



Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200 or
(800) 648-0271

Application for Extended Insurance Benefits (Waiver of Premium)

For H.O. Use Only	
Eff	_____
PTD	_____
Benefits	_____

(To Avoid Delay Please Answer All Questions)

EMPLOYER'S STATEMENT				
Employee's Name		Policy/Certificate Number		Group Policy Number
Employee's Date of Hire	Employee's Effective Date of Ins.	Last Day Worked	Reason for Stopping Work	Returned to Work On
Occupation at Time of Disability			Employer's Fax Number	
Employee Works: Mon____ Tue____ Wed____ Thurs____ Fri____ Sat____ Sun____				Hours Worked Per Day: _____
Employee's Annual Salary		Effective Date of Annual Salary		
Briefly describe the general duties of the Employee's Occupation:				
Does this job require any of the following?				
	Yes	No	If yes, please specify how often it is required	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	____ Hours ____% of the time require in an average 8 hour day	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	____ Hours ____% of the time require in an average 8 hour day	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	____ Hours ____% of the time require in an average 8 hour day	
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	____ Hours ____% of the time require in an average 8 hour day	
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	____ Hours ____% of the time require in an average 8 hour day	
Does this job require driving or business travel? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes; a) What is the average distance per day? _____				
b) How often is travel required? _____				
How many pounds must he or she be able to lift? _____ How Often? _____				
How often are the following required in an 8 hour day? (Use the abbreviations R = Rarely O = Occasionally F = Frequently C = Continuously)				
Bending _____	Reaching _____	Kneeling _____		
Squatting _____	Climbing _____	Repetitive Tasks _____		
What degree of dexterity is required? <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low				
Employer			Date	
Signature		Title	E-mail Address	
Name (Please Print or Type)			Telephone ()	
Address		City, State, Zip		



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EMPLOYEE'S STATEMENT

Full Name (Last, First)	Social Security Number
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Address	City	State	Zip	Phone Number
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Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation (List the duties of your occupation at the time of disability)
Height	Weight	

I have been unable to work because of this disability since Month _____ Day _____ Year _____	I returned to work on a part-time basis on Month _____ Day _____ Year _____	I returned to work on a full-time basis on Month _____ Day _____ Year _____
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Date of your accident or the date you first noticed the symptoms of your illness Month _____ Day _____ Year _____	Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain
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Describe how and where accident occurred or describe the first symptoms of your illness:

Date you were first treated for your illness or injury Month _____ Day _____ Year _____	Treated by Hospital _____ Name _____ Address _____ Doctor _____ Name _____ Address _____
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Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? Month _____ Day _____ Year _____	Treated by Hospital _____ Name _____ Address _____ Doctor _____ Name _____ Address _____
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EDUCATIONAL BACKGROUND

Circle Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12

College Business Vocational

Other (specify) _____

Degree(s) Received: _____

Major Field(s) of Study: _____

Were You in the Armed Forces? Yes No

Branch of Service: _____ Highest Rank: _____

WORK EXPERIENCE

List chronologically all the jobs you have had, making sure to indicate:

a) Type of work (Please be specific such as auto sales, accountant, clerk, laborer, etc.)
 b) Physical requirements (Lifting heavy boxes, standing, sitting, etc.)
 c) Supervisory experience.

Dates	Type of Work	Physical Requirements	Supervisory Experience, if any
_____	_____	_____	_____
_____	_____	_____	_____

Date: _____ Employee's Signature: _____

Please complete Authorization on Page 3 and obtain Attending Physician's Statement on Page 4.



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 US Able 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 US Able 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 US Able 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, US Able 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 US Able 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, US Able Life may deny my application or claim for benefits. I acknowledge that I have received a copy of this authorization.

FRAUD NOTICE: For your protection, the laws of some states may require us to furnish you with the following notice:

Except as otherwise noted below, 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. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania: 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant's Name (please print)

Date

Applicant's Signature

Application for Extended Insurance Benefits

ATTENDING PHYSICIAN'S STATEMENT

Must be completed IN FULL by physician who has examined patient within the last 30 days.

Patient's Name: _____

1. DIAGNOSIS

- (a) Diagnosis (including any complications): _____ ICD-9 Code(s) _____
- (b) Subjective symptoms: _____
- (c) Objective findings (Including current X-rays, EKG's Laboratory Data and any clinical findings): _____

2. DATES OF TREATMENT

- (a) Date of first visit _____
- (b) Date of last visit _____
- (c) Frequency of visits _____

3. NATURE OF TREATMENT

(Including surgery, medication, physical therapy, etc.)

4. EXTENT OF DISABILITY *IMPORTANT*****

- (a) Are you aware of the main duties patient performs in his/her usual work or business? Yes No
- (b) Are you aware of patient's background (education, training, experience, etc.)? Yes No
- (c) Describe any restrictions (what patient SHOULD NOT do): _____
- (d) Describe any limitations (what patient CANNOT do): _____

5. CARDIAC (If Applicable)

- (a) Functional capacity (American Heart Ass'n)..... Class 1 (No Limitations) Class 2 (Slight Limitation)
 Class 3 (Marked Limitation) Class 4 (Complete Limitation)
- (b) Blood Pressure (last visit)..... _____
Systolic/Diastolic

6. PHYSICAL IMPAIRMENT (*As defined in Federal Dictionary of Occupational Titles)

- (a) Class 1 – No limitation of functional capacity; capable of heavy work. * No restrictions. (0-10%)
 Class 2 – Medium manual activity* (15-30%)
 Class 3 – Slight limitation of functional capacity; capable of light work* (35-55%)
 Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
 Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)
- (b) Remarks: _____

7. MENTAL/NERVOUS IMPAIRMENT (If applicable)

- (a) Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
 Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
 Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
 Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
 Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
- (b) Remarks: _____

8. PROGRESS

- (a) Has patient: Recovered Improved Unchanged Retrogressed
 If recovered, date able to return to work _____
- (b) Is Patient: Ambulatory House confined Bed confined Hospital confined
- (c) Has patient been hospital confined? Yes No Admitted _____
 If yes, give name and Address of Hospital _____ Discharged _____
- (d) Do you expect any significant improvement in the future? Yes No
1. If yes, when will patient recover sufficiently to perform the duties of:
- a) Patient's regular occupation: _____ or 1 Month 1-3 Months 3-6 Months Never
- b) Any other type of work: _____ or 1 Month 1-3 Months 3-6 Months Never
2. If No, please explain: _____

Physician's Signature			Date
Physician's Name			Degree
Address			Telephone ()
City	State	Zip	Fax ()