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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 $

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	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

***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 the Accident 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?	☐	☐

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

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	

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

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)
3. Within the past two years, has any proposed insured engaged in any of the following activities as a professional: racing any type of vehicle in an organized event, or any sport for wage or profit?
   ☐ Yes ☐ No If "Yes", list person(s) and details: _____
4. 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: _____
5. Within the past three years, has any proposed insured been the driver in a motor vehicle accident or charged with a moving violation, including driving under the influence of drugs or alcohol? Has any proposed insured's driver's license ever been suspended?
   ☐ Yes ☐ No If "Yes", list person(s) and details: _____

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) 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