USAble Life
P. O. Box 1650
Little Rock, AR 72203

Please Print Using Dark Ink

ARKANSAS PUBLIC SCHOOL EMPLOYEES GROUP
Application, Change Form & Beneficiary Change Form

For Office Use Only		
Class	Dep	SIC
Eff. Date		
Group #		

Instructions:
1. **For $5,000 Basic Life/AD&D *ONLY* – complete rows 1, 2, 3, 4, 5, 7, 8, 9 and sign as well as date the form.**
2. **For $5,000 Basic Life/AD&D *AND/OR* Supplemental Life/AD&D, Dependent Life – complete all areas.**
3. **Return Completed Form to Your School District Payroll Office.**

☐ New Applicant ☐ Benefit Change ☐ Name Change ☐ Beneficiary Change

APPLICANT INFORMATION

1. Employer (Agency /School District Name)	Group Number	Product(s)
	AS004404-_____	☒ Basic Life/AD&D ☐ Supplemental Life/AD&D ☐ Dependent Life

2. Employee Social Security #	Employee Last Name	First Name	Middle Initial	Date of Birth (Mo Date Year)

3. Home Address (Street City State Zip)	Birth State or Country

4. Sex ☐ Male ☐ Female	Height (ft.-in.)	Weight (lbs)	Marital Status	Date of Hire **(Include Month/Day/Year)**	Occupation

5. Home Phone #	Work Phone #	Annual Salary

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

Person Proposed for insurance Show first, middle, last name	Social Security #	Occupation	Date of Birth & Place				Height	Weight	Marital Status	Sex
			Mo.	Day	Yr.	State or Country				
(spouse)										
(child)										
(child)										
(child)										

BASIC/SUPPLEMENTAL/DEPENDENT LIFE

Supplemental Employee Life and AD&D

Are you currently enrolled in one of the Arkansas Public School Employees qualified health plans? ☐ Yes ☐ No

Classification By Basic Annual Earnings	Insurance Amount	Check One
$10,000 or less	$20,000	☐
$10,001 - $15,000	$30,000	☐
$15,001 - $20,000	$40,000	☐
$20,001 - $25,000	$50,000	☐
$25,001 - $30,000	$60,000	☐
$30,001 and above	$70,000	☐

Dependent Life

☐ Yes ☐ No

Spouse: $2,500

Your spouse/child will not be covered for Dep. Life if also covered as an employee of the AR Public School Group.

Child(ren):
$2,500 - 3 years of age and over
$1,000 - 14 days of age to 3 years of age

Monthly Premium

$5,000 Basic Employee Life **$**_____

Supplemental Employee Life **$**_____

Dependent Life **$**_____

Total Monthly Premium $_____

In signing below, I (a) represent that the statements and answers given on all pages of this application, are true, complete and correctly recorded to the best of my knowledge and belief; (b) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc., having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid for two (2) years from the application date; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (f) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act; and (g) acknowledge receipt of the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

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 may be guilty of a crime and subject to fines and confinement in prison.

DATE OF APPLICATION _____ **MONTH/DAY/YEAR**

_____ **EMPLOYEE SIGNATURE**

_____ **SIGNATURE OF EMPLOYER/WITNESS**

_____ **PRINTED NAME OF EMPLOYER/WITNESS**

7. Employee Name (Last, First, M.I.)	Social Security #	Employer	Group # AS004404-____

BASIC AND SUPPLEMENTAL LIFE/AD&D BENEFICIARY DESIGNATION

I hereby designate the following (beneficiaries) under this Plan and revoke any existing beneficiary designation I may have made for basic and/or supplemental life/AD&D insurance benefits. I understand that this change must be on a form acceptable to USAble Life and received at our Home Office. I further acknowledge that any designation or change will be effective the date made, subject to any payment USAble Life may have made before it is received.

PRIMARY BENEFICIARY(IES) [Will receive proceeds if living at death of Employee.]:

8. Last Name	First Name	MI	SSN	Birthdate	Relationship	Percentage
					Total	= (Total must equal 100%)

CONTINGENT BENEFICIARY(IES) [Will receive proceeds if Primary Beneficiary(ies) are not living.]:

9. Last Name	First Name	MI	SSN	Birthdate	Relationship	Percentage
					Total	= (Total must equal 100%)

Complete this section only if applying for Supplemental Life or Dependent Life more than 31 days after your hire date. Complete the information below on yourself *(if applying for Supplemental Life)* and on your dependents *(if applying for Dependent Life).*

1. Have you, your spouse or children been hospitalized for any reason during the past five (5) years? ☐ No ☐ Yes
   If yes, give date, reason hospitalized and name of person hospitalized:

2. Have you, your spouse or children consulted a physician in the past one (1) year? ☐ No ☐ Yes
   If yes, give name of person seen by doctor, reason seen, and name(s) of doctors seen:

3. Have you, your spouse, or children ever been diagnosed by or received treatment from a member of the medical profession for:

	No	Yes
1) Cancer or any cancer related disease?	☐	☐
2) Disease of the heart or blood vessels, or had a stroke?	☐	☐
3) Kidney disease or diabetes?	☐	☐
4) AIDS or AIDS Related Complex, Immune Deficiency Disorder, or tested positive for antibodies to HIV?	☐	☐
5) Alcohol or Drug Abuse?	☐	☐
6) Lung, Liver or Blood Disorder?	☐	☐
7) Emotional, Nervous System or Mental Health Problems?	☐	☐
8) Hypertension (high blood pressure)? (Give last two blood pressure readings, dates, medication taken, and medication dosage below)?	☐	☐

GIVE DETAILS TO ANY "YES" ANSWERS TO QUESTION 3 above, including name of person, diagnosis, and dates of treatment:

4. Do you, your spouse or children have any impairments, diseases or illnesses not covered in questions 1, 2, or 3? ☐ No ☐ Yes
   If yes, give details, including name of person, diagnosis, and dates of treatment:

5. Are you, your spouse or children currently taking medication(s)? ☐ No ☐ Yes If yes, give name of person, medication(s) and dosage:

6. Name, address, and phone number of personal physician(s):