Colonial Life

State of Arkansas

Instructions for the completion and submission of paper forms for Colonial Life's Group Term Life with AD&D Insurance Master Group Number M0002871

FAX this direction	FAX completed forms to: 803-678-6861 Or mail to: Colonial Life, PO Box 1365, Mail Stop: SC269 Columbia SC 29202	From: _____ ☐ Active Employee ☐ Retiree Date: _____ Number of pages: _____

Complete the designated form and include this cover sheet with your fax or mailing.
Please check the boxes that apply to the service you are requesting.

Enrollment form:

- ☐ Enroll as newly eligible employee[1]
- ☐ Enroll a newly eligible spouse after marriage[2]
- ☐ Enroll a newly eligible dependent child after birth / adoption[2]

Evidence of Insurability form:

- ☐ Elect coverage Expanded Basic Group Term Life with AD&D or Supplemental Group Term Life with AD&D as a late entrant[1]
- ☐ Increase existing Expanded Basic Group Term Life with AD&D for Employee, Spouse or Child(ren) Supplemental Group Term Life with AD&D[2]

Service form:

- ☐ Address change
- ☐ Name change
- ☐ Continuation of coverage as a surviving spouse
- ☐ Decrease Expanded Basic Group Term Life with AD&D or Supplemetal Group Term Life with AD&D[2]
- ☐ Cancel Expanded Basic Group Term Life with AD&D or Supplemental Group Term Life with AD&D[2]
- ☐ Decrease or Cancel Spouse or Dependent Child(ren) Supplemental Group Term Life with AD&D[2]
- ☐ Change premium payment method to bank draft or direct bill as a terminating employee[3]

Other forms:

- ☐ Retiree Service form and Payment Authorization Form[3]
- ☐ Other: _____

Do you have questions while completing your forms? Please contact Sylvia Landers at 501-682-5581 8 a.m. to 4:30 p.m. CT.

Complete within 60 days of your hire date, if applicable[1]

Complete within 60 days of your qualifying life event, if applicable[2]

Complete within 31 days of your retirement or termination, if applicable[3]

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365, COLUMBIA, SC 29202
STATE OF ARKANSAS PUBLIC SCHOOL EMPLOYEES - GROUP TERM WITH AD&D INSURANCE ENROLLMENT FORM

District Name:				**District Code:**
SECTION 1: EMPLOYEE INFORMATION – Always complete				
Proposed Insured Name (First, MI, Last)		Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street City State Zip Code				Member ID No.
Email Address			Primary Phone No. Secondary Phone No.	
Date Employed	Actively Employed by: AR Public School			Annual Salary

SECTION 2: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage				
Spouse Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			
Are there any eligible dependent children applying for coverage?				☐Yes ☐ No

SECTION 3: GUARANTEED ISSUE COVERAGE INFORMATION – Always complete
(For any amount over the maximum benefit shown below, you must complete Evidence of Insurability form.) *Administrative use only

Coverage Type	**Tax Status**	**Coverage Amount**	***Plan Code**	***Monthly Premium**
☐ Basic Group Term Life with AD&D ($10,000)		$10,000	8F1B	$
☐ Expanded Basic Group Term Life with AD&D ($1,000 increments, up to $40,000)	Pre-Tax ☐ Post Tax ☐	$	8F1E	$
☐ Supplemental Group Life with AD&D ($1,000 increments, up to $100,000)	Post Tax	$	8F1S	$
☐ Spouse Supplemental Group Term Life with AD&D ($1,000 increments, up to $10,000)	Post Tax	$	8SP1	$
☐ Dependent Child(ren) Supplemental Group Term Life with AD&D ($1,000 increments, up to $10,000)	Post Tax	$	4CH1	$
☐ I do not wish to participate/continue the State of Arkansas Public School Employee (PSE) Group Tern Life with AD&D Plan. I understand that if I enroll later, I must provide evidence of insurability.			**Total Premium $**	

SECTION 4: BENEFICIARY INFORMATION – for the employee benefit only					
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. I have read this form and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this form will not be binding upon Colonial Life & Accident Insurance Company (Colonial Life) until both: 1) the certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this form are the basis for any certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the form.

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If I have elected to pay my premiums for Colonial Life & Accident Insurance Company's Group Term Life insurance with pre-tax dollars, I am aware of the tax savings I receive through a flexible benefits plan. While the Internal Revenue Service (IRS) allows me to receive tax savings on my premiums, the IRS also may require me to pay taxes on insurance benefits I receive from coverage purchased through a flexible benefits plan.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices.

Signed at: City_____ State _____ Date _____
mm/dd/yyyy

(x)_____

AGENT SECTION

Agent's Name (If Present) _____
Please Print

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this form. I further certify that I am a licensed agent in the state where this form is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

Date_____ x _____
mm/dd/yyyy Signature of Licensed Agent (full name as it appears on license)

License No._____ Code No._____