

Participant Enrollment Form

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



Please print in UPPER CASE letters in Black or Dark Blue ink!

A. Plan Information

Plan Number G70820

Division _____

Plan Name BIG SPRING ISD

B. Participant Information

First Name

M.I.

Last Name

Social Security Number or Taxpayer ID Number

Sex

M F

Date of Birth

/ /
M M D D Y Y Y Y

Street Address Line 1

Street Address Line 2

City

State

Zip Code

-
M M D D Y Y Y Y

Work Telephone Number

Ext.

Home Telephone Number

Email Address

C. Employment Information

To be Completed by Employer for Employer Sponsored Plans, or by Participant for Voluntary 403(b) and IRA Plans.

New Participant

Rehired Participant

Date of Hire / /
M M D D Y Y Y Y

Date of Rehire / /
M M D D Y Y Y Y

R-20087



D. Participation and Investment Options Contributions

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

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.aul.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

Broker/Dealer Authorization

Date

Print Producer / Broker Dealer Name Producer / Broker Dealer Signature AUL Producer / Broker Dealer # Date



Participant Beneficiary Designation Form

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Instructions For Participants

1. Read carefully the "Information for Plan Participant" section.
2. If you wish to designate a beneficiary, complete the "Beneficiary Designation" section.
3. Sign and date the form at the bottom of the last page.
4. Keep a copy of this form for your records, and return the original to your plan administrator.

Information For Plan Participant

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

Only applicable in: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin.

If there has been no previous written notice of a community property interest, 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.

If there is previous written notice of a community property interest, spousal consent if required.

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 divorced; 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.

Participant Name: _____

Social Security Number: _____ Birth Date: _____

Plan Name: Big Spring ISD Plan Number: G70820

Beneficiary Designation

Complete this section to designate a beneficiary or beneficiaries. Enter full names, relationship to you (for example, spouse, child, grandchild, etc.) and date of birth (DOB).

Indicate any that apply: Initial Election Change Receiving Annuity Payments

Benefits are payable to the survivors within the highest class (first, second or third) in equal shares unless specified otherwise here.

The rights of other beneficiaries shall terminate upon such payment. The beneficiary or beneficiaries for the benefit payable at my death should be as follows:

First Beneficiary(ies)

1. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP
2. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP
3. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP

If no first beneficiary is living at the time of the participant's death, proceeds shall be paid to the second beneficiary

Second Beneficiary(ies)

1. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP
2. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP
3. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP

If no first or second beneficiary is living at the time of the participant's death, proceeds shall be paid to the third beneficiary.

Third Beneficiary(ies)

1. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP
2. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP
3. _____ M F
NAME (FIRST, M.I., LAST) SOC. SEC. # RELATIONSHIP DOB
ADDRESS CITY, STATE, ZIP

Participant Signature

My signature here certifies that I am designating the beneficiary(ies) defined in the "Beneficiary Designation" section 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: _____

REQUIRED TO BE COMPLETED IF ANY COMMUNITY PROPERTY EXISTS IN THIS POLICY.

Marital Status: I am married (spouse's signature required below) I am not married

I consent to this Designation.

Spouse's Signature _____

Witness Signature (Required - Cannot be Participant) _____