

Please Print Using Dark Ink

ACCIDENT POLICY APPLICATION & CHANGE FORM

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

P.O. Box 1650 Little Rock, Arkansas 72203

Agent Name/Number		New Appl	ication			Chang	e Form		Class					
	□ Re	einstateme	nt Polic	v #			Пв	ces Pol	licv #					
				<i>)</i>				101101						
SECTION 1 – PERSONAL	IDENTIF	ICATION												
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	y Sex Male Female			Work Ph	none		Hom	Home Phone			
Type of Business					Applicant's email address (if any)					ss (if any))			
Name of Employer			Da	Date Employed Full-Time Oc				Occupation				Hours Worked Weekly		
DEPENDENT INFORMAT	ION - Co	mplete if A	Applyin	g for	Depen	dent's (Coverag	e.						
									Date o	of Birth		irth	Stata	
Full Name (First	, MI, Last)						Sex	Мо	Mo. Day				Birth State or Country	
<u> </u>														
SECTION 2 – PLAN SELE	CTION				New A	Applicar	nt		Applic	cation for	Chang	е		
CHECK COVERAGE DES	IRED:													
Applicant [Applica	ınt & Spou	se		□ Арр	licant &	Children		□ A	pplicant, S	Spouse	& C	hildren	
Applying for Accident Po	licy Plan	•									PREMI	184		
☐ Basic (3 units of Mode	-		and 4 i	ınite	of Modu	ulos 2 /	and 8)				PKEWII	ועוכ		
		J, O and T	and 4 c	JI III S	or ivioud	1103 2, 4,	and o)							
Select (4 units of all N	,							,						
Ultra (4 units of Modul	e 6, 5 uni	ts of Modu	ile 8, an	1d 6 L	inits of a	all other	Modules	5)		\$				
Optional Accidental Disabili	ty Rider*:													
☐ Off-The Job or ☐ 24-Hour ☐ \$400 ☐ \$600 ☐ \$800 §														
Optional Sickness Disab	ility Rider	*	\$400		□ \$6	00				\$				
					TOTA	L MON	THLY P	REMI	IUM	\$				
Industry Class			Class A	4/B			C			Class	D			
Monthly Premium	S	Basic	Selec		Ultra	Basic			Ultra	Basic	Selec		Ultra	
Applicant		\$15.80	\$19.3		\$27.88	\$23.36			\$41.32	\$27.80	\$34.0	_	\$49.12	
Applicant & Spouse		22.48	27.52	2	39.68	29.88	36.6	4	52.80	33.92	41.60		60.00	
Applicant & Children		26.28	32.16		46.40	30.28			53.52	34.24	41.92	2	60.44	
Applicant, Spouse & Childr	en	32.96	40.32		58.20	36.80		_	65.00	40.36			71.32	
Optional Rider(s)	` '		-Job	b 24-Hour		Off-TI	Off-The-Job		-Hour	Off-The-Job		2	4-Hour	
Accident Disability Rider*:	·					ΦE 50		047.00		N1/A			.	
\$400		\$3.12		\$8.40			\$5.52		17.92	N/A		N/A		
\$600 \$800		4.68 6.24		12.60			8.28		26.88				N/A	
Sickness Disability Rider*			t Class <i>l</i>	16.80		+ '1	11.04 35.84 Class C			N/A N/A Class D				
\$400 \$7							\$8.08			1	N/A			
\$600			11.16				12.1			1	N/A			
*Coverage applies to prin	nary insu	red only.												

Employee's Name (Last, First, M.I.)			So	cial Security #	Employer						
SE	CTION 3 - PERSONAL INFORMATION (Only Com	plete If	Appl	ying	for ANY Disability Rider.)						
1.	Do you have other short-term disability coverage? I	f ves ni	A26A	liet v	our weekly benefit and your wee	Yes	No				
١.	salary. Weekly Benefit Weekly Sala			,KIY							
2.	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.											
	Answer questions 4 through	7 if app	olying	for	Sickness Disability Rider.						
4.											
		Yes	No			Yes	No				
	(a) Cancer, Cancer related disease or benign tumor?			(f)	Lung, Liver or Blood Disorder?						
	(b) Disease of the Heart or Blood Vessels, or had a Stroke?			(9)	Emotional, Nervous System (including Muscular Dystrophy Multiple Sclerosis), Eating Diso						
	(c) Kidney Disease or Diabetes?			/L-\	or Mental Health Problems?						
	(d) Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or			(n)	Ulcer, Stomach or Digestive Disorder?		Ш				
	Human Immunodeficiency Virus ("HIV")?		_	(i)	Arthritis, Bones or Joint Disorde	er?					
	(e) Alcohol or Drug Abuse?	Ш		(j)	Bladder, Urinary System or Reproductive Organs Disorder?	?					
	pressure)?										
6.	Are you currently pregnant? Yes No Ha	ave you	ever	had	a problem pregnancy? Yes	☐ No					
7.	Primary Physician's Name:	-			Address:						
Phone Number: City, State, Zip:											
	Give details for "yes" answers to any	quest	ions a	and i	ndicate to whom answers rela	ite.					
						<u>- </u>					

Employee's Name (Last, First, M.I.)	Social Sec	curity #	Employer		
SECTION 4 – BENEFICIARY	Name Benefic	ciary ■ Cha	ange of Beneficiary		
I hereby revoke the appointment of any exist				under thi	s policy.
Name	Birthdate	Relationship	Primary or Second	dary	Indicate Percentage
			☐ Primary or ☐ Se	condary	1 0.02
			☐ Primary or ☐ Se	condary	
SECTION 5 – AUTHORIZATION					
Is this insurance to replace or change oth name of company.	her insurance?	☐ Yes ☐	No If "Yes", give detail	ls includin	ıg
Have you received the Outline of Covera	ge (in those st	ates where requ	ired by law)?	No (ch	eck one)
In signing below, I (a) represent that the statement correctly recorded; (b) authorize USAble Life or it (c) authorize any physician, medical practitioner, company, or Medical Information Bureau, Inc. has applied for coverage on this application) regard activities, character, general reputation, finances, any and all such information to use for underwriting knowledge to any agency employed by the comsubmission; (e) agree that this authorization shall of this authorization shall be as valid as the origin request; (g) acknowledge receipt of written notificated Fair Credit Reporting Act and the Information Pracencessary payroll deductions to pay for my insurated condition may void the policy.	its reinsurer to hospital, clinic aving informatic ding our mental and vocation to ginsurance; (d) hopany to collect be valid for two hall and I understation describing ctices Notice.	make a brief report, or other medical and physical and give to USAble authorize all said and transmit so (2) years from the stand that a copy the use of the In applying for in	port of my personal heal cally related facility, insign of my family health, other insurance election Life, its reinsurers, or it id sources, except MIB, such information in order the application date; (f) and y is available to me or my Medical Information Burensurance, I authorize my	alth inform surance or (only those coverage its legal reto give super to facility agree that my represe eau as remployer	ation to MIB; r reinsurance se who have e, hazardous epresentative ach records or itate its rapid a photocopy entative upon quired by the r to make the
Important Note – The entire contract will of the insurance will not be effective on the propose first modal premium is paid; and (3) There has be policy in the health of the proposed insured as become effective on the first day of the month following underwriting approvapolicy.	ed insured unle een no change s stated in this ollowing the eff	ess: (1) The police since the date of application. Infective date (ann	icy is delivered to the proof this application and the understand that my poleniversary date for resolice.	rimary insome effectivolicy will be citation) c	ured; (2) The re date of the de dated and or on the first
Insurance Fraud Warning – It is or may be a consurance company for the purpose of defrauding and denial of insurance benefits in accordance with	g the company	or other person			
I have read and understand the above statements	and agreemen	its.			
Applicant's Signature	Siç	gned at:			
Applicant's Signature			(City and Stat	te)	
Agent's Statement: I have accurately recorded information supplied by the applicant.		ate of Application	(Month, Day	v Year)	
XAgent's Signature			(····s·····, = =-)	y, 16a.,	
rigorità Ergilleria					
			Date Re	ceived Ho	me Office