



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

ACCIDENT POLICY APPLICATION & CHANGE FORM

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

Agent Name/Number

New Application Change Form
 Reinstatement Policy # _____ 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.	

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 and 8, and 6 units of all other Modules) \$

Optional Accidental Disability Rider*:

Off-The Job or 24-Hour
 \$400 \$600 \$800 \$

Optional Sickness Disability Rider*
 \$400 \$600 \$

TOTAL MONTHLY PREMIUM

Industry Class Monthly Premiums	Class A/B			Class C			Class D		
	Basic	Select	Ultra	Basic	Select	Ultra	Basic	Select	Ultra
Applicant	\$18.28	\$21.84	\$29.68	\$25.84	\$31.12	\$42.80	\$30.28	\$36.56	\$50.40
Applicant & Spouse	27.12	32.16	43.36	34.52	41.28	56.16	38.56	46.24	63.20
Applicant & Children	31.32	37.20	50.32	35.32	42.16	57.28	39.28	46.96	64.00
Applicant, Spouse & Children	40.16	47.52	64.00	44.00	52.32	70.64	47.56	56.64	76.80
Optional Rider(s)	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
Sickness Disability Rider*	Class A/B			Class C			Class D		
\$400	\$7.44			\$8.08			N/A		
\$600	11.16			12.12			N/A		

*Coverage applies to primary insured only.

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

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)

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) 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
