USAble Life

Employee Insurance Application

Home Office: P.O. Box 1650
Little Rock, Arkansas 72203

For Home Office use only
Date Received:

Accident Recovery, Hospital Care, Critical Care, Cancer Care

Group #: _____	REASON FOR REQUEST:	Class: _____
❑ New Hire/Enrollee	❑ Decline Coverage	❑ Other: _____
❑ Initial Enrollment Event	❑ Change Request	❑ Qualifying Event; Date: _____ Event:_____

SECTION I. EMPLOYEE INFORMATION (*please print*)

Employer Name	Employer Address	Dept/Location	
❑ Mr. ❑ Mrs. ❑ Ms (Check one) ❑ Other: _____	Employee's Legal Name (First, MI, Last)	❑ M ❑ F	Social Security No.
Height:	Weight:	Have you used any tobacco products within the past 36 months? ❑ Yes ❑ No	
Mailing Address	City	State	Zip
Day Phone:	Evening Phone:	Work Phone:	Email Address:
Birth Date:	Date of Hire:	Age:	Birth State:
Occupation/Job Title	Regular Weekly Hours	Salary ❑ Monthly ❑ Annual ❑ N/A $_____	Employee ID

SECTION II. SPOUSE & CHILDREN INFORMATION

Full Name (First, Middle, Last)	Domestic Partner	Occupation	Gender	Birth Date (Mo/day/Yr)	Height ft /in	Weight Lbs	Social Security #
Spouse	❑ Yes ❑ No		❑ M ❑ F				
Child			❑ M ❑ F				
Child			❑ M ❑ F				
Child			❑ M ❑ F				

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

Spouse includes your legal married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the policyholder and the Insurer.

SECTION III. CITIZENSHIP INFORMATION:

No.	Question	Employee	Spouse
1.	Are you a US or Canadian citizen?	❑ Yes ❑ No	❑ Yes ❑ No
2.	If no to question 1, have you been issued a permanent residency VISA?	❑ Yes ❑ No	❑ Yes ❑ No
3.	If yes to question 2, have you lived continuously in the US or Canada for the last 6 months?	❑ Yes ❑ No	❑ Yes ❑ No

SECTION IV. BENEFICIARY

❑ Name Beneficiary ❑ Change of Beneficiary

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

Name	Date of Birth	Relationship	Primary or Secondary	Indicate % Distribution Primary	Secondary
			❑ Primary or ❑ Secondary		
			❑ Primary or ❑ Secondary		
			Total must equal 100%	100%	100%

SECTION V. ELIGIBILITY QUESTIONS (*required for all applicants*)

No.	Question	Answer
1.	Are you actively at work on a full time/part time basis and able to perform the regular duties of your occupation?	❑ Yes ❑ No
2.	If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled? If "yes", List name(s) _____ who will be excluded from coverage.	❑ Yes ❑ No
3.	Is anyone proposed for coverage covered under Title XIX program (e.g. Medicaid)? If "yes", List name(s) _____ who will be excluded from coverage.	❑ Yes ❑ No

SECTION V. ELIGIBILITY QUESTIONS (*required for all applicants*) - CONTINUED

No.	Question	Answer
Accident Coverage Only:		
4.	Within the past 3 years, has any applicant had their driver's license suspended or revoked? If "yes", List name(s) _____ who will be excluded from coverage.	❑ Yes ❑ No

SECTION VI. PLAN SELECTION

Type of Election: ❑ Add New ❑ Delete ❑ Increase ❑ Decrease Change to: ❑ Employee ❑ Spouse ❑ Child(ren)

Accident Recovery	Plan Selection	Individual Coverage	Family Coverage
❑ Yes ❑ No	❑ Basic ❑ Select ❑ Ultra	❑ Employee only	❑ Employee & Spouse ❑ Employee & Children ❑ Employee & Family

Additional Riders: (*Only available if included in the plan selected by the policyholder*)

Optional Riders for Employee & Family	Amount Per Unit	Available Units
☑ Accident Hospital/ICU Daily Benefit	$25/$50	10

Type of Election: ❑ Add New ❑ Delete ❑ Increase ❑ Decrease Change to: ❑ Employee ❑ Spouse ❑ Child(ren)

Cancer Care with Critical Care	Critical Care	Cancer Care
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Individual Coverage	Family Coverage	Elected Benefit Amount:
❑ Employee only	❑ Employee & Spouse ❑ Employee & Children ❑ Employee & Family	❑ Employee ($5,000 to $100,000 in $5,000 increments) $_____ ❑ Spouse* ($5,000 to $100,000 in $5,000 increments) $_____ ❑ Child(ren)* ❑ $5,000 ❑ $10,000

Additional Rider: (*Only available if included in the plan selected by the policyholder*)

❑ Accumulation Benefit		❑ Yes ❑ No

**Dependent amounts cannot exceed the employee amount.*

Type of Election: ❑ Add New ❑ Delete ❑ Increase ❑ Decrease Change to: ❑ Employee ❑ Spouse ❑ Child(ren)

Hospital Care	Plan Selection	Individual Coverage	Family Coverage
❑ Yes ❑ No	❑ Basic ❑ Select ❑ Ultra	❑ Employee only	❑ Employee & Spouse ❑ Employee & Children ❑ Employee & Family

SECTION VII. REPLACEMENT

Do you currently have insurance like or similar to the coverage applied for? ❑ Yes ❑ No If "yes" list the type of insurance, carrier, termination date and submit a copy of the prior billing: _____

Will the insurance applied for replace any existing insurance? ❑ Yes ❑ No If "yes" list the type of insurance, carrier, termination date and submit a copy of the prior billing: _____

SECTION VIII. AUTHORIZATION:

REMARKS OR SPECIAL PROVISIONS:

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" below; (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) 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; (h) 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 failure to disclose a proposed insured person's true health condition may void this policy.

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. 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 is guilty of a crime and may be subject to fines and confinement in prison.

I have read and understand the above statements and agreements.

X _____ Signed at: , HAWAII

Applicant's Signature (City and State)

Date of Application: _____

(Month, Day, Year)

Agent's Statement: I have accurately recorded the information supplied by the applicant.

X Cheryl Archer 305479

Agent's Signature Agent's License ID Number

CHERYL ARCHER

Agent's Printed Name