USAble Life℠

P.O. Box 1650
Little Rock, Arkansas 72203

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Please Print Using Dark Ink

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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 Policy, $100 Emergency Accident Rider, $1,000 Surgery & Anesthesia Rider, $250/$500 Ambulance Ground/Air Rider, and Specified Injury Rider.

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

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

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 any portion of the premium for this coverage being paid by the employer either directly, through wage adjustments, or by other means of reimbursement? ☐ Yes ☐ No
2. Does the employer or any proposed insured intend to treat this plan as part of a plan or program for the purposes of sections 106, 125, or 162 of the Internal Revenue Code? ☐ Yes ☐ No If "Yes", is any part of the plan or program funded by the employer? ☐ Yes ☐ No
3. 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). _____
4. Have you received the Outline of Coverage (in those states where required by law)? ☐ Yes ☐ No (check one)

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

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	

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 member of the medical profession 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