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% =

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 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	☐	☐	☐	☐		

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

EVIDENCE OF INSURABILITY (Please Print)

A completed Enrollment Form must accompany this form.

SECTION 1 –Completed By Employer

Group Name	Date of Hire	Telephone # (include area code)	Group Number

Amount of Insurance Applying for:
Employee Life: $ Dependent Life $ Disability $ Other:

Employee's Annual Salary

SECTION 2 – Completed by Employee ☐ **Vol. Group Term Life** ☐ **Amount over Guarantee Issue** ☐ **Late Enrollee**

Name (First, MI, Last)	Social Security No.

Home Address	City	State	Zip	County

Date of Birth	Birth State or Country	Gender ☐ M ☐ F	Height (ft-in.)	Weight (lbs.)	Work Phone	Home Phone

Spouse & Children Information – Complete if Applying for Dependent's Coverage.

Person Proposed for Insurance Show first, middle, last name	Occupation	Date of Birth & Place				Height	Weight	Marital Status	Sex
		Month	Day	Year	State or Country				
(Spouse)									
(Child)									
(Child)									
(Child)									
(Child)									

Spouse's Social Security No.: Spouse's Work Telephone #:

SECTION 3 – Insurability Questionnaire	**Yes**	**No**
1. Has anyone to be covered used any tobacco or nicotine products in the past year?	☐	☐
2. Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised?	☐	☐
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years?	☐	☐
4. Has anyone to be covered consulted a physician in the past one (1) year for any reason?	☐	☐

5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for:

	Yes	No		Yes	No
a. Cancer, cancer related disease or benign tumor?	☐	☐	f. Emotional, nervous system, eating disorder, or mental health problems?	☐	☐
b. Disease of the heart or blood vessels, or had a stroke?	☐	☐	g. Ulcer, stomach or digestive disorder?	☐	☐
c. Kidney disease or diabetes?	☐	☐	h. Arthritis, back, bones or joint disorder?	☐	☐
d. Alcohol or drug abuse?	☐	☐	i. Bladder, urinary system or reproductive organs disorder?	☐	☐
e. Lung, asthma, liver or blood disorder?	☐	☐			

6. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")?	☐	☐
7. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4.	☐	☐
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4.	☐	☐
9. Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8?	☐	☐
10a. Are you now pregnant? ☐ Yes ☐ No 10b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?	☐	☐
11. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If No, give full details in Section 4.	☐	☐

12. Names, addresses, and phone numbers of the personal physicians of all applicants:

SECTION 4 – Give Details to "Yes" answers to questions 2 through 10 include dates of treatment: ☐ **Separate Sheet Attached**

Ques. No.& Individual	Illness/Reason for Checkup or Medication & Dosage or Doctor's Treatment/Consultation	Date & Duration	Full Name, Complete Address and Telephone Number of Doctors & Hospitals

Be Sure to Read the Important Disclosures and sign on Page 2/Reverse

Employee's Name (First, MI, Last)	Social Security #	Employer Name

NOTICE FOR PROPOSED INSURED

IMPORTANT NOTICE FOR DISABILITY COVERAGE

Acceptance of your application for disability income insurance will be based upon the information contained in the Evidence of Insurability, including the medical information disclosed and information obtained from your medical providers. **Your insurance coverage may not be issued as applied for.** If not, an "Exclusion of Coverage Amendment" will be attached to your certificate of coverage.

PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT.

IMPORTANT NOTICE CONCERNING YOUR EFFECTIVE DATE

1. Insurance will not be effective until the application is approved by USAble Life.
2. Insurance will not be effective if there has been a change in the health of the proposed insured(s) after the date of the application and prior to the effective date.
3. For benefits sheltered under a Section 125 Cafeteria plan: To satisfy premium deduction requirements of your employer and dating requirements of the Section 125 Plan, your coverage will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) of the Section 125 agreement or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In signing below, I authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc., and any consumer reporting agency to release any information regarding me or my past or present health to USAble Life, its reinsurers and legal representatives for the purpose of evaluating this Enrollment Form for insurance. Information subject to this authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities, driving record; age; occupation; income; and my use of alcohol, drugs, and tobacco. This information will be used to determine eligibility for insurance. This authorization does not authorize the release of genetic screening or testing results.

I also authorize USAble Life or its reinsurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance. I authorize USAble Life, its reinsurers, and its legal representatives to make a brief report of my/our personal health information to MIB, Inc. All sources except MIB, Inc. may give these facts to any insurance support organization authorized by USAble Life to collect and transmit them.

This authorization shall remain valid for a period of two years from the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to USAble Life.

I understand that this authorization may be revoked at any time. Such revocation must be in writing, and will not be effective until USAble Life and the provider of the information receive it. My revocation will not be effective with respect to disclosures made by a covered entity in reliance on this authorization before it was revoked.

Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

I understand that any insurance will not take effect unless and until USAble Life approves this enrollment request. If coverage is not issued as requested, I authorize USAble Life to issue reduced benefits and adjust premiums to match the coverage issued. I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am requesting allows for alternate methods to pay insurance premiums).

I have read and understand this form in its entirety and the notices, authorizations, and certifications contained within.

Insurance Fraud Warning – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at: _____ Date of Application _____

City and State — Month, Day, Year

X _____ X _____

Agent's Signature — Applicant's Signature

Date Received Home Office

EOI (4-17)