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

VOLUNTARY LIFE ENROLLMENT FORM
(PLEASE PRINT)

☐ New Enrollee	☐ Change	☐ Decline coverage	Group #:

Employer: If Evidence of Insurability (EOI) is required, please submit the Evidence of Insurability form along with this enrollment form to us.

Employer's Name

SECTION I. EMPLOYEE INFORMATION

Employee's Legal Name (First, MI, Last)			Social Security No.	
Home Address	City	State	Zip	Telephone No.
Date of Birth	Gender ☐ M ☐ F	Salary $ _____ ☐ Weekly ☐ Monthly ☐ Annual		
Occupation (Be Exact)		Dept/Location		
Hours Worked Weekly		Date Employed Full-time		

PLAN INFORMATION - Ask your employer for the details about the cost, if any, and whether you will be required to complete Evidence of Insurability (EOI).

SECTION II. VOLUNTARY – SEE INSTRUCTIONS ON REVERSE OR PAGE 2

Complete this Section if applying for these coverages. Evidence of Insurability may be required.			Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
Voluntary Group Life:	**Employee**	☐ Yes ☐ No	☐	☐	☐	☐		
	Spouse	☐ Yes ☐ No	☐	☐	☐	☐		
	Children	☐ Yes ☐ No	☐	☐	☐	☐		

Dependents to be covered	Gender	Relationship	Social Security No.	Date of Birth
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

Have you or your spouse (if applying for coverage) used tobacco products in the past year? **Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

Are you actively at work on the date of this application? ☐ Yes ☐ No

SECTION III. EMPLOYEE BENEFICIARY DESIGNATION ☐ Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% = 0

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% = 0

I represent that the information provided above is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For coverage I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability may be required. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

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.

Date Received - Home Office

_____ Employee's Signature

_____ Date

VGTL-APP (5-09)

INSTRUCTIONS – How to Complete Section II

Initial Enrollment –Adding Coverage:

Check "Yes" by each coverage you want. Check "No" by each coverage you do not want.

If you checked "Yes" by a coverage, check the "Add New" box, and complete the "Total Amount of Coverage" for which you are applying.

For Example, you are applying for:

- Voluntary Group Life: $50,000 on yourself, $20,000 on your spouse, and no coverage on your children

SECTION II. VOLUNTARY COVERAGE(S) Complete this Section if applying for these coverages. Evidence of Insurability may be required.			Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	**Employee**	☒ Yes ☐ No	☒	☐	☐	☐	$50,000	
	Spouse	☒ Yes ☐ No	☒	☐	☐	☐	$20,000	
	Children	☐ Yes ☒ No	☐	☐	☐	☐		

How To Change or Delete Coverage:

If you are changing any of your coverage, please complete the information for all of the coverage you have, so that we are sure we have everything correct. Be sure to check the appropriate "Add," "Delete," "Increase", or "Decrease" box.

For Example, you **currently** have:

- Voluntary Group Life: $60,000 on yourself, $30,000 on your spouse, and $10,000 coverage on your children

You want to **change** your coverage to:

- Voluntary Group Life: $100,000 on yourself (increase), $20,000 on spouse (decrease), and no coverage for children (delete)

SECTION II. VOLUNTARY COVERAGE(S) Complete this Section if applying for these coverages. Evidence of Insurability may be required.			Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	**Employee**	☒ Yes ☐ No	☐	☐	☒	☐	$100,000	
	Spouse	☒ Yes ☐ No	☐	☐	☐	☒	$20,000	
	Children	☐ Yes ☒ No	☐	☒	☐	☐		

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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 ☐ M ☐ 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 #:

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?	☐	☐	g. Ulcer, stomach or digestive disorder?	☐	☐
c. Kidney disease or diabetes?	☐	☐	h. Arthritis, back, bones or joint disorder?	☐	☐
d. Alcohol or drug abuse?	☐	☐	i. Bladder, urinary system or reproductive organs disorder?	☐	☐
e. Lung, asthma, liver or blood 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) 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.	☐	☐
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, 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

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

Employee's Name (First, MI, Last)	Social Security #	Employer Name

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.

Date Received Home Office

Signed at: _____ Date of Application _____

City and State — Month, Day, Year

X _____ X _____

Agent's Signature — Employee's Signature

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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. USAble 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.

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