USAble Life

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

VOLUNTARY STD INCOME PROTECTION (VIP) ENROLLMENT FORM

(PLEASE PRINT)

❑ New Enrollee ❑ Change ❑ Decline coverage	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). If you are a late applicant or if you are applying for an increase in coverage, you will be required to submit Evidence of Insurability.

SECTION II. VOLUNTARY STD INCOME PROTECTION (VIP)

Evidence of Insurability may be required when applying for this coverage.

I hereby apply for a Weekly Benefit of: $__________ Premium (*to be completed by employer*): $ ___________

(Instructions: If you are changing your benefit amount, list the new amount of coverage)

Your weekly benefit may not exceed the benefit percentage stated in the policy.

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

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

PRE-EXISTING CONDITIONS

- Pre-existing Condition Exclusion: 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.

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 coverage 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