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

VOLUNTARY LIFE AND AD&D ENROLLMENT FORM
(PLEASE PRINT)

❑ New Enrollee	❑ Change	❑ Decline all coverages	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 COVERAGE(S) – 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)
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	☐	☐	☐	☐		

Do you intend to replace existing coverage with this policy? ☐ 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 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 purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date Received - Home Office

_____ Employee's Signature

_____ Date

VGLA-APP (5-09)

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

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 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	

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 AD&D: $100,000 on yourself only

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 (no change), $50,000 on spouse (add)

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 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	☒	☐	☐	☐	$50,000	
	Children	☐ Yes ☒ No	☐	☐	☐	☐		