Please Print Using Dark Ink

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

ACCIDENT POLICY APPLICATION & CHANGE FORM

Office Use Only	
Policy Number	
Group 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 ☐ Male ☐ 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 Mo.	Day	Yr.	Birth State or Country

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, and 4)

☐ Select (4 units of all Modules)

☐ Ultra (4 units of Module 6 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 $

***Coverage applies to primary insured only.** **TOTAL MONTHLY PREMIUM** $

Industry Class Monthly Premiums	Class A/B			Class C			Class D		
	Basic	Select	Ultra	Basic	Select	Ultra	Basic	Select	Ultra
Applicant	$13.08	$16.64	$24.48	$19.30	$24.56	$36.20	$22.94	$29.20	$43.00
Applicant & Spouse	18.58	23.60	34.76	24.70	31.44	46.28	28.10	35.76	52.68
Applicant & Children	21.74	27.60	40.68	25.10	31.92	47.00	28.26	35.92	52.92
Applicant, Spouse & Children	27.30	34.64	51.08	30.50	38.80	57.08	33.42	42.48	62.60

Optional Rider(s)*	Off-The-Job	24-Hour	Off-The-Job	24-Hour	Off-The-Job	24-Hour
*Coverage applies to primary insured only.						
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

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

SECTION 3 – PERSONAL INFORMATION (APPLIES TO PRIMARY INSURED ONLY.)
Only Complete If Applying for ANY 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 _____	☐	☐
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. Are you currently disabled?	☐	☐

Answer questions 4 through 7 if applying for Sickness Disability Rider.

4. Have you been diagnosed or treated by a member of the medical profession in the past 10 years for:

	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?	☐	☐	(g) Emotional, Nervous System (including Muscular Dystrophy and Multiple Sclerosis), Eating Disorder or Mental Health Problems?	☐	☐
(c) Kidney Disease or Diabetes?	☐	☐			
(d) Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")?	☐	☐	(h) Ulcer, Stomach or Digestive Disorder?	☐	☐
			(i) Arthritis, Bones or Joint Disorder?	☐	☐
(e) Alcohol or Drug Abuse?	☐	☐	(j) Bladder, Urinary System or Reproductive Organs Disorder?	☐	☐

5. Have you been diagnosed or treated by a member of the medical profession in the past 10 years for hypertension (high blood pressure)? ☐ Yes ☐ No
If "Yes," list person(s), medications taken, medication dosage and last two blood pressure readings.
Medication, Dosage, Readings with Dates: _____

_____

6. Are you currently pregnant? ☐ Yes ☐ No Have 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 questions and indicate to whom answers relate.

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

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
			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ 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 subject to the Time Limits on Certain Defenses Provision.

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