

Bank Draft Authorization

American United Life Insurance Company® a ONEAMERICA® company One American Square P.O. Box 6002 Indianapolis, IN 46206-6002 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 406 Indianapolis, IN 46206 1-800-428-2316



Check all that apply: American United Life Insurance Company® (AUL) Pioneer Mutual Life Insurance Company The State Life Insurance Company Golden Rule Insurance Company
Administered by The State Life Insurance Company
Hereinafter referred to as "the Company."

HOME OFFICE USE ONLY

Please print all information with the exception of signatures.

Policy Number(s): _____

Last Name of Insureds: _____

Policy Number(s): _____

Last Name of Insureds: _____

(If payments are to be made to repay a policy loan or premium deposit fund, please indicate the policy number and the amount to be deducted. May not be available for all plans.)

General Information

Monthly Draft Days Available For: American United Life Insurance Company® – 1 through 28
The State Life Insurance Company – 1 through 28
Pioneer Mutual Life Insurance Company – 1, 5, 10, 15, 20, 25

Current Draft Date
HOME OFFICE USE ONLY

- Start a new monthly deduction on _____
- Change scheduled deduction day to _____
- Change financial institution for account effective _____
- Other _____

Account Information

Type of Bank Account: Checking Savings

Financial Institution Name

Name on the Account

Address of Financial Institution

Account Number

City, State, Zip Code

Routing and Transit Number

A BLANK VOIDED CHECK FROM THIS ACCOUNT IS REQUIRED FOR VERIFICATION (NOT A DEPOSIT SLIP).

Authorization

For my benefit and convenience, I authorize the Company to charge my account for checks/electronic debits drawn on my account to pay premiums due on my policies, or to make other payments due on my policies. I understand that this agreement does not modify any of the policy provisions and I agree to pay the Company for any withdrawal that is not honored at my financial institution. I may revoke this authorization by written request received by the Company at its Home Office. I also understand and agree that further withdrawals may be discontinued by the Company if any withdrawal is dishonored when presented at my financial institution.

Signatures

Requested change is needed in our Home Office 30 days prior to your next deduction date.

Signature of Account Holder

Printed Name of Account Holder

Account Holder Address: Street/P.O. Box Number

Account Holder Daytime Telephone Number

Account Holder Address: City, State, Zip

Date

Send completed form to OneAmerica, P.O. Box 6002, Indianapolis, IN 46206-6002.
Send completed form for Variable Products to OneAmerica, P.O. Box 7127, Indianapolis, IN 46206-7127.