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## ARKANSAS PUBLIC SCHOOL RETIREE LIFE INSURANCE PROGRAM

### LIFE INSURANCE APPLICATION AND CHANGE FORM

For Office Use Only		
Class	Dep	SIC
Eff. Date		
Group #		

New Applicant   
  Benefit Change   
  Name Change   
  Beneficiary Change

#### APPLICANT INFORMATION

Employee Name (Last, First, M.I.)			Date of Birth		Social Security #	
Street Address		City			State	Zip
Annual Salary at Retirement	Were you a Certified or Classified Employee?	Is retirement due to disability? Yes <input type="checkbox"/> No <input type="checkbox"/>		Agency/School District Name		
Date of Hire	Date of Retirement		Home Phone #		Work Phone #	

#### RETIREE LIFE SELECTION

Please enroll me for the following Retiree Life Insurance Coverage

Retiree Insurance Amount	Monthly Premiums	Select One	Retiree Insurance Amount	Monthly Premiums	Select One
\$ 4,000	\$10.32	<input type="checkbox"/>	\$17,500	\$45.15	<input type="checkbox"/>
\$ 5,000	\$12.90	<input type="checkbox"/>	\$19,000	\$49.02	<input type="checkbox"/>
\$ 7,500	\$19.35	<input type="checkbox"/>	\$24,000	\$61.92	<input type="checkbox"/>
\$10,000	\$25.80	<input type="checkbox"/>	\$29,000	\$74.82	<input type="checkbox"/>
\$12,500	\$32.25	<input type="checkbox"/>	\$34,000	\$87.72	<input type="checkbox"/>
\$14,000	\$36.12	<input type="checkbox"/>	\$39,000	\$100.62	<input type="checkbox"/>
\$15,000	\$38.70	<input type="checkbox"/>			

#### RETIREE LIFE BENEFICIARY DESIGNATION FOR BENEFITS

**This will revoke any existing beneficiary designation you may have under basic and supplemental life benefits.**

Name (Last, First, MI)	Date of Birth	Relationship	Primary/Contingent
			<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent
			<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent
			<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent

I represent that the information provided on this application is true, complete and correctly recorded. I hereby designate the above beneficiary(ies) under this certificate and revoke the appointment of any existing beneficiary. In applying for insurance, I authorize the Teacher Retirement System or the Public Employee Retirement System (whichever is applicable) to make payroll deductions to cover my life insurance. This application must be received within 31 days of the date of retirement or coverage will terminate on the effective date of your retirement or the last date through which premiums were paid.

I hereby authorize any provider of medical services or supplies to make available to US Able Life, its agents or any of its subsidiaries, any and all medical records pertaining to me.

**Insurance Fraud Warning** - 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 may be guilty of a crime and subject to fines and confinement in prison.

**DATE OF APPLICATION**

\_\_\_\_\_  
 MONTH/DAY/YEAR

\_\_\_\_\_  
 EMPLOYEE'S SIGNATURE