Group Enrollment or Change Form- County Commissioners' Only

USAble Life
PO Box 1650
Little Rock, Arkansas 72203

Group # _____ Class: _____
District # : _____Eff Date:_____

Employee Paid $25,000 Policy/$16,250 for age 70 & Older = $5.50 or $3.58

☐ Newly Elected/Appointed ☐ Benecificary Change ☐ Open Enrollment

☐ Other (Indicate reason): _____

SECTION 1-APPLICANT INFORMATION

Employee Legal Name (First, M.I.,Last)			For Name Change, give Prior Last Name		
Home Address		City	State	Zip	Phone
Social Security #	Date of Birth	Salary $ _____ ☐ Monthly	Gender ☐ Male ☐ Female		Marital Status
Term Elected:					

SECTION 2- Complete this Section if applying for Dependent Coverage

***(Dependent Spouse cannot be an employee of Sullivan Co Government Offices or School)

Add	Delete		
☐	☐	Option #1 10,000 spouse/5,000 each child 6month to 26 years	**$2.60 per month**
☐	☐	Option #2 20,000 spouse/10,000 each child 6month to 26 years	**$5.20 per month**

Dependent Information | Indicate Date of: Marriage_____Birth of Child_____

Add	Delete	Dependent Name	Relationship	DOB	SSN
☐	☐				
☐	☐				
☐	☐				
☐	☐				
☐	☐				

SECTION 3-BENEFICIARY DESIGNATION

(This will revoke any existing beneficiary desingations you may have for these benefits.)

Name (Last, First, MI)	Address	SSN	DOB	Relation	Percentage
				Total Must equal 100% =	

☐ **Acceptance of Coverage:**

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-Any person who knowingly presesnts a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

_____ _____
Date Signature of Employee

☐ **I decline enrollment/coverage at this time:**

_____ _____
Employee Signature Date