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

Agency Name:				**Agency Code:**
Employee Information				
Employee Name (First, MI, Last)		Gender M ☐ F☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street	City State Zip Code			Member No.
Email Address			Primary Phone No. Secondary Phone No.	
List all policies/certificate numbers related to this request (Required to process):				
Qualifying Life Event ☐ Marriage ☐Legal Separation ☐ Birth or Adoption of Child ☐Death of Spouse ☐ Divorce ☐Annulment ☐ Placement of Child for Adoption ☐Death of Dependent Child				Event Date

Service Requested

☐Cancel Employee Coverage ☐Decrease Coverage ☐Cancel Dependent Child(ren) Coverage ☐Change Address
☐Surviving Spouse Coverage Continuation ☐Cancel Spouse Coverage ☐Change Name ☐Change Premium Payment Method
☐Election of Portability Coverage*

If adding or increasing employee, spouse and/or child coverage, an Enrollment Form or Evidence of Insurability Form must be completed.
If canceling or decreasing coverage, complete Cancel/ Decrease Details below. For all other changes, complete the corresponding section below.
*Portable coverage is reduced by 50% of the active employee coverage. At Age 75, coverage is reduced by an additional 50%.

Surviving Spouse Coverage Continuation

Surviving Spouse Name:

Cancel/Decrease Details

Coverage Type	Check only if you wish to cancel or decrease coverage	New Amount of Coverage Requested (required)
Basic Group Term Life and AD&D	State Paid Benefit	
Expanded Basic Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
Spouse Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$
[1]Dependent Child(ren) Supplemental Group Term Life and AD&D	☐ Cancel ☐ Decrease	$

[1]Elected child(ren) coverage includes all eligible dependents. If cancelling, all dependent child(ren) coverage will be removed.

Name Change

Previous: Current: Reason: ☐ Marriage/Divorce ☐ [2]Correction ☐ [2]Other

[2]A copy of legal documentation is required unless your name is changing due to reason of marriage or divorce.

Address Change

Home Address – Street City State Zip Code

Email Address | Primary Phone No. Secondary Phone No.

Premium Payment Method Change

1. ☐ **Please deduct monthly premiums from my bank account.**
☐1st - 5th ☐6th - 10th ☐11th - 15th ☐16th - 20th ☐21st - 26th

Your draft will occur on one of the dates within the range you have selected.
Please include a voided check or provide:
Routing # _____ Account #_____

_____
Signature of bank account owner (REQUIRED)

2. ☐ Please bill me directly. (Choose one of the following):

☐ Quarterly (3 times your monthly premium)
☐ Semi-Annual (6 times your monthly premium)
☐ Annual (12 times your monthly premium)

Authorization Section

ACTIVE EMPLOYEES ONLY: I authorize my employer to make these changes and withdraw any premiums from my salary to pay for life insurance coverage. I understand that premium for cancelled coverage is due through the end of the month in which Colonial Life & Accident Insurance Company receives my signed request. If my premiums are pre-taxed, I understand that my elections can only be changed if I have a qualifying status change event and that I must request such changes within 60 days of the qualifying event.

_____ _____
Employee Signature Date (mm/dd/yyyy)