USAble LIFE **GROUP LIFE INSURANCE CHANGE FORM**

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

Return completed and signed 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. SUPPLEMENTAL LIFE INSURANCE

☐ Decrease coverage to:

☐ 1x salary ☐ 2x salary

☐ Cancel Supplemental Coverage

C. DEPENDENT LIFE INSURANCE

☐ Cancel Dependent Life Coverage

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 or 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 **X**	Phone Number	Date Signed

Employer Signature		Effective Date

RETURN FORM TO RISK MANAGEMENT DEPARTMENT