)</i>	<input type="checkbox"/> Traditional (Regular) IRA

Current Carrier/Custodian Name \_\_\_\_\_

Rollover Amount Requested \_\_\_\_\_ % or \$ \_\_\_\_\_

Account Number \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**For 403(b) Rollovers, please provide the following additional information:**

403(b) 12/31/86 balance: \$ \_\_\_\_\_

The 12/31/86 balance is requested to ensure that any required minimum distribution (RMD) is not calculated on contributions prior to 12/31/86. If we do not have this information, more might be distributed through the RMD than is necessary.

403(b) 12/31/88 balance: \$ \_\_\_\_\_

The pre 12/31/88 balance is requested to calculate a hardship distribution accurately by removing amounts contributed prior to 12/31/88.

**If your rollover contains after-tax contributions, please select the appropriate box(es) and provide the following additional information:**

Roth after-tax contributions

First date of deposit for Roth contributions \_\_\_\_\_

Amount of Roth contributions (not including gains/losses) \$ \_\_\_\_\_

Non-Roth after-tax contributions

Amount of non-Roth contributions (not including gains/losses) \$ \_\_\_\_\_

**Section I: (continued)**

**Account Transfer**

**Account Transfer** (Please check one box, if applicable)

- Traditional (Regular) IRA or SEP IRA INTO a Traditional (Regular) IRA  
(After-tax IRA money must transfer to another IRA)
- Governmental 457(b)/DCP plan INTO a Governmental 457(b)/DCP plan
- "Top Hat" 457(b) plan sponsored by a tax exempt organization to a "Top Hat" 457(b) plan sponsored by a tax exempt organization.

Current Carrier/Custodian Name \_\_\_\_\_

Transfer Amount Requested \_\_\_\_\_ % or \$ \_\_\_\_\_

Account Number \_\_\_\_\_ Telephone Number (\_\_\_\_\_) \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**If your transfer contains after-tax contributions, please select the appropriate box(es) and provide the following additional information:**

Roth after-tax contributions

First date of deposit for Roth contributions \_\_\_\_\_

Amount of Roth contributions (not including gains/losses) \$ \_\_\_\_\_

Non-Roth after-tax contributions

Amount of non-Roth contributions (not including gains/losses) \$ \_\_\_\_\_

**Section II: Signature Section**

By signing below, I hereby direct the investment provider identified on this form to liquidate the designated estimated total rollover/transfer amount listed on this form, and to release the proceeds to my account under my employer's plan with American United Life Insurance Company® (AUL), except to the extent my current employer or any of my former employers prohibit such release. In the event of such prohibition, I hereby direct said investment provider to retain the nontransferable portion of my account(s) in a separate account or contract and to release the remainder.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

I am including the rollover/transfer check with this form.

**Section III: Instructions To Current Carrier/Custodian**

Please send check along with a copy of this form to:

**American United Life Insurance Company®**

**6805 Reliable Parkway**

**Chicago, IL 60686-0053**

**This document will act as a letter of acceptance and verification that these funds will be deposited into an American United Life Insurance Company® Group Annuity contract.** This transaction is intended to qualify as a direct rollover/transfer and therefore not constitute actual or constructive receipt for Federal income tax purposes.

\_\_\_\_\_  
Authorized Home Office Representative

Retirement Services Division

American United Life Insurance Company®

\_\_\_\_\_  
Date