

SECTION I. GROUP INFORMATION

1. Legal Name of Policyholder	2. Taxpayer ID#
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3. Type of Company: Corporation LLC PC S-Corp Sole Proprietor Partnership Government

4. Mailing Address of Policyholder	City	State	Zip+4
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5. Street Address of Policyholder (if different from above)	City	State	Zip+4
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6. Contact Information at Company:

Benefits Contact Person: _____
Phone Number: _____ Fax Number: _____
Email Address: _____ Web Address: _____

Billing Contact Person: _____
Phone Number: _____ Fax Number: _____
Email Address: _____ Web Address: _____

7. Name of Subsidiary or Affiliate Companies to be Covered	8. Nature of Business	9. SIC Code
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10. Do you have any employees located in states other than the Policyholder's main address? If yes, please list states below. <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Number of eligible Employees	12. Billing Method: <input type="checkbox"/> Self Administration <input type="checkbox"/> Billed by Blue Plan <input type="checkbox"/> Benefit Focus <input type="checkbox"/> List Bill
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13. Changes in Benefits will Become Effective on:
 First day of the following month The next anniversary date The date of change

14. Do you allow Domestic Partner Coverage under the existing Blue Cross Blue Shield Medical Plan? Yes No

15. 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.*)

First of Policy Month following: (a) completion of _____ days of continuous active work, or (b) hire date
 Day following: (a) completion of _____ days of continuous active work, or (b) hire date

Does Waiting Period apply to employees rehired within 12 months of their termination date? Yes No

16. Eligibility Waiting Period Applies to: <input type="checkbox"/> Future Employees only <input type="checkbox"/> Present & Future Employees	17. Minimum hours worked per week to be eligible: Basic benefits: _____ Voluntary benefits: _____
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18. Annual Enrollment date for Voluntary Coverage: _____

19. 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	Description of Class	Waiting Period, if Different
1		
2		
3		
4		

Employees working less than the minimum hours per week are not eligible for coverage unless otherwise noted in class description above and approved by us. If more than four classes, use a separate sheet.

SECTION II. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

This application is made for the following coverages. Check only those boxes that apply.

Coverage	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
<input type="checkbox"/> Basic Life				
<input type="checkbox"/> Basic AD&D*				
<input type="checkbox"/> Supplemental Life*				
<input type="checkbox"/> Supplemental AD&D*				
<input type="checkbox"/> Dependent Life* (Option 1)				
<input type="checkbox"/> Dependent Life* (Option 2)				
<input type="checkbox"/> Voluntary Life				
<input type="checkbox"/> Voluntary AD&D				

*Cannot be purchased as stand alone coverage.

Multiple of salary benefits will be rounded to the nearest lower higher \$ _____, if not already a multiple

SECTION II. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT CONTINUED

Basic Life and/or AD&D

Class	Flat Amount ■	Multiple of Salary ■	(Complete if Multiple of Salary)	
			Min Amount of Coverage	Max Amount of Coverage
1				
2				
3				
4				

Supplemental Life and/or AD&D

Class	Flat Amount ■	Multiple of Salary ■	Elected in Increments of ■	(Complete if Multiple of Salary or Increments)	
				Min Amount of Coverage	Max Amount of Coverage
1					
2					
3					
4					

Voluntary Life and/or AD&D

Employee and Spouse coverage elected in \$10,000 increments: \$10,000 min \$_____ Max
 Employee coverage elected as multiple of salary schedule: _____ times annual salary \$_____ Maximum.
 Spouse coverage 50% of employee amount.
 Are Voluntary Life rates smoker distinct rates: Yes No Children - \$5,000 and \$10,000 only

Dependent Life

Class	Option 1			Option 2 (if available)		
	Spouse Amount	Child Amount	Reduced Infant Amount	Spouse Amount	Child Amount	Reduced Infant Amount
1						
2						
3						
4						

Infant Ages: from live birth to 6 months from 15 days to 6 months
 Child Ages: 6 months to 25 years 6 months to age _____

AD&D Riders		Reductions & Termination Benefit reduction due to age will be effective on the employee's birthday*				
		Reduction at Age of Employee				
		65	70	75	80	
Standard Riders*	<input checked="" type="checkbox"/>					
Special Education	<input type="checkbox"/>	<input type="checkbox"/>	66 2/3%	33 1/3%	N/A	N/A
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	65%	50%	N/A	N/A
Common Carrier	<input type="checkbox"/>	<input type="checkbox"/>	65%	50%	25%	N/A
Felonious Assault	<input type="checkbox"/>	<input type="checkbox"/>				
Child Care Center	<input type="checkbox"/>	*Employee benefits terminate at retirement, unless termination age is noted. Termination age _____. Spouse benefits terminate at employee's retirement or spouse age 65, whichever is earlier. All reductions apply to the pre-age 65 amount.				
Spouse Training	<input type="checkbox"/>					
HIV	<input type="checkbox"/>					

*AD&D Standard Riders: Seat Belt/Air Bag, Coma, Repatriation, Exposure and Disappearance

Portability:

Voluntary Life Basic Life (Underwriting approval and rate adjustment required)

Replacement: Are any of the following a replacement of similar coverage?

Yes	No		If yes, Previous Carrier	Termination Date
<input type="checkbox"/>	<input type="checkbox"/>	Basic Life		
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Life		
<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Life		

If prior coverage, include a copy of the prior carrier's plan.

SECTION III. SHORT TERM DISABILITY

This application is made for the following coverages. Check only those boxes that apply.

	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
<input type="checkbox"/> Basic/Core STD				
<input type="checkbox"/> Buy Up STD*				
<input type="checkbox"/> Voluntary STD (VIP)				

*Cannot be purchased as stand alone coverage.

SECTION III. SHORT TERM DISABILITY CONTINUED

Basic Short Term Disability

Class	Core/Buy Up	Flat Amount	Percent of Salary	Max. benefit	Benefit Plan*
1	<input type="checkbox"/> Core				
	<input type="checkbox"/> Buy Up				
2	<input type="checkbox"/> Core				
	<input type="checkbox"/> Buy Up				
3	<input type="checkbox"/> Core				
	<input type="checkbox"/> Buy Up				
4	<input type="checkbox"/> Core				
	<input type="checkbox"/> Buy Up				

*Example of a Benefit Plan: 1-8-13; This means disabilities due to accidents begin on the first day. Disabilities due to sickness begin on the eighth day. Benefits will be paid for a 13 week duration.

Voluntary STD Income Protection (VIP)

Amount of insurance selected by the employee in increments of \$10 not to exceed _____% of weekly earnings.

Minimum: \$100 Maximum: \$750 _____

Benefit Plan*: _____ Industry Class: _____

Reduction & Termination: Benefit reduction due to age will be effective on the anniversary following the insured's birthday. Benefits reduce to 66 2/3% at age 65, and terminate at age 70 or upon retirement, whichever occurs first.

Are premiums sheltered under a Section 125 Cafeteria plan? Yes No

*Example of a Benefit Plan: 1-8-13; This means disabilities due to accidents begin on the first day. Disabilities due to sickness begin on the eighth day. Benefits will be paid for a 13 week duration

Replacement: Is VIP a Replacement from Another Carrier? Yes No

Previous Carrier _____ Termination Date _____

If prior coverage, include a copy of the prior carrier's plan.

SECTION IV. LONG TERM DISABILITY

This application is made for the following coverages. Check only those boxes that apply.

	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
<input type="checkbox"/> Basic LTD				
<input type="checkbox"/> Buy Up LTD*				
<input type="checkbox"/> Voluntary LTD				

*Cannot be purchased as stand alone coverage.

Basic and Buy Up Features

Class	Elimination Period	Own Occupation Monthly Period	Salary Includes		SS Integration		Benefit Calculation	
			Bonuses	Commissions	Primary Only	Primary/Family	Direct	70% all Sources
1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

Class	Basic		Buy Up	
	% of Salary	Monthly Max	% of Salary	Monthly Max
1				
2				
3				
4				

Maximum Benefit Period	Class			
	1	2	3	4
Reducing Benefit Duration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SS Normal Retirement Age (SSNRA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Year benefit (ADEA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Year benefit (ADEA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Year benefit (ADEA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Minimum Monthly Benefit

Flat amount \$ _____; or Flat amount of \$ _____ or 10%, whichever is greater

Optional LTD Riders

Education Benefit Medical and COBRA Premium \$ _____ Cost of Living Adjustment _____ # of Adjustments _____ %
 Activities of Daily Living Accidental Dismemberment

SECTION IV. LONG TERM DISABILITY CONTINUED

Disability Definition: Earnings & Occupation Test Occupation Test Only
 Earnings, Occupation, and Contagious Disease (Only available for Medical Groups)

Pre-Existing Condition Exclusion
 3/3/12 3/6/12 12/6/24 6/12 6/6/12 12/12 _____

Voluntary Long Term Disability (VLTD)
Industry Class: _____ Elimination Period: 90 Days 180 Days
Maximum Benefit Period:
 2 years Sickness or Accident 5 years Sickness or Accident SSNRA Sickness or Accident
a. Amount of Insurance: Selected by the employee in increments of \$100 not to exceed 60% of monthly salary.
b. Pre-existing Condition Exclusion: 12/6/24 (unless state law requires otherwise)
c. The Minimum Monthly Benefit is \$ 50.00 or 10% of the Monthly Disability Benefit, whichever is less (unless state law requires otherwise)
d. Policy Features include: • 24 Month Own Occupation • Three month Survivor Benefit • Waiver of Premium
• 24 Month Special Conditions Limitation • Primary and Family Social Security Integration
e. Are premiums sheltered under a Section 125 Cafeteria plan? Yes No

Replacement: Are any of the following a replacement of similar coverage?

Yes	No	If yes, Previous Carrier	Termination Date
<input type="checkbox"/>	<input type="checkbox"/>	LTD	
<input type="checkbox"/>	<input type="checkbox"/>	VLTD	

If prior coverage, include a copy of the prior carrier's plan.

W-2 Service Options for LTD:
 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.

SECTION V. AUTHORIZATION

REMARKS OR SPECIAL PROVISIONS:

The undersigned employer and/or authorized representative hereby request that it be approved for insurance coverage through USAble Life and agrees to comply with all terms and provisions of the Group Policy(ies) issued in response to this application.
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.
Warning: It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines or a denial of insurance benefits in accordance with applicable state law.

_____	_____	_____
Dated at (City, State)	Date	Signature of Policyholder and Title
_____	_____	_____
Signature of Marketing Representative	Signature of Marketing Manager	Signature of Broker, if applicable

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	Date of Hire	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	Gender <input type="checkbox"/> M <input type="checkbox"/> F	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				Height	Weight	Marital Status	Sex
		Month	Day	Year	State or Country				
(Spouse)									
(Child)									
(Child)									
(Child)									
(Child)									

Spouse's Social Security No.:	Spouse's Work Telephone #:
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SECTION 3 – Insurability Questionnaire

	Yes	No																																				
1. Has anyone to be covered used any tobacco products in the past year?	<input type="checkbox"/>	<input type="checkbox"/>																																				
2. Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised?	<input type="checkbox"/>	<input type="checkbox"/>																																				
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>																																				
4. Has anyone to be covered consulted a physician in the past one (1) year for any reason?	<input type="checkbox"/>	<input type="checkbox"/>																																				
5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for:																																						
<table style="width:100%; border:none;"> <tr> <td style="width:45%;"></td> <td style="text-align:center;">Yes</td> <td style="text-align:center;">No</td> <td style="width:10%;"></td> <td style="text-align:center;">Yes</td> <td style="text-align:center;">No</td> </tr> <tr> <td>a. Cancer, cancer related disease or benign tumor?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>f. Emotional, nervous system, eating disorder, or mental health problems?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Disease of the heart or blood vessels, or had a stroke?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>g. Ulcer, stomach or digestive disorder?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Kidney disease or diabetes?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>h. Arthritis, back, bones or joint disorder?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Alcohol or drug abuse?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>i. Bladder, urinary system or reproductive organs disorder?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>e. Lung, asthma, liver or blood disorder?</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> </table>		Yes	No		Yes	No	a. Cancer, cancer related disease or benign tumor?	<input type="checkbox"/>	<input type="checkbox"/>	f. Emotional, nervous system, eating disorder, or mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>	b. Disease of the heart or blood vessels, or had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	g. Ulcer, stomach or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	c. Kidney disease or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Arthritis, back, bones or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>	d. Alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	i. Bladder, urinary system or reproductive organs disorder?	<input type="checkbox"/>	<input type="checkbox"/>	e. Lung, asthma, liver or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>					
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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")?	<input type="checkbox"/>	<input type="checkbox"/>																																				
7. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4.	<input type="checkbox"/>	<input type="checkbox"/>																																				
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4.	<input type="checkbox"/>	<input type="checkbox"/>																																				
9. Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8?	<input type="checkbox"/>	<input type="checkbox"/>																																				
10a. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>																																				
10b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?	<input type="checkbox"/>	<input type="checkbox"/>																																				
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.	<input type="checkbox"/>	<input type="checkbox"/>																																				
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

Be Sure to Read the Important Disclosures and sign on Page 2/Reverse

Employee's Name (First, MI, Last)	Social Security #	Employer Name
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NOTICE FOR PROPOSED INSURED

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, an "Exclusion of Coverage Amendment" will be 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.

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 medical facility, insurance or reinsurance company, or MIB, Inc., formerly known as 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 date the authorization is signed; (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 I have read and understand all disclosures on this form; and (h) acknowledge receipt of written notification describing the use of the MIB as required by the Fair Credit Reporting Act and the Notice of Information Practices. I have read and understand the above statements and agreements.

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. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Signed at: _____	Date of Application _____
City and State	Month, Day, Year
X _____	X _____
Agent's Signature	Employee's Signature

Date Received Home Office



P.O. Box 1650
Little Rock, AR 72203

NOTICE FOR PROPOSED INSURED

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

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. US Able Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

US Able 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. Information for consumers about MIB may be obtained on its website at www.mib.com.