

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  
P.O. Box 2167  
Fargo, ND 58107  
1-800-437-4692

The State Life  
Insurance Company  
a ONEAMERICA® company  
P.O. Box 6062  
Indianapolis, IN 46206  
1-800-275-5101



Website: [www.oneamerica.com](http://www.oneamerica.com)

**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 reason 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**

We or our reinsurers may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau. The MIB is a not-for-profit organization of insurance companies. It is an information exchange for its members. If you apply to an MIB member company for life or health insurance coverage, the MIB, upon request, will give the company the information in the MIB's file. This may include previously filed claims.

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 in the MIB's file, you may contact the MIB and seek a correction under the procedures in the federal Fair Credit Reporting Act. The address of the MIB is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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 website at [www.mib.com](http://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. I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB. 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.