USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

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	Gender ☐ 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	

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

SECTION 2 – SPOUSE* & CHILDREN INFORMATION

Full Name	Domestic Partner	Occupation	Gender	Date of Birth (month/day/year)	Birth State or Country	Height ft /in	Weight lbs
(spouse)	☐ Yes ☐ No						
child							
child							
child							

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

**Spouse means your spouse or domestic partner.*

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		= $

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

TOTAL PREMIUM AMOUNT $

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	

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

SECTION 5 – MEDICAL INFORMATION
NOTE: If Spouse or Children coverage IS NOT being requested answer questions only as applies to applicant.

1. To the best of your knowledge, has any person to be insured been diagnosed with or advised to take a diagnostic test by a licensed medical professional, been treated by a licensed medical professional, or taken medication on the advice of a licensed medical professional in the last 10 years 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?	☐	☐

2. To the best of your knowledge, has any person to be insured been diagnosed by a licensed medical professional in the last 10 years with:

	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. To the best of your knowledge, 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 in the last 10 years? ☐ Yes ☐ No
4. To the best of your knowledge, 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
5. To the best of your knowledge, is any person to be insured currently taking any prescription medicine(s) on the advice of a licensed medical professional or have they taken prescription medicine(s) on the advice of a licensed medical professional in the last three (3) years? ☐ Yes ☐ No
6. To the best of your knowledge, 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 in the last 10 years? ☐ Yes ☐ No
7. To the best of your knowledge, does any person to be insured have any consultation, surgery, or test scheduled? ☐ Yes ☐ No
8. To the best of your knowledge, has any person to be insured been diagnosed by a licensed 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 in the last 10 years? ☐ Yes ☐ No
9. To the best of your knowledge, 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
10. Give details to any "Yes" answers, including name of person, prescription medicine(s), diagnosis, and dates of treatment:

_____

_____

11. Name, address, and phone number of the personal physician(s) of all applicants with date last seen, reason for visit, and results:

_____

_____

_____

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

SECTION 6 – AUTHORIZATION

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? ☐ 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.

X _____ Signed at: _____

Applicant's Signature (City and State)

X _____ Date of Application: _____

Spouse's Signature (if required) (Month, Day, Year)

X _____ _____

Agent's Signature Agent's License ID Number

_____

Agent's Printed Name

Date Received Home Office