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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	

☐ 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	Gender ☐ 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

1. Are you a US citizen? ☐ Yes ☐ No

2. If no to question 1, have you been issued a permanent residency VISA? ☐ Yes ☐ No

3. If yes to question 2, have you lived continuously in the US or Canada for the last 6 months? ☐ Yes ☐ No

SPOUSE* & CHILDREN INFORMATION – Complete if Applying for Dependent's Coverage

Full Name (First, Middle, Last)	Domestic Partner	Occupation	Gender	Date of Birth (month/day/year)	Birth State or Country
Spouse	☐ Yes ☐ No				
Child					
Child					
Child					

*Spouse means your spouse or domestic partner.

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 (5 units of Module 8 and 4 units of all other 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 $

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

SECTION 3 – PERSONAL INFORMATION

	Yes	No
1. Within the past five years, has any applicant had their driver's license suspended or revoked?	☐	☐
2. Are you currently disabled?	☐	☐

Answer question 3 if applying for ANY Disability Rider.

3. Do you have other short-term disability coverage? If yes please list your weekly benefit and your weekly salary. Weekly Benefit _____ Weekly Salary _____

Answer questions 4 through 8 if applying for Sickness Disability Rider.

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

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

5. Has anyone to be covered tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a licensed member of the medical profession as having AIDS Related Complex or Acquired Immunodeficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No
6. Have you ever been diagnosed or treated by a licensed 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: _____
7. Are you currently pregnant? ☐ Yes ☐ No Have you ever had a problem pregnancy? ☐ Yes ☐ No
8. Name, address and phone number of the personal physician(s): _____

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. REPLACEMENT: Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company._____
2. OUTLINE: Have you received the Outline of Coverage? ☐ 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 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) 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 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. 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, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I have read and understand the above statements and agreements.

X _____ Signed at: _____

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 _____ _____

Agent's Signature Agent's License ID Number

_____

Agent's Printed Name

Date Received Home Office