ARSEBA ENROLLMENT FORM

FIRST NAME	LAST NAME	SSN#	GENDER M / F

MARITIAL STATUS Singe / Married	DATE OF MARRIAGE	DATE OF BIRTH	TOBACCO/NICOTINE USE Y / N	DISABLED Y / N

EMPLOYER ARKANSAS STATE EMPLOYEES	LOCATION	EMPLOYEE AT WORK Y / N	PAY FREQUENCY 24

OCCUPATION	ANNUAL SALARY	HIRE DATE	HOURS PER WEEK

HOME ADDRESS	MOTHER'S MAIDEN NAME	SPOUSE AT WORK Y / N

CITY	STATE	ZIPCODE

PHONE NUMBER	EMAIL ADDRESS

PERSONS TO BE COVERED SECTION

FIRST NAME	LAST NAME	RELATIONSHIP	GENDER	DOB	DISABLED	TOBACCO
		Spouse	M / F		Y / N	Y / N
		Child	M / F		Y / N	Y / N
		Child	M / F		Y / N	Y / N
		Child	M / F		Y / N	Y / N
		Child	M / F		Y / N	Y / N

BENEFICIARY SECTION *Employee will be the beneficiary for any dependent coverage.*

BENEFICIARY FIRST NAME	BENEFICIARY LAST NAME	SSN	DOB	RELATIONSHIP

ADDRESS LINE 1	ADDRESS LINE 2	CITY	STATE	ZIP CODE

UL10 COVERAGE SECTION

PAYROLL DEDUCTION FREQUENCY 24	FIRST DEDUCTION DATE 12/15/2023	COVERAGE EFFECTIVE DATE 12/1/2023

EMPLOYEE GI AMOUNT $200,000	EMPLOYEE ISSUE AGE*
EMPLOYEE FACE AMOUNT	EMPLOYEE PREMIUM
SPOUSE GI AMOUNT $50,000	SPOUSE ISSUE AGE*
SPOUSE FACE AMOUNT	SPOUSE PREMIUM
CHILD TERM FACE AMOUNT $10,000 / $20,000	CHILD TERM PREMIUM

TOTAL LIFE PREMIUM PER PAYROLL DEDUCTION:

**** Issue age in the age insured will be ON the Policy Issue date (1st of the month after the Coverage Effective Date) so if coverage begins on 01/01 then what will the insured's age be on 02/01***

EMPLOYEE NAME **EMPLOYER**

EVIDENCE OF INSURABILITY SECTION (IF REQUIRED)

1. In the past six months, has any proposed insured been hospitalized (inpatient or outpatient) or missed more than five days of work due to any accident or sickness, except for normal pregnancy?

EMPLOYEE: Y / N **SPOUSE:** Y / N

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	HEIGHT FT	HEIGHT IN	WEIGHT LBS
EMPLOYEE			

	HEIGHT FT	HEIGHT IN	WEIGHT LBS
SPOUSE			

3. In the past five years, has any proposed insured been diagnosed or treated by a member of the medical profession (licensed physician in FL, KS and KY) for any of the following?

•Acquired Immune Deficiency Syndrome (AIDS)
Residents of FL: tested positive for exposure to the HIV infection, been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection
•Blood (including Anemia, platelet disorders, Hemochromatosis, Thalassemia or any other abnormality of the spleen, bone marrow or blood or a blood transfusion)
•Brain or Nervous System (including Alzheimer's, Dementia, Multiple Sclerosis, Optic Neuritis, Parkinson's, seizures, Vertigo or any other disease or disorder of the brain or nervous system)
•Cancer (including Melanoma, Leukemia, Lymphoma or any other cancer or tumor other than nonmelanoma skin cancer)
•Anxiety, depression, chronic fatigue, suicidal thoughts, or any other psychiatric, emotional, behavioral or mental or nervous disorder?
•Digestive (including Barrett's Esophagus, Cirrhosis, Hepatitis, Ulcerative Colitis, Crohn's Disease or any other disease or disorder of the esophagus, stomach, liver, pancreas, intestine or colon)
•Glandular (including Diabetes, Addison's, Cushing's, thyroid or any other disease or disorder of the endocrine system)
•Heart or Blood Vessels (including Aneurysm, heart attack, stroke, high blood pressure requiring more than two medications to control, or any other disease or disorder of the heart, blood vessels or circulatory system)
•Lung (including Asthma, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic bronchitis, Tuberculosis, Interstitial lung disease or any other disease or disorder of the lungs or airways)
•Musculoskeletal (including Fibromyalgia, Lupus, Sjogren's syndrome, Osteoporosis, Muscular Dystrophy, Paralysis, Rheumatoid Arthritis, Autoimmune disorder or any other disease or disorder of the musculoskeletal system)
•Renal or Reproductive (including disorders of the breasts, ovaries, prostate, bladder, kidney or any other disease or disorder of the urinary or reproductive organs)

EMPLOYEE: Y / N **SPOUSE:** Y / N

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.

ADDITIONAL TERMS

INITIAL BELOW	
	I authorize the above amount to be payroll deducted each pay period.
	I have read and understand the Limitations and Exclusions clause associated with my policy(s).
	WAIVE ONLY: I do not wish to participate and understand that future application for such insurance may require evidence

EMPLOYEE SIGNATURE	DIGITAL SIGNATURE = LAST 4 SSN, DOB (MMDD), and MOTHER'S MAIDEN NAME
DATE:	
MOTHER'S MAIDEN NAME:	