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 #
Pulaski County Employees	50000047

Employee's Salary ☐ Weekly ☐ Monthly ☑ Annual

Hours Worked Weekly	Dept/Location

Date Employed Full-time

SECTION I. EMPLOYEE INFORMATION

Employee's Name (First, MI, Last)	Social Security No.

Occupation (Be Exact)	Employee's State of Residence
	AR

Date of Birth	Sex
	☐ Male ☐ Female

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 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	☐	☐	☐	☐		
B. Voluntary Group Life:	**Spouse*** ☐ Yes ☐ No	☐	☐	☐	☐		
C. Voluntary Group Life:	**Children** ☐ Yes ☐ No	☐	☐	☐	☐		

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

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%	=

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. 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 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
Eff. Date