P.O. Box 1650
Little Rock, Arkansas 72203

VOLUNTARY STD INCOME PROTECTION (VIP) ENROLLMENT FORM

(PLEASE PRINT)

❑ New Enrollee ❑ Benefit Increase ❑ Benefit Decrease ❑ Decline Coverage
(List current VIP Benefit: $ ___________)

SECTION I. EMPLOYEE INFORMATION		EMPLOYER INFORMATION	
Employee's Name (First, MI, Last)		Employer's Name	Group #
Social Security No	Employee's State of Residence	Employee's Salary ☐ Weekly ☐ Monthly ☐ Annual $______________	
Date of Birth	Sex ☐ Male ☐ Female	Hours Worked Weekly	Dept/Location
Occupation (Be Exact)		Date Employed Full-time	VIP Benefit Plan

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 COVERAGE

EOI 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)

Benefit Guidelines and Pre-Existing Conditions Exclusion:

- Your weekly benefit may not exceed the benefit percentage stated in the policy.
- If you are eligible for state-mandated temporary disability benefits, or any employer-paid income replacement plan, the combination of your state mandated benefit or other income benefit and your VIP weekly benefit may not exceed the benefit percentage stated in the policy.
- 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.

If your earnings are based in whole or in part on commissions, commissions will be averaged over the 12-months period prior to the date disability begins.

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

Please check the box next to the statement that applies to you.
(Check One Only):

❑ I represent that the information provided above is true, complete, and correctly recorded. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay. 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.

❑ I have been given an opportunity to participate in my employer's Voluntary STD Income Protection Program, and I decline to participate. I understand that if I apply for this coverage at a later date, satisfactory Evidence of Insurability may be required.

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.

_______________________________________ Employee's Signature

_______________ Date

Date Received – Home Office	
Eff. Date	