USAble Life

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 Show first, middle, last name	Relationship	Date of birth mo.	day	yr.	Birth State or Country	Marital Status	Age	Sex
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. 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) 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.

Signed at: _____ (City and State) Date of Application _____ (Month, Day, Year)

Date Received Home Office

X _____ Agent's Signature

X _____ Applicant's Signature

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

SECTION 4 – MEDICAL INFORMATION

	Yes	No
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)_____	☐	☐
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)_____	☐	☐
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)_____	☐	☐

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.

	Yes	No
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)_____	☐	☐
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 _____ _____	☐	☐

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.