



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

CANCER APPLICATION & CHANGE FORM

Office Use Only table with columns: Policy Number, Effective Date, Group Number, Dept./Loc

Form type selection: New Business, Change Form, Replace USABLE Policy No., Policy Lost, Policy Attached

SECTION 1 - APPLICANT INFORMATION

Form fields for Section 1: Name, Home Address, Name of Employer, Date of Birth, Birth State or Country, Sex, Work Phone, Home Phone

SECTION 2 - SPOUSE & CHILDREN INFORMATION

Table for Section 2 with columns: Person Proposed for Insurance, Relationship, Date of birth (mo., day, yr.), Birth State or Country, Marital Status, Age, Sex

SECTION 3 - PLAN SELECTION

Plan selection options: New Applicant, Application for Change

Form fields for Section 3: Coverage selection (Applicant, Applicant & Children, Applicant, Spouse & Children), CEP Policy options, Add/Delete/Elective Rider(s) section, Total Monthly Premium

- 1. REPLACEMENT: Is this insurance to replace or change other insurance?
2. OUTLINE: Have you received the Outline of Coverage (in those states where required by law)?

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" 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 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; (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) know that I or my authorized representative may revoke this authorization at any time; (h) 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; (i) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act; and (j) 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 state no person to be insured is covered by any Title XIX program - Medicaid or any similar name. I understand failure to disclose a proposed insured person's true health condition may void this policy.

Be sure to complete the Medical Information on page 2/reverse side.

Signature and date fields: Signed at, Date of Application, Date Received Home Office, Agent's Signature, Applicant's Signature

Name (First, MI, Last)	Social Security #	Employer
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SECTION 4 – MEDICAL INFORMATION

1. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: cancer or any malignancy which includes carcinoma, sarcoma, Hodgkins Disease, leukemia, lymphoma, or malignant tumor? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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2. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: Addison's Disease, Brucellosis, Budd-Chiari Syndrome, Cystic Fibrosis, Diphtheria, Encephalitis, Histoplasmosis, Legionnaires' Disease, Lou Gehrig's Disease, Malaria, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Osteomyelitis, Poliomyelitis, Q-Fever, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Spinal Meningitis, Systemic Lupus Erythematosus, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Trichinosis, Tuberculosis, Tularemia, Typhoid Fever, Whooping Cough? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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3. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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The person(s) named above in questions 1, 2, or 3 may be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy issuance.

4. Name, address, and phone number of your personal physician(s): _____ _____

Answer the questions below if applying for the Hospital Intensive Care Rider.

5. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: a heart condition, heart trouble, a heart attack, any abnormality of the heart (including artery disease), or a stroke? If "Yes," list person(s), and condition(s): Person(s) _____ Condition(s) _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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6. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? If "Yes," list person(s), medications taken, and medication dosage and last two blood pressure readings. Person(s) _____ Medication, Dosage, Readings with Dates _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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The person(s) named in questions 5 or 6 may be excluded in part or in total from coverage for any intensive care confinement resulting from any disorder of the heart and limited to three days in connection with any other intensive care confinement. The person(s) named above may be excluded in part or in total from coverage by an Elimination rider to be signed by the applicant prior to policy/rider issuance.

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 false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.