SEIU503 MEMBERSHIP ADVANTAGES

Term Life, Disability & Beneficiary Enrollment Form

Important notice: This form replaces all other enrollment forms on file and must be signed and dated to be valid. Group Life and Disability insurance is underwritten by USABle Life, Group # 50059083.

Section 1 Member Information

This enrollment is for: ❍ New Membr ❍ Open Enrollment ❍ Cancel ❍ Beneficiary Designation Only ❍ Change-Qualifying Event _____ Date of Event _____

Name	Date of Birth	Gender ❍M ❍F	E-mail

Social Security Number	Agency Employed	Home/Cell Phone

Mailing Address	City/State	Zip	Work Phone

Marital Status ❍Single ❍Married ❍Domestic Partnership (per Certificate of Registered Domestic Partnership) ❍Widowed ❍Divorced ❍Domestic Partner (per Affidavit of Domestic Partnership)

If enrolling a domestic partner attach a completed SEIU Local 503 Affidavit of Domestic Partnership form.

How many hours per month do you work in your SEIU Local 503 represented position? _____

☑ **Free $2,500 Member Term Life**

Section 2 Voluntary Term Life Insurance *(you must work at least 40 hours per month to enroll in life insurance)*

Member Voluntary Term Life [1]

(Member term life benefit levels are $10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000 , $100,000, $110,000, $120,000, $130,000, $140,000, $150,000, $160,000, $170,000, $180,000, $190,000 or $200,000)

❍$10,000, ❍$20,000, ❍$30,000, ❍$40,000, ❍$50,000

❍Other Amount (max. $200,000) $ _____

Child Voluntary Term Life [3]

❍$5,000 or ❍$10,000

Child Name	Date of Birth	Relationship

Spouse/Partner Voluntary Term Life [2, 3]

(Spouse term life benefit levels are $10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000 , $100,000, $110,000, $120,000, $130,000, $140,000, $150,000, $160,000, $170,000, $180,000, $190,000 or $200,000)

❍$10,000, ❍$20,000, ❍$30,000, ❍$40,000

❍Other Amount (max. $200,000) $ _____

Spouse/Partner Name	Date of Birth	Relationship

[1]Member Voluntary Term Life-new member (within 90 days of new SEIU membership) guaranteed up to $100,000 .

[2]Spouse Voluntary Term Life-new member (within 90 days of new SEIU membership) guaranteed up to $40,000.

[3]You must be enrolled in voluntary member term life to apply for spouse/partner or child term life.

Section 3 Voluntary Short Term Disability Insurance *(you must work at least 80 hours per month to enroll in short term disability insurance)*

Short Term Disability Insurance: $ _____ *(current monthly salary)*

Monthly Salary: ❍Class 1 *up to $999* ❍Class 2 *$1,000-$2,999* ❍Class 3 *$3,000-$3,999* ❍Class 4 *$4,000 and up*

Section 4 Beneficiary Designation *(attach an additional sheet if more space is required. Additional sheet must be signed and dated to be valid)*

You may choose a beneficiary(s) to receive life benefits. If no beneficiary survives, payment will be made in accordance with the terms of the policy. Unless designated otherwise, beneficiary designations for all life coverage will be the same. For Spouse/Partner and Child Term Life, you are the beneficiary.

	Name of Beneficiary	Social Security #	Date of Birth	Phone Number	Address	Relationship
Primary						
Contingent						

Section 5 Signature for Enrollment , Beneficiary Designation and Authorization for Payroll Deduction

I (we) request to be insured and authorize payroll deductions to cover the cost of coverage (if payroll deduction is available)*. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; and (b) all insurance is subject to the eligibility provisions of the Policy; and (c) I must be Actively at Work (as defined in the Group Policy) to be insured. If I am not Actively at Work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

Signature _____ **Date** _____

Please read the information on the back of this form.

FOR SEIU USE ONLY

MEMBER DATE	CODE A M S C D	DEDUCTION AMOUNT	AGENCY	EFFECTIVE DATE	Group # 50059083

Please keep a photocopy for your records and mail this original to: **SEIU Local 503 at P.O. Box 12159, Salem, Oregon 97309, email to membershipadvantages@seiu503.org, or fax to 503-776-7341.**

Revised for 2025 PY

Insurance will become effective the 1st of the month for which payroll deduction is taken. If the deduction is taken on the last day of the month, the insurance will become effective the 1st of the following month. *Payroll deduction may not be available through all employers. Contact your payroll department or the SEIU Local 503 Membership Advantages office if you have any questions. If payroll deduction is not available you will be required to self pay your premium.

Eligibility

To be eligible for coverage under this plan you must maintain your membership with SEIU Local 503. You must work at least 40 hours per month in your SEIU Local 503 represented position to purchase life insurance. You must work at least 80 hours per month in your SEIU Local 503 represented position to purchase short term disability insurance. You must be scheduled for the minimum required hours and actively working for your insurance to take effect.

Dependents eligible for coverage include spouse/partner and all unmarried dependent children under age 26. If enrolling a domestic partner attach a completed Affidavit of Domestic Partnership form or indicate on the front of this form that you have obtained a Certificate of Registered Domestic Partnership.

If a dependent cannot perform the normal activities of a person of his or her age and sex on the date of his or her coverage would begin, his or her coverage will not begin until he or she is so able.

Enrollment and Premium Change

Enrollment elections can only be changed or canceled during an Open Enrollment period or with a qualified status event. You must notify SEIU Local 503 Membership Advantages office within 31 days of the qualified event to be eligible for the enrollment change. The amount of insurance and premium is subject to change as determined by the salary and age schedule as outlined in the benefit booklet and master policy issued by USAble Life.

Termination of Coverage

Coverage under the term life plan ends when the participant fails to make the required monthly premium payment, or fails to meet the eligibility requirements and/or is no longer a member of SEIU Local 503.

If a plan participant retires or terminates employment, life insurance will be continued without cost for 31 days. Within that period, you may convert your voluntary term life Insurance to an individual guaranteed permanent policy. Application for conversion must be made within 31 days of retirement or employment termination. It is your responsibility to contact the SEIU Local 503 Membership Advantages office to request an application for conversion.

If a plan participant terminates employment prior to age 65, voluntary term life Insurance benefits can be ported. You must apply within 31 days from the date your employment terminated. It is your responsibility to contact the SEIU Local 503 Membership Advantages office to request an application for portability.

Benefit eligibility and termination provisions are detailed in the USAble Life Benefit Booklet. The booklet is located on the SEIU Local 503 website at **seiu503.org** click on the Membership Advantages **page**. You can obtain a printed copy of the booklet by contacting the SEIU Local 503 Membership Advantages office at the number below.

The plan may be amended from time to time or terminated in its entirety at any time by SEIU Local 503.

SEIU Local 503
PO Box 12159
Salem, Oregon 97309-0159

1.844.503.SEIU (7348)

USAble Life

PO Box 1650 | Little Rock | AR | 72203

STATEMENT OF INSURABILITY

Group Term Life – Group Accidental Death & Dismemberment – Group Disability Income

SECTION 1 – COMPLETED BY UNION			
Group Name SEIU LOCAL 503	Group Number 50059083	Telephone # (Include Area Code) ( )	Date of Hire
Amount of Insurance Applying For: Employee Life: $ Dependent Life: $ Disability: $ Other: $			Employee's Annual Salary

SECTION 2 – COMPLETED BY EMPLOYEE ■ **Voluntary Group Term Life** ■ **Amount Over Guarantee Issue** ■ **Late Enrollee**

Name (First, MI, Last)					Social Security No.		
Home Address			City		State	Zip	County
Date of Birth	Birth State or Country	Gender	Height (ft-in.)	Weight (lbs.)	Work Phone ( )	Home Phone ( )	

Spouse & Children Information – Complete if applying for dependent's coverage.

Person Proposed For Insurance Show First, Middle, Last Name	Occupation	Date of Birth & Place				Height	Weight	Marital Status	Sex
		Month	Day	Year	State or Country				
(Spouse)									
(Child)									
(Child)									
(Child)									
(Child)									
Spouse's Social Security No:		Spouse's Work Telehone #: ( )							

SECTION 3 – INSURABILITY QUESTIONNAIRE	Yes	No
1. Has anyone to be covered used any tobacco or nicotine products in the past year?	☐	☐
2. Does anyone to be covered have scheduled, or been advised to have any consultation, diagnostic tests, medical or surgical procedures, or is anyone awaiting results? (annual wellness exams, routine mammogram, pap smear, prostate exam, or colonoscopy recommended due to age only are excluded)	☐	☐
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years?	☐	☐
4. Has anyone to be covered consulted a member of the medical profession in the past one (1) year for any reason?	☐	☐
5. Within the past five (5) years, has anyone to be covered been diagnosed or treated by a member of the medical profession for any of the conditions listed below? Please check all that apply. ○ Cancer, cancer related disease or benign tumor? ○ Heart or Circulatory System disease/disorder, or had a Stroke? ○ Blood or Bone Marrow, Lymphatic, Endocrine or Immune System disease/disorder? ○ Kidney disease or diabetes? ○ Nervous System or Brain disease/disorder? ○ Arthritis, back, bone or joint disorder or injuries? ○ Bladder, urinary system or reproductive organs disorder? ○ COPD, Emphysema, Asthma, Chronic Bronchitis or other Lung disease/disorder? ○ Ulcer, stomach, Intestines, Pancreas, Liver or other Digestive System disease/disorder? ○ Emotional disorder, eating disorder or mental health problems?		
6. Within the past ten (10) years, has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, Human Immunodeficiency Virus ("HIV"), or other sickness or condition derived from such infection?	☐	☐
7. Within the past five (5) years, has anyone to be covered been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4.	☐	☐
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4.	☐	☐
9. Within the past five (5) years, has anyone to be covered been diagnosed with, treated or counseled by a licensed medical professional for, or taken medication for alcohol or substance abuse, or been convicted of DUI, or currently confined to a penal institution?	☐	☐
10a. Are you now pregnant? ○ Yes ○ No 10b. Within the past five (5) years, have you had an ectopic pregnancy, problem pregnancy, miscarriage, problem delivery, therapeutic abortion, or Cesarean section that was diagnosed or treated by a physician?	☐	☐
11. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If no, give full details in Section 4.	☐	☐
12. Names, addresses, and phone numbers of the personal physicians of all applicants:		

SECTION 4 – GIVE DETAILS TO "YES" ANSWERS TO QUESTIONS 2 THROUGH 10 INCLUDE DATES OF TREATMENT: ■ Separate Sheet Attached			
Ques. No. & Individual	Illness/Reason for Checkup or Medication & Dosage or Doctor's Treatment/Consultation	Date & Duration	Full Name, Complete Address, and Telephone Number of Doctors & Hospitals

NOTICE FOR PROPOSED INSURED

IMPORTANT NOTICE FOR DISABILITY COVERAGE

Acceptance of your application for disability income insurance will be based upon the information contained in the Statement of Insurability, including the medical information disclosed and information obtained from your medical providers. Your insurance coverage may not be issued as applied for. If not, an "Exclusion of Coverage Amendment" will be attached to your certificate of coverage.

PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT.

IMPORTANT NOTICE CONCERNING YOUR EFFECTIVE DATE

1. Insurance will not be effective until the application is approved by USAble Life.
2. Insurance will not be effective if there has been a change in the health of the proposed insured(s) after the date of the application and prior to the effective date.
3. For benefits sheltered under a Section 125 Cafeteria plan: To satisfy premium deduction requirements of your employer and dating requirements of the Section 125 Plan, your coverage will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) of the Section 125 agreement or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In signing below, I authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc., and any consumer reporting agency to release any information regarding me or my past or present health to USAble Life, its reinsurers and legal representatives for the purpose of evaluating this Enrollment Form for insurance. Information subject to this authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities, driving record; age; occupation; income; and my use of alcohol, drugs, and tobacco. This information will be used to determine eligibility for insurance. This authorization does not authorize the release of genetic screening or testing results.

I also authorize USAble Life or its reinsurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance. I authorize USAble Life, its reinsurers, and its legal representatives to make a brief report of my/our personal health information to MIB, Inc. All sources except MIB, Inc. may give these facts to any insurance support organization authorized by USAble Life to collect and transmit them.

This authorization shall remain valid for a period of two years from the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to USAble Life.

I understand that this authorization may be revoked at any time. Such revocation must be in writing, and will not be effective until USAble Life and the provider of the information receive it. My revocation will not be effective with respect to disclosures made by a covered entity in reliance on this authorization before it was revoked.

Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

I understand that any insurance will not take effect unless and until USAble Life approves this enrollment request. If coverage is not issued as requested, I authorize USAble Life to issue reduced benefits and adjust premiums to match the coverage issued. I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am requesting allows for alternate methods to pay insurance premiums).

I have read and understand this form in its entirety and the notices, authorizations, and certifications contained within.

Insurance Fraud Warning – Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

EMPLOYEE'S SIGNATURE	DATE OF APPLICATION (MONTH, DAY, YEAR)	SIGNED AT (CITY AND STATE)
AGENT'S SIGNATURE	DATE OF APPLICATION (MONTH, DAY, YEAR)	SIGNED AT (CITY AND STATE)

DATE RECEIVED BY HOME OFFICE _____

USAble Life

PO Box 1650 | Little Rock | AR | 72203

NOTICE FOR PROPOSED INSURED

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

Federal Fair Credit Reporting Act Notice

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

Medical Information Bureau Disclosure Notice

Information regarding your insurability will be treated as confidential. USAble Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

USAble Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

SEIU LOCAL 503
MEMBERSHIP ADVANTAGES
AFFIDAVIT OF DOMESTIC PARTNERSHIP

SECTION ONE - AFFIRMATION OF DOMESTIC PARTNERSHIP

(1) Are each eighteen (18) years of age or older.
(2) Share a close personal relationship and are responsible for each other's common welfare.
(3) Are each other's sole domestic partner.
(4) Are not married to anyone nor have had another domestic partner within the prior six months.
(5) Are not related by blood closer than would bar marriage in the State of Oregon.
(6) Have jointly shared the same regular and permanent residence for at least six (6) months immediately preceding the date of this affidavit with the intent to continue doing so indefinitely.
(7) Have signed a domestic partner declaration (applicable in jurisdictions, which provides for domestic partner declarations).
(8) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. If requested I would be able to provide at least three of the following as verification of our joint responsibility.
    (a) Joint mortgage or lease.
    (b) Designation of the domestic partner as primary beneficiary for a life insurance or a retirement contract.
    (c) Designation of the domestic partner as primary beneficiary in the employee's will.
    (d) Durable power of attorney for health care or financial management.
    (e) Joint ownership of a motor vehicle, a joint checking account, or a joint credit account.
    (f) A relationship or cohabitation contract which obligates each of the parties to provide support for the other party.

SECTION TWO - DECLARATION OF MEMBER

(1) I understand that my domestic partner is eligible for enrollment:
    (a) Within 90 days of my becoming a new member of SEIU Local 503.
    (b) During an open enrollment period.
    (c) Within 31 days of meeting the criteria listed in Section One.
(2) I understand that children of my domestic partner are eligible if they meet the requirement for an eligible dependent as defined by USAble Life, and/or ARAG Group.
(3) I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in circumstance attested to in this Affidavit.
(4) I agree to file a Statement of Termination of Domestic Partnership with the SEIU Local 503 Membership Advantages office within 30 days of any change to circumstances attested to in this Affidavit.
(5) After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed with the SEIU Local 503 Membership Advantages until such time as the conditions of Section One above have been met.

SECTION THREE - DECLARATION OF PARTNERS

(1) We understand that the information contained in the Affidavit relates to eligibility for benefits under the SEIU Local 503 life and/or legal insurance program. Any other use of this information will be subject to disclosure only upon either of our written authorization or as required by law.
(2) We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit of Domestic Partnership.
(3) We understand that in addition to the eligibility requirements of SEIU Local 503 Membership Advantages program for domestic partner coverage, there are terms and conditions of coverage set forth in the Service Agreement of each insurance plan offered through SEIU Local 503, plans which we agree to be bound.
(4) We understand willful falsification of information contained in this Affidavit will result in termination of enrollment pursuant to this agreement by the SEIU Local 503 Membership Advantages program.

We certify under penalty of perjury under the laws or the State of Oregon, that the foregoing is true and accurate to the best of our knowledge

Signature of Member _____ Print Name _____

Signature of Domestic Partner _____ Print Name _____

Date _____

This affidavit of domestic partnership is for SEIU Local 503 life and/or legal insurance enrollment only and must be received by the SEIU Local 503 Membership Advantages office to be valid.

Mail completed enrollment forms and domestic partner affidavit to SEIU Local 503, PO Box 12159, Salem , OR 97309-0159 or e-mail to membershipadvantages@seiu503.org.