USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

GROUP LONG TERM DISABILITY INSURANCE APPLICATION

Type Or Print In Black Ink

1. Legal Name of Policyholder Type of Company: ☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ LLC ☐ S-Corp ☐ PC	Taxpayer ID#	Home Office Use – Group #

2. Mailing Address of Policyholder	City	State	Zip+4
3. Street Address of Policyholder (if different from above)	City	State	Zip+4

4. Name of CEO, President or Owner of Company	Name of Insurance Contact at Company	Telephone Number of Policyholder
5. Name of Subsidiary or Affiliate Companies to be Covered	Email Address for Company Contact	Fax Number of Policyholder

6. Nature of Business	SIC Code	Billing Method ☐ On-Line ☐ List-Bill
7. Effective Date as of 12:01 a.m.	First Anniversary Date	Number of Employees Eligible Enrolled

8. Do you have any employees located in states other than the policyholder's main address? ☐ Yes ☐ No If yes, please list states below.

9a. Eligibility Waiting Period *(Should an employee enter another class, he will not be eligible for any additional benefits until he has completed a 30-day waiting period and has been actively at work one full day in the new class.)*

☐ Premium Due Date following completion of _____days

☐ Day following completion of _____days

9b. Eligibility Waiting Period Applies to:

☐ Future Employees Only

☐ Present & Future Employees

9c. Employer Contribution _____%

☐ Pre-Tax ☐ Post-Tax

10. Class Definitions (if more than one class, definitions must be specific)

(The insurer reserves the right to review and terminate all classes insured under this policy if any class ceases to be covered.)

Class 1 _____

Class 2 _____

Class 3 _____

Class 4 _____

Employees working less than 30 hours per week are not eligible for coverage unless otherwise noted in class description above and approved by us.

11. AMOUNT OF INSURANCE

☐ _____%(Benefit Percentage) of Monthly Income Loss Not To Exceed a Maximum Monthly Benefit of $_____

☐ Core/Buy-up Plan:

Core Plan: _____%(Benefit Percentage) of Monthly Income Loss Not To Exceed a Maximum Monthly Benefit of $_____

Buy-Up Plan: _____%(Benefit Percentage) of Monthly Income Loss Not To Exceed a Maximum Monthly Benefit of $_____

LESS OTHER INCOME BENEFITS STATED IN THE POLICY INCLUDING: ☒ Primary Social Security ☐ Family Social Security ☐ Other Retirement Benefits

The Minimum Monthly Benefit is: ☐ Flat Amount of $ **or** ☐ Flat Amount of $ or % whichever is greater.

Maximum Covered Payroll per Employee: $ per month. | Guaranteed Issue Amount: $

12. BENEFIT CALCULATION: ☐ Direct with Return to Work Incentive ☐ Alternate with Backdoor & Return to Work Incentive ☐ Direct without Return to Work Incentive ☐ Alternate with Backdoor & No Return to Work Incentive

13. Elimination Period

_____ days

14. Pre-Existing Conditions Exclusion *(All options are not available in all states)*

☐ 3/3/12 ☐ 12/6/24 ☐ 12/12/24 ☐ 6/6/12 ☐ _____

15. MAXIMUM DURATION OF BENEFIT PERIOD

☐ Reducing Benefit Duration ☐ 5 Year Benefit ☐ Other _____

☐ SSNRA (Elimination Period ≥ 180 days) ☐ 2 Year Benefit

☐ SSNRA (Elimination Period < 180 days)

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Legal Name of Policyholder	Taxpayer ID#

16. POLICY BENEFITS

A. ☐ Yes ☐ No 24 Month Own Occupation Benefit *Applies to Class(es)*_____

B. ☐ Yes ☐ No 36 Month Own Occupation Benefit *Applies to Class(es)*_____

C. ☐ Yes ☐ No 60 Month Own Occupation Benefit *Applies to Class(es)*_____

D. ☐ Yes ☐ No Own Occupation Benefit *Applies to Class(es)*_____

E. ☐ Yes ☐ No _____Month Mental Illness & Substance Abuse Limitation

F. ☐ Yes ☐ No Survivor Benefit _____months

G. ☐ Yes ☐ No Activities of Daily Living Benefit _____% to $_____ maximum

H. ☐ Yes ☐ No Pension Contribution Benefit _____% or $_____ maximum

I. ☐ Yes ☐ No Work Place Modification Benefit

J. ☐ Yes ☐ No COLA with _____ Adjustments –_____%

K. ☐ Yes ☐ No _____ Year Rate Guarantee

L. Time Period for Averaging Commissions: _____ months

M. Additional Policy Benefits:

17. Is this a Replacement of Similar Coverage? ☐ Yes ☐ No	Prior Insurance Credit Included? ☐ Yes *(If yes, a copy of prior carrier's plan is required.)* ☐ No
18. Previous Carrier	Termination Date of Prior Plan
19. Premium Monthly (unless otherwise specified) _____	Deposit of $_____ to apply to the first premium.

20. W-2 Service Options:

☐ Option 1: Withhold federal income taxes and the employee's portion of FICA. Prepare and file W-2 Forms.

☐ Option 2: Withhold federal income taxes and the employee's portion of FICA. Policyholder waives W-2 Forms services.

A detailed description of the W-2 services elected by policyholder pursuant to this application will be sent to the policyholder by mail. Such services will be performed in accordance with the above election and established standard procedures.

REMARKS OR SPECIAL PROVISIONS

It is understood and agreed that this application shall be made a part of the policy or policies applied for and that no insurance shall be effective until approved by the Company at its Home Office.

COMPLIANCE NOTICE: USAble Life does not provide legal or tax advice. Based upon information you have provided us about your group, we will notify you if we perceive any obvious deficiency in your plan, but you must consult your own legal counsel for definitive advice and opinions regarding your plan's compliance.

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. The Company may terminate the group policy if the policyholder or his administrator has filed or assisted with the filing of a fraudulent claim with us.

_____ Dated at (City, State)

_____ Date

_____ Signature of Policyholder and Title

_____ Signature of Marketing Representative

_____ Signature of Marketing Manager

_____ Signature of Broker, if applicable