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

EMPLOYEE ENROLLMENT FORM
(PLEASE PRINT)

❑ **New Enrollee** ❑ **Change** ❑ **Rehire** ❑ **Other:**

SECTION I. POLICYHOLDER INFORMATION (to be completed by the Policyholder)

Policy Number	Division Number	Policyholder Name

Employee Information: Class (if applicable): _____ Hours Worked Per week: _____ Hire Date: _____

Occupation/Title: _____ Annual Salary: $_____

Application Type ☐ Initial Request ☐ Change in Status ☐ Annual Enrollment | Date of Event (m/d/yyyy)

SECTION II. EMPLOYEE INFORMATION (to be completed by the Employee)

Employee Legal Name (Last) First) (MI)					Social Security Number
☐ Married ☐ Unmarried	☐ Male ☐ Female	Date of Birth	Tobacco User ☐ Yes ☐ No	Telephone	E-Mail

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

Employee Home Address (Street, City, State, Zip)

If you are applying for *Voluntary disability* coverage do you currently have other disability coverage: ☐ Yes ☐ No, if "yes", what is the monthly amount $ _____ Do you intend to replace this coverage with this policy: ☐ Yes ☐ No

SECTION III. ENROLLMENT INFORMATION (to be completed by the Employee, check all that apply)

PLAN INFORMATION – Your 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).

BASIC COVERAGES*

COVERAGE	YES	NO
Life	☐	☐
AD&D	☐	☐
Dependent Life	☐	☐
Short term Disability	☐	☐
Long term Disability	☐	☐

**If your employer is paying 100% of the cost you will automatically be enrolled, you must elect "Yes"*

VOLUNTARY COVERAGES

COVERAGE	PARTICIPANT	YES	NO	AMOUNT
Life	Employee	☐	☐	$ _____
	Spouse	☐	☐	$ _____
	Child	☐	☐	$ _____
AD&D	Employee	☐	☐	$ _____
	Spouse	☐	☐	$ _____
	Child	☐	☐	$ _____
Short term Disability	Employee	☐	☐	$ or % _____
Long term Disability	Employee	☐	☐	$ or % _____

If you do not enroll for coverage when first eligible, you will be required to submit satisfactory evidence of insurability to us. Amounts above the guarantee issue amount will be subject to satisfactory evidence of insurability.

SECTION IV. DEPENDENT INFORMATION (Completed by the Employee if dependents are elected for "Voluntary" Coverage)

Spouse Legal Name (Last) (First) (MI)			Social Security Number
☐ Male ☐ Female	Date of Birth	Tobacco User ☐ Yes ☐ No	

SECTION V. BENEFICIARY INFORMATION (to be completed by the Employee)

Beneficiary Name(s): Please provide full legal name of beneficiary (Example Helen Louise Jones not Mrs. H.L. Jones)

Use a separate sheet for additional beneficiaries, if necessary. If more than one beneficiary is named, payment will be made in equal amounts unless otherwise stated in writing.

Name	Date of Birth	Relationship	Primary or Secondary	Indicate % Distribution	
				Primary	Secondary
			☐ Primary or ☐ Secondary		
			☐ Primary or ☐ Secondary		
			Total must equal 100%	100%	100%

SECTION VI. SIGNATURE (to be completed by the Employee)

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.

Signed at: _____ Date of Application _____
City and State Month, Day, Year

_____
Employee's Signature

Date Received Home Office