**USAble Life**
P.O. Box 1650
Little Rock, Arkansas 72203

# Group Enrollment or Change Form

**(Please print or type in Black ink.)**

☐ New Employee ☐ Declination ☐ Class or Salary Change
☐ Beneficiary Change ☐ Change of Name ☐ Termination Date: _____
☐ Dependent Status Change (Indicate reason _____)
☐ Reinstatement (Complete Date of Rehire as Employment Date)

**Group #** _____
**Class** _____
**Dept/Location** _____
**Eff Date** _____

## SECTION 1 - APPLICANT INFORMATION

| Employee Legal Name (First, M.I., Last) | | | For Name Change, Give Prior Last Name | |
|---|---|---|---|---|
| Home Address | City | State | Zip | Telephone No. |
| Social Security # | Date of Birth | Gender ☐ Male ☐ Female | | Marital Status |
| Occupation | Hours worked weekly | | Date Employed Full-time | |
| Employer's Name | | | Salary $ _____ ☐ Weekly ☐ Monthly ☐ Annual | |

## SECTION 2 - Complete this Section if applying for Optional Coverage(s). Evidence of Insurability (EOI) may be required when applying for these coverage(s).

| | Add | Delete |
|---|---|---|
| Dependent Life | ☐ | ☐ |
| Supp Life | ☐ | ☐ |
| Supp AD&D | ☐ | ☐ |
| STD | ☐ | ☐ |
| LTD | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

Indicate Date of: Marriage/Divorce_____ Birth of Child_____

| Dependents to be Covered | Relationship | Birthdate | SSN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## SECTION 3 - BENEFICIARY DESIGNATION /CHANGE ■ Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

**PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):**

| Name (Last, First, MI) | Address | SSN | Birthdate | Relationship | Percentage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Total must equal 100%** = 0

**CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):**

| Name (Last, First, MI) | Address | SSN | Birthdate | Relationship | Percentage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Total must equal 100%** = 0

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. For those coverages I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability 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.

_____ Date

_____ Signature of Employee

**Date Received - Home Office**

**USAble Life**
P.O. Box 1650 · Little Rock, Arkansas 72203

# VOLUNTARY LIFE ENROLLMENT FORM
(PLEASE PRINT)

| ☐ New Enrollee | ☐ Change | ☐ Decline coverage | Group #: |
|---|---|---|---|

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

Employer's Name

## SECTION I. EMPLOYEE INFORMATION

| Employee's Legal Name (First, MI, Last) | | | Social Security No. | |
|---|---|---|---|---|
| Home Address | City | State | Zip | Telephone No. |
| Date of Birth / Gender ☐ M ☐ F | Salary $ _____ ☐ Weekly ☐ Monthly ☐ Annual | | | |
| Occupation (Be Exact) | Dept/Location | | | |
| Hours Worked Weekly | Date Employed Full-time | | | |

**PLAN INFORMATION - Ask your employer for the details about the cost, if any, and whether you will be required to complete Evidence of Insurability (EOI).**

## SECTION II. VOLUNTARY – SEE INSTRUCTIONS ON REVERSE OR PAGE 2

| Complete this Section if applying for these coverages. Evidence of Insurability may be required. | | Add New | Delete | Increase Existing | Decrease Existing | Total Amount of Coverage | Premium (Completed by Employer) |
|---|---|---|---|---|---|---|---|
| **Voluntary Group Life:** | **Employee** ☐ Yes ☐ No | ☐ | ☐ | ☐ | ☐ | | |
| | **Spouse** ☐ Yes ☐ No | ☐ | ☐ | ☐ | ☐ | | |
| | **Children** ☐ Yes ☐ No | ☐ | ☐ | ☐ | ☐ | | |

| Dependents to be covered | Gender | Relationship | Social Security No. | Date of Birth |
|---|---|---|---|---|
| | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |

Have you or your spouse (if applying for coverage) used tobacco products in the past year? **Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

Are you actively at work on the date of this application? ☐ Yes ☐ No

## SECTION III. EMPLOYEE BENEFICIARY DESIGNATION ☐ Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

**PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):**

| Name (Last, First, MI) | Address | SSN | Birthdate | Relationship | Percentage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | **Total must equal 100% =** | 0 |

**CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):**

| Name (Last, First, MI) | Address | SSN | Birthdate | Relationship | Percentage |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | **Total must equal 100% =** | 0 |

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. For coverage I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability 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 purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

_____ Employee's Signature

_____ Date

**Date Received - Home Office**

VGTL-APP (5-09)

MONTHLY RATES FOR EMPLOYEE AND SPOUSE COVERAGE

| Ages -> | < 35 | 35 - 39 | 40 - 44 | 45 - 49 | 50 - 54 | 55 - 59 | 60 - 64 | 65 - 69 | 70 - 74 | 75 - 79 | 80+ |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate --> | $ 0.09 | $ 0.12 | $ 0.20 | $ 0.36 | $ 0.58 | $ 0.90 | $ 1.36 | $ 1.91 | $ 2.72 | $ 3.97 | $ 5.80 |
| Additional Amount | | | | | | | | | | | |
| $10,000 | $ 0.90 | $ 1.20 | $ 2.00 | $ 3.60 | $ 5.80 | $ 9.00 | $ 13.60 | $ 19.10 | $ 27.20 | $ 39.70 | $ 58.00 |
| $20,000 | $ 1.80 | $ 2.40 | $ 4.00 | $ 7.20 | $ 11.60 | $ 18.00 | $ 27.20 | $ 38.20 | $ 54.40 | $ 79.40 | $ 116.00 |
| $30,000 | $ 2.70 | $ 3.60 | $ 6.00 | $ 10.80 | $ 17.40 | $ 27.00 | $ 40.80 | $ 57.30 | $ 81.60 | $ 119.10 | $ 174.00 |
| $40,000 | $ 3.60 | $ 4.80 | $ 8.00 | $ 14.40 | $ 23.20 | $ 36.00 | $ 54.40 | $ 76.40 | $ 108.80 | $ 158.80 | $ 232.00 |
| $50,000 | $ 4.50 | $ 6.00 | $ 10.00 | $ 18.00 | $ 29.00 | $ 45.00 | $ 68.00 | $ 95.50 | $ 136.00 | $ 198.50 | $ 290.00 |
| $60,000 | $ 5.40 | $ 7.20 | $ 12.00 | $ 21.60 | $ 34.80 | $ 54.00 | $ 81.60 | $ 114.60 | $ 163.20 | $ 238.20 | $ 348.00 |
| $70,000 | $ 6.30 | $ 8.40 | $ 14.00 | $ 25.20 | $ 40.60 | $ 63.00 | $ 95.20 | $ 133.70 | $ 190.40 | $ 277.90 | $ 406.00 |
| $80,000 | $ 7.20 | $ 9.60 | $ 16.00 | $ 28.80 | $ 46.40 | $ 72.00 | $ 108.80 | $ 152.80 | $ 217.60 | $ 317.60 | $ 464.00 |
| $90,000 | $ 8.10 | $ 10.80 | $ 18.00 | $ 32.40 | $ 52.20 | $ 81.00 | $ 122.40 | $ 171.90 | $ 244.80 | $ 357.30 | $ 522.00 |
| $100,000 | $ 9.00 | $ 12.00 | $ 20.00 | $ 36.00 | $ 58.00 | $ 90.00 | $ 136.00 | $ 191.00 | $ 272.00 | $ 397.00 | $ 580.00 |
| $110,000 | $ 9.90 | $ 13.20 | $ 22.00 | $ 39.60 | $ 63.80 | $ 99.00 | $ 149.60 | $ 210.10 | $ 299.20 | $ 436.70 | $ 638.00 |
| $120,000 | $ 10.80 | $ 14.40 | $ 24.00 | $ 43.20 | $ 69.60 | $ 108.00 | $ 163.20 | $ 229.20 | $ 326.40 | $ 476.40 | $ 696.00 |
| $130,000 | $ 11.70 | $ 15.60 | $ 26.00 | $ 46.80 | $ 75.40 | $ 117.00 | $ 176.80 | $ 248.30 | $ 353.60 | $ 516.10 | $ 754.00 |
| $140,000 | $ 12.60 | $ 16.80 | $ 28.00 | $ 50.40 | $ 81.20 | $ 126.00 | $ 190.40 | $ 267.40 | $ 380.80 | $ 555.80 | $ 812.00 |
| $150,000 | $ 13.50 | $ 18.00 | $ 30.00 | $ 54.00 | $ 87.00 | $ 135.00 | $ 204.00 | $ 286.50 | $ 408.00 | $ 595.50 | $ 870.00 |

**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

| SECTION II. VOLUNTARY COVERAGE(S) Complete this Section if applying for these coverages. Evidence of Insurability may be required. | | | | Add New | Delete | Increase Existing | Decrease Existing | Total Amount of Coverage | Premium (Completed by LKSD) |
|---|---|---|---|---|---|---|---|---|---|
| Voluntary Group Life: | Employee | Yes | No | ✓ | | | | $50,000 | |
| | Spouse | Yes | No | ✓ | | | | $20,000 | |
| | Children | Yes | No | | | | | | |

*Spouse amount CANNOT exceed Employee Amount

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

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)

| SECTION II. VOLUNTARY COVERAGE(S) Complete this Section if applying for these coverages. Evidence of Insurability may be required. | | | | Add New | Delete | Increase Existing | Decrease Existing | Total Amount of Coverage | Premium (Completed by LKSD) |
|---|---|---|---|---|---|---|---|---|---|
| Voluntary Group Life: | Employee | Yes | No | | | ✓ | | $100,000 | |
| | Spouse | Yes | No | | | | ✓ | $20,000 | |
| | Children | Yes | No | | ✓ | | | | |