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

**District Name:** | **District 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 | ☐ Cancel / Decline | |
| 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)