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	Indicate Date of: Marriage/Divorce____________ Birth of Child______________			
Dependent Life	☐	☐				
Supp Life	☐	☐	**Dependents to be Covered**	**Relationship**	**Birthdate**	**SSN**
Supp AD&D	☐	☐				
STD	☐	☐				
LTD	☐	☐				
	☐	☐				
	☐	☐				
	☐	☐				

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%	=

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%	=

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