USAble Life

c/o BCBST Membership Services
1 Cameron Hill Circle
Chattanooga, TN 37402-0001

Voluntary Products Enrollment Form

- Please Use Blue or Black Ink Only -

Plan Use Only
Rec:_____

NOTE: Products are offered by USAble Life which are independent and solely responsible. These are NOT BlueCross BlueShield products.

- CONFIDENTIAL -

EMPLOYER: If Evidence of Insurability *(EOI)* is required, please submit the Evidence of Insurability form along with this enrollment form.

Group No. _____ Employer Name _____ ❑ New Enrollee ❑ Change/Delete ❑ Decline All Coverages

Section 1 - Employee Information – Employee Must Complete In Full.

Employee Last Name _____ Employee First Name _____ MI _____ Jr., Sr., Etc. _____ Social Security No.* _____ Date of Birth ___/___/_____ Male ❑ Female ❑

Address _____ Phone ___—___—_____

City *(Please do not abbreviate)* _____ State _____ ZIP _____ Email Address** _____

Occupation *(Be specific)* _____ Dept. / Location _____ Full-Time Date Of Hire ___/___/_____ Hrs. Wkd. / Wk. _____ Salary $_____.00 ❑ Weekly ❑ Monthly ❑ Annual

Section 2 – Voluntary Coverage(s) - Complete this Section if applying for these coverages. Evidence of Insurability may be required.

Plan Information - ***Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any and whether you will be required to complete an Evidence of Insurability (EOI).***

Voluntary Group Term Life *(VGTL)*:

❑ Employee: ❑ Add New ❑ Delete ❑ Increase Existing ❑ Decrease Existing Total Amount of Coverage: $_____.00 Premium *(Completed by Employer)*: $_____.__

❑ Spouse: ❑ Add New ❑ Delete ❑ Increase Existing ❑ Decrease Existing Total Amount of Coverage: $_____.00 Premium *(Completed by Employer)*: $_____.__

❑ Children: ❑ Add New ❑ Delete ❑ Increase Existing ❑ Decrease Existing Total Amount of Coverage: $_____.00 Premium *(Completed by Employer)*: $_____.__

Voluntary Accidental Death & Dismemberment *(VAD&D) (EOI not required)*:

❑ Employee: ❑ Add New ❑ Delete ❑ Increase Existing ❑ Decrease Existing Total Amount of Coverage: $_____.00 Premium *(Completed by Employer)*: $_____.__

❑ Spouse: ❑ Add New ❑ Delete ❑ Increase Existing ❑ Decrease Existing Total Amount of Coverage: $_____.00 Premium *(Completed by Employer)*: $_____.__

❑ Children: ❑ Add New ❑ Delete ❑ Increase Existing ❑ Decrease Existing Total Amount of Coverage: $_____.00 Premium *(Completed by Employer)*: $_____.__

❑ **Voluntary Short-Term Disability *(VSTD)*:**
❑ Add New ❑ Delete ❑ Increase Existing ❑ Decrease Existing Total Amount of Coverage *(per week)*: $_____.00 Premium *(Completed by Employer)*: $_____.__

❑ **Voluntary Long-Term Disability *(VLTD)*:**
❑ Add New ❑ Delete ❑ Increase Existing ❑ Decrease Existing Total Amount of Coverage *(per month)*: $_____.00 Premium *(Completed by Employer)*: $_____.__

Do you presently have other disability coverage? ❑ No ❑ Yes If "Yes," give the monthly amount: $_____.00 **Do you intend to replace existing coverage with this policy? ❑ Yes ❑ No**

Have you or your spouse *(if applying for coverage)* used tobacco products in the past year? Employee: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No Are you actively at work on the date of this application? ❑ Yes ❑ No

Pre-Existing Conditions:

- **New Voluntary STD plans and benefit increases:** *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 or an increase in coverage.*
- **New Voluntary LTD plans and benefit increases:** *During the first 2 years 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 or an increase in coverage, unless you go six (6) consecutive months treatment free.*

Section 3 – Acknowledgement *(Signature and Date MUST BE COMPLETED.)*

I represent that the information provided on all pages of this enrollment form 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.*

Be sure to complete the Employee Beneficiary Designation on Page 2(reverse side).

Employee's Signature: X _____ **Date:** ___/___/_____

** To comply with Federal regulations we must have Social Security Number.*

***By providing your email address, you are agreeing to receive all communications (presently available or that become available during the term of your policy) related to this policy, the benefits considered under this policy, your relationship with USAble, etc., in electronic form from USAble, its affiliates and contractors.*

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

Employee Last Name | Employee First Name | Social Security No. | Group No.

Section 4 - Dependent(s) To Be Covered:

Spouse Last Name | Spouse First Name | MI | Male ❑ Female ❑ | Date of Birth | Social Security No. | Relationship: Spouse

Dependent Last Name | Dependent First Name | MI | Male ❑ Female ❑ | Date of Birth | Social Security No. | Relationship

Dependent Last Name | Dependent First Name | MI | Male ❑ Female ❑ | Date of Birth | Social Security No. | Relationship

Dependent Last Name | Dependent First Name | MI | Male ❑ Female ❑ | Date of Birth | Social Security No. | Relationship

Dependent Last Name | Dependent First Name | MI | Male ❑ Female ❑ | Date of Birth | Social Security No. | Relationship

Section 5 – Employee Beneficiary Designation ❑ 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.)*:

Last Name | First Name | MI | Date of Birth | Social Security No. | Relationship | Percentage

Address | City *(Please do not abbreviate)* | State | ZIP

Last Name | First Name | MI | Date of Birth | Social Security No. | Relationship | Percentage

Address | City *(Please do not abbreviate)* | State | ZIP

Last Name | First Name | MI | Date of Birth | Social Security No. | Relationship | Percentage

Address | City *(Please do not abbreviate)* | State | ZIP

Percentage Total Must Equal 100 % =

Contingent Beneficiary(ies) *(Will receive proceeds if primary beneficiaries are not living.)*:

Last Name | First Name | MI | Date of Birth | Social Security No. | Relationship | Percentage

Address | City *(Please do not abbreviate)* | State | ZIP

Last Name | First Name | MI | Date of Birth | Social Security No. | Relationship | Percentage

Address | City *(Please do not abbreviate)* | State | ZIP

Last Name | First Name | MI | Date of Birth | Social Security No. | Relationship | Percentage

Address | City *(Please do not abbreviate)* | State | ZIP

Percentage Total Must Equal 100 % =