Please Print Using Dark Ink

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

CRITICAL ILLNESS APPLICATION

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc	

■ New Application ☐ Change Form ☐ Replaces Policy No. _____

SECTION 1 - APPLICANT INFORMATION

Name (First, MI, Last)				Social Security No.	
Home Address	City	State	Zip	County	
Occupation (Be Exact)	Date of Birth	Age	Birth State or Country	Sex ☐ Male ☐ Female	Height (ft-in.) / Weight (lbs.)
Employer	Date Employed Full-time	Work Phone	Home Phone	Have you used any tobacco products within the past 36 months? ☐ Yes ☐ No	

SECTION 2 – SPOUSE & CHILDREN INFORMATION

Full Name	Occupation	Sex	Date of birth mo.	day	yr.	Birth State or Country	Ht. Ft. Ins.	Wt. lbs.
(spouse)								
(child)								
(child)								
(child)								

Has your spouse used any tobacco products within the past 36 months? ☐ Yes ☐ No

SECTION 3 – PLAN SELECTION

■ New Applicant ■ Application for Change

Select Type of Policy/Optional Rider:

- ☐ CRITICAL ILLNESS WITH CANCER
- ☐ CRITICAL ILLNESS WITHOUT CANCER
- ☐ OPTIONAL RECURRENT BENEFIT RIDER

I hereby apply for the following coverage:

- ☐ Applicant Only
- ☐ Applicant & Spouse
- ☐ Applicant & Children
- ☐ Applicant, Spouse & Children

	Face Amount Applying For (Increments of $5,000)	Number of Units ($5,000 per Unit)	Rate	Monthly Premium
Applicant			X	= $
Spouse*			X	= $
Children**	☐ $5,000 ☐ $10,000		X	= $
		TOTAL PREMIUM AMOUNT		$

* **Spouse's signature required if amount exceeds $25,000.**
** **The maximum amount of Children's coverage is $10,000.**

1. Does any person applying for coverage currently have a Critical Illness or Cancer Policy with us or any other insurance company? ☐ Yes ☐ No If yes, give name of company, list type of policy and amount of coverage._____
2. REPLACEMENT: Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____
3. OUTLINE: Have you received the Outline of Coverage (in those states where required by law)? ■ Yes ☐ No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" on page 2 of this application; (c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (f) agree that this authorization shall be valid for two (2) years from the application date; (g) know that I or my authorized representative may revoke this authorization at any time; (h) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (i) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand no person to be insured is also covered by any Title XIX program – Medicaid or any similar name. I understand failure to disclose a proposed insured person's true health condition may void this policy.

Be sure to complete the Medical Information on page 2/reverse side.

Signed at: _____ HAWAII (City and State) Date of Application _____ (Month, Day, Year)

Date Received Home Office

I have truly and accurately recorded the information supplied by the applicant.

X _____ Agent's Signature

X _____ Applicant's Signature

CIP2-APP-HI (1-13)

X _____ Spouse's Signature (if required)

Employee's Name (Last, First, M.I.)	Social Security # ***-**-_____	Employer

CRITICAL ILLNESS — MONTHLY PREMIUMS PER $5,000 UNIT

CRITICAL ILLNESS WITH CANCER					CRITICAL ILLNESS WITHOUT CANCER				
	INCLUDES RECURRENT BENEFIT		WITHOUT RECURRENT BENEFIT			INCLUDES RECURRENT BENEFIT		WITHOUT RECURRENT BENEFIT	
Issue Age	**Non-Tobacco**	**Tobacco**	**Non-Tobacco**	**Tobacco**	**Issue Age**	**Non-Tobacco**	**Tobacco**	**Non-Tobacco**	**Tobacco**
All Children	$1.66	$1.66	$1.46	$1.46	All Children	$1.00	$1.00	$0.82	$0.82
18 - 29	2.50	5.22	2.22	4.58	18 – 29	1.76	3.06	1.48	2.52
30 - 39	4.08	9.56	3.62	8.38	30 – 39	2.74	5.72	2.30	4.68
40 - 49	6.44	16.92	5.68	14.80	40 – 49	4.20	10.06	3.50	8.18
50 - 59	9.92	27.10	8.74	23.68	50 – 59	6.30	15.82	5.20	12.82
60 - 64	13.36	34.06	11.74	29.74	60 – 64	8.36	19.96	6.88	16.16

SECTION 4 – BENEFICIARY

☐ **Name Beneficiary** ☐ **Change of Beneficiary**

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Relationship	Date of Birth	Primary or Secondary	Indicate % Distribution
			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ Secondary	

SECTION 5 – MEDICAL INFORMATION

NOTE: If Spouse or Children coverage IS NOT being requested answer questions only as applies to applicant.

1. Has any person to be insured ever been diagnosed with, been treated by a member of the medical profession, or taken medication for:

	Yes	No
(a) Any form of internal cancer, carcinoma in-situ, malignant melanoma, or other precancerous findings?	☐	☐
(b) Any chronic or progressive disease or disorder of the heart, kidneys, liver, lungs, pancreas, or bone marrow?	☐	☐
(c) Quadriplegia, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease?	☐	☐
(d) Alcohol or substance abuse (in the last 5 years)?	☐	☐
(e) Heart Attack or heart disease, stroke or transient ischemic attack (TIA), or been advised to have coronary bypass surgery, stent insertion, or laser treatment to coronary arteries?	☐	☐
(f) Diabetes (except during a pregnancy), or any blood pressure reading recorded in the last three months exceeding 149/94?	☐	☐
(g) Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)?	☐	☐

2. Has any person to be insured ever been diagnosed by a member of the medical profession with, or does anyone currently have:

	Yes	No
(a) Any abnormal cancer screening tests currently being followed by your doctor?	☐	☐
(b) Any cysts, growths, lumps, or any mole or freckle that has bled, become painful, changed color, increased in size, required medical attention or evaluation for which you have not yet sought medical advice?	☐	☐
(c) Carotid artery stenosis, peripheral vascular disease, chronic atrial fibrillation, or chest pain not evaluated by a medical doctor and determined to be non-cardiac?	☐	☐
(d) Multiple sclerosis, memory loss, schizophrenia, systemic lupus erythematosus, pulmonary or cystic fibrosis?	☐	☐

3. Has any person to be insured had any two or more natural parents, brothers, or sisters diagnosed with coronary artery disease, diabetes, or the same cancer (other than skin cancer) prior to age 55? Or, has any person to be insured had one or more natural parents, brothers, or sisters diagnosed with coronary artery disease or colorectal cancer prior to age 45? ☐ Yes ☐ No
4. Is any person to be insured currently taking any prescription medicine(s) or have they taken prescription medicine(s) in the last three (3) years? ☐ Yes ☐ No
5. Has any person to be insured had any abnormal tests (including blood test, urinalysis, X-ray, MRI, ultrasound, stress test, echocardiogram) not found to be normal or benign on further testing, or requiring follow-up by a physician? ☐ Yes ☐ No
6. Does any person to be insured have any consultation, surgery, or test scheduled or anticipated? ☐ Yes ☐ No
7. Has any person to be insured ever been diagnosed by a member of the medical profession with a benign tumor, disorder of blood or autoimmune disorder, digestive disorder, urinary system or reproduction organs disorder, heart or circulatory disorder, hypertension (list last two blood pressure readings and dates), mental or nervous disorder, neurological disorder, or respiratory disorder? ☐ Yes ☐ No
8. Has any person to be insured had any application for critical illness, disability, health, or life insurance modified, rated, or declined in the last 5 years? ☐ Yes ☐ No
9. Give details to any "Yes" answers, including name of person, prescription medicine(s), diagnosis, and dates of treatment: _____
10. Name, address, and phone number of the personal physician(s) of all applicants with date last seen, reason for visit, and results:

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application. I understand that my policy will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) 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.

Insurance Fraud Warning - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

USAble Life

P.O. 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.

Automatic Payment Authorization

To have your premiums automatically drafted from your bank account, complete this Authorization and return it with a voided check and premium payment for the current month.

1. **Complete the Authorization:**

   Print your name (exactly as it appears on your bank statement), phone number, policy numbers (if you only have one policy, please leave the other fields blank), bank name, and city. Sign and date the Authorization (be sure your signature matches your bank records).

2. **Mail the Authorization, a voided check, and your payment to USAble Life:**

   Return the Authorization, a voided personal check (business and temporary checks are not accepted for automatic payment authorization), and payment for the current month due to:

   USAble Life
   P.O. Box 204665
   Dallas, Texas 75320-4665

3. **USAble Life takes over from here!**

   USAble Life will process your Authorization within 8-10 business days. Once your Authorization is processed, your insurance premium will automatically be deducted from your checking account by USAble Life on the fourth day of each calendar month.

Automatic Payment Authorization

Name:	**Phone Number:**
Email:	**Policy Number(s)**
Policy Number(s)	**Policy Number(s)**
Bank Name:	**City:**

I hereby authorize USAble Life to debit my account in the financial institution named above and authorize the financial institution to honor these actions and debit my account. The initial amount debited by USAble Life will be equal to the amount of premium due for the above-referenced policies at the time of the automatic draft in order to pay the policies current. Thereafter, the amount will equal one month's premium each month. The draft will be initiated on the 4th day of the month for which the premium is being paid. If USAble Life is unable to draft my account (or to draft the full amount due) on the scheduled draft day, USAble Life may draft my account more than once in the month in order to collect the current month's premium as well as past premiums of up to $300 per month, in order to bring the policies current.

I understand that I may cancel this Authorization by notifying USAble Life or the bank in writing in time to afford USAble Life and the bank a reasonable opportunity to act on it.

Signature _____ Date _____

Sign, date, and return this Authorization Agreement, along with a voided check (temporary checks are not accepted) and payment for the current month due. If payment for the current premium is not included, USAble Life will draft your account to bring the policies current.

Questions?

If you have additional questions, please contact Customer Care at 800-370-5856, Monday through Friday, 8 a.m. to 5 p.m. (CT).

USAble Life℠