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

North Carolina Bar Association Open Enrollment Group Enrollment Form

(Please print or type in Black ink.)
Effective May 1, 2012

☐ New Enrollment ☐ Change Enrollment **Group #** ______

SECTION 1 - APPLICANT INFORMATION

Employee Legal Name (First, M.I., Last)				For Name Change, Give Prior Last Name
Home Address	City	State	Zip	Telephone No.
Social Security #	Date of Birth	Gender ☐ Male ☐ Female		Marital Status
Occupation	Hours worked weekly		Date Employed Full-time	
Employer's Name			Salary $ N/A ☐ Weekly ☐ Monthly ☐ Annual	

SECTION 2 - Complete this Section if applying for Optional Coverage(s).

	Add	Current Supp Benefit Amount	Requested Supp Benefit Amount
Supp Life/AD&D	☐		
Option 1: Dependent Life	☐	Option 1: ($10,000 Spouse/$5,000 Child)	
Option 2: Dependent Life	☐	Option 2: ($20,000 Spouse/$10,000 Child)	
		Dependent children are eligible to age 26	

Dependents to be Covered	Relationship	Birthdate	SSN

SECTION 3 - BENEFICIARY DESIGNATION /CHANGE ☐ Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

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

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

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

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

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 - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and a denial of insurance benefits in accordance with applicable state law.

______ Date ______ Signature of Employee

Date Received - Home Office