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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 – DEPENDENT 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, 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 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 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.

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

X _____ Spouse's Signature (if required)

| Employee's Name (Last, First, M.I.) | Social Security # | Group # |
|---|---|---|

**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 | $1.16 | $1.16 | $1.00 | $1.00 | All Children | $0.44 | $0.44 | $0.36 | $0.36 |
| 18 - 29 | 2.30 | 4.74 | 2.00 | 4.12 | 18 – 29 | 1.60 | 2.74 | 1.34 | 2.28 |
| 30 - 39 | 3.74 | 8.70 | 3.26 | 7.56 | 30 – 39 | 2.50 | 5.06 | 2.08 | 4.22 |
| 40 - 49 | 5.88 | 15.34 | 5.12 | 13.34 | 40 – 49 | 3.80 | 8.86 | 3.16 | 7.38 |
| 50 - 59 | 9.06 | 24.54 | 7.88 | 21.34 | 50 – 59 | 5.62 | 13.88 | 4.68 | 11.56 |
| 60 - 64 | 12.16 | 30.82 | 10.58 | 26.80 | 60 – 64 | 7.44 | 17.48 | 6.20 | 14.56 |

## 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.**

**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. Within the past 10 years, has any person to be insured 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? | ☐ | ☐ |
| (g) Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)? | ☐ | ☐ |

2. Has any person to be insured ever been diagnosed by a member of the medical profession 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. 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
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. In the past 5 years, 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. In the past 5 years, has any person to be insured 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.