Lilly Statement of Insurability and Notice of Insurance Information Practices Packet

ONEAMERICA®

Products and financial services provided by
AMERICAN UNITED LIFE INSURANCE COMPANY® | *a* ONEAMERICA® *company*
One American Square, P.O. Box 368 | Indianapolis, Indiana 46206-0368 | 1-800-553-5318 | www.oneamerica.com

Lilly Statement of Insurability

American United Life Insurance Company®
a OneAmerica® *company*
P.O. Box 6123
Indianapolis, IN 46206-6123
Attn: Group Division, Medical Underwriting
Support Unit

OneAmerica®

This form is to be used by Lilly employees whenever they are required to submit evidence of insurability (EOI) after electing supplemental life insurance, dependent life insurance, or Flexible CarePLUS during annual enrollment or after a qualifying change in status.

This information must be submitted and postmarked:

Annual Enrollment - By January 15 for all life insurance elections made during annual enrollments requiring EOI. (If January 15 falls on a weekend or holiday, the deadline will be the next available business day).

Change in Status - Within 60 days after the qualifying event date for all life insurance elections made after a change in status requiring EOI.

Note: If this form is not received at AUL by the deadlines noted above, your request for life insurance will be denied. Any coverage or additional coverage applied for within the deadlines noted above will not become effective until Evidence of Insurability is approved by AUL. 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.

Notices Affecting Coverages

Medical Information Bureau Notice

We or our reinsurers may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, if allowed by state law. The MIB is a nonprofit organization of life insurance companies. It is an information exchange for its members. If you apply to a MIB member company for life or health insurance, or file a claim with such a company, the MIB, upon request, will give the company the information in the MIB's file.

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

We or our reinsurers may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim 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

AUL shall not be liable for any claim with respect to any individual commencing prior to the date of such approval until the pre-existing conditions limitations are met. Approval is subject to all policy provisions including the pre-existing conditions limitation.

Fraud Notice

- **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 fines and confinement in prison.**
- **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, fines, denial of insurance, and civil damages. Any insurance company or agent 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: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**
- **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.**
- **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.**
- **Louisiana and 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.**
- **Maine: Any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties may include imprisonment, fines or denial of insurance benefits.**
- **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 or knowingly and willfully fails to provide material information in connection with the person's eligibility or continued eligibility for benefits under a disability insurance policy, is guilty of a crime and may be subject to fines and imprisonment.**
- **New Jersey: Any person who includes any false or misleading information on any application for an insurance policy is subject to criminal and civil penalties.**
- **New Mexico: 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.**
- **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.**
- **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.**
- **Tennessee, Virginia and 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 include imprisonment, fines, and denial of insurance benefits.**

THE FLEXIBLE CAREPLUS POLICY DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE INDIANA LONG TERM CARE PROGRAM. HOWEVER, THE POLICY IS AN APPROVED LONG TERM CARE INSURANCE POLICY UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE INDIANA LONG TERM CARE PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE INDIANA DEPARTMENT OF INSURANCE AT 1-800-452-4800.

Receipt of the Flexible CarePLUS Accelerated Benefit may be taxable. Please seek assistance from a personal tax advisor.

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American United Life Insurance Company®
a OneAmerica® company
P.O. Box 6123
Indianapolis, IN 46206-6123
Attn: Group Division, Medical Underwriting
Support Unit

OneAmerica®

A. General Employee Information

Employee Name (Last, First, Middle)	Birthplace	DOB	Sex	Height	Weight
CHRISMAN, STEVE K	Marion, IN	07/01/1970	Male	5'5"	175

Complete Home Address 1 MAIN STREET City/State Helmer, IN Zip Code 46777

Home Phone Number with Area Code (317) 7736940 Social Security Number 000916760

Monthly Base Salary Amount _____ E-mail Address STEVE.CHRISMAN@ONEAMERICA.COM

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

Spouse Name (Last, First, Middle)			Birthplace	DOB	Sex	Height	Weight
CHRISMAN, S			Garrett, IN	03/01/1970	Female	5'	185
Other Dependents	**Relationship to You**	**Full-Time Student**	**Birthplace**	**DOB**	**Sex**	**Height**	**Weight**
CHRISMAN, A	Son	X Y/N	Indianapolis, IN	05/01/1999	Male	5'5"	110
CHRISMAN, R	Daughter	X Y/N	Indianapolis, IN	09/01/2002	Female	4'3"	70
Chrisman, K	Daughter	Y/N X	Indianapolis, IN	11/24/2006	Female	4'0"	40
		Y/N					

C. Medical Questions

1. Within the past 7 years, have you (if applying for coverage) and/or your dependents (if applying for coverage) been diagnosed or treated by a physician or qualified professional, or tested positive for the presence of, or taken prescribed medicine for:

	Yes	No		Yes	No
Cancer		X	Kidney/Bladder/Pancreatic Disease		X
Diabetes or other Glandular Disorders		X	Prostate/Reproductive Organ Disorder		X
Chest Pain or Heart Attack		X	Neurological or Brain Disorder including Epilepsy or Paralysis		X
Heart Disease or Disorder including Murmurs		X	Psychological/Emotional Disorder or Depression		X
High Blood Pressure. If yes, please provide Last Reading _____ Date _____		X	Neuromuscular or Musculoskeletal Disorders including Arthritis and Back Disorders		X
Anemia or Blood Disorders (except HIV)		X	Lung or Respiratory Disorder/Disease		X
Liver Disorder or Hepatitis		X	Skin or Lymph Gland Disorders		X
Stomach and/or Intestinal Disorders	X		Eye, Ear, Nose and Throat Disorders		X
Stroke		X	Any sexually transmitted disease (except HIV)		X

2. Within the past 7 years, have you (if applying for coverage) and/or your dependents (if applying for coverage) been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or immune deficiency related disorders or tested positive for antibodies to the HIV virus (CA only, except HIV infection/exposure)?

Yes	No
	X

*Residents of the following states are not required to answer the above question with regard to the following diagnosis or test: ME and GA – immune deficiency related disorders; MI and VT – ARC or HIV; NC – ARC; NJ – HIV; WI – HIV testing other than FDA approved.

*Residents of California: "California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."

3. Within the past 5 years, have you (if applying for coverage) and/or your dependents (if applying for coverage): (Please provide full details for any "Yes" responses in Question 4.)

	Yes	No
a. Taken or currently take any prescription medicine? If yes, include name of medicine/reason for using it in question 4.		X
b. Had an electrocardiogram, x-ray, blood study, urinalysis or any other diagnostic study?		X
c. Been rejected, rated, postponed or modified for life insurance?		X
d. Received or been instructed to seek treatment for use or abuse of alcohol or drugs?		X
e. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates or any other habit forming drugs?		X
f. Had any illness, injury, operation or treatment other than stated above?		X

4. Describe details of "Yes" answers to Questions 1, 2 or 3. Be sure to include employee or dependent name, question number, date(s), detail of injury, illness or disorder, medications and name/address of physician/specialist/hospital. If more room is needed, use a separate sheet of paper.

Employee or Dependent Name	Question #	Date	Details of Injury, Illness or Disorder, Medications	Name/Address of Physicians/Specialist/Hospital

5. Provide name(s), address(es) and phone number(s) of any physician(s) and or specialist(s) who have seen you or your dependents in the last 3 years:

Employee or Dependent Name	Date and Reason Last Consulted	Treatment Given or Medication Provided	Name/Address/Telephone Number of Physician/Specialist/Hospital

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. This authorization does not apply to the release of genetic screening or testing. 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.

I represent that the statements and answers given on this form are true and complete to the best of my knowledge and belief. I understand and agree that any insurance which shall be issued is in consideration of these statements being complete and correct. I certify that the notices attached were read and understood prior to the completion of this form, and that I have retained these notices for my records.

Signature of Insured/Employee Date

Signature of Spouse/Eligible Child age 18 or over Date

AMERICAN UNITED LIFE INSURANCE COMPANY®
PIONEER MUTUAL LIFE INSURANCE COMPANY*
R.E. MOULTON, INC.
THE STATE LIFE INSURANCE COMPANY

Authorization for the Release of Health-Related Information
(HIPAA-Compliant Form)

STEVE K CHRISMAN _____ 7 / 1 / 1970
Name of Proposed Insured/Patient (Please type or print.) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider, insurance company, the Medical Information Bureau, or other organization or person that has provided payment, treatment or services to me or on my behalf within the past 10 years or has any records or knowledge of my health within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the partners of OneAmerica Financial Partners, Inc., as listed above. This includes information on the diagnosis or treatment of human immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that partners of OneAmerica® may:

1) underwrite my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
2) obtain reinsurance;
3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) administer coverage; and
5) conduct other legally permissible activities that relate to any coverage I have or have applied for with a OneAmerica financial partner.

This authorization shall remain in force for twenty-four (24) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to:

Attention: Privacy Officer
OneAmerica Financial Partners, Inc.
One American Square
P.O. Box 368
Indianapolis, Indiana 46206

Please Do Not Send Medical Records, etc. to the Privacy Officer

I understand that a revocation is not effective to the extent that any of My Providers have already relied on this authorization to disclose information about me or to the extent that OneAmerica partners have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by any OneAmerica partner except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, OneAmerica partner companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____/_____/_____
Signature of Proposed Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

**A stock subsidiary of American United Mutual Insurance Holding Company.*

American United Life Insurance Company®
a OneAmerica® company
One American Square
P.O. Box 6003
Indianapolis, IN 46206-6003
1-800-537-6442

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United Mutual Insurance Holding Company
a OneAmerica® company
101 North 10th Street
Fargo, ND 58102
1-800-437-4692

The State Life Insurance Company
a OneAmerica® company
P.O. Box 6062
Indianapolis, IN 46206

OneAmerica®

For general inquiries call: 1-877-999-9883

ALWAYS GIVE THIS DOCUMENT TO THE PROPOSED INSURED UPON HIS/HER SIGNING APPLICATION OR EVIDENCE OF INSURABILITY FORM

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 reasons 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 46206-0368.

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 website at www.mib.com.

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.

Answers to Medical Questions

#1 - Stomach and/or Intestinal Disorders

Answer: Yes

Applies to: CHRISMAN, R

Description: test