

P.O. Box 1650 Little Rock, Arkansas 72203

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Please Print Using D	Office Use Only			
ACCIDENT	Policy Number			
ACCIDENT	Group Number			
PPLICATION & O	Effective Date			
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	☐ Change Form	Class		

Agent Name/Number		New Appl	ication			Change	FOIII		Class					
	☐ Reinstatement Po				icy# Replaces Policy#									
SECTION 1 PERSONAL	. IDENTIF	ICATION												
Name (First, MI, Last)				For	For Name Change, Give Prior Last Name Social Se				Security No.					
Home Address				City	City State			Zip Count			ounty	ity		
Date of Birth			or Count	ry	y Sex Male Work Phone Female				Home Phone					
Type of Business Applicant's email address (if any)														
Name of Employer				Date Employed Full-Time			Occupation				Hours Worked Week			
DEPENDENT INFORMAT	TION - Coi	mplete if A	Applyir	ng fo	r Depen	dent's C	overage	€.						
							Date of			Birth		D:-41	- 04-4-	
Full Name (Firs	t, MI, Last)			Rel	lationship		Sex		Da	av Y	Yr. Birth State or Country			
,	<u> </u>				<u> </u>									
SECTION 2 PLAN SELE	ECTION				New A	pplican	1		Applic	cation f	or Cha	nge		
CHECK COVERAGE DES	SIRED:													
CHECK COVERAGE DES		nt & Spou	se			icant & (Children		Па	pplicant	. Spous	e & (Children	
☐ Applicant [Applica	int & Spou	se		☐ Appl	icant & (Children		☐ A	pplicant			Children	
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Applying for Accident Po	Applica	 !		units					<u> </u>	pplicant				
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Applicant Applying for Accident Po Basic (3 units of Mod Select (4 units of all I Ultra (4 units of Modu	Applica blicy Plans lules 1, 3, Modules) lle 6, 5 uni	5, 6 and 7	and 4		of Modu	les 2, 4,	and 8)							
Applicant Applying for Accident Po Basic (3 units of Mod Select (4 units of all I Ultra (4 units of Modu Optional Accidental Disabil	Application Applic	5, 6 and 7	and 4 le 8, ar	nd 6 เ	of Modu	les 2, 4,	and 8) /lodules)			\$				
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Em	ployee's Name (Last, First, M.I.)		Social Security #			Employer		
0.5	OTION A DEPOSITAL INFORMATION (O	ala O amarila (a. 16	A conditions from the	- Assistant Disability D	· · · · · ·			
SE	CTION 3 PERSONAL INFORMATION (Or	nly Complete if	Applying for th	e Accident Disability R	ider.)	Yes	No	
1.	Do you have other short-term disability coversalary. Weekly Benefit Wee	erage? If yes ple ekly Salary	ease list your we	ekly benefit and your we	ekly	□ □		
2	, ,		eter vehicle acc	ident or charged with a		Ш	Ш	
۷.	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.	3. Are you currently disabled?							
	Give details for "yes" answer	s to any questi	ons and indicat	te to whom answers re	ate.			
SE	CTION 4 BENEFICIARY	Name Benefic	ciary ■ Cha	ange of Beneficiary				
	I hereby revoke the appointment of any exist	sting beneficiary	and designate t	the following beneficiary	under thi	s polic	y.	
	Name	Birthdate	Relationship	Primary or Second	ary		icate entage	
				☐ Primary or ☐ Sec	condary			
				☐ Primary or ☐ Sec	condary			

Employee	's Name (Last, First, M.I.)	Social Security #	Employer						
SECTION	N 5 AUTHORIZATION								
1.	Is this insurance to replace or change other insuran name of company.	ce? Yes No If "Ye	es", give details including						
2. 3.	Have you received the Outline of Coverage (in those Within the past two years, has any proposed insurancing any type of vehicle in an organized event, or a Yes No If "Yes", list person(s) and details	ed engaged in any of the follow any sport for wage or profit?	,						
	Does any proposed insured drive any commercial passenger-carrying or cargo vehicle, other than a school bus, for wage, compensation, or profit? Yes No If "Yes", list person(s) and details:								
ı	Within the past three years, has any proposed insur- moving violation, including driving under the influer license ever been suspended? Yes No If "Yes", list person(s) and details	nce of drugs or alcohol? Has							
correctly personal facility, in family (or coverage legal reprigive such facilitate that a phrepresent as requiremployer	g below, I (a) represent that the statements and answ recorded to the best of my knowledge and belief; (b) health information to MIB; (c) authorize any physicial surance or reinsurance company, or Medical Information those who have applied for coverage on this applier, hazardous activities, character, general reputation, resentative any and all such information to use for una records or knowledge to any agency employed by its rapid submission; (e) agree that this authorization notocopy of this authorization shall be as valid as the tative upon request; (g) acknowledge receipt of writtened by the Fair Credit Reporting Act and the Information make the necessary payroll deductions to pay for true health condition may void the policy.	authorize USAble Life or its reingler, medical practitioner, hospital ation Bureau, Inc. having informalication) regarding our mental and finances, and vocation to give to derwriting insurance; (d) authorist the company to collect and trainshall be valid for two (2) years for e original and I understand that in notification describing the use ation Practices Notice. In apply	nsurer to make a brief report of my l, clinic, or other medically related ation on me or any member of my d physical health, other insurance of USAble Life, its reinsurers, or its ze all said sources, except MIB, to nsmit such information in order to rom the application date; (f) agree to a copy is available to me or my of the Medical Information Bureau ving for insurance, I authorize my						
The insurfirst mode policy in become	nt Note – The entire contract will consist of trance will not be effective on the proposed insured all premium is paid; and (3) There has been no char the health of the proposed insured as stated in the effective on the first day of the month following the month following underwriting approval, whichever	unless: (1) The policy is deliveringe since the date of this application. I understand effective date (anniversary date	ed to the primary insured; (2) The ation and the effective date of the that my policy will be dated and e for resolicitation) or on the first						
insurance	ce Fraud Warning – It is or may be a crime to known e company for the purpose of defrauding the companial of insurance benefits in accordance with applicable	any or other person. Penalties							
I have rea	ad and understand the above statements and agreen	nents.							
Х		Signed at:							
	Applicant's Signature		(City and State)						
	Statement: I have accurately recorded the on supplied by the applicant.	Date of Application	(Month, Day, Year)						
Χ			(, 24 _j , 1041 _j						
	Agent's Signature								
			Date Received Home Office						