



P.O. Box 1650  
Little Rock, Arkansas 72203

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## Application for Continuation of Group Term Life to USABLE Life Group Insurance Trust

Office Use Only	
Policy #	
Effective Date	
Group #	

### SECTION A - APPLICANT INFORMATION

Name (First, MI, Last)				Social Security No.	
Home Address		City	State	Zip	County
Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Home Phone
Date of Termination of Employment	Reason for termination: <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> _____			Are you a fulltime member of the armed forces of any country? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### SECTION B - 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Applicant's Employment Terminated
Did the Insured Employee terminate his employment due to retirement? <input type="checkbox"/> Yes <input type="checkbox"/> No		

### SECTION C - PLAN INFORMATION

1. Current Amount of Term Life on Employee:	\$ _____	
2. Current Amount of Term Life on Spouse:	\$ _____	Continue Spouse's Term Life? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Premium Mode:	<input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	

### SECTION D - SPOUSE INFORMATION (Complete only if applying for Continuation of Spouse's Group Life Coverage)

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

### SECTION E - BENEFICIARY This will revoke any existing beneficiary designations you may have under these benefits.

#### PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at applicant's death):

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% =**

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded. Further, my signature below acknowledges that I have received a copy of this application. I hereby designate the above beneficiaries under this certificate and revoke the appointment of any existing beneficiary.

**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.

Signed at \_\_\_\_\_ on \_\_\_\_\_  
City State Month Day Year

X \_\_\_\_\_  
Signature of Applicant

EMPLOYER'S STATEMENT: I represent the above information is true, complete, and correctly recorded.

X \_\_\_\_\_  
Employer's Signature

### SECTION F - DECLINATION

I have been informed of my option to continue my group term life coverage under the USABLE Life Group Insurance Trust Policy. The 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