



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

CANCER APPLICATION & CHANGE FORM

Office Use Only	
Policy Number	
Effective Date	
Group Number	
Dept./Loc	

☐ New Business ☐ Change Form ☐ Replace US Able Policy No. _____

☐ Policy Lost ☐ Policy Attached

SECTION 1 - APPLICANT INFORMATION

Name (First, MI, Last)		For Name Change, Give Prior Last Name		Social Security #	
Home Address		City	State	Zip	County
Name of Employer		Date Employed Full-Time		Occupation	
Date of Birth	Birth State or Country	Sex	Work Phone		Home Phone

SECTION 2 - SPOUSE & CHILDREN INFORMATION

Person Proposed for Insurance Show first, middle, last name	Relationship	Date of birth			Birth State or Country	Marital Status	Age	Sex
		mo.	day	yr.				
a.								
b.								
c.								
d.								
e.								

SECTION 3 - PLAN SELECTION

☐ New Applicant

☐ Application for Change

I hereby apply for the following coverage: ☐ Applicant ☐ Applicant & Children ☐ Applicant, Spouse & Children

CEP Policy

- ☐ Plan I - (\$100 Hosp. Confinement, \$5,000 Radiation/Chemo/Blood, \$1,000 Surgical/Anesthesia, and Specified Disease Benefit)
- ☐ Plan II - (\$250 Hosp. Confinement, \$10,000 Radiation/Chemo/Blood, \$2,000 Surgical/Anesthesia, and Specified Disease Benefit)
- ☐ Plan III - (\$300 Hosp. Confinement, \$15,000 Radiation/Chemo/Blood, \$4,000 Surgical/Anesthesia, and Specified Disease Benefit)

Add Delete Elective Rider(s):

- ☐ ☐ \$_____ Cancer Diagnosis Rider
- ☐ ☐ \$_____ Hospital Intensive Care Rider
- ☐ ☐ \$_____ Monthly Disability Rider:
- Spouse Coverage ☐ Yes ☐ No

Total Monthly Premium: \$ _____

1. Do all persons to be insured currently have an Individual or Group Comprehensive Health insurance or HMO that provides medical, hospital and surgical coverage? ☐ Yes ☐ No **If no, such persons are not eligible for this policy.**
2. REPLACEMENT: Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____
3. Have you received the Notice regarding the Minnesota Life & Health Guaranty Association 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" on page 2 of this application; (c) authorize US Able 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, character, general reputation, finances, and vocation to give to US Able 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 24 months after it is signed, or until any contract of insurance issued as a result of this applications ends, whichever comes first; (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 (i) acknowledge receipt of the Information Practices Notice and the Insurance Fraud Warning. 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 state no person to be insured is 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.

This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; or (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "Emergency Medical Personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan Law.

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	

Name (First, MI, Last)	Social Security #	Employer
SECTION 4 – MEDICAL INFORMATION		
The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; or (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the authorization on the reverse side for a definition of "Emergency Medical Personnel."		
1. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: 1) cancer or any malignancy which includes carcinoma, sarcoma, Hodgkins Disease, leukemia, lymphoma, or malignant tumor? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: Addison's Disease, Brucellosis, Budd-Chiari Syndrome, Cystic Fibrosis, Diphtheria, Encephalitis, Histoplasmosis, Legionnaires' Disease, Lou Gehrig's Disease, Malaria, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Osteomyelitis, Poliomyelitis, Q-Fever, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Spinal Meningitis, Systemic Lupus Erythematosus, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Trichinosis, Tuberculosis, Tularemia, Typhoid Fever, Whooping Cough? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The person(s) named above in questions 1, 2, or 3 may be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy issuance.		
4. Name, address, and phone number of your personal physician(s): _____ _____		
Answer the questions below if applying for the Hospital Intensive Care Rider.		
5. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: a heart condition, heart trouble, a heart attack, any abnormality of the heart (including artery disease), or a stroke? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? If "Yes," list person(s), medications taken, and medication dosage and last two blood pressure readings. Person(s) _____ Medication, Dosage, Readings with Dates _____ _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
The person(s) named above may be excluded in part or in total from coverage for any intensive care confinement resulting from any disorder of the heart and limited to three days in connection with any other intensive care confinement. The person(s) named above may be excluded in part or in total from coverage by an Elimination rider to be signed by the applicant prior to policy/rider issuance.		

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; (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; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan 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 false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.



PO Box 1650 • Little Rock, AR 72203-1650
(501) 375-7200 • (800) 648-0271

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, **SUBJECT TO LIMITS AND EXCLUSIONS**, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, Minnesota 55110
Phone: (651) 407-3149
Fax: (651) 407-3150

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$500,000. Subject to this \$500,000 limit, the guaranty association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$250,000 in annuity net cash surrender and net cash withdrawal values, \$410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

The coverage provided by the guaranty association is not a substitute for using care in selecting insurance companies that are well managed and financially stable. In selecting an insurance company or policy, you should not rely on coverage by the guaranty association.

This notice is required by Minnesota state law to advise policyholders of life, annuity, or health insurance policies of their rights in the event their insurance carrier becomes financially insolvent. This notice in no way implies that the company currently has any type of financial problems. All life, annuity, and health insurance policies are required to provide this notice.



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NOTICE FOR PROPOSED INSURED

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

Federal Fair Credit Reporting Act Notice

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

Medical Information Bureau Disclosure Notice

Information regarding your insurability will be treated as confidential. US Able Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

US Able Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.