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USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

# ACCIDENT POLICY APPLICATION & CHANGE FORM

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

Agent Name/Number

☐ New Application ☐ Change Form

☐ Reinstatement Policy # _____ ☐ Replaces Policy #_____

## SECTION 1 – PERSONAL IDENTIFICATION

| Name (First, MI, Last) | For Name Change, Give Prior Last Name | Social Security No. |
|---|---|---|
| | | |

| Home Address | City | State | Zip | County |
|---|---|---|---|---|
| | | | | |

| Date of Birth | Age | Birth State or Country | Sex ☐ Male ☐ Female | Work Phone | Home Phone |
|---|---|---|---|---|---|
| | | | | | |

| Type of Business | Applicant's email address (if any) |
|---|---|
| | |

| Name of Employer | Date Employed Full-Time | Occupation | Hours Worked Weekly |
|---|---|---|---|
| | | | |

**DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage.**

| Full Name (First, MI, Last) | Relationship | Sex | Date of Birth Mo. | Day | Yr. | Birth State or Country |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## SECTION 2 – PLAN SELECTION ☐ New Applicant ☐ Application for Change

**CHECK COVERAGE DESIRED:**

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Applicant, Spouse & Children

**Applying for Accident Policy Plan:** **PREMIUM**

☐ Basic (3 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8)

☐ Select (4 units of all Modules)

☐ Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) $

Optional Accidental Disability Rider*:

☐ Off-The Job or ☐ 24-Hour ☐ $400 ☐ $600 ☐ $800 $

☐ Optional Sickness Disability Rider* ☐ $400 ☐ $600 $

**TOTAL MONTHLY PREMIUM** $

| Industry Class Monthly Premiums | Class A/B | | | Class C | | | Class D | | |
|---|---|---|---|---|---|---|---|---|---|
| | Basic | Select | Ultra | Basic | Select | Ultra | Basic | Select | Ultra |
| Applicant | $15.80 | $19.36 | $27.88 | $23.36 | $28.64 | $41.32 | $27.80 | $34.08 | $49.12 |
| Applicant & Spouse | 22.48 | 27.52 | 39.68 | 29.88 | 36.64 | 52.80 | 33.92 | 41.60 | 60.00 |
| Applicant & Children | 26.28 | 32.16 | 46.40 | 30.28 | 37.12 | 53.52 | 34.24 | 41.92 | 60.44 |
| Applicant, Spouse & Children | 32.96 | 40.32 | 58.20 | 36.80 | 45.12 | 65.00 | 40.36 | 49.44 | 71.32 |

| Optional Rider(s) | Off-The-Job | 24-Hour | Off-The-Job | 24-Hour | Off-The-Job | 24-Hour |
|---|---|---|---|---|---|---|
| Accident Disability Rider*: | | | | | | |
| $400 | $3.12 | $8.40 | $5.52 | $17.92 | N/A | N/A |
| $600 | 4.68 | 12.60 | 8.28 | 26.88 | N/A | N/A |
| $800 | 6.24 | 16.80 | 11.04 | 35.84 | N/A | N/A |
| Sickness Disability Rider* | Class A/B | | Class C | | Class D | |
| $400 | $7.44 | | $8.08 | | N/A | |
| $600 | 11.16 | | 12.12 | | N/A | |

***Coverage applies to primary insured only.**

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

**SECTION 3 – PERSONAL INFORMATION (Only Complete If Applying for ANY Disability Rider.)**

| | Yes | No |
|---|---|---|
| 1. Do you have other short-term disability coverage? If yes please list your weekly benefit and your weekly salary. Weekly Benefit _____ Weekly Salary _____ | ☐ | ☐ |
| 2. Within the past three years, have you been the driver in a motor vehicle accident or charged with a moving violation, including driving under the influence of drugs or alcohol? Has your driver's license ever been suspended? | ☐ | ☐ |
| 3. Are you currently disabled? | ☐ | ☐ |

**Answer questions 4 through 7 if applying for Sickness Disability Rider.**

4. Have you ever been diagnosed or treated by a member of the medical profession for:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| (a) Cancer, Cancer related disease or benign tumor? | ☐ | ☐ | (f) Lung, Liver or Blood Disorder? | ☐ | ☐ |
| (b) Disease of the Heart or Blood Vessels, or had a Stroke? | ☐ | ☐ | (g) Emotional, Nervous System (including Muscular Dystrophy and Multiple Sclerosis), Eating Disorder or Mental Health Problems? | ☐ | ☐ |
| (c) Kidney Disease or Diabetes? | ☐ | ☐ | | | |
| (d) Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")? | ☐ | ☐ | (h) Ulcer, Stomach or Digestive Disorder? | ☐ | ☐ |
| | | | (i) Arthritis, Bones or Joint Disorder? | ☐ | ☐ |
| (e) Alcohol or Drug Abuse? | ☐ | ☐ | (j) Bladder, Urinary System or Reproductive Organs Disorder? | ☐ | ☐ |

5. Have you ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? ☐ Yes ☐ No
If "Yes," list person(s), medications taken, medication dosage and last two blood pressure readings.
Medication, Dosage, Readings with Dates: _____

6. Are you currently pregnant? ■ Yes ☐ No Have you ever had a problem pregnancy? ☐ Yes ☐ No

7. Primary Physician's Name: _____ Address: _____
Phone Number: _____ City, State, Zip: _____

**Give details for "yes" answers to any questions and indicate to whom answers relate.**

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

**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 | Birthdate | Relationship | Primary or Secondary | Indicate Percentage |
|---|---|---|---|---|
| | | | ☐ Primary or ☐ Secondary | |
| | | | ☐ Primary or ☐ Secondary | |

**SECTION 5 – AUTHORIZATION**

1. Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____
2. 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) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (c) 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; (d) 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; (e) agree that this authorization shall be valid for two (2) years from the application date; (f) 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; (g) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Information Practices Notice. 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 the 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 primary insured; (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** – It is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

I have read and understand the above statements and agreements.

X _____ Signed at: _____
Applicant's Signature (City and State)

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

Date of Application _____
(Month, Day, Year)

X _____
Agent's Signature

| Date Received Home Office |
|---|
| |

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.