



P.O. Box 1650
Little Rock, Arkansas 72203

HOSPITAL CONFINEMENT POLICY
APPLICATION & CHANGE FORM

Office Use Only
Table with 2 columns: Field Name, Value. Fields include Effective Date, Policy Number, Group Number, Dept./Loc.

Application type selection: New Application, Change Form, Replaces Policy No.

SECTION 1 - PERSONAL IDENTIFICATION

Form for personal identification including Name, Home Address, Date of Birth, Sex, Work Phone, etc.

SPOUSE & CHILDREN INFORMATION - Complete if Applying for Dependent's Coverage

Table for spouse and children information with columns for Name, Date of Birth, Birth State, Marital Status, Age, Sex, Height, Weight.

SECTION 2 - PLAN SELECTION

Application type: New Applicant, Application for Change

CHECK COVERAGE DESIRED:

Coverage options: Applicant, Applicant & Spouse, Applicant & Children, Applicant, Spouse & Children

Hospital Confinement Plan(s):

- Plan I - \$50 Daily Hospital Confinement, \$100 Emergency Accident, \$1,000 Surgery & Anesthesia, \$250/\$500 Ambulance Ground/Air, and Specified Injury.
Plan II - \$100 Daily Hospital Confinement, \$250 Emergency Accident, \$1,500 Surgery & Anesthesia, \$75 Outpatient Sickness, \$250/\$500 Ambulance Ground/Air, \$75 Wellness, and Specified Injury.
Plan III - \$200 Daily Hospital Confinement, \$500 Emergency Accident, \$2,500 Surgery & Anesthesia, \$75 Outpatient Sickness, \$500/\$1,000 Ambulance Ground/Air, \$75 Wellness, and Specified Injury.

Optional Rider(s) section with columns for Add, Delete, Rider Name, and Amount.

Total Monthly Premium: \$

1. Is this insurance to replace or change other insurance? Yes No If "Yes", give details including name of company. If "No", list all other Hospital Indemnity policies and their daily benefit(s).

2. Have you received the Outline of Coverage (in those states where required by law)? Yes No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded; (b) state that I have read and understand the "Important Note and the Insurance Fraud Warning" on page 2 of this application; (c) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. (MIB) 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 written notification describing the use of the (MIB) as required by the Fair Credit Reporting Act; and (h) acknowledge receipt of the Information Practices Notice and the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void the policy.

Be sure to complete the Beneficiary & Medical Information on page 2/reverse side.

Signed at: Date of Application: Date Received Home Office: Agent's Signature: Applicant's Signature: HIP2-APP (8-07) Page 1 of 2

Employee's Name (Last, First, M.I.)	Social Security #	Employer Name
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SECTION 3 – BENEFICIARY Name Beneficiary Change of Beneficiary

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Birthdate	Relationship	Primary or Secondary	Indicate Percentage
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	

SECTION 4 – MEDICAL INFORMATION

1. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a physician? If "Yes," list person(s) and details: Yes No
 Person(s): _____ Details: _____

2. Has anyone to be covered been confined in a hospital or nursing home within the last 12 months because of internal cancer, melanoma, heart surgery, heart attack, congestive heart failure, vascular disease, hypertension, chronic obstructive pulmonary disease, chronic liver disease, stroke, emphysema, sickle-cell anemia, asthma, chronic bronchitis, Parkinson's disease, multiple sclerosis, or rheumatoid arthritis? Yes No
 Person(s): _____ Details: _____

3. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Alzheimer's disease, senile dementia, systemic lupus, kidney failure, diabetes, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)? Yes No
 Person(s): _____ Details: _____

4. Is anyone to be covered now pregnant? Yes No
 Person(s): _____ Details: _____

5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? Yes No If "Yes," list person(s), medications taken, medication dosage and last two blood pressure readings. Person(s): _____
 Medication, Dosage, Readings with Dates: _____

The person(s) named above in questions 1 through 5 may be excluded from coverage by an Exclusion rider to be signed by the applicant prior to policy issuance.

6. PRIMARY PHYSICIAN'S NAME: _____ Address: _____
 Phone Number: _____ City, State, Zip: _____

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan effective date (anniversary date for resolicitation) 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.

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.



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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

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. 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, 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.

INDIVIDUAL HOSPITAL CONFINEMENT POLICY – MONTHLY RATES

COVERAGE TYPES & PLANS							
APPLICANT				APPLICANT & SPOUSE			
Issue Ages	PLAN I	PLAN II	PLAN III	Issue Ages	PLAN I	PLAN II	PLAN III
Under 55	\$13.60	\$41.08	\$ 61.16	Under 55	\$25.14	\$ 75.98	\$113.10
55-59	\$17.40	\$53.14	\$ 79.44	55-59	\$32.18	\$ 98.30	\$146.94
60-64	\$23.92	\$71.44	\$108.20	60-64	\$44.26	\$132.20	\$200.24
APPLICANT & CHILDREN				APPLICANT, SPOUSE & CHILDREN			
Issue Ages	PLAN I	PLAN II	PLAN III	Issue Ages	PLAN I	PLAN II	PLAN III
Under 55	\$ 26.80	\$ 73.84	\$114.26	Under 55	\$ 38.34	\$108.70	\$166.14
55-59	\$ 29.42	\$ 82.78	\$128.40	55-59	\$ 44.20	\$127.92	\$195.86
60-64	\$ 34.16	\$ 97.58	\$151.74	60-64	\$ 54.50	\$158.32	\$243.74

OPTIONAL RIDERS:

ANNUAL FIRST OCCURRENCE HOSPITAL CONFINEMENT RIDER							
APPLICANT				APPLICANT & SPOUSE			
Amounts	\$500	\$750	\$1,000	Amounts	\$500	\$750	\$1,000
Issue Ages				Issue Ages			
Under 55	\$ 4.60	\$ 6.90	\$ 9.20	Under 55	\$ 8.50	\$ 12.74	\$ 17.00
55-59	\$ 7.10	\$ 10.64	\$ 14.20	55-59	\$ 13.10	\$ 19.64	\$ 26.20
60-64	\$ 11.24	\$ 16.88	\$ 22.50	60-64	\$ 20.80	\$ 31.20	\$ 41.60
APPLICANT & CHILDREN				APPLICANT, SPOUSE & CHILDREN			
Amounts	\$500	\$750	\$1,000	Amounts	\$500	\$750	\$1,000
Issue Ages				Issue Ages			
Under 55	\$ 6.80	\$ 10.20	\$ 13.60	Under 55	\$ 10.70	\$ 16.04	\$ 21.40
55-59	\$ 8.10	\$ 12.14	\$ 16.20	55-59	\$ 14.10	\$ 21.14	\$ 28.20
60-64	\$ 12.24	\$ 18.38	\$ 24.50	60-64	\$ 21.80	\$ 32.70	\$ 43.60

HOSPITAL INTENSIVE CARE CONFINEMENT RIDER							
APPLICANT				APPLICANT & SPOUSE			
Amounts	\$200	\$400	\$600	Amounts	\$200	\$400	\$600
Issue Ages				Issue Ages			
Under 55	\$ 1.56	\$ 3.12	\$ 4.68	Under 55	\$ 2.88	\$ 5.76	\$ 8.64
55-59	\$ 3.44	\$ 6.88	\$ 10.32	55-59	\$ 6.36	\$ 12.72	\$ 19.08
60-64	\$ 5.20	\$ 10.40	\$ 15.60	60-64	\$ 9.64	\$ 19.28	\$ 28.92
APPLICANT & CHILDREN				APPLICANT, SPOUSE & CHILDREN			
Amounts	\$200	\$400	\$600	Amounts	\$200	\$400	\$600
Issue Ages				Issue Ages			
Under 55	\$ 2.08	\$ 4.16	\$ 6.24	Under 55	\$ 3.40	\$ 6.80	\$ 10.20
55-59	\$ 3.92	\$ 7.84	\$ 11.76	55-59	\$ 6.84	\$ 13.68	\$ 20.52
60-64	\$ 6.00	\$ 12.00	\$ 18.00	60-64	\$ 10.44	\$ 20.88	\$ 31.32

HEART, STROKE, COMA, PARALYSIS RIDER							
APPLICANT				APPLICANT & SPOUSE			
Amounts	\$1,000/\$500	\$2,000/\$1,000		Amounts	\$1,000/\$500	\$2,000/\$1,000	
Issue Ages				Issue Ages			
Under 55	\$ 0.28	\$ 0.56		Under 55	\$ 0.52	\$ 1.04	
55-59	\$ 1.12	\$ 2.24		55-59	\$ 2.08	\$ 4.16	
60-64	\$ 1.80	\$ 3.60		60-64	\$ 3.32	\$ 6.64	
APPLICANT & CHILDREN				APPLICANT, SPOUSE & CHILDREN			
Amounts	\$1,000/\$500	\$2,000/\$1,000		Amounts	\$1,000/\$500	\$2,000/\$1,000	
Issue Ages				Issue Ages			
Under 55	\$ 0.28	\$ 0.56		Under 55	\$ 0.52	\$ 1.04	
55-59	\$ 1.12	\$ 2.24		55-59	\$ 2.08	\$ 4.16	
60-64	\$ 1.80	\$ 3.60		60-64	\$ 3.32	\$ 6.64	