USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

Application for Continuation of Voluntary Group Life to USAble Life Group Insurance Trust

Office Use Only	
Policy #	
Effective Date	
Group #	10007131

SECTION A - APPLICANT INFORMATION

Name (First, MI, Last)			Social Security No.	
Home Address	City	State	Zip	County
Date of Birth / Age	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Home Phone ( )	
Date of Termination of Employment	Are you now disabled or retired? ☐ Yes ☐ No	Are you a full-time member of the armed forces of any country? ☐ Yes ☐ No		

SECTION B – PLAN INFORMATION

1. Current Amount of VGL on Employee: $_____

2. Current Amount of VGL on Spouse: $_____ Continue Spouse's VGL? ☐ Yes ☐ No

3. Premium Mode: ☐ Quarterly ☐ Semi-Annually ☐ Annually

SECTION C – SPOUSE INFORMATION
(Complete only if applying for Continuation of Spouse's VGL Coverage)

Name (First, MI, Last)		Sex	Social Security No.
Date of Birth	Age		

SECTION D – BENEFICIARY
This will revoke any existing beneficiary designations you may have under these benefits.

Name	Relationship	Date of Birth	Primary or Secondary	Indicate Percentage Distribution
			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ Secondary	

SECTION E - EMPLOYER INFORMATION
(This section is to be completed by the Employer)

1. Employer Name	Group Policy Number
2. Did the Insured Employee terminate his employment due to disability or retirement? ☐ Yes ☐ No	Date Applicant's Employment Terminated

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief. Further, my signature below acknowledges that I have received a copy of this application.

Signed at _____ (City) _____ (State) on _____ (Month Day Year)

X _____
Signature of Applicant

EMPLOYER'S STATEMENT: To the best of my knowledge, the above information is correct and complete.

X _____
Employer's Signature

X _____
Signature of Applicant, Owner, if other than Primary Insured

SECTION F - DECLINATION

I have been informed of my option to continue my Voluntary Group Life (VGL) coverage under the USAble Life Group Insurance Trust Policy. The VGL Portability provision has been explained to me, and I have been given the opportunity to continue this coverage. I understand my option and decline such coverage.

_____
Signature of Terminating Employee

_____
Signature of Witness