



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

ACCIDENT POLICY APPLICATION & CHANGE FORM

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

| | | | | |
|-------------------|--|--------------------------------------|---|--|
| Agent Name/Number | <input type="checkbox"/> New Application | <input type="checkbox"/> Change Form | <input type="checkbox"/> Reinstatement Policy # _____ | <input type="checkbox"/> 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 | <input type="checkbox"/> Male <input type="checkbox"/> 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 | | | Birth State or Country |
|-----------------------------|--------------|-----|---------------|-----|-----|------------------------|
| | | | Mo. | Day | Yr. | |
| | | | | | | |
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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 _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently disabled? | <input type="checkbox"/> | <input type="checkbox"/> |

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

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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 |
|------|-----------|--------------|--|---------------------|
| | | | <input type="checkbox"/> Primary or <input type="checkbox"/> Secondary | |
| | | | <input type="checkbox"/> Primary or <input type="checkbox"/> 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