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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 | |

☐ New Application ☐ Change Form ☐ Reinstatement Policy No. _____ ☐ Replaces Policy No. _____

## 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 |
|---|---|---|---|
| | | | |

## SPOUSE & CHILDREN INFORMATION - Complete if Applying for Dependent's Coverage

| Full Name | 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

| Accident Policy: | | | | **PREMIUM** |
|---|---|---|---|---|
| ☐ Plan I (4 units of all Modules)<br>☐ Plan II (4 units of Module 6, 5 units of Module 8, 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 | | $ |
| | | **TOTAL MONTHLY PREMIUM** | | $ |

1. Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company:
   _____
2. Within the past three years, has any proposed insured been the driver in a motor vehicle accident or charged with a moving violation, including driving under the influence of drugs or alcohol? Has any proposed insured's driver's license ever been suspended? ☐ Yes ☐ No If "Yes", list person(s) and details: _____
   _____
3. Within the past two years, has any proposed insured engaged in: scuba diving below 70 feet; rock or mountain climbing; parachuting or hang gliding; any sport for wage or profit; taxi driving; or racing any type vehicle in an organized event? ☐ Yes ☐ No
   If "Yes", list person(s) and details: _____
   _____
4. Have you received the Outline of Coverage (in those states where required by law)? ☐ Yes ☐ No (check one)

**If Applying for Disability Rider(s) Complete Information on Page 2 of Application**

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 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 the policy.

**Complete the Beneficiary Information on Page 2**
**If Applying for a Disability Rider Complete the Personal Information on Page 2**

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

X _____ Agent/Producer's Signature X _____ Applicant's Signature

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

**Accident Policy - Industry Class Monthly Premiums**

| | Class A/B | | Class C | | Class D | |
|---|---|---|---|---|---|---|
| | Plan I | Plan II | Plan I | Plan II | Plan I | Plan II |
| **Applicant** | $19.36 | $27.88 | $28.64 | $41.32 | $34.08 | $49.12 |
| **Applicant & Spouse** | 27.52 | 39.68 | 36.64 | 52.80 | 41.60 | 60.00 |
| **Applicant & Children** | 32.16 | 46.40 | 37.12 | 53.52 | 41.92 | 60.44 |
| **Applicant, Spouse & Children** | 40.32 | 58.20 | 45.12 | 65.00 | 49.44 | 71.32 |
| **Optional Accident Disability Rider*:** | Off-The-Job | 24-Hour | Off-The-Job | 24-Hour | Off-The-Job | 24-Hour |
| **$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 |
| **Optional Sickness Disability Rider*** | Class A/B | | Class C | | Class D | |
| **$400** | $7.44 | | $8.08 | | N/A | |
| **$600** | 11.16 | | 12.12 | | N/A | |

***Coverage applies to primary insured only.**

## 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 – PERSONAL INFORMATION

**PLEASE COMPLETE QUESTIONS 1 AND 2 IF APPLYING FOR ANY DISABILITY RIDER.**

1. Do you have other short-term disability coverage? If yes please list your weekly benefit and your weekly salary. Yes ☐ No ☐
   Weekly Benefit _____ Weekly Salary _____
2. Are you currently disabled? Yes ☐ No ☐

**Answer questions 3 through 6 if applying for Sickness Disability Rider.**

3. Have you ever been diagnosed or treated by a member of the medical profession 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? | ☐ | ☐ |
| | | | (j) Bladder, Urinary System or Reproductive Organs Disorder? | ☐ | ☐ |
| (e) Alcohol or Drug Abuse? | ☐ | ☐ | | | |

4. Have you 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.
   Medication, Dosage, Readings with Dates: _____
5. Are you currently pregnant? ☐ Yes ☐ No Have you ever had a problem pregnancy? ☐ Yes ☐ No
6. PRIMARY PHYSICIAN'S NAME: _____ Address: _____
   Phone Number: _____ City, State, Zip: _____

**Give details for "yes" answers to any questions and indicate to whom answers relate.**

**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; 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 a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.