USAble Life
P.O. Box 1650 • Little Rock, Arkansas 72203

EVIDENCE OF INSURABILITY (Please Print)

A completed Enrollment Form must accompany this form.

SECTION 1 –Completed By Employer

Group Name	Telephone # (include area code)	Group Number

Amount of Insurance Applying for:
Employee Life: $ Dependent Life $ Disability $ Other:

Employee's Annual Salary

SECTION 2 – Completed by Employee ☐ Vol. Group Term Life ☐ Amount over Guarantee Issue ☐ Late Enrollee

Name (First, MI, Last)				Social Security No.	
Home Address	City	State	Zip	County	
Date of Birth	Birth State or Country	Sex ☐ Male ☐ Female	Height (ft-in.)	Weight (lbs.)	Work Phone ( ) / Home Phone ( )

Spouse & Children Information – Complete if Applying for Dependent's Coverage.

Person Proposed for Insurance Show first, middle, last name	Occupation	Date of Birth & Place: Month	Day	Year	State or Country	Height	Weight	Marital Status	Sex
(Spouse)									
(Child)									
(Child)									
(Child)									
(Child)									

SECTION 3 – Insurability Questionnaire

	Yes	No
1. Has anyone to be covered used any tobacco products in the past year?	☐	☐
2. Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised?	☐	☐
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years?	☐	☐
4. Has anyone to be covered consulted a physician in the past one (1) year for any reason?	☐	☐

5. Has anyone to be covered 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. Emotional, nervous system, eating disorder, or mental health problems?	☐	☐
b. Disease of the heart or blood vessels, or had a stroke?	☐	☐			
c. Kidney disease or diabetes?	☐	☐	g. Ulcer, stomach or digestive disorder?	☐	☐
d. Alcohol or drug abuse?	☐	☐	h. Arthritis, back, bones or joint disorder?	☐	☐
e. Lung, asthma, liver or blood disorder?	☐	☐	i. Bladder, urinary system or reproductive organs disorder?	☐	☐

6. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")?	☐	☐
7. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? If yes, list name of person(s), medications taken, medication dosage, and last two blood pressure readings in Section 4	☐	☐
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, medications and dosage in Section 4.	☐	☐
9. Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8?	☐	☐
10a. Are you now pregnant? ☐ Yes ☐ No 10b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?	☐	☐
11. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If No, give full details in Section 4.	☐	☐

12. Names, addresses, and phone numbers of the personal physicians of all applicants:

SECTION 4 – Give Details to "Yes" answers to questions 2 through 10 include dates of treatment: ☐ Separate Sheet Attached

Ques. No.& Individual	Illness/Reason for Checkup or Medication & Dosage or Doctor's Treatment/Consultation	Date & Duration	Full Name, Complete Address and Telephone Number of Doctors & Hospitals

In signing below, I: (a) represent that the statements and answers given in this application, are true, complete and correctly recorded; (b) understand that the insurance applied for is not effective until the application is approved by USAble Life; (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 the Important Notice for Disability Coverage; and (h) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act. I have read and understand the above statements and agreements. Warning – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

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

X _____ Agent's Signature X _____ Employee's Signature

Date Received Home Office

USAble Life

P.O. Box 1650
Little Rock, AR 72203

NOTICE FOR PROPOSED INSURED
PLEASE KEEP FOR YOUR RECORDS.

IMPORTANT NOTICE FOR DISABILITY COVERAGE

Acceptance of your application for disability income insurance will be based upon the information contained in the Evidence of Insurability, including the medical information disclosed and information obtained from your medical providers. **Your insurance coverage may not be issued as applied for.** If not, there will be an "Exclusion of Coverage Amendment" attached to your certificate of coverage.

PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT.

Important Notice Concerning Your Effective Date

1. Insurance will not be effective until the application is approved by USAble Life.
2. Insurance will not be effective if there has been a change in the health of the proposed insured(s) after the date of the application and prior to the effective date.
3. For benefits sheltered under a Section 125 Cafeteria plan: To satisfy premium deduction requirements of your employer and dating requirements of the Section 125 Plan, your coverage will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) of the Section 125 agreement 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.

NOTICE OF INSURANCE INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of our information practices. If you would like to receive a more detailed explanation of those practices, please send your request to the chief underwriter, P.O. Box 1650, Little Rock, AR 72203

INSURANCE FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

FEDERAL FAIR CREDIT REPORTING ACT NOTICE

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. USAble Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (Bureau), a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Tel. (617) 426-3660.

USAble Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

USAble Life

P.O. Box 1650
Little Rock, AR 72203-1650
(501) 375-7200 • (800) 648-0271

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization must be fully completed as a condition of obtaining insurance coverage.

I hereby request and authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, other health care provider, healthcare clearinghouse, insurance company, reinsurer, the Medical Information Bureau ("MIB") or consumer reporting agency ("providers") that has provided payment, treatment or services to me and any member of my family who has applied for coverage ("family member"), or other person on whose behalf I am acting, to disclose the entire medical record and any other protected health information concerning me and any family member to USAble Life and its agents, employees, legal representatives, reinsurers, and the MIB. This includes information on the diagnosis of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information do not apply to this authorization, and I instruct any providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that USAble Life may: 1) underwrite an application for coverage; 2) make eligibility, risk rating, policy issuance and enrollment determinations; 3) obtain reinsurance; 4) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 5) administer coverage; and 6) conduct other legally permissible activities that relate to any coverage I or any family member, or other person whom I represent has or has applied for with USAble Life.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I or my family member, or other person whom I represent has the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Privacy Officer, USAble Life, PO Box 1650, Little Rock, AR 72203-1650, or to privacyofficer@usablelife.com. I understand that a revocation is not effective to the extent that any of the providers have relied on this authorization or to the extent that USAble Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the providers may not refuse to provide treatment if I refuse to sign this authorization. However, I further understand that if I refuse to sign this authorization to release complete medical records, USAble Life may deny my application or claim for benefits. I acknowledge that I have received a copy of this authorization.

_____ _____

Applicant's Name (please print) Date

_____

Applicant's Signature

White Copy – Return to USAble Life Yellow Copy – Retain for your records