USAble Life

P.O. Box 1650 · Little Rock, Arkansas 72203

VOLUNTARY PRODUCTS ENROLLMENT FORM (PLEASE PRINT)

❑ New Enrollee ❑ Change ❑ Decline all coverages

Employer: If evidence of insurability (EOI) is required, please submit the Evidence of Insurability form along with this enrollment form to us.

EMPLOYER INFORMATION

Employer's Name		Group #
Employee's Salary $ ____________ ☐ Weekly ☐ Monthly ☐ Annual		
Hours Worked Weekly	Dept/Location	
Date Employed Full-time	Voluntary STD Income Protection Plan, if offered	
Voluntary LTD Plan, if offered Plan: ________ Elimination Period: ________ days Class: ______		

SECTION I. EMPLOYEE INFORMATION

Employee's Name (First, MI, Last)		Social Security No.
Occupation (Be Exact)		Employee's State of Residence
Date of Birth	Sex ☐ Male ☐ Female	

PLAN INFORMATION - Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete Evidence of Insurability (EOI).

SECTION II. VOLUNTARY COVERAGE(S) – SEE INSTRUCTIONS ON REVERSE OR PAGE 2

Complete this Section if applying for these coverages. EOI may be required.			Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	**Employee**	☐ Yes ☐ No	☐	☐	☐	☐		
	Spouse*	☐ Yes ☐ No	☐	☐	☐	☐		
	Children	☐ Yes ☐ No	☐	☐	☐	☐		
B. Voluntary AD&D:	**Employee**	☐ Yes ☐ No	☐	☐	☐	☐		
(EOI not required)	**Spouse***	☐ Yes ☐ No	☐	☐	☐	☐		
	Children	☐ Yes ☐ No	☐	☐	☐	☐		
C. Voluntary STD Income Protection (VIP):		☐ Yes ☐ No	☐	☐	☐	☐	**per week**	
D. Voluntary Long Term Disability:		☐ Yes ☐ No	☐	☐	☐	☐	**per month**	

Do you presently have other disability coverage? ☐ Yes ☐ No
If yes, give monthly amount $ ________________

Do you intend to replace existing coverage with this policy? ☐ Yes ☐ No

*If applying for Spouse's coverage - Spouse's Name (First, MI, Last)	Social Security No.	Spouse's Date of Birth	Sex ☐ Male ☐ Female

Have you or your spouse used tobacco products in the past year? Employee ☐ Yes ☐ No Spouse (if applying for coverage) ☐ Yes ☐ No
Are you actively at work on the date of this application? ☐ Yes ☐ No

PRE-EXISTING CONDITIONS LIMITATIONS AND BENEFIT GUIDELINES

- New Voluntary STD (VIP) plans and benefit increases: During the first year of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage.
- New Voluntary LTD plans and benefit increases: During the first 2 years of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage, unless you go 6 consecutive months treatment free.
- Your Voluntary STD (VIP) weekly benefit may not exceed the benefit percentage stated in your policy. Your Voluntary LTD monthly benefit may not exceed 60% of your basic monthly income (excluding bonus, overtime or any extra compensation other than commissions). If you are eligible for state-mandated temporary disability benefits, or any employer-paid disability income plan, the combination of your state mandated benefit or employer-paid disability income benefit and your VIP weekly benefit may not exceed 70% of your basic weekly earnings.

SECTION III. EMPLOYEE BENEFICIARY DESIGNATION

☐ **Check if Change Only**

Must be completed if you have applied for Voluntary Life or AD&D insurance. If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If you list benefit percentages, the total must equal 100%. If no primary beneficiary survives you, proceeds will be paid to the secondary beneficiary(ies). The employee is the beneficiary of his spouse and/or children.

Name (Last, First, MI)	Address	SSN	Birth Date	Relationship	Primary or Secondary	Percentage Distribution

I represent that the information provided above is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I hereby designate the above beneficiaries under this certificate and revoke the appointment of any existing beneficiary. For those coverages I have declined, I understand that if I choose to enroll at a later date, an EOI may be required. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay. **Warning - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and a denial of insurance benefits in accordance with applicable state law.**

______________________________ Employee's Signature

______________ Date

Date Received - Home Office	
Eff. Date	

INSTRUCTIONS – How to Complete Section II

Initial Enrollment –Adding Coverage:

Check "Yes" by each coverage you want. Check "No" by each coverage you do not want.
If you checked "Yes" by a coverage, check the "Add New" box, and complete the "Total Amount of Coverage" for which you are applying.

For Example, you are applying for:

- Voluntary Group Life: $50,000 on yourself, $20,000 on your spouse, and no coverage on your children
- Voluntary AD&D: $100,000 on yourself; $50,000 on your spouse, $5,000 on your children
- Voluntary LTD: $2,000 per month

SECTION II. VOLUNTARY COVERAGE(S) Complete this Section if applying for these coverages. EOI may be required when applying for these coverage(s).				Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	Employee	☒ Yes	☐ No	☒	☐	☐	☐	$50,000	
	Spouse*	☒ Yes	☐ No	☒	☐	☐	☐	$20,000	
	Children	☐ Yes	☒ No	☐	☐	☐	☐		
B. Voluntary AD&D:	Employee	☒ Yes	☐ No	☒	☐	☐	☐	$100,000	
(EOI not required)	Spouse*	☒ Yes	☐ No	☒	☐	☐	☐	$50,000	
	Children	☒ Yes	☐ No	☒	☐	☐	☐	$5,000	
C. Voluntary STD Income Protection (VIP):		☐ Yes	☒ No	☐	☐	☐	☐	per week	
D. Voluntary Long Term Disability:		☒ Yes	☐ No	☒	☐	☐	☐	$2,000 per month	

How To Change or Delete Coverage:

If you are changing any of your coverage, please complete the information for all of the coverage you have, so that we are sure we have everything correct. Be sure to check the appropriate "Add," "Delete," "Increase", or "Decrease" box.

For Example, you **currently** have:

- Voluntary Group Life: $60,000 on yourself, $30,000 on your spouse, and $10,000 coverage on your children
- Voluntary STD (VIP): $300 per week

You want to **change** your coverage to:

- Voluntary Group Life: $100,000 on yourself (increase), $20,000 on spouse (decrease), and no coverage for children (delete)
- Voluntary AD&D: $100,000 on yourself only (add)
- Voluntary STD (VIP): $300 per week (no change)

SECTION II. VOLUNTARY COVERAGE(S) Complete this Section if applying for these coverages. EOI may be required when applying for these coverage(s).				Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	Employee	☒ Yes	☐ No	☐	☐	☒	☐	$100,000	
	Spouse*	☒ Yes	☐ No	☐	☐	☐	☒	$20,000	
	Children	☐ Yes	☒ No	☐	☒	☐	☐		
B. Voluntary AD&D:	Employee	☒ Yes	☐ No	☒	☐	☐	☐	$100,000	
(EOI not required)	Spouse*	☐ Yes	☒ No	☐	☐	☐	☐		
	Children	☐ Yes	☒ No	☐	☐	☐	☐		
C. Voluntary STD Income Protection (VIP):		☒ Yes	☐ No	☐	☐	☐	☐	$300 per week	
D. Voluntary Long Term Disability:		☐ Yes	☒ No	☐	☐	☐	☐	per month	