USAble LIFE **GROUP LIFE INSURANCE SPECIAL ENROLLMENT 2024**

USAble Life Insurance Company ● P.O. Box 45132 ● Jacksonville, FL 32232-5132

EMPLOYER NAME: Alachua County

Please check one of the following:

☐ Board ☐ Clerk ☐ Property Appraiser ☐ Sheriff's Office ☐ Tax Collector

1. **Return completed and signed Enrollment form to Risk Management**.

A. EMPLOYEE INFORMATION

First Name	Middle Initial	Last Name

Street Address	City	State	Zip Code

Are you actively working at your employer's normal place of business at least 20 hours per week? ☐ Yes ☐ No

Will the insurance applied for replace or change an existing policy? ☐ Yes ☐ No

Date of birth	Social Security number	Date of employment	Annual Salary	Gender
				☐ Male ☐ Female

B. EMPLOYEE LIFE INSURANCE

All employees receive 1x salary up to $60,000 - 100% employer paid. This replaces current $10,000 employer paid and 1x salary up to $50,000 - 80% employer paid

Total Amount of Supplemental Insurance Requested

☐ Increase coverage to:

☐ 1x salary ☐ 2x salary ☐ 3x salary (100% employee paid)

☐ Decrease coverage to:

☐ 1x salary ☐ 2x salary

☐ Cancel supplemental life coverage

Employees can elect supplemental life coverage, either 1x, 2x or 3x their salary, without answering any health questions this year only.

C. DEPENDENT LIFE INFORMATION

Employees can elect dependent life coverage for spouse and/or children, without answering any health questions this year only.

☐ Dependent Life Coverage: $20,000 Spouse/$10,000 Child Cancel Dependent Life (list dependents below)

Name	relationship	Date of birth	Gender	SS#

☐ Cancel Dependent Life Coverage

Turn form over to sign ⟶

D. ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Total Amount of Employee AD&D Requested

☐ Increase coverage to: $_____
☐ Decrease coverage to: $_____
☐ Cancel AD&D Coverage

All AD&D coverage is guaranteed, no health questions asked. Available in increments of $25,000 up to the lesser of 5x salary or $500,000.

E. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for supplemental insurance coverage. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING AMY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Employee Signature	Daytime Phone Number	Evening Phone Number	Date Signed
Employer Signature			Effective Date

RETURN FORM TO RISK MANAGEMENT