| USADE Ife ACCIDENT POLICY Policy Number Appent Name/Number APPLICATION & CHANGE FORM Policy Number Policy Number Agent Name/Number Invertige Change Form Pelicy Number Pelicy Number Agent Name/Number Invertige Change Form Replaces Policy # Pelicy Number Section 1 - PERSONAL IDENTIFICATION Name (First, ML Last) For Name Change, Give Pror Last Name Social Security No. Home Address City State Zp County Date of Birth Age Birth State or Country Sec Maile More Prove Name of Employer Date Employed Ful-Time Occupation Hours Worked Weekly DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage. More of Birth More of Birth More of Birth Full Name (First, ML, Last) Relationship Sex Date of Birth More of Country Section 2 - PLAN SELECTION New Applicant & Children Applicant Section Applicant Section PREMIUM Basic Section 1 - Applicant & Spouse Applicant Section Section 1 - Applicant | Please Print Using Dark Ink Office Use Only | | | | | | | | | | | | | | | |
|--|---|------------------------|-------------|-------------|------------------------------------|--------------|---------|-------|----------|------------|---------|----------|---------------------|---------|----------|--|
| How store How store Group Number Group Number Agent NameNumber | USA blad ifa | | _ | _ | | | _ | | | F | Policy | | | | | |
| Little Rock, Atamasa 72203 APTELCATION & CHANGE FORM Dept.Loc. Agent NameAlumber New Application Change Form Class Reinstatement Policy # Resplaces Policy # Section 1 - PERSONAL IDENTIFICATION Section 1 - PERSONAL IDENTIFICATION Section 2 - PLAN Section Section 2 - PLAN Section Section 2 - PLAN Section Brith State or Country Section 2 - PLAN Section Home Phone Home Phone | US <u>ADIĘ</u> LIIE | | AC | CIDI | ΕN | IT POL | _IC \ | Y | | | , | | | | | |
| Litterede, Marines 12003 Dept. Loc. Agent Name/Number New Application Change Form Dept. Loc. SECTION 1 - PERSONAL IDENTIFICATION For Name Change, Give Prior Last Name Social Security No. Name (First, Mi, Last) For Name Change, Give Prior Last Name Social Security No. Name (First, Mi, Last) Age Birth State or Country Sec Applicant's email address (if any) Name of Employer Date of Birth Age Birth State or Country Sec Date of Birth Home Phone Tope of Business Name of Employer Date Employed Full-Time Occupation Hours Worked Weekly DEPENDENT INFORMATION - Complete if Applying for Dependent'S Coverage. Name of Employer Bart State or Country Birth State or Country Section 100 - PLAN SELECTION Relationship Sec Date of Birth or Change Birth State or Country Basic (Suits of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) Select (4 units of all Modules) \$ PREMIUM Select (4 units of all Module 6, 5 units of Modules 1, 3, 5, 6 and 7 and 4 units of all other Modules) \$ Select (2 units of Module 6, 5 units of Module 6, 3 and 6 units of all other Modules) <t< td=""><td>P.O. Box 1650</td><td></td><td></td><td>'INN</td><td>ם ו</td><td></td><td></td><td>= 6</td><td></td><td>νл</td><td>Effecti</td><td>ve Date</td><td>•</td><td></td><td></td></t<> | P.O. Box 1650 | | | 'INN | ם ו | | | = 6 | | νл | Effecti | ve Date | • | | | |
| Reinstatement Policy # Replaces Policy # SECTION 1 – PERSONAL IDENTIFICATION Sodal Security No. Name (First, MI, Last) For Name Change, Give Prior Last Name Sodal Security No. Home Address City State Zip County Date of Birn Age Birth State or Country Sex Manle Work Phone Home Phone Type of Business Applicant's email address (If any) Applicant's email address (If any) Hours Worked Weekly. DEPENDENT INFORMATION - Complete If Applying for Dependent's Coverage. Indue of Birnh Birth State or Country Full Name (First, MI, Last) Relationship Sex Mo. Date of Birth Full Name (First, MI, Last) Relationship Sex Application for Change Sectro PLAN SELECTION Indue Applicant & Children Application for Change CHECK COVERAGE DESIRED: Applicant & Applicant & Spouse & Children Applicant, Spouse & Children Select (4 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) S S Optional Accidented Disability Rider*: Stodo Stodo S S Optional Schenes Disab | | | LICAI | | | | IGI | - ' | | | Dept./ | Loc. | | | | |
| Section 1 - PERSONAL IDENTIFICATION Name (First, MI, Last) For Name Change, Give Prior Last Name Social Security No. Home Address City State Zp County Date of Birth Age Birth State or Country Set Male York Phone Home Phone Type of Business Applicant's email address (if any) Applicant's email address (if any) Hours Worked Weekly Date Employed Full-Time Occupation Mours Worked Weekly Date Employed Full-Time Date of Birth Mours Worked Weekly Date Employed Full-Time Occupation Birth State or Country Full Name (First, MI, Last) Relatonship Sex Date of Birth Birth State or Country Certon 2 Image: Sex Mon Day Yr. Birth State or Country Sex Date Employed Full-Time Occupation Date Or Change Certon 2 Image: Sex Mon Day Yr. Birth State or Country Certon 2 Image: Sex Applicant & Children Applicant | Agent Name/Number | | New Appl | cation | | | Char | nge | Form | | Class | | | | | |
| Name (First, MI, Last) For Name Change, Give Prior Last Name Social Security No. Home Address City State Zp County Date of Birth Age Birth State or Country Sex Male Work Phone Home Phone Type of Business Applicant's email address (if arry) Applicant's email address (if arry) Hours Worked Weekly DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage. Date of Birth Birth State or Country Sex Mol Date of Birth Birth State or Country Birth State or Country Sex Date of Birth Birth State or Country Birth State or Country Sex Date of Birth Birth State or Country Sex Date of Birth Birth State or Country Sex Date or Birth Birth State or Country Sex Early (if the Country or Country Sex Early (if the Country or Country Sex Early (if the Country or Country or Country or Country or Country or Country Sex Applicant (if the Country or Country or Country or Co | | 🗌 Re | instateme | nt Polie | cy # | ŧ | | | | eplace | es Po | licy # | | | | |
| Home Address City State Zp County Date of Birth Age Birth State or Country Sex Made Work Phone Home Phone Type of Business Age Birth State or Country Sex Made More Phone Home Phone Name of Employer Date Employed Full-Time Occupation Hours Worked Weekly DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage. Date of Birth Burth State Full Name (First, Mi, Last) Relationship Sex Mo. Date SectriON 2 – PLAN SELECTION New Applicant Applicant Source Sector Burth State CHECK COVERAGE DESIRED: | SECTION 1 – PERSONAL | IDENTIFI | CATION | | | | | | | | | | | | | |
| Date of Birth Age Birth State or Country Sex Male Female Work Phone Home Phone Type of Business Applicant's email address (if any) Applicant's email address (if any) Home Worked Weekly DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage. Date Employed Full-Time Occupation Hours Worked Weekly DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage. The of Birth Birth State or Country Birth State or Country Full Name (First, ML Last) Relationship Sex Mo. Day Yr. Sector Coverage Full Name (First, ML Last) Relationship Sex Application for Change Sector Coverage for Coverage Implicant & Spouse Applicant & Children Applicant, Spouse & Children Applying for Accident Policy Plan: Implicant & Spouse Applicant & Children Applicant, Spouse & Children Basic (3 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) S S Select (4 units of Module 6, 5 units of Module 7 \$400 \$600 \$200 \$ Optional Accidental Disability Rider* \$400 \$600 \$23.00 | | | | | | | | | | | | | | | | |
| 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. Date of Birth Birth State Full Name (First, MI, Last) Relationship Sex Date of Birth Birth State Full Name (First, MI, Last) Relationship Sex Date of Change For Country SECTION 2 – PLAN SELECTION New Applicant Applicant for Change For Change CHECK COVERAGE DESIRED: New Applicant & Children Applicant, Spouse & Children Applicant Applicant & Spouse Applicant & Children Applicant, Spouse & Children Applicant Applicant & Spouse Select 4 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) \$ Select (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ \$ \$ Optional Accidental Disability Rider* \$400 \$\$ \$ \$ \$ Optional Accidental Disability Rider* \$400 \$\$ \$ \$ \$ Applicant \$13 | Home Address | | | | C | City State | | | | Zi | Zip Cou | | | unty | | |
| Name of Employer Date Employed Full-Time Occupation Hours Worked Weekly DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage. Date of Birth Birth. State Full Name (First, MI, Last) Relationship Sex Mo. Date of Birth Birth. State Full Name (First, MI, Last) Relationship Sex Mo. Date of Birth Birth. State SECTION 2 – PLAN SELECTION New Applicant Applicant Applicant for Change CHECK COVERAGE DESIRED: | Date of Birth | Age Birth State or Cou | | | | | | | one | Home Phone | | | | | | |
| DEPENDENT INFORMATION - Complete if Applying for Dependent's Coverage. Full Name (First, MI, Last) Relationship Sax Date of Birth Mo. Date of Birth Mo. Birth State or Country SECTION 2 – PLAN SELECTION Image: Construct the state of Birth Applicant Image: Construct the state of Birth Mo. Image: Construct the state of Birth Mo. Image: Construct the state of Birth Mo. Image: Construct the state of Country SECTION 2 – PLAN SELECTION Image: Construct the state of Birth Applying for Accident Policy Plan: Image: Construct the state of Birth Applying for Accident Policy Plan: Image: Construct the state of Birth Basic (3 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) Image: Construct the state of Birth Basic (3 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) Image: Construct the state of Birth Basic (3 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) Image: Construct the state of Birth the s | Type of Business Applicant's email address (if any) | | | | | | | | | | | | | | | |
| Full Name (First, MI, Last) Relationship Sex Date of Birth Birth State or Country SECTION 2 – PLAN SELECTION Industry New Applicant Applicant or Country SECTION 2 – PLAN SELECTION Industry Applicant Applicant Applicant Applicant Applicant Applicant Pressort Applicant Applicant & Spouse Applicant & Children Applicant, Spouse & Children Applicant Applicant & Spouse Applicant & Children Applicant, Spouse & Children Basic 3 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) Select Variation of Modules 3 Select 4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ Select Class D Optional Accidental Disability Rider* \$400 \$600 \$ \$ Select Ultra Applicant & Spouse 19.28 23.60 \$ Class D Class D Select Ultra Applicant & Spouse 19.28 23.60 34.42 \$23.76 \$23.12 \$41.98 Applicant & Spouse 19 | Name of Employer | | | 0 | Date Employed Full-Time Occupation | | | | on | | | | Hours Worked Weekly | | | |
| Full Name (First, MI, Last) Relationship Sex Date of Birth Birth State or Country SECTION 2 – PLAN SELECTION Industry New Applicant Applicant or Country SECTION 2 – PLAN SELECTION Industry Applicant Applicant Applicant Applicant Applicant Applicant & Spouse Applicant & Children Applicant, Spouse & Children Applicant Applicant & Spouse Applicant & Children Applicant, Spouse & Children Basic G units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) Select Industry Select (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ S Optional Accidental Disability Rider*: State Select Ultra Basic Select Ultra Optional Sickness Disability Rider* \$400 \$600 \$ \$ Class D Applicant & Spouse 19.28 23.60 34.02 25.56 31.36 45.18 29.10 35.68 51.44 Applicant & Spouse 19.28 23.60 34.42 31.64 | DEPENDENT INFORMATI | ON - Cor | nplete if A | pplyir | ng f | for Depen | dent's | s Co | overage |) . | | | 1 | | | |
| Full Name (First, MI, Last) Relationship Sex Mo. Day Yr. or Country Image: Constraint of the second | | | - | | - | | | | - | | Date | of Birth | | | | |
| SECTION 2 – PLAN SELECTION New Applicant Application for Change CHECK COVERAGE DESIRED: | Full Name (First | ML Last) | | | Pelationshin | | | | Sex | Мо | | Day Vr | | | | |
| CHECK COVERAGE DESIRED: Applicant & Spouse Applicant & Spouse 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, 4, and 8) PREMIUM Select (4 units of all Modules) \$ \$ Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ \$ Optional Accidental Disability Rider*: \$400 \$600 \$800 \$ Optional Sickness Disability Rider* \$400 \$600 \$ \$ Industry Class Class A/B Class C Class D \$ Monthly Premiums Basic Select Ultra Basic Select Ultra Applicant & Spouse \$13.46 \$16.48 \$23.74 \$20.10 \$24.64 \$35.54 \$23.76 \$29.12 \$41.98 Applicant & Spouse \$19.28 23.60 34.02 25.58 31.36 45.66 29.32 \$1.74 Applicant & Spouse & Children 22.50 27.52 39.72 25.84 31.66 45.66 29.34 35.92 51.78 | | | | | | tolationomp | | | | | ay | | | | | |
| CHECK COVERAGE DESIRED: Applicant & Spouse Applicant & Spouse 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, 4, and 8) PREMIUM Select (4 units of all Modules) \$ \$ Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ \$ Optional Accidental Disability Rider*: \$400 \$600 \$800 \$ Optional Sickness Disability Rider* \$400 \$600 \$ \$ Industry Class Class A/B Class C Class D \$ Monthly Premiums Basic Select Ultra Basic Select Ultra Applicant & Spouse \$13.46 \$16.48 \$23.74 \$20.10 \$24.64 \$35.54 \$23.76 \$29.12 \$41.98 Applicant & Spouse \$19.28 23.60 34.02 25.58 31.36 45.66 29.32 \$1.74 Applicant & Spouse & Children 22.50 27.52 39.72 25.84 31.66 45.66 29.34 35.92 51.78 | | | | | | | | | | | | | | | | |
| CHECK COVERAGE DESIRED: 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, 4, and 8) PREMIUM Select (4 units of all Modules) \$ PREMIUM Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ \$ Optional Accidental Disability Rider*: \$400 \$600 \$800 \$ Optional Sickness Disability Rider* \$400 \$600 \$ \$ Industry Class Class A/B Class C Class D \$ Monthly Premiums Basic Select Ultra Basic Select Ultra Applicant & Spouse \$13.46 \$16.48 \$23.74 \$20.10 \$24.64 \$35.54 \$23.76 \$29.12 \$41.98 Applicant & Spouse \$19.28 23.60 34.02 25.58 31.36 45.66 29.32 \$1.74 Applicant & Spouse & Children 22.50 23.72 25.84 31.68 45.66 29.32 \$1.78 Applicant & Spo | | | | | | | | | | | | | | | | |
| CHECK COVERAGE DESIRED: 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, 4, and 8) PREMIUM Select (4 units of all Modules) \$ PREMIUM Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ \$ Optional Accidental Disability Rider*: \$400 \$600 \$800 \$ Optional Sickness Disability Rider* \$400 \$600 \$ \$ Industry Class Class A/B Class C Class D \$ Monthly Premiums Basic Select Ultra Basic Select Ultra Applicant & Spouse \$13.46 \$16.48 \$23.74 \$20.10 \$24.64 \$35.54 \$23.76 \$29.12 \$41.98 Applicant & Spouse \$19.28 23.60 34.02 25.58 31.36 45.66 29.32 \$1.74 Applicant & Spouse & Children 22.50 23.72 25.84 31.68 45.66 29.32 \$1.78 Applicant & Spo | | | | | | | | | | | | | | | | |
| CHECK COVERAGE DESIRED: 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, 4, and 8) PREMIUM Select (4 units of all Modules) \$ PREMIUM Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ \$ Optional Accidental Disability Rider*: \$400 \$600 \$800 \$ Optional Sickness Disability Rider* \$400 \$600 \$ \$ Industry Class Class A/B Class C Class D \$ Monthly Premiums Basic Select Ultra Basic Select Ultra Applicant & Spouse \$13.46 \$16.48 \$23.74 \$20.10 \$24.64 \$35.54 \$23.76 \$29.12 \$41.98 Applicant & Spouse \$19.28 23.60 34.02 25.58 31.36 45.66 29.32 \$1.74 Applicant & Spouse & Children 22.50 23.72 25.84 31.68 45.66 29.32 \$1.78 Applicant & Spo | | | | | | | | | | | | | | | | |
| | SECTION 2 – PLAN SELEC | CTION | | | | New A | pplica | ant | | | Appli | catio | n for | Change | | |
| | CHECK COVERAGE DESI | RED: | | | | | | | | | | | | | | |
| □ Basic (3 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8) □ <td< td=""><td></td><td>_</td><td>nt & Spou</td><td>se</td><td></td><td>🗌 Appl</td><td>icant &</td><td>& C</td><td>hildren</td><td></td><td></td><td>pplica</td><td>ant, S</td><td>pouse &</td><td>Children</td></td<> | | _ | nt & Spou | se | | 🗌 Appl | icant & | & C | hildren | | | pplica | ant, S | pouse & | Children | |
| □ Select (4 units of all Modules) \$ \$ □ Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ \$ ○ Optional Accidental Disability Rider*: \$ \$ \$ \$ □ Optional Sickness Disability Rider* \$400 \$ \$ \$ \$ □ Optional Sickness Disability Rider* \$< | Applying for Accident Pol | icy Plan: | | | | | | | | | | | F | REMIU | М | |
| □ Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ ○ Optional Accidental Disability Rider*: \$400 \$600 \$800 \$ □ Optional Sickness Disability Rider* \$400 \$600 \$800 \$ □ Optional Sickness Disability Rider* \$400 \$600 \$ \$ \$ □ Optional Sickness Disability Rider* \$400 \$600 \$ \$ \$ \$ □ Optional Sickness Disability Rider* \$400 \$600 \$ | Basic (3 units of Modu | les 1, 3, 9 | 5, 6 and 7 | and 4 | uni | ts of Modu | les 2, | 4, a | and 8) | | | | | | | |
| □ Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules) \$ ○ Optional Accidental Disability Rider*: \$400 \$600 \$800 \$ □ Optional Sickness Disability Rider* \$400 \$600 \$800 \$ □ Optional Sickness Disability Rider* \$400 \$600 \$ \$ \$ □ Optional Sickness Disability Rider* \$400 \$600 \$ \$ \$ \$ □ Optional Sickness Disability Rider* \$400 \$600 \$ | Select (4 units of all M | odules) | | | | | | | | | | | | | | |
| Optional Accidental Disability Rider*: □ Off-The Job or □ 24-Hour \$400 \$600 \$800 \$ □ Optional Sickness Disability Rider* \$400 \$600 \$ \$ □ Optional Sickness Disability Rider* \$400 \$600 \$ \$ TOTAL MONTHLY PREMIUM \$ TOTAL MONTHLY PREMIUM \$ Monthly Premiums Easic Select Ultra Basic Select Ultra Applicant & Spouse \$13.46 \$16.48 \$23.76 \$21.01 \$24.64 \$35.54 \$23.76 \$29.12 \$41.94 Applica | | , | s of Modu | le 8 a | nd 6 | 6 units of a | ll othe | er M | lodules) | | | ¢ | | | | |
| □ Off-The Job or □ 24-Hour □ \$400 \$600 \$800 \$ □ Optional Sickness Disability Rider* □ \$400 □ \$600 \$ □ Optional Sickness Disability Rider* □ \$400 □ \$600 \$ TOTAL MONTHLY PREMIUM Class A/B Class A/B Select Ultra Basic Select Ultra Applicant \$13.46 \$16.48 \$23.74 \$20.10 \$24.64 \$35.54 \$23.76 \$29.12 \$41.98 Applicant & Spouse 19.28 23.60 34.02 25.58 31.36 45.18 29.10 35.68 51.44 Applicant & Spouse & Children 28.20 34.48 49.76 31.44 38.56 55.54 34.56 42.32 61.04 Optional Rider(s) Off-The-Job 24-Hour Off-The-Job 24-Hour Off-The-Job 24-Hour Accident Disability Rider*: - <td< td=""><td> `</td><td></td><td></td><td>10 0, u</td><td></td><td></td><td></td><td>/ //</td><td></td><td></td><td></td><td>Ф</td><td></td><td></td><td></td></td<> | ` | | | 10 0, u | | | | / // | | | | Ф | | | | |
| Image: Contract of the contr | | • | |] ¢400 | | □ \$6 | 00 | | □ \$80 | 0 | | • | | | | |
| TOTAL MONTHLY PREMIUM\$Industry Class Monthly PremiumsClass A/B Class C Class C Class C BasicSelectUltraBasicSelectUltraBasicSelectUltraApplicant\$13.46\$16.48\$23.74\$20.10\$24.64\$35.54\$23.76\$29.12\$41.98Applicant & Spouse19.2823.6034.0225.5831.3645.1829.1035.6851.44Applicant & Children22.5027.5239.7225.8431.6845.6629.3435.9251.78Applicant, Spouse & Children28.2034.4849.7631.4438.5655.5434.5642.3261.04Optional Rider(s)Off-The-Job24-HourOff-The-Job24-HourOff-The-Job24-Hour24-HourAccident Disability Rider*: 45.81 12.60 8.28 26.88N/AN/A\$600 4.68 12.60 8.28 26.88N/AN/A\$800 6.24 16.80 11.04 35.84N/AN/A\$600 4.68 12.60 $82.8C$ $Class C$ $Class C$ $Class C$ \$4400 $$7.44$ $$8.08$ N/A N/A \$600 11.16 12.12 N/A N/A | | | * | | | | | | L VOC | | | | | | | |
| $ \begin{array}{ c c c c c c } \hline Industry Class $$ Monthly Premiums $$ Basic $$ Select $$ Ultra $$ $$ Select $$ Ultra $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$ $$$ | | | | φ400 | | | | | | | | - | | | | |
| Monthly PremiumsBasicSelectUltraBasicSelectUltraBasicSelectUltraApplicant\$13.46\$16.48\$23.74\$20.10\$24.64\$35.54\$23.76\$29.12\$41.98Applicant & Spouse19.28 23.60 34.02 25.58 31.36 45.18 29.10 35.68 51.44 Applicant & Children 22.50 27.52 39.72 25.84 31.68 45.66 29.34 35.92 51.78 Applicant, Spouse & Children 28.20 34.48 49.76 31.44 38.56 55.54 34.56 42.32 61.04 Optional Rider(s)Off-The-Job 24 -HourOff-The-Job 24 -HourOff-The-Job 24 -Hour 46.8 12.60 8.28 80.8 N/A N/A \$400 $$3.12$ $$8.40$ $$5.52$ \$17.92 N/A N/A N/A \$600 4.68 12.60 8.28 26.88 N/A N/A \$ickness Disability Rider* $Class A/B$ $Class C$ $Class D$ N/A N/A \$400 $$7.44$ 88.08 N/A N/A N/A \$600 11.16 12.12 N/A N/A | | | | | | <u>э</u> | | | | | | | | | | |
| Applicant \$13.46 \$16.48 \$23.74 \$20.10 \$24.64 \$35.54 \$23.76 \$29.12 \$41.98 Applicant & Spouse 19.28 23.60 34.02 25.58 31.36 45.18 29.10 35.68 51.44 Applicant & Children 22.50 27.52 39.72 25.84 31.68 45.66 29.34 35.92 51.78 Applicant, Spouse & Children 28.20 34.48 49.76 31.44 38.56 55.54 34.56 42.32 61.04 Optional Rider(s) Off-The-Job 24-Hour 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 \$400 \$3.12 \$8.40 \$5.52 \$17.92 N/A N/A \$800 6.24 16.80 11.04 35.84 N/A N/A \$800 6.24 16.80 11.04 \$8.08 N/A N/A \$400 \$7.44 \$8.08 N/A N/A \$600 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<> | | | | | | | | | | | | | | | | |
| Applicant & Spouse 19.28 23.60 34.02 25.58 31.36 45.18 29.10 35.68 51.44 Applicant & Children 22.50 27.52 39.72 25.84 31.68 45.66 29.34 35.92 51.78 Applicant, Spouse & Children 28.20 34.48 49.76 31.44 38.56 55.54 34.56 42.32 61.04 Optional Rider(s) Off-The-Job Z4-Hour Off-The-Job 24-Hour Off-The-Job 24-Hour Off-The-Job 24-Hour Off-The-Job 24-Hour N/A \$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 11.04 35.84 N/A N/A \$400 $\$7.44$ $\$8.08$ N/A N/A N/A \$600 11.16 12.12 N/A N/A | | | | | | | | | | | | | | | | |
| $\begin{array}{c c c c c c c c c c c c c c c c c c c $ | | | | | | | | | | | | | | | | |
| Applicant, Spouse & Children28.20 34.48 49.76 31.44 38.56 55.54 34.56 42.32 61.04 Optional Rider(s)Off-The-Job24-HourOff-The-Job24-HourOff-The-Job24-Hour 24 -HourOff-The-Job24-HourAccident Disability Rider*: $\$ | | | | | | | | | | | | | | | | |
| Optional Rider(s) Off-The-Job 24-Hour Off-The-Job 24-Hour Off-The-Job 24-Hour Accident Disability Rider*: < | | en | | | | | | | | | | | | | | |
| Accident Disability Rider*: Image: Constraint of the state of the sta | | | | | | | | | | | | | | | | |
| \$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 | | | | | | | | | | | | | | | | |
| \$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 | \$400 | | \$3.1 | 2 | | \$8.40 | 9 | \$5.5 | 52 | \$17 | 7.92 | | N/A | 1 | 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 | | | | | | | | | | | | | | | | |
| \$400 \$7.44 \$8.08 N/A \$600 11.16 12.12 N/A | | | | | | | | | | | | | | | | |
| \$600 11.16 12.12 N/A | | | | | | 3 | | | | | | | | | | |
| | \$/100 | | | <u>^-</u> · | | | | | | ` | | | | KI/A | | |
| | | | | | | | | | | | | | | | | |

| Em | ployee's Name (Last, First, M.I.) Social Security # Emp | Employer | | | | | |
|---|--|------------------------|------------------|--|--|--|--|
| SE | CTION 3 – PERSONAL INFORMATION (Only Complete If Applying for ANY Disability Rider.) | | | | | | |
| The or em wh | e applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a crin crime victim as a result of a crime that was reported to the police; (2) to a patient who received the regency medical services personnel at a hospital or medical care facility; or (3) to emergency med o were tested as a result of performing emergency medical services. Refer to the authorization of le for a definition of "Emergency Medical Personnel." | he servio ical pers | ces of connel | | | | |
| 1. | Do you have other short-term disability coverage? If yes please list your weekly benefit and your weekly | Yes | No | | | | |
| | salary. Weekly Benefit Weekly Salary | | | | | | |
| 2. Within the past three years, have you been convicted as the driver in a motor vehicle accident or convicted of a moving violation, including driving under the influence of drugs or alcohol? Within the last 5 years, has your driver's license been suspended? | | | | | | | |
| 3. | Are you currently disabled? | | | | | | |
| | Answer questions 4 through 7 if applying for Sickness Disability Rider. | | | | | | |
| 4. | Within the last 10 years, have you been diagnosed or treated by a member of the medical profession for: | | | | | | |
| | Yes No | Yes | No | | | | |
| | (a) Cancer, Cancer related disease or benign (c) Kidney Disease or Diabetes? | | | | | | |
| | (b) Disease of the Heart or Blood Vessels, or had a Stroke? (c) Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")? | | | | | | |
| 5. | Within the last 5 years, have you been diagnosed or treated by a member of the medical profession for: | | | | | | |
| | (a) Alcohol or Drug Abuse? | | | | | | |
| | (b) Lung, Liver or Blood Disorder? | _ | _ | | | | |
| | (c) Emotional, Nervous System (including Muscular Dystrophy and Multiple Sclerosis), Eating Disorder or Mental Health Problems? (f) Arthritis, Bones or Joint Disorder? (g) Bladder, Urinary System or Reproductive Organs Disorder? | | | | | | |
| 6. Within the last 5 years, have you 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: | | | | | | | |
| 7. | Are you currently pregnant? Yes No | | | | | | |
| | Within the last 5 years, have you had a problem pregnancy? Yes No | | | | | | |
| 8. | Primary Physician's Name: Address: | | | | | | |
| | Phone Number: City, State, Zip: | | | | | | |
| | Give details for "yes" answers to any questions and indicate to whom answers relate. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| <u> </u> | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| Employee's Name (Last, First, M.I.) | | Social Sec | curity # | Employer | | | |
|---|--------------|--------------|----------|---------------------|------------------------|--|--|
| SECTION 4 – BENEFICIARY | Name Benefic | ciary | ■ Cha | ange of Beneficiary | | | |
| I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy. | | | | | | | |
| Name | Birthdate | Relationship | | Primary or Second | Indicate Percentage | | |
| | | | | Primary or Sec | condary | | |
| | | | | Primary or Sec | ondary | | |
| SECTION 5 – AUTHORIZATION | | | | | | | |
| 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) | | | | | | | |

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 to the best of my knowledge and belief; (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 24 months after it is signed, or until any contract of insurance issued as a result of this applications ends, whichever comes first; (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 limit on certain defenses provision.

This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; or (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "Emergency Medical Personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the Good Samaritan Law.

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 and (2) The first modal premium is paid. 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, subject to the time limit on certain defenses. 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.

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