



P.O. Box 1650  
Little Rock, Arkansas 72203

Please Print Using Dark Ink

# CANCER APPLICATION & CHANGE FORM

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

New Business       Change Form       Replace USABLE Policy No. \_\_\_\_\_       Policy Lost       Policy Attached

### SECTION 1 - APPLICANT INFORMATION

|                        |                        |                                       |            |                   |            |
|------------------------|------------------------|---------------------------------------|------------|-------------------|------------|
| 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        |            |
| Date of Birth          | Birth State or Country | Sex                                   | Work Phone |                   | Home Phone |

### SECTION 2 - SPOUSE & CHILDREN INFORMATION

| Person Proposed for Insurance<br>Show first, middle, last name | Relationship | Date of birth |     |     | Birth State<br>or Country | Marital<br>Status | Age | Sex |
|--|--------------|---------------|-----|-----|---------------------------|-------------------|-----|-----|
|  |              | mo.           | day | yr. |                           |                   |     |     |
| a.   |              |               |     |     |                           |                   |     |     |
| b.   |              |               |     |     |                           |                   |     |     |
| c.   |              |               |     |     |                           |                   |     |     |
| d.   |              |               |     |     |                           |                   |     |     |
| e.   |              |               |     |     |                           |                   |     |     |

### SECTION 3 - PLAN SELECTION

New Applicant       Application for Change

I hereby apply for the following coverage:       Applicant       Applicant & Children       Applicant, Spouse & Children

**CEP Policy**

Plan I - (\$100 Hosp. Confinement, \$5,000 Radiation/Chemo/Blood, \$1,000 Surgical/Anesthesia, and Specified Disease Benefit)

Plan II - (\$250 Hosp. Confinement, \$10,000 Radiation/Chemo/Blood, \$2,000 Surgical/Anesthesia, and Specified Disease Benefit)

Plan III - (\$300 Hosp. Confinement, \$15,000 Radiation/Chemo/Blood, \$4,000 Surgical/Anesthesia, and Specified Disease Benefit)

**Add    Delete    Elective Rider(s):**

       \$\_\_\_\_\_ Cancer Diagnosis Rider

       \$\_\_\_\_\_ Hospital Intensive Care Rider

       \$\_\_\_\_\_ Monthly Disability Rider:  
Spouse Coverage  Yes  No

**Total Monthly Premium: \$ \_\_\_\_\_**

1. REPLACEMENT: Is this insurance to replace or change other insurance?  Yes  No If "Yes", give details including name of company. \_\_\_\_\_
2. Is any person to be insured currently covered under any other specified disease policy that is not going to be replaced?  Yes  No  
**If yes, such persons are not eligible for this policy. List name(s):** \_\_\_\_\_
3. OUTLINE: 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) 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) 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 Medical Information Bureau 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 this policy.

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

|                                      |   |                                 |
|--------------------------------------|---|---------------------------------|
| Signed at: _____<br>(City and State) | Date of Application _____<br>(Month, Day, Year) | Date Received Home Office _____ |
| X _____<br>Agent's Signature         | X _____<br>Applicant's Signature                |                                 |

|                        |                   |          |
|------------------------|-------------------|----------|
| Name (First, MI, Last) | Social Security # | Employer |
|------------------------|-------------------|----------|

**SECTION 4 – MEDICAL INFORMATION**

|  |                                 |                                |
|--|---------------------------------|--------------------------------|
| 1. In the past 5-10 years, has any person to be insured 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):<br>Person(s) _____ Condition(s) _____   | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |
| 2. In the past 5-10 years, has any person to be insured 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):<br>Person(s) _____ Condition(s) _____ | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |
| 3. In the past 5-10 years, has any person to be insured 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):<br>Person(s) _____ Condition(s) _____  | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |

**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):<br>_____<br>_____ |
|---|

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

|   |                                 |                                |
|---|---------------------------------|--------------------------------|
| 5. In the past 5-10 years, has any person to be insured 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):<br>Person(s) _____ Condition(s) _____    | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |
| 6. In the past 5-10 years, has any person to be insured 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.<br>Person(s) _____ Medication, Dosage, Readings with Dates _____ | Yes<br><input type="checkbox"/> | No<br><input type="checkbox"/> |

**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 WARNINGS. KS** - 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 as determined by a court of law. **MO** - 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.