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

VOLUNTARY DISABILITY 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 #
Employee's Salary $ ____________ ☐ Weekly ☐ Monthly ☐ Annual	
Hours Worked Weekly	Dept/Location
Date Employed Full-time	Voluntary STD Income Protection Plan, if offered
Voluntary LTD Plan, if offered Plan: ________ Elimination Period: ________ days Class: ______	

SECTION I. EMPLOYEE INFORMATION

Employee's Name (First, MI, Last)		Social Security No.
Occupation (Be Exact)		Employee's State of Residence
Date of Birth	Sex ☐ Male ☐ Female	Are you married? ☐ Yes ☐ No

PLAN INFORMATION - Your non-medical 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).

SECTION II. VOLUNTARY COVERAGE(S)

Complete this Section if applying for these coverages. EOI may be required when applying for these coverage(s).

	Add	Delete	Increase	Decrease	Total Amount of Coverage Applied for	Premium (Completed by Employer)
A. Voluntary STD Income Protection (VIP): ☐ Yes ☐ No	☐	☐	☐	☐	**per week**	
B. Voluntary Long Term Disability: ☐ Yes ☐ No	☐	☐	☐	☐	**per month**	

Do you presently have other disability coverage? ☐ Yes ☐ No If yes, give monthly amount $ _________

Do you intend to replace existing coverage with this policy? ☐ Yes ☐ No

Have you used tobacco products in the past year? ☐ Yes ☐ No

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

PRE-EXISTING CONDITIONS LIMITATIONS AND BENEFIT GUIDELINES

- New Voluntary STD (VIP) plans and benefit increases: During the first year of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage.
- New Voluntary LTD plans and benefit increases: During the first 2 years of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage, unless you go 6 consecutive months treatment free.
- Your Voluntary STD (VIP) weekly benefit may not exceed 70% of your basic weekly income (excluding bonus, overtime or any extra compensation other than commissions). Your Voluntary LTD monthly benefit may not exceed 60% of your basic monthly income (same exclusions apply). If you are eligible for state-mandated temporary disability benefits, or any employer-paid disability income plan, the combination of your state mandated benefit or employer-paid disability income benefit and your VIP weekly benefit may not exceed 70% of your basic weekly earnings.

SECTION III. EMPLOYEE BENEFICIARY DESIGNATION ☐ Check if Change Only

Must be completed if you have applied for Voluntary Life or AD&D insurance. If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If you list benefit percentages, the total must equal 100%. If no primary beneficiary survives you, proceeds will be paid to the secondary beneficiary(ies). The employee is the beneficiary of his spouse and/or children.

Name (Last, First, MI)	Address	SSN	Birth Date	Relationship	Primary or Secondary	Percentage Distribution

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: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.**

_______________________________ Employee's Signature

_______________________________ Date

Date Received - Home Office	
Eff. Date	