HOSPITAL CONFINEMENT PLAN

BENEFIT ELECTION FORM

Name of Employee _____ ☐ **Licensed** ☐ **Classified**

Social Security Number_____ **Effective Date** _____

☐ Employee only (premium paid by School District)

Voluntary –

☐ $5.32 Employee and one (1) dependent

☐ $8.08 Employee and two (2) or more dependents

Basic plan pays for overnight stays in the hospital: $200 for the first day

$62 per day for days 2 – 10

$31 per day for days after 10

EMPLOYEE AUTHORIZATION

☐ **I hereby waive dependent (Family) enrollment**

☐ I would like to pay on a pre-tax basis under Section 125.

Signature of Applicant _____

Date _____

✸ A USAble Life Group Enrollment or Change form (form #1000) must also be completed with enrollment of this plan.

RETURN FORMS TO THE INSURANCE DEPARTMENT

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

Group Enrollment or Change Form

(Please print or type in Black ink.)

☐ New Employee ☐ Declination ☐ Class or Salary Change
☐ Beneficiary Change ☐ Change of Name ☐ Termination Date: _____
☐ Dependent Status Change (Indicate reason _____)
☐ Reinstatement (Complete Date of Rehire as Employment Date)

Group # 10003475.02
Class _____
Dept/Location _____
Eff Date _____

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 CONWAY SCHOOL DISTRICT			Salary $ _____ ☐ Weekly ☐ Monthly ☐ Annual	

SECTION 2 - Complete this Section if applying for Optional Coverage(s). Evidence of Insurability (EOI) may be required when applying for these coverage(s).

SECTION 2 NOT APPLICABLE

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% = 0

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% = 0

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

1000 (5-09)