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USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

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

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

☐ **By checking this box, I confirm my understanding that this hospital care policy does not meet the federal government requirement for minimum essential health coverage.**

☐ New Application ☐ Change Form ☐ Replaces Policy No. _____

SECTION 1 – PERSONAL IDENTIFICATION

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		Height (ft-in)	Weight (lbs.)
Date of Birth	Birth State or Country	Sex	Work Phone	Home Phone	

SPOUSE & CHILDREN INFORMATION - Complete if Applying for Dependent's Coverage

Person Proposed for Insurance Show first, middle, last name	Date of birth mo.	day	yr.	Birth State or Country	Marital Status	Age	Sex	Height (ft-in)	Weight (lbs.)
(spouse)									
(child)									
(child)									
(child)									
(child)									

SECTION 2 – PLAN SELECTION ☐ New Applicant ☐ Application for Change

CHECK COVERAGE DESIRED:

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Applicant, Spouse & Children

Hospital Confinement Plan(s):

☐ Plan I - $50 Daily Hospital Confinement, $100 Emergency Accident, $1,000 Surgery & Anesthesia, $250/$500 Ambulance Ground/Air, and Specified Injury.

☐ Plan II - $100 Daily Hospital Confinement, $250 Emergency Accident, $1,500 Surgery & Anesthesia, $75 Outpatient Sickness, $250/$500 Ambulance Ground/Air, $75 Wellness, and Specified Injury.

☐ Plan III - $200 Daily Hospital Confinement, $500 Emergency Accident, $2,500 Surgery & Anesthesia, $75 Outpatient Sickness, $500/$1,000 Ambulance Ground/Air, $75 Wellness, and Specified Injury.

Add	Delete	Optional Rider(s):	Amount		
☐	☐	Annual Hospital Admission Rider	☐ $500	☐ $750	☐ $1,000
☐	☐	Hospital Intensive Care Confinement Rider	☐ $200	☐ $400	☐ $600
☐	☐	Heart Attack, Stroke, Coma & Paralysis Benefit Rider	☐ $1,000/$500	☐ $2,000/$1,000	

Total Monthly Premium: $_____

1. Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____
   If "No", list all other Hospital Indemnity policies and their daily benefit(s). _____

2. Have you received the Outline of Coverage (in those states where required by law)? ☐ Yes ☐ No (check one)

SECTION 3 – 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 Name

SECTION 4 – MEDICAL INFORMATION

1. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a physician? If "Yes," list person(s) and details: Yes ☐ No ☐

   Person(s): _____ Details: _____

2. Has anyone to be covered been confined in a hospital or nursing home within the last 12 months because of internal cancer, melanoma, heart surgery, heart attack, congestive heart failure, vascular disease, hypertension, chronic obstructive pulmonary disease, chronic liver disease, stroke, emphysema, sickle-cell anemia, asthma, chronic bronchitis, Parkinson's disease, multiple sclerosis, or rheumatoid arthritis? ☐ ☐

   Person(s): _____ Details: _____

3. Has anyone to be covered ever been diagnosed or treated by a physician or an appropriately licensed clinical professional acting within the scope of his/her license for: Alzheimer's disease, senile dementia, systemic lupus, kidney failure, diabetes, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)? ☐ ☐

   Person(s): _____ Details: _____

4. Is anyone to be covered now pregnant? ☐ ☐

   Person(s): _____ Details: _____

5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? ☐ Yes ☐ No If "Yes," list person(s), medications taken, medication dosage and last two blood pressure readings. Person(s): _____

   Medication, Dosage, Readings with Dates: _____

The person(s) named above in questions 1 through 5 may be excluded from coverage by an Exclusion rider to be signed by the applicant prior to policy issuance.

6. PRIMARY PHYSICIAN'S NAME: _____ Address: _____

Phone Number: _____ City, State, Zip: _____

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

SECTION 5 – Authorization

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 MIB 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 (MIB) 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 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 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 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.

I, the applicant, hereby attest that I currently have other health coverage in force that qualifies as minimum essential coverage, as defined by Section 5000A(f) of the Internal Revenue Code. ☐ Yes ☐ No I understand that by checking "no" this hospital care policy will not be issued.

Signed at: _____ (City and State)

Date of Application _____ (Month, Day, Year)

Date Received Home Office

X _____ Agent's Signature

X _____ Applicant's Signature