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

Retired: ☐ AR State Employee ☐ AR Public School Employee	Retirement Date (mm/dd/yyyy):
Name of District/Agency retired from:	Code of District/Agency retired from:

Retiree Information

Retiree 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	Event Date
☐ Marriage ☐Legal Separation ☐ Birth or Adoption of Child ☐Death of Spouse ☐ Divorce ☐Annulment ☐ Placement of Child for Adoption ☐Death of Dependent Child	

Service Requested

☐ Cancel Retiree Coverage	☐ Decrease Coverage	☐ Cancel Dependent Child(ren) Coverage	☐ Change Address
☐ Surviving Spouse Coverage Continuation	☐ Cancel Spouse Coverage	☐ Change Name	☐ Change Retiree Premium Payment Method

If adding a spouse or child coverage as a result of a qualifying life event, 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.

Surviving Spouse Coverage Continuation

Surviving Spouse Name:

Cancel/Decrease Details
All coverages are reduced by 50% of the active employee coverage. At age 75, coverage is reduced by an additional 50%.

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	$5,000
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.

Select the retirement system in which you participate. Always complete. Check only one of the following:

☐ APERS State (998)	☐ ATRS School (059001)
☐ APERS School (059002)	☐ ATRS State (999)
☐ HIGHWAY DEPARTMENT (091)	☐ JUDICIAL (021)

If you wish to pay your premiums on a direct pay basis, check and complete Premium Payment Method Change Section below. ☐

Premium Payment Method Change – If your premiums will not be deducted from your retirement check, please select a payment method

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)

IPG for direct pay retiree policies (Internal use only): I2058329

Authorization Section

If this form is not received by Colonial Life & Accident Insurance Company before the monthly pension deduction deadline, a direct bill will be mailed to you. Failure to pay this bill may result in cancelled coverage. Once the initial bill is paid, monthly deductions from your pension check will automatically begin. In the event my retirement annuity does not have sufficient funds for premium deduction, a Bank Draft Authorization form, along with a voided check must be attached. Premiums paid will be post-tax. 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.

I hereby authorize you to deduct from my retirement check such amounts as necessary to pay the premiums for my life insurance plan. I further authorize you to pay such amounts to the insurance company providing such insurance or its authorized representative. This authorization remains in effect until you receive notice from me in writing that it has been changed or revoked.

_____ _____

Retiree Signature Date (mm/dd/yyyy)