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

Date Received Home Office

X _____ Agent's Signature

X _____ Applicant's Signature

CIP2-APP-IA (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 or advised to take a diagnostic test, 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?	☐	☐

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 ever been diagnosed with or treated by a member of the medical profession for Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)? ☐ 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.