Authorization for Disclosure

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

OneAmerica Retirement Services LLC
a OneAmerica® company
11270 W. Park Place, Suite 300
Milwaukee, WI 53224
1-800-858-3829

OneAmerica Retirement Services LLC
a OneAmerica® company
225 Broadway, Suite 500
San Diego, CA 92101-5029
Questions? 1-800-660-6282

This form authorizes the participant service center to provide participant account information to another individual not listed on the account when the individual calls the service center.

Plan and Participant Information

Plan Name ______________________ Plan Number ______________________

Participant Name ______________________ Social Security Number ______________________

Participant Authorization

I hereby allow the designated individual to have access to my account information by calling the Participant Service Center of American United Life Insurance Company® (AUL) or OneAmerica Retirement Services LLC (OARS), as applicable. I realize the AUL or OARS representative will verify the individual's identity using the information on this form before providing my account information over the phone. No information will be mailed to this individual.

I may revoke this authorization by sending a signed letter indicating my request to AUL or OARS at the appropriate address listed on this form.

I understand that AUL or OARS will not allow the individual to take any action (changing personal data, elections, contributions, withdrawals, etc.) in regard to my account with AUL or OARS. Only disclosure of account information over the phone will be allowed. I hereby hold AUL or OARS harmless for any action that the individual referenced may take using the authorized account information which I have agreed to disclose.

______________________ ______________________ ______________
Participant's Printed Name *Participant's Signature* *Date*

Witnessed by:

______________________ ______________
Plan Representative's 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: ______________

Designated Individual Information

______________________ ______________________
Name Relationship to Participant

______________________ ______________________
Street Address City, State, Zip

______________________ ______________________
Telephone Number Email Address

*Plan Representative: DCP Trustees, Southwest Services Administrators staff, Local 49 staff.

Submit completed form to Local 49:

Fax: (505) 266-5879

E-mail: info@smwlu49.org

Mail: 2300 Buena Vista Dr. SE, Ste. 110, Albuquerque, NM 87106