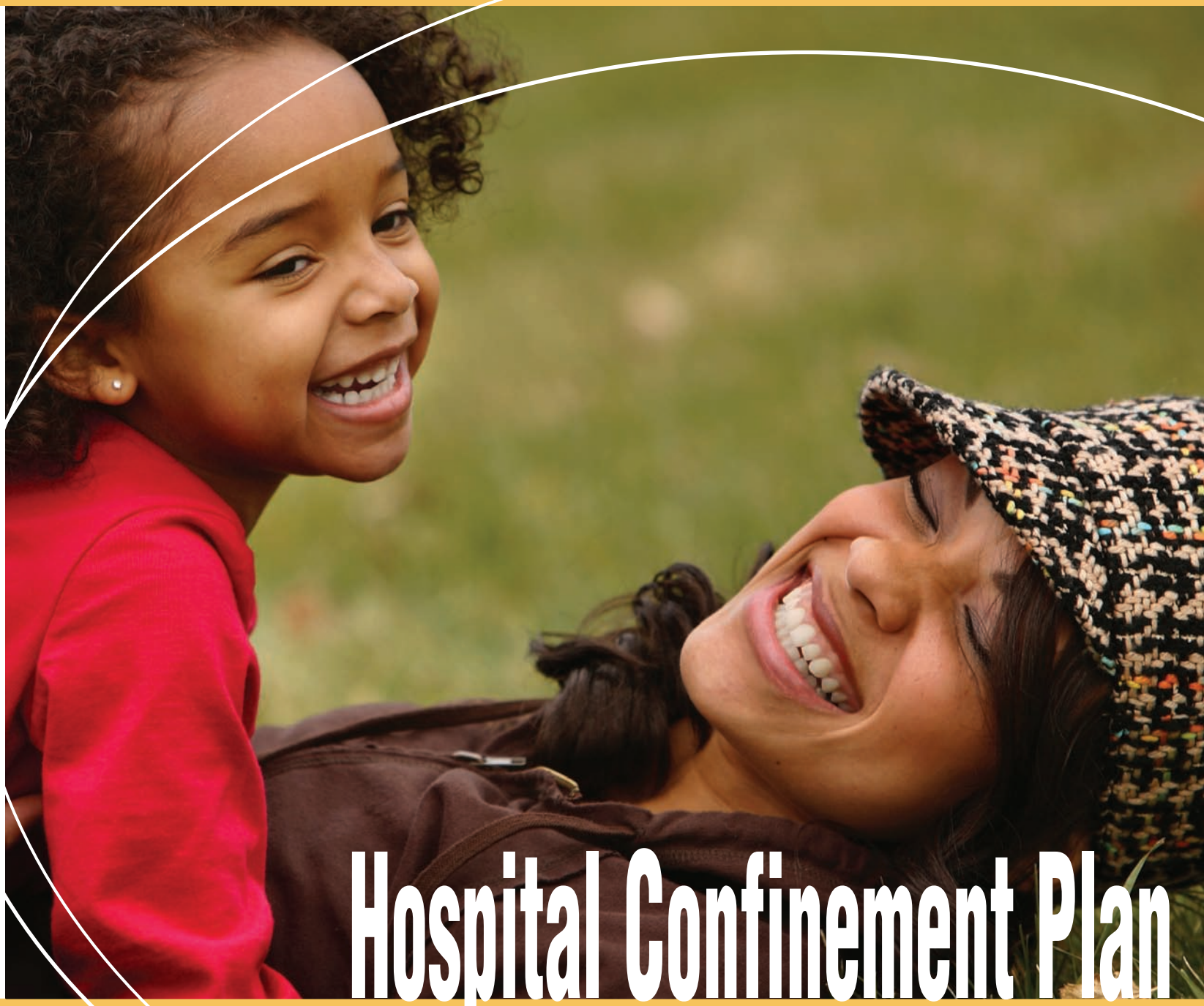
USAble

Hospital Indemnity Product Manual

Includes:

Brochure
Field Reference Manual
Forms

GIS
GROUP INSURANCE SERVICES



Hospital Confinement Plan

Now's the time.... an opportunity to cover those "out-of-pocket" expenses.

USAble® Life

You'll Choose Us For Life

HIP2-OC (2-07)

READ YOUR POLICY CAREFULLY **— This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.**

Hospital Confinement Indemnity Coverage **— Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any *additional benefits described below*.**

BENEFITS	PLAN 1	PLAN 2	PLAN 3
Daily Hospital Confinement Pays a daily benefit for inpatient hospital confinement due to a covered accident or sickness. *Maximum 180 days per confinement.*	$50 per day	$100 per day	$200 per day
Surgery and Anesthesia Pays according to the policy surgical schedule, up to the amount selected, for a surgical procedure, inpatient or outpatient, when surgery is due to a covered accident or sickness. Anesthesia pays 25% of the amount payable under the surgical benefit.	Up to $1,000 per operation	Up to $1,500 per operation	Up to $2,500 per operation
Emergency Accident Pays the charges incurred, up to the maximum selected, if the insured person is injured in a covered accident and received treatment in a hospital emergency room, physician's office, or standalone emergency center within 72 hours after the accident. *Benefit is paid 2 times per calendar year per insured person, except for dependent children. The maximum number of visits for all dependent children combined is 2 visits per calendar year.*	Maximum $100 per covered accident	Maximum $250 per covered accident	Maximum $500 per covered accident
Outpatient Sickness Pays for treatment by a physician in a physician's office, clinic, urgent care facility, or emergency room for a covered sickness. *Benefits are limited to 5 visits per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children (combined) is 5 visits per calendar year.*	None	$75 per visit	$75 per visit
Specified Injury			
Burns treated within 72 hours. *Payable once per accident.*	$375		
Tendon / Ligament surgically repaired within 1 year.*	$150		
Dislocation (separated joint) diagnosed within 30 days.* *Payable only for the first dislocation of a joint. Subsequent dislocation of the same joint will not be covered.*	up to $625		
Eye injury requiring surgery or removal of a foreign object within 30 days. *Payable once per accident.*	up to $75		
Fractures diagnosed within 14 days and requiring open or closed reduction by a physician.*	up to $625		
Torn Knee Cartilage and Ruptured Disc treated within 60 days and surgically repaired within 1 year. *Payable once per accident.*	up to $155		
Torn Rotator Cuff surgically repaired within 90 days.	$155		
Internal Injuries resulting in open abdominal, hernia or thoratic surgery within 30 days.	$315		
Concussion resulting in EEG abnormality within 30 days.	$15		
Lacerations repaired within 72 hours. **If the insured receives a fracture or a dislocation and tears, ruptures, or severs a tendon or ligament, we will pay only one benefit, whichever is the largest. If the insured receives a fracture and a dislocation in the same accident, we will pay for both, but no more than 150% of the bone or joint with the highest amount.*	up to $125		
Ambulance Pays for ground ambulance or air ambulance to or from a hospital or between medical facilities. *Pays only one benefit, whichever occurs first, per calendar year per person.*	Ground Ambulance $250 Air Ambulance $500	Ground Ambulance $250 Air Ambulance $500	Ground Ambulance $500 Air Ambulance $1,000

You choose coverage that best *fits your needs*

- **coverage from $50 to $200 for inpatient hospital stays**
- **coverage for sickness and accidents**
- **coverage for surgery and anesthesia**
- **coverage for specified injuries**
- **family coverage available**

plus choose optional benefits for:

- **initial hospitalization**
- **intensive care/coronary care**
- **lump sum benefits for certain critical illnesses**

ADDITIONAL COVERAGE OPTIONS	YOUR CHOICES
Annual Hospital Admission Pays an annual benefit if the insured person is admitted to a hospital and confined as a resident bed patient because of a covered accident or sickness. *This benefit is payable only once per calendar year for each insured person.*	$500 $750 $1,000
Hospital Intensive Care Confinement Pays a daily benefit when an insured person is confined in a hospital intensive care or coronary care unit, due to a covered injury or sickness. *Limited to 30 days for any one period of confinement.*	$200 $400 $600
Heart Attack, Stroke, Coma, or Paralysis Pays a lump sum benefit for first diagnosis and reoccurrence, upon diagnosis of a Heart Attack, Stroke, Coma or Paralysis. *First diagnosis benefit is only paid once per insured person. Reoccurrence benefit is paid for a diagnosis occurring more than 180 days after this benefit was last paid. No lifetime benefit maximum.*	$1,000 first diagnosis $500 reoccurrence **OR** $2,000 first diagnosis $1,000 reoccurrence

WELLNESS BENEFIT

Pays per calendar year for an insured person to undergo a routine examination or other preventative testing. *Payable once per insured per calendar year and 2 times per family per calendar year.*

PLAN 1 *none* **PLAN 2** *$75* **PLAN 3** *$75*

- Mammogram
- Pap Smear
- Flexible Sigmoidoscopy
- Prostatic Specific Antigen (PSA) Test
- Chest X-Ray
- EKG
- Cholesterol & Diabetes Screening
- Colonoscopy
- Vision Examination
- Hearing Examination
- Dental X-Ray

RENEWABILITY AND CONTINUATION

The Hospital Confinement Plan (HCP) and riders are guaranteed renewable during your lifetime. The company may change the established premium rate, but only if the rate is changed for all policies and riders like yours in your state. This coverage will not be issued to anyone 65 years of age or over. If you purchase the HCP and/or riders prior to your 65th birthday, you may continue coverage after age 65, except for disability riders, as long as you continue to pay the premium by the due date or during the 31 days that follow. Covered dependents who no longer meet eligibility requirements, may convert to a comparable individual HCP without evidence of insurability. A spouse can continue coverage under this policy upon your death.

EXCEPTIONS AND LIMITATIONS

The policy pays only for loss resulting from a covered sickness or accident as defined in the policy. It DOES NOT cover loss due to:

1. War or any act of war, declared or undeclared.
2. Intentional self-inflicted injury or attempted suicide.
3. Being engaged in an illegal occupation or felony.
4. Routine physicals.
5. Custodial, intermediate care, or rehabilitative confinement.
6. Mental, nervous, or emotional disorder without organic origin.
7. Alcoholism or drug addiction.
8. The use of alcohol or drugs, unless taken as prescribed by a physician.
9. Dental, elective, or cosmetic surgery or treatment, except as a result of a covered injury or congenital defect of a newborn child.
10. Hernia, tonsils or adenoids during the first six months of coverage, unless treated on an emergency basis.
11. Well baby care.
12. Voluntarily acting as an organ donor.

PRE-EXISTING CONDITIONS

Benefits will not be paid for pre-existing conditions during the first twelve months the coverage is in force. A "pre-existing condition" means a sickness or injury which was diagnosed or treated within twelve months before the effective date of coverage, or a pregnancy existing on the effective date of coverage. After the coverage has been in force for twelve months, we will pay benefits for any pre-existing condition not specifically excluded.

COVERAGE EFFECTIVE DATE

Effective date means the date shown on the Policy Schedule page for all persons accepted for coverage at the time of issue, provided the application has been accepted and approved by us; the policy is issued; and the first premium has been paid; or the date shown by endorsement for all persons added to coverage after the policy has been issued. The effective date is assigned by the Company in accordance with our policy dating rules in effect at the time your policy is issued. The coverage provided by the policy will not be effective unless there has been no change since the date of the application and the effective date of the policy in the health of any proposed insured person listed on the application.

USAble Life will mail your policy and purchased riders to you. If you do not receive your policy, please call our Customer Service Department at 1-800-370-5856.

USAble Life®

You'll Choose Us For Life

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A Rating and Analysis from the A.M. Best Rating Company represents an independent opinion from the leading provider of insurer ratings of a company's financial strength and ability to meet its obligations to policyholders. Upon completion of evaluations, A.M. Best assigns the following Best's Ratings: A++ and A+ (Superior); A and A- (Excellent); B++ and B+ (Very Good); B and B- (Fair); C++ and C+ (Marginal); C and C- (Weak); D (Poor); E (Under Regulatory Supervision); F (In Liquidation); S (Rating Suspended). **Based on this analysis, USAble Life is rated "A" (Excellent).**

Standard & Poor's Insurer Financial Strength Ratings provide powerful decision-making tools for anyone interested in buying insurance. Standard & Poor's ratings are prospective evaluations of an insurer's financial security to its policyholders. Standard & Poor's Insurer Financial Strength Ratings range from "AAA" to "CC". An insurer rated "BBB" and higher ("A", "AA", "AAA") is regarded as having financial security characteristics that outweigh any vulnerabilities and is highly likely to have the ability to meet financial commitments. An insurer rated "BB" or lower is in the "vulnerable" range and is regarded as having vulnerable characteristics that may outweigh its strengths. "BB" indicates the least degree of vulnerability within the range. "CC" the highest degree of vulnerability. **Based on this analysis, USAble Life is rated "A" (Strong).**

FIELD REFERENCE MANUAL

HOSPITAL CONFINEMENT

FOR: ALABAMA, ARKANSAS, COLORADO, HAWAII, IDAHO, IOWA, LOUISIANA, MISSISSIPPI, MISSOURI, NEBRASKA, NEVADA, NEW MEXICO, NORTH CAROLINA, OKLAHOMA, OREGON, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, TEXAS, WISCONSIN, & WYOMING

HIP2-FRM (3-07)

USAble Life

You'll Choose Us For Life

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HOSPITAL CONFINEMENT

Field Reference Manual

IMPORTANT NOTE

This document does not constitute a statement of contract, nor a complete description of the conditions, benefits, exclusions and other terms of coverage. The product and/or all benefits may not be available in all states and coverage is subject to all applicable policy provisions as authorized by the proper state regulatory authorities. For more complete information, please consult the terms of the product policy form approved in the applicable state or consult with USAble Life's Agent Service Center, toll-free telephone number (866) 666-0300 or email agentservicecenter@usablelife.com.

This information is intended only for use by licensed and appointed agents of USAble Life and must not be distributed to the general public.

GENERAL INFORMATION

The purpose of this booklet is to provide you with easy to understand information on USAble Life's Hospital Confinement Indemnity policy. The policy was developed after many months of research and customer input. If, after studying this booklet and our sales brochures, you have questions please contact us.

HOSPITAL CONFINEMENT COVERAGE

We are offering two separate packages for the product: Hospital Confinement and HSA Hospital Confinement. Each allow an applicant a choice of three plans to fit his/her individual needs. In addition, three optional benefit riders are available with the Hospital Confinement Plan.

The HSA Hospital Confinement Plan is designed with benefits that qualify for the premiums to be paid from a Health Savings Account (HSA). Therefore, optional riders are not available.

Benefits	
Hospital Confinement Plan	**HSA Hospital Confinement Plan**
• Daily Hospital Confinement • Surgery and Anesthesia • Emergency Accident • Outpatient Sickness • Specified Injury • Ambulance • Wellness **Optional Riders** • Annual Hospital Admission • Heart Attack, Stroke, Coma, Paralysis • Hospital Intensive Care Confinement	• Daily Hospital Confinement • Emergency Accident • Annual Hospital Admission • Hospital Intensive Care Confinement t

EMPLOYEE GROUPS ONLY

The Hospital Confinement plans are priced to sell to employees and their family members who qualify and is not sold outside of the employer's group. No direct sales will be approved. Also, the Applicant (employee) must be the primary insured and may not apply for coverage on family members only.

RENEWABILITY PROVISION

Coverage provided by the policy is guaranteed renewable for life subject to the company's right to change premium rates by class. "Class" means all policies of the same form, premium classification, and issue state.

AVAILABLE COVERAGE

There are four choices of coverage available to the applicant: (1) Applicant only; (2) Applicant & Spouse; (3) Applicant & Children; and (4) Applicant, Spouse & Children.

ISSUE AGES

Applicant - 18 to 64
Eligible Spouse - Up to 64
Children - 0 to 23

If the policy is issued prior to the applicant's 65th birthday, the coverage will be continued after age 65 as long as the premium is paid by the due date or during the 31 days that follow.

HOSPITAL CONFINEMENT PLAN BENEFITS

(Please refer to page 8 for HSA Hospital Confinement Plan Benefits)

This package of benefits is primarily intended to provide supplemental coverage for costs associated with hospital confinement. A choice of three plans are available. A summary of the benefit descriptions is as follows:

Daily Hospital Confinement: Pays a daily benefit for inpatient hospital confinement due to a covered accident or sickness for up to 180 days per confinement:

PLAN I
Pays $50 per day

PLAN II
Pays $100 per day

PLAN III
Pays $200 per day

"Confinement" means medically necessary care as a resident bed patient for at least 12 hours in the same facility. Confinement does not mean care as an outpatient or in an emergency or observation room. Successive periods of confinement are considered to be the same period of confinement unless separated by more than 30 days.

Surgery and Anesthesia: Pays the benefit shown in the Surgical and Anesthesia Beneift Schedule (see Appendix A) per unit of coverage up to the selected amount. Anesthesia pays 25% of the amount payable under the surgical benefit.

PLAN I
Pays up to $1,000 per operation (1 unit of coverage).

PLAN II
Pays up to $1,500 per operation (1.5 units of coverage).

PLAN III
Pays up to $2,500 per operation (2.5 units of coverage).

Emergency Accident: Pays the charges incurred, up to the maximum selected, if the insured person is injured in a covered accident and receives treatment in an emergency room, physician's office, or stand alone emergency center within 72 hours of the accident. Benefit is payable 2 times per calendar year per insured person, except for dependent children. The maximum number of visits for all dependent children combined is 2 visits per calendar year.

PLAN I
Pays up to $100 per covered accident.

PLAN II
Pays up to $250 per covered accident.

PLAN III
Pays up to $500 per covered accident.

Outpatient Sickness: Pays for treatment by a physician in a physician's office, clinic, urgent care facility, or emergency room for a covered sickness.

PLAN I – No benefit.

PLAN II and **PLAN III** pay $75 per visit. Benefits are limited to 5 visits per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children combined is 5 visits per calendar year.

Ambulance: Pays for ground or air ambulance to or from a hospital or between medical facilities. Pays only one benefit, whichever occurs first, once per calendar year per insured person.

	PLAN I	**PLAN II**	**PLAN III**
Ground Ambulance	$250	$250	$500
Air Ambulance	$500	$500	$1000

Wellness: Pays the benefit amount for any insured person to undergo routine examination or other preventive testing.

PLAN I – No benefit.

PLAN II and **PLAN III** pay $75 per visit. This benefit is payable once per insured per calendar year and two times per family per calendar year. Benefits include and are payable for: Mammograms, Flexible Sigmoidoscopy, Chest X-Ray, EKG, Pap Smear, Cholesterol and Diabetes Screening, Colonoscopy, Prostatic Specific Antigen (PSA), Hearing Exams, and Dental X-Rays.

Specified Injury *(all plans include the benefits below):*

Burn: Pays $375 for treatment of a second degree burn which covers at least 36% of the body surface or for a third degree burn which covers at least nine square inches of the body surface. Treatment must be received within 72 hours after the accident. This benefit is paid once per accident.

Tendon or Ligament: Pays $150 for the surgical repair of one or more torn, ruptured, or severed tendon or ligament within one year of the accident.

If there is both a tear, rupture, or severance in a tendon or ligament and a dislocation and/or fracture; we will pay the larger of either the Tendon/Ligament benefit, the Dislocation benefit, or the Fracture benefit. Pays $25 if exploratory arthroscopic surgery is performed and no repair is done.

Dislocations*: Pays an indemnity benefit for a dislocation diagnosed by a physician within 30 days after the accident as shown below:

	Open Reduction	Closed Reduction	Without Anesthesia
Hip	$625	$155	$40
Knee	$155	$ 60	$15
Shoulder	$155	$ 60	$15
Collar Bone	$250	$ 50	$15
Ankle or Foot	$155	$ 50	$15
Lower Jaw	$155	$ 80	$20
Wrist	$125	$ 60	$15
Elbow	$125	$ 60	$15
Toe or Finger	$ 30	$ 15	$ 5

*If there is more than one dislocation, this benefit will pay for all dislocations individually, but the total payment under this benefit cannot exceed 150% of the HIGHEST individual joint amount. If the insured person receives a fracture and a dislocation in the same accident, we will pay for both. However, we will pay no more than 150% of the amount for the bone or joint involved which has the highest benefit amount.

Eye Injury: Pays the benefit shown below if the insured sustains an eye injury requiring surgery or removal of a foreign object within 30 days of the accident.

	Amount
With Surgical Repair	$75
Removal of Foreign Body	$15

Fractures:* Pays an indemnity benefit as shown below for treatment of a fracture diagnosed within 14 days after the accident:

	Open Reduction	Closed Reduction	Chip Fracture
Hip	$625	$315	$ 40
Leg	$315	$160	$ 20
Hand (excluding fingers)	$155	$ 80	$ 10
Foot (excluding toes/heel)	$155	$ 80	$ 10
Wrist	$155	$ 80	$ 10
Elbow	$155	$ 80	$ 10
Shoulder Blade	$155	$ 80	$ 10
Forearm	$155	$ 80	$ 10
Ankle or Kneecap	$155	$ 80	$ 10
Sternum or lower jaw	$155	$ 80	$ 10
Vertebrae (body of)	$315	$160	$ 20
Pelvis (excluding coccyx)	$315	$160	$ 20
Upper Jaw	$185	$ 90	$ 12
Upper Ann	$185	$ 90	$ 12
Face (excluding nose)	$185	$ 90	$ 12
Rib or Ribs	$315	$ 35	$ 20
Nose, Heel or Fingers	$155	$ 35	$ 10
Coccyx	$ 65	$ 35	$ 4
Toes	$ 65	$ 35	$ 4
Vertebral Process	$315	$ 50	$ 20
Skull			
Depressed	$470	$470	$470
Simple	$155	$155	$155

* If there is more than one fracture, this benefit will pay for all fractures individually, but the total payment under this benefit cannot exceed 150% of the HIGHEST individual bone amount. If there is both a dislocation and a fracture, this benefit and the Dislocation benefit will pay individually, but the total payment amount under these benefits cannot exceed 150% of the HIGHEST individual benefit amount.

Knee Cartilage – Torn: Pays the benefit shown below if the insured receives the treatment listed for a torn knee cartilage. The injury must be treated by a physician within 60 days of the accident, and the surgery must be performed within one year after the accident.

	Amount
Exploratory surgery without repair	$75
Surgical Repair	$155

Only one payment amount under this benefit will be paid.

Ruptured Disc: Pays $155 treatment of a ruptured disc within 60 days of the accident. It must be repaired through surgery within one year of the accident.

Torn Rotator Cuff: Pays $155 for surgery to repair one or two rotator cuffs within 90 days of a covered accident.

Internal injuries: Pays $315 for internal injuries resulting in open abdominal, hernia or thoracic surgery within 30 days after the accident.

Concussion: Pays $15 for treatment resulting in electroencephalogram abnormality within 30 days after the accident.

Lacerations: pays the benefit shown below if the insured receives the treatment listed for a laceration sustained in a covered accident. The injury must be repaired by a physician within 72 hours of the accident.

	Amount
Single laceration less than 2 inches	$15
Total of all lacerations:	
At least 2 inches but not more than 6 inches (total of all lacerations)	$65
Over 6 inches (total of all lacerations)	$125
Laceration(s) not requiring stitches, staples or glue	$8

OPTIONAL BENEFIT RIDERS

Any available amount of these optional benefits may be chosen regardless of the Hospital Confinement Plan issued – I, II or III.

Annual Hospital Admission: Pays a choice of $500, $750, or $1,000 for admission to a hospital and confinement as a resident bed patient because of a covered accident or sickness. Payable once per calendar year for each insured person.

Hospital Intensive Care Confinement: Pays a choice of $200, $400, or $600 per day for up to 30 days of confinement in a Hospital Intensive Care or Coronary Care Unit, due to a covered accident or sickness. This benefit is in addition to the Hospital Confinement benefit. Successive periods of confinement are considered to be the same period of confinement unless separated by more than 30 days.

Heart Attack, Stroke, Coma, or Paralysis: pays a choice of $1,000 or $2,000 for first diagnosis and $500 or $1,000 for reoccurrence respectively upon diagnosis of a Heart Attack, Stroke, Coma or Paralysis. The first diagnosis benefit is only paid once per insured person. Reoccurrence benefit is paid for a diagnosis occurring more than 180 days after this benefit was last paid. No lifetime benefit maximum.

HSA HOSPITAL CONFINEMENT PLAN BENEFITS

(Please refer to page 3 for Hospital Confinement Plan Benefits)

This benefit package is designed with benefits that qualify for the premiums to be paid from a Health Savings Account (HSA). A choice of three plans are available. A summary of the benefit descriptions is as follows:

Daily Hospital Confinement: Pays a daily benefit for inpatient hospital confinement due to a covered accident or sickness. *Maximum 180 days per confinement.*

PLAN I pays $50 **PLAN II** pays $100 **PLAN III** pays $200

Confinement means medically necessary care as a bed patient for at least 12 hours in the same facility. Confinement does not mean care as an outpatient or observation room. Successive periods of confinement are considered to be the same period of confinement unless separated by more than 30 days.

Emergency Accident: Pays the charges incurred, up to the maximum selected per accident, if the insured person is injured in a covered accident and receives treatment in an emergency room, physician's office, or stand alone emergency center within 72 hours of the accident. Benefit is payable 2 times per calendar year per insured person, except for dependent children. The maximum number of visits for all dependent children combined is 2 visits per calendar year.

PLAN I pays $100 **PLAN II** pays $250 **PLAN III** pays $500

Annual Hospital Admission: Pays for admission to a hospital and confinement as a resident bed patient because of a covered accident or sickness. Payable once per calendar year for each insured person.

PLAN I pays $500 **PLAN II** pays $750 **PLAN III** pays $1,000

Hospital Intensive Care Confinement: Pays a daily benefit when an insured person is confined in a Hospital Intensive Care or Coronary Care Unit, due to a covered accident or sickness. Limited to 30 days for any one period of confinement. This benefit is in addition to the Daily Hospital Confinement benefit. Successive periods of confinement are considered to be the same period of confinement unless separated by more than 30 days.

PLAN I pays $200 **PLAN II** pays $400 **PLAN III** pays $600

EXCEPTIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS--LIMITATIONS FOR CERTAIN CONDITIONS:

The benefits of this policy will not be payable for loss caused by pre-existing conditions during the first twelve months this policy is in force. After this twelve-month period, however, loss due to such pre-existing conditions will be payable unless specifically excluded from coverage. This twelve month period is measured from the effective date of coverage for each insured person.

"Pre-existing Condition" means a sickness or injury which is diagnosed or for which treatment is received within the twelve month period prior to the effective date of coverage for each insured person, or a pregnancy existing on the effective date of coverage.

EXCEPTIONS—WHAT WE WILL NOT PAY FOR:

The policy pays only for loss resulting from a covered sickness or accident as defined in the policy. It DOES NOT cover loss due to:

1. War or any act of war, declared or undeclared.
2. Intentional self-inflicted injury or attempted suicide.
3. Being engaged in an illegal occupation or felony.
4. Routine physicals.
5. Custodial, intermediate care, or rehabilitative confinement.
6. Mental, nervous or emotional disorder without organic origin.
7. Alcoholism or drug addiction.
8. The use of alcohol or drugs, unless taken as prescribed by a physician.
9. Dental, elective, or cosmetic surgery or treatment, except as a result of a covered injury or congenital defect of a newborn child.
10. Hernia, tonsils or adenoids during the first six months of coverage unless treated on an emergency basis.
11. Well baby care.
12. Voluntarily acting as an organ donor.

DEATH OF INSURED – CONVERSION PROVISION

A spouse may continue coverage under this policy upon the death of the Insured. The spouse will be substituted as the primary insured and rates will be adjusted accordingly. Children who reach the age when coverage terminates may convert their coverage to a like policy. Contact USAble Life Customer Service Department (1-800-370-5856).

SUPPLIES

The form numbers referenced in this manual are shown without the version date. Forms are updated frequently as conditions change or as the form is improved. When that happens a new date is assigned to the form number. Please refer to your supply order form to order the most current and appropriate version of each form for your state. Go to www.usablelife.com to download forms.

APPLICATION & BROCHURE

Application: The approved applications are HIP2-APP or HIP2-HSA-APP. See Attachment #1 and #1a.

Brochure: The approved brochures are form HIP2-OC or HIP2-HSA-OC.

UNDERWRITING

Applications will be underwritten based upon completion of the Hospital Confinement Application & Change Form, HIP2-APP or HIP2-HSA-APP.

All questions on the application must be completed.

Subject to underwriting approval, most Applicants under age 65 and actively at work who can answer questions 1 through 5 "No" will be accepted for coverage.

Full details to any "Yes" answers must be given in the space provided on the application. An underwriting decision will be made based upon the information provided.

Guaranteed issue is not available.

Even though one family member may be uninsurable, the Hospital Confinement policy may still be sold to other family members. We will issue a Hospital Confinement Indemnity Exclusion of Coverage Rider, Form IHIP-EXC, excluding the uninsurable person from coverage.

There is not a rating class for Spouse or Children only. The Applicant (employee) must apply and be included for coverage. If the Applicant is uninsurable, we will not be able to issue a Hospital Confinement policy.

PREMIUMS

Premiums are based upon the Applicant's age at issue and remain level thereafter.

Premiums for both the Hospital Confinement Plan and HSA Hospital Confinement Plan are unisex, unismoker and are in three age-brackets, under 55, 55-59 and 60-64.

GUARANTEED ISSUE

Guaranteed Issue is not available. The applications are designed for underwriting as Simplified Issue. Although medical records may be requested, generally there are no requirements for medical examinations, blood profiles or additional tests.

30 HOURS MINIMUM

Employees must work a minimum of 30 hours per week to qualify for coverage.

EXCLUSION RIDER

A Policy Exclusion Rider, Form IHIP-EXC, will be issued for applicants who are uninsurable for the Hospital Confinement Indemnity Policy due to answers obtained from the application. The Medical Underwriter will mail the Exclusion Rider to the applicant for signature when coverage cannot be offered as requested. See Attachment #2 for the exclusion rider that ONLY a Medical Underwriter prepares.

REPLACEMENT COVERAGE - OTHER COMPANIES

Please Note: Not all States require the completion of a Replacement Form, but we recommend it. Please refer to the State-Specific Notes.

A 12/12 pre-existing limitation applies to Hospital Confinement and it may not be in the best interest of the prospective insured to replace another company's policy.

There is no "prior credit" provision in the Hospital Confinement policy and it is not anticipated that exceptions will be made to allow this administratively.

Regardless of a particular state's requirement, in the event an applicant is replacing coverage of another company, please complete "Notice to Applicant Regarding Replacement of Insurance," form, IND-REP.

See Attachment # 3 for copy of form IND-REP.

URGENT NOTE: Please advise your applicant that he/she should not cancel existing coverage until the USAble Life coverage has been approved. USAble Life does not want you to be placed in the position of having an applicant's existing coverage terminated if he is uninsurable with us.

REPLACEMENT OF USABLE LIFE HOSPITAL INDEMNITY

Existing Hospital Indemnity or HealthCare Plus policyholders are allowed to retain their policies and apply to purchase a new Hospital Confinement policy.

There may be requests from existing Hospital Indemnity policyholders to exchange their policy for the new Hospital Confinement policy. While we do not recommend that the Sales Representative actively solicit replacement of Hospital Indemnity policies, we will permit replacement if an applicant makes this request.

A Hospital Indemnity insured wanting to "upgrade" their benefits, may replace their policy with Hospital Confinement. We will not back date new or change coverage prior to the date of the application.

Incurred claims will be adjudicated under the terms and provisions of the hospital indemnity policy at the time the claim was incurred (please also refer to "Note" below).

Although there is no "prior credit" provision in the Hospital Confinement policy, administratively we will allow credit for the time insured under the current USAble policy toward the new policy's pre-existing limitation.

If you are replacing an existing USAble Life Hospital Indemnity policy, the applicant must sign form HIP-REP2, NOTICE TO APPLICANT REGARDING REPLACEMENT OF USABLE LIFE HOSPITAL INDEMNITY INSURANCE. The original must be given to the applicant. Send the copy in with the Hospital Confinement application. This form must accompany the application before a new policy can be issued.

The original policy must be returned with the application for the replacement policy to be issued. A lost Policy form must be signed if the original policy can not be found. However, please try to secure the old policy as it is not in our best interest to have an insured with two policies where one is no longer in force.

Commissions will be paid in accordance with the replacement section of your commission agreement.

NOTE: If there have been claims filed on the existing Hospital Indemnity Policy, USAble

Life may not be able to exchange the policy. Our Underwriters will investigate the reason for the claim and a decision will be made based upon that information.

See Attachment #4 for a copy of form HIP2-REP.

REQUEST FOR CHANGE

When you are enrolling an existing group you will encounter many employees who currently have USAble Life Hospital Indemnity coverage. Changes to existing Hospital Indemnity coverage can be quickly handled by completing a Request For Change Form.

See Attachment #5 for a copy of form IND-CHG.

Use the **Request for Change** form for the following changes:

- Name Change
- Address Change
- Deletions
- Continuation of Coverage for Handicapped Dependents
- Cancellation of Rider
- Request for Duplicate Policy

The following activities by a current policyholder would require a **Hospital Confinement Application and Change Form:**

- Adding additional riders
- Adding family members

Submit the form to USAble Life's New Business Department, along with other applications.

See Attachment #1 and #1a for copies of forms HIP2-APP and HIP2-HSA-APP.

SUBMISSION OF BUSINESS

As a new agent submitting business to USAble Life, our aim is to help simplify the process of submitting business. Listed below are general guidelines used to submit business by the various lines of products for new groups and existing or re-enrolling groups.

General Guidelines

1. Product approval by state:
   Individual Products – Verify that products being written have been approved in the state where the employee resides.
2. Producer/Agent Appointments – Writing Producer or Agent must be licensed and appointed by USAble Life in the state where the applications are solicited and written. State regulations vary, so be sure to check with the Licensing and Section 125 Proposal Coordinator, before authorizing a non-appointed agent or producer to solicit or write applications.
3. Complete a Business Transmittal form to submit with all applications. Approximately 13 applications can be submitted with each form.

See Attachment #6 and #6a for sample business transmittal form AFFBUSTR.

CLAIMS

Claims for Hospital Confinement are paid promptly from USAble Life's Home Office. A claim form may be requested from the Customer Service Department or downloaded from the USAble Life website, www.usablelife.com. Wellness claims are paid with a minimum amount of documentation.

WELLNESS CLAIM

A claim form is not necessary; however there is certain information needed to process the wellness benefit.

Required information:

- Name of Claimant
- Name of Insured
- Social Security Number of Claimant
- Social Security Number of Insured
- Itemized Bills for Covered Tests
- Insured's Current Mailing Address
- It is helpful for the Insured to provide their policy number.

Most wellness benefits provide a maximum payment per calendar year, based on the Schedule of Benefits. Examples of covered diagnostic tests are listed below:

- Mammogram
- Pap Smear
- Flexible Sigmoidoscopy
- Prostatic Specific Antigen (PSA)
- Chest X-ray
- EKG
- Cholesterol & Diabetes Screening
- Colonoscopy
- Vision Examination
- Hearing Examination
- Dental X-Ray

HOSPITAL CONFINEMENT CLAIM

See instructions on the front of the claim form, CL-HIP2

- **The Employee** should complete the Insured's Statement and the Authorization to Obtain Information sections only.
- **The Physician** should complete the Attending Physician's Statement.
- **Itemized bills** should accompany the completed claim form.

See Attachment #7 for a copy of the claim form.

HOME OFFICE CONTACT INFORMATION

Hopefully, this guide will answer most of your questions. If you have other questions or need further assistance, the following USAble Life Home Office Departments may be of service:

Agents Service Center: 1-866-666-0300
Call for special state forms

Medical Underwriting: 1-800-648-0271
Call for questions concerning the use of Exclusion Riders.

Acquisition Services: 1-800-648-0271
Call for questions concerning policy issue.

ATTACHMENTS

Appendix A, Surgical and Anesthesia Schedule

#1 Hospital Confinement Application & Change Form, HIP2-APP

#1a HSA Hospital Confinement Application & Change Form, HIP2-HSA-APP

#2 Hospital Confinement Indemnity Exclusion of Coverage Rider, IHIP-EXC

#3 Notice to Applicant Regarding Replacement of other Hospital Indemnity Insurance, IND-REP

#4 Notice To Applicant Regarding Replacement of USAble Life Hospital Indemnity Insurance, HIP2-REP

#5 Request for Change and Duplicate Policy Request, IND-CHG

#6 Business Transmittal Form, AFFBUSTR AR & TN

#6a Business Transmittal Form, AFFBUSTR

#7 Hospital Income Claim Form, CL-HIP2

For the most up-to-date version of the above forms, go to “Download Forms” on the USAble Life website **www.usablelife.com**.

STATE SPECIFIC NOTES

These notes are being added to reference specific changes to benefits and underwriting that were required in order to be in compliance with state laws.

These notes are also intended to assist you during multi-state enrollments.

- The following states require completion of a Replacement form (IND-REP) for takeovers from other carriers: AR.
- HI requires us to allow dependent coverage for reciprocal beneficiaries as defined by Hawaii state law.

Appendix A

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
AMPUTATIONS		
Arm at shoulder joint	$380	$95
Arm below shoulder joint	$200	$50
Finger	$110	$28
Leg at hip joint	$400	$100
Leg at knee	$280	$70
Leg above or below knee	$290	$73
Toe	$62	$16
ARTERIES		
Arteriotomy, extremity	$300	$75
Carotid endarterectomy	$780	$195
Excision and graft, abdominal aortic aneurysm	$530	$133
Injection, varicose veins	$18	$5
Thromboendarterectomy	$400	$100
BREAST		
Biopsy	$70	$18
Excision of chest wall tumor	$340	$85
Excision of cyst of benign tumor	$100	$25
Mastectomy, radical	$380	$95
Mammoplasty, reconstructive	$360	$90
Mastectomy, simple	$208	$52
DIGESTIVE SYSTEM		
Appendectomy	$220	$55
Aspiration biopsy of liver, pancreas or bile duct	$40	$10
Cholecystectomy	$284	$71
Cholecystotomy	$250	$63
Colostomy	$240	$60
Diverticulectomy	$240	$60
Enterectomy	$352	$88
Enterotomy	$354	$89
Enterostomy	$180	$45
Enterolysis	$292	$73
Fissurectomy or hemorrhoidectomy	$80	$20
Fistulotomy	$60	$15
Gastrectomy, partial	$480	$120
Gastrectomy, total	$560	$140
Gastrorrhaphy	$280	$70
Gastroscopy	$84	$21
Gastrostomy	$230	$58

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
DIGESTIVE SYSTEM (continued)		
Gastrotomy	$270	$68
Herniotomy	$210	$53
Laparotomy	$170	$43
Pancreatectomy, partial	$350	$88
Pancreatectomy, total	$700	$175
Proctectomy	$560	$140
Proctoplasty	$200	$50
Proctosigmoidoscopy	$14	$4
Removal of external hemorrhoids	$50	$13
Sphincterotomy	$24	$6
DISLOCATIONS		
Ankle	$54	$14
Collar bone (requiring reduction)	$48	$12
Fingers or toes	$10	$3
Hip or knee	$155	$39
Jaw	$40	$10
Shoulder (humerus with anesthesia) or elbow	$27	$7
Wrist	$30	$8
EAR		
Drainage of abscess	$20	$5
Labyrinthotomy or labyrinthectomy	$560	$140
Mastoidectomy, simple	$300	$75
Myringotomy	$20	$5
Tympanoplasty	$620	$155
ENDOCRINE SYSTEM		
Adreanalectomy	$390	$98
Incision and drainage of thyroid gland	$18	$5
Local excision of thyroid cyst or adenoma	$200	$50
Thyroidectomy or parathyroidectomy	$520	$130
EYE		
Excision of lacrimal glad or sac	$260	$65
Excision of pterygium	$140	$35
Extraction of lens (including cataract extraction)	$560	$140
Iridectomy	$440	$110
Muscle operation (one or more muscles)	$380	$95
Reattachment of retina	$820	$205
Removal of eye	$250	$63
Sclerotomy, anterior	$200	$50
Sclerotomy, posterior	$200	$50

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
FRACTURES		
Ankle	$130	$33
Collar bone	$70	$18
Fingers	$30	$8
Foot	$64	$16
Hand	$50	$13
Jaw	$160	$40
Lower arm (radius)	$86	$22
Lower arm (ulna)	$66	$17
Lower leg (fibula)	$80	$20
Lower leg (tibia)	$60	$15
Nose	$30	$8
Vertebrae, one or more	$200	$50
Shoulder blade (scapula)	$230	$58
Skull	$360	$90
Toes	$22	$6
Upper arm	$100	$25
Upper leg	$200	$50
GENITAL SYSTEM – MALE		
Biopsy, prostate	$40	$10
Circumcision	$20	$5
Excision of epididymis, hydrocele, varicocele	$160	$40
Orchiectomy	$126	$32
Prostatectomy, partial	$440	$110
Prostatectomy – radical	$520	$130
Reduction of torsion of testis	$200	$50
Vasectomy	$90	$23
GENITAL SYSTEM – FEMALE		
Amniocentesis	$20	$5
Biopsy or removal of cervical lesion or polyp	$16	$4
Dilation and curettage	$80	$20
Cesarean section	$290	$73
Hysterectomy, radical for cancer including lymph nodes	$480	$120
Hysterectomy, vaginal or abdominal	$380	$95
Myomectomy	$240	$60
Obstetrical delivery	$210	$53
Repair of cystocele or rectocele	$140	$35
Repair of uterine suspension	$242	$61
Salpingo-oophorectomy	$340	$85
Tubal ligation	$200	$50

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
HEART –CARDIOVASCULAR SYSTEM		
Angioplasty, percutaneous	$460	$115
Catheterization of heart	$230	$58
Coronary bypass, single or multiple	$1,000	$250
Heart transplant	$1,000	$250
Pervenous or transvenous insertion of pacemaker	$390	$98
Repair of myocardial aneurysm	$760	$190
Repair of septal defect	$780	$195
Suture of heart wound or injury	$480	$120
Valvotomy, aortic and pulmonic valve	$740	$185
Valvotomy, mitral valve	$860	$215
Valvuloplasty or replacement aortic and mitral valve	$1,000	$250
HEMIC & LYMPHATIC SYSTEMS		
Biopsy of lymph node	$30	$8
Radical lymphadenectomy	$420	$105
Splenectomy	$320	80
JOINTS		
Ankle, arthrotomy	$240	$60
Ankle, arthroplasty	$400	$100
Hammertoe	$96	$24
Hip, arthrotomy	$282	$71
Hip, arthroplasty	$650	$163
Knee, arthrotomy	$250	$63
Knee, arthroplasty	$460	$115
Shoulder or elbow, arthrotomy	$220	$55
Shoulder or elbow, arthroplasty	$440	$110
Wrist, arthrotomy	$160	$40
Wrist, arthroplasty	$300	$75
LARYNX		
Laryngectomy	$500	$125
Laryngoscopy	$20	$5
LUNGS		
Pneumocentesis	$30	$8
Pneumonectomy, total	$600	$150
Pneumonotomy	$280	$70
Thoracentesis	$40	$10
Thoracoscopy (including biopsy)	$140	$35
Thoracotomy	$280	$70
Wedge resection of lung, single or multiple	$380	$95

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
MUSCULOSKELETAL SYSTEM		
BONE OR CARTILAGE GRAFT		
Spinal fusion	$360	$90
Spinal fusion for scoliosis	$600	$150
NERVOUS SYSTEM		
Burr holes	$200	$50
Cranioplasty	$480	$120
Craniotomy or craniectomy	$176	$44
Laminectomy	$700	$175
Median nerve decompression (carpal tunnel)	$168	$42
Paravertebral block, lumbar, or thoracic nerve	$30	$8
Spinal puncture	$40	$10
NOSE		
Excision of nasal polyps	$48	$12
Sumusous resection, classic nasal sept	$220	$55
SINUSES		
Frontal sinusotomy – radical	$250	$63
Frontal sinusotomy – simple	$210	$53
SKIN – INTEGUMENTARY SYSTEM		
Acne surgery	$10	$3
Biopsy	$20	$5
Chemosurgery – malignancies of skin	$92	$23
Electro-ssurgical destruction of chemocautery	$18	$5
Excision of benign tumor	$40	$10
Excision of malignant tumor (trunk, arms or legs)	$30	$8
Excision of malignant tumor (face, scalp, ears, neck, hands, feet, genitalia)	$60	$15
Excision of malignant tumor (eyelids, nose, lips, mucous membrane)	$60	$15
Excision of nail	$76	$19
Incision and drainage of cyst	$16	$4
Repair, complex wounds (linear repair)	$35	$9
Repair, skin grafts (multiple stage)	$70	$18
Repair, skin grafts (single stage)	$35	$9
Repair, simple wounds	$16	$4
TENDONS		
Lengthening or shortening (e.g. Achilles tendon)	$160	$40
Repair or suture	$60	$15

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
TRACHEA & BRONCHI		
Bronchoscopy	$120	$30
Closure of tracheotomy	$98	$25
Tracheotomy	$20	$5
URINARY SYSTEM		
Cystectomy, complete	$510	$128
Cystectomy, partial	$245	$62
Cystoplasty	$400	$100
Cystotomy	$340	$85
Dilation of urethra	$30	$8
Kidney transplant	$600	$150
Lithotripsy	$375	$94
Nephrectomy	$420	$105
Nephrolithotomy	$400	$100
Renal biopsy	$56	$14
Urethroscopy or cystoscopy	$40	$10

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink **Attachment #1**

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc.	

☐ New Application ☐ Change Form ☐ Replaces Policy No. _____

SECTION 1 – PERSONAL IDENTIFICATION

Name (First, MI, Last)	For Name Change, Give Prior Last Name			Social Security #	
Home Address	City	State	Zip	County	
Name of Employer	Date Employed Full-Time	Occupation		Height (ft-in)	Weight (lbs.)
Date of Birth / Birth State or Country	Sex	Work Phone		Home Phone	

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

Person Proposed for Insurance Show first, middle, last name	Date of birth mo.	day	yr.	Birth State or Country	Marital Status	Age	Sex	Height (ft-in)	Weight (lbs.)
(spouse)									
(child)									
(child)									
(child)									
(child)									

SECTION 2 – PLAN SELECTION ■ New Applicant ■ Application for Change

CHECK COVERAGE DESIRED:

☐ 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.

Add	Delete	Optional Rider(s):	Amount		
☐	☐	Annual Hospital Admission Rider	☐ $500	☐ $750	☐ $1,000
☐	☐	Hospital Intensive Care Confinement Rider	☐ $200	☐ $400	☐ $600
☐	☐	Heart Attack, Stroke, Coma & Paralysis Benefit Rider	☐ $1,000/$500	☐ $2,000/$1,000	

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: _____ (City and State) Date of Application _____ (Month, Day, Year)

Date Received Home Office

X _____ Agent's Signature

X _____ Applicant's Signature

Attachment #1

Employee's Name (Last, First, M.I.)	Social Security #	Employer Name

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
			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ 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? ☐ ☐

   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)? ☐ ☐

   Person(s): _____ Details: _____

4. Is anyone to be covered now pregnant? ☐ ☐

   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.

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

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Attachment #1a

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

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Policy Number	
Group Number	
Dept./Loc.	

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Date of Birth	Birth State or Country	Sex	Work Phone	Home Phone	

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

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(spouse)									
(child)									
(child)									
(child)									
(child)									

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☐ Plan III - $200 Daily Hospital Confinement, $500 Emergency Accident, $1,000 Annual Hospital Admission, $600 Hospital Intensive Care.

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: _____ (City and State) Date of Application _____ (Month, Day, Year)

Date Received Home Office

X _____ Agent's Signature

X _____ Applicant's Signature

Employee's Name (Last, First, M.I.)	Social Security #	Employer Name

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			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ Secondary	

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   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? ☐ ☐

   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)? ☐ ☐

   Person(s): _____ Details: _____

4. Is anyone to be covered now pregnant? ☐ ☐

   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.

Attachment #2

USAble Life

P.O. Box 1650 • Little Rock, AR 72203-1650

HOSPITAL CONFINEMENT INDEMNITY
EXCLUSION OF COVERAGE RIDER

RIDER DATE (same as Policy Date if no date shown):

In consideration of the issuance or reinstatement of the Policy to which this Rider is attached, it is hereby understood and agreed that the person named below is completely excluded from all coverage under the policy:

_____

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy other than as stated above.

Signed for us at our Home Office on the Rider Date.

Accepted by:

USAble Life

President

_____
Signature of Applicant

Attachment #3

USAble Life

PO Box 1650
Little Rock, AR 72203-1650

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INSURANCE

According to your application, you intend to lapse or otherwise terminate existing

☐ Cancer ☐ Accident ☐ Hospital Indemnity

☐ Heart Attack & Stroke ☐ Coronary or Intensive Care ☐ _____

insurance and replace it with a policy to be issued by USAble Life. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. Or, even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(4) Finally, before you terminate your present policy, be certain that your application for the new policy has been accepted by USAble Life.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

Original - Applicant Copy - Insurance Company

Attachment #4

USAble Life

NOTICE TO APPLICANT REGARDING REPLACEMENT OF USABLE LIFE HOSPITAL INDEMNITY INSURANCE

According to your application, you intend to lapse or otherwise terminate existing USAble Life Hospital Indemnity insurance and replace it with another type of Hospital Indemnity policy to be issued by USAble Life. For your own information and protection, you should be aware of and seriously consider certain factors, which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in the denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) Please study the benefits in your present policy and compare them to the benefits available to you in the new policy. Some specific benefits may be better and some may not. Make your decision to exchange your policy upon benefits, premium amount and on which coverage fits your particular situation best.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims, rescind your policy, and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(4) Remember, you have 30 days to review your new policy to be sure you understand all of the provisions and agree to accept the new policy.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
(Applicant's Signature)

Original - Applicant Copy – USAble Life

Attachment #5

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200

REQUEST FOR CHANGE AND DUPLICATE POLICY REQUEST

Name of Policyholder: _____ Policy Number: _____

Social Security #: _____ Group #: _____

Current Address: _____ City: _____ State: _____ Zip: _____

If payment is made through Payroll Deduction,
please enter Employer or Group Name: _____

Please make the following changes to my Policy:

☐ **NAME CHANGE**

Name Shown on Policy _____
Change Name To _____
Reason _____
Effective Date of Name Change _____

☐ **ADDRESS CHANGE**

New Address _____
_____
Phone _____

☐ **DELETIONS**

Person to be Deleted _____ Relationship _____
Birthdate of Person to be Deleted _____ Effective Date of Deletion _____
New Policyholder's Full Name _____ Reason for deletion: ☐ Death ☐ Marriage ☐ No longer dependent
Social Security # _____ Birthdate of New Policyholder _____
Type of Coverage now desired ☐ Individual ☐ Family ☐ Applicant & Children
New Monthly Premium $ _____

☐ **CONTINUATION OF COVERAGE FOR HANDICAPPED DEPENDENTS**

I am advising you that the following dependent is incapable of self support by reason of mental or physical handicap as defined in the policy and is eligible for continuation of coverage:

Full Name	Date of Birth	Relationship

☐ **CANCELLATION OF RIDER**

I hereby request that the following Rider(s) attached to the policy referenced above be cancelled effective _____:

_____ _____
_____ _____

☐ **REQUEST FOR DUPLICATE POLICY**

I hereby declare that the Policy referenced above has been lost or destroyed, and I have no knowledge of its whereabouts. I request issuance of a duplicate policy.

_____ _____ _____
Date **City** **State**

_____ _____
Witness to Signature **Insured's Signature**

Attachment #6

USAble Life

BUSINESS TRANSMITTAL FORM

FORMS MAY BE DOWNLOADED FROM HTTPS://WWW.USABLELIFE.COM

ENROLLMENT COMPLETE:
(All Applications Submitted) ☐ Yes ☐ No

GROUP NAME _____ **DATE SUBMITTED:** _____

CONTACT PERSON _____ **ELIGIBLE EMPLOYEES:** _____ **NUMBER ENROLLED:** _____

Address _____ **List any subsidiaries to be billed with this group:**

Phone number: _____ _____

email address: _____ _____

Section 125 Anniversary Date (if applicable) _____ **Group Billing Number (existing groups only)** _____

5500 Benefit Plan Year _____ **USAble Life offers preparation of W-2s for disability claims. If desired please complete form W2-AGREE (12-04)**

TYPE OF BUSINESS: (DESIGNATE BELOW)	**BILLING OPTIONS:** (CHOOSE ONE)
☐ New Group ☐ Resolicitation (Existing Group) ☐ New Employee (Existing Group) ☐ New Product (Existing Group)	☐ Advance Billing (example: July payroll deductions pay August premiums) ☐ Current Billing (example: July payroll deductions pay July premiums)
BILLING CYCLE: (CHOOSE FROM DROP DOWN BOX) MONTHLY	***NOTE: WHEN CHOOSING NINTHLY OR TENTHLY BILLING CYCLE PLEASE DESIGNATE WHICH MONTHS IN THE CALENDAR YEAR WILL NOT BE BILLED**
☐ **E-bill (Online)** **or** ☐ **List bill (Invoice sent via mail)**	

AR AND TN ONLY: PLEASE USE THE COMMISSION DISTRIBUTION FORM FOR PRODUCER INFORMATION AND COMMISSION DISTRIBUTION AS IT IS NECESSARY TO PROCESS THIS GROUP.

SPECIAL INSTRUCTIONS:

WHEN SUBMITTING A GROUP, A LISTING OF APPLICATIONS SUBMITTED IS REQUIRED. PLEASE SUBMIT IN A FORMAT SIMILAR TO BELOW.

Name First	MI	Last	Product Type	Date	Effective Date of Policy	Monthly Premium	Upgrade Change

REPRESENTATIVE SIGNATURE _____

TOTAL APPLICATIONS SUBMITTED: _____ **TOTAL MONTHLY PREMIUM:** $ _____

GROUP NAME _____ **GROUP NUMBER** _____ **DATE SUBMITTED:** _____ **Page** _____ **Of** _____

Name First	MI	Last	Product Type	Date	Effective Date of Policy	Monthly Premium	Upgrade Change

REPRESENTATIVE SIGNATURE: _____

TOTAL APPLICATIONS SUBMITTED: _____ **TOTAL MONTHLY PREMIUM:** $ _____

Attachment #6a

USAble Life

BUSINESS TRANSMITTAL FORM

FORMS MAY BE DOWNLOADED FROM HTTPS://WWW.USABLELIFE.COM

ENROLLMENT COMPLETE:
(All Applications Submitted) ☐ Yes ☐ No

GROUP NAME _____ **DATE SUBMITTED:** _____

CONTACT PERSON _____ **ELIGIBLE EMPLOYEES:** _____ **NUMBER ENROLLED:** _____

Address _____ **List any subsidiaries to be billed with this group:**

Phone number: _____ _____

email address: _____ _____

Section 125 Anniversary Date (if applicable) _____ **Group Billing Number (existing groups only)** _____

5500 Benefit Plan Year _____ **USAble Life offers preparation of W-2s for disability claims. If desired please complete form W2-AGREE (12-04)**

TYPE OF BUSINESS: (DESIGNATE BELOW)

☐ New Group ☐ Resolicitation (Existing Group)
☐ New Employee (Existing Group)
☐ New Product (Existing Group)

BILLING OPTIONS: (CHOOSE ONE)

☐ Advance Billing (example: July payroll deductions pay August premiums)

☐ Current Billing (example: July payroll deductions pay July premiums)

☐ E-bill (Online) **or** ☐ List bill (Invoice sent via mail)

PLEASE COMPLETE THE PRODUCER INFORMATION BELOW AS IT IS NECESSARY TO PROCESS THIS GROUP. USE THE CHECKBOXES TO INDICATE IF COMMISSIONS ARE PAYABLE →

		Yes	No
USABLE LIFE AFFILIATE AGENCY	_____	☐	☐
AFFILIATE AGENCY REPRESENTATIVE	_____	☐	☐
BCBS REFERRING REPRESENTATIVE	_____	☐	☐
BCBS MANAGER	_____	☐	☐
BROKER	_____	☐	☐
ENROLLED BY USABLE REP	_____	☐	☐
	_____	☐	☐
	_____	☐	☐

BILLING CYCLE: (CHOOSE FROM DROP DOWN BOX)
MONTHLY

***NOTE: WHEN CHOOSING NINTHLY OR TENTHLY BILLING CYCLE PLEASE DESIGNATE WHICH MONTHS IN THE CALENDAR YEAR WILL NOT BE BILLED**

SPECIAL INSTRUCTIONS: _____

WHEN SUBMITTING A GROUP, A LISTING OF APPLICATIONS SUBMITTED IS REQUIRED. PLEASE SUBMIT IN A FORMAT SIMILAR TO BELOW.

Name First	MI	Last	Product Type	Date	Effective Date of Policy	Monthly Premium	Upgrade Change

REPRESENTATIVE SIGNATURE: _____

TOTAL APPLICATIONS SUBMITTED: _____ **TOTAL MONTHLY PREMIUM:** $ _____

AFFBUSTR

GROUP NAME _____ **GROUP NUMBER** _____ **DATE SUBMITTED:** _____ **Page** _____ **Of** _____

Name First MI Last	Product Type	Date	Effective Date of Policy	Monthly Premium	Upgrade Change

REPRESENTATIVE SIGNATURE: _____

TOTAL APPLICATIONS SUBMITTED: _____ **TOTAL MONTHLY PREMIUM:** $ _____

Attachment #7

USAble Life
Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200
1-800-648-0271
Fax (501) 399-3806

HOSPITAL CONFINEMENT INDEMNITY CLAIM FORM & INSTRUCTION PACKET

Dear Policyholder:

Thank you for choosing USAble Life to provide your Hospital Confinement Indemnity coverage. We have included these instructions and the necessary forms to assist you in the event you need to file a claim. Please remember that claims must be received within 90 days of the loss or date of confinement. You and your attending physician must complete the claim form. An Authorization for Release of Medical Records must be completed and returned along with the completed claim form. If faxing a claim, the original must also be mailed.

IMPORTANT NOTE: Losses resulting from motor vehicle accidents or homicide require a copy of the investigating officer's report. Incomplete claims cannot be processed and will be returned to you.

CLAIMS FOR MEDICAL EXPENSES

1. Complete the Insured Employee/Patient's Statement on page 2.
2. Obtain the Attending Physician's Statement – Medical Expenses found in this packet.
3. Obtain ITEMIZED bills from all medical providers.
4. Complete the Authorization for Release of Medical Records.
5. Mail the completed forms and ITEMIZED bills to USAble Life.

WELLNESS BENEFIT (If applicable to your policy.)

1. Please mail us an ITEMIZED bill for the covered test or service. Payment will be mailed to the address on the bill. Please make sure this address is correct. (Do not rely on your physician or hospital to file your claim.)
2. You do NOT need a claim form or an Authorization for Release of Medical Records to collect reimbursement for these benefits BUT the following information must be submitted:
    - Insured's name and Social Security number.
    - Policy Number (very important)
    - Patient's Name, Date of Birth and Social Security Number
    - Date of Service
    - You may write the above on the itemized bill for submission

For Questions or Assistance or to Submit Claim Forms and Itemized Bills:

By Mail:
USAble Life
Attention: Claims Department
PO Box 1650, Little Rock AR 72203-1650
Telephone: (501) 375-7200 or 1-800-648-0271
8:00 a.m. – 4:30 p.m. Central Time

By Fax:
USAble Life
Attention: Claims Department
(501) 399-3806

FRAUD WARNING: Except as noted in separate Fraud Notice, 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, and denial of insurance benefits in accordance with applicable state law.

USAble Life

Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (501) 375-7200
1-800-648-0271
Fax (501) 399-3806

Statement of Claim
Hospital Confinement Indemnity

For H.O. Use Only	
Eff.	
PTD	
Plan Code	
Issue Age	

How To File Your Claim:

1. **Please make sure all questions in the Insured Employee/Patient's Statement section are completed in full.**
2. **Authorization must be signed and currently dated.**
3. **Physician Statement on page 3 must be completed.**

Type of Claim: ☐ Inpatient Hospital ☐ Accident/Injury

Insured Employee/Patient's Statement

Employee's Name (Last, First, MI)	Employee's Birthdate	Employee's Social Security No.
Employee's Address (Street, City, State, Zip)		Employee's Daytime Telephone No.
Employer Name	Group Policy #	Current Employment Status ☐ Full-Time ☐ On Leave ☐ Retired ☐ Not Employed
Employer Address (Street, City, State, Zip)		If on leave, retired or not employed: Date Last Worked Mo Day Year
Patient's Name (Last, First MI)	Patient's Birthdate	Patient's Social Security No.
Patient is: ☐ Self ☐ Spouse ☐ Child ☐ Other:		Specify Relationship
If Patient is your child, is he living in your household? ☐ Yes ☐ No	(If no, specify with whom the child resides.)	
If patient is your child, is he a full-time student? ☐ Yes ☐ No	School Name	
Nature of Illness or Injury	Date of 1st Treatment	
Accident Date	Time (include a.m. or p.m.)	Place
How did the accident happen?		
Has the patient ever had same or similar condition? ☐ Yes ☐ No	If Yes, indicate date and describe	

Has patient had other medical attention in the past 5 years? ☐ Yes ☐ No

If Yes, Describe conditions, name doctors consulted, hospitals where treated, their addresses, and give dates seen. (Attach separate sheet if needed.)

_____

_____

Authorization to Obtain Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photostatic copy of this Authorization shall be as valid as the original. I acknowledge that I have a right to a copy of this authorization upon request."

FRAUD WARNING: Except as noted in separate Fraud Notice, 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, and denial of insurance benefits in accordance with applicable state law.

Date: _____ Signature of Patient _____

Parent/Guardian (if patient is a minor)

Please have your Attending Physician complete Page 3 and attach itemized copies of your bills.

ATTENDING PHYSICIAN'S STATEMENT – MEDICAL EXPENSES

Please Answer All Applicable Questions

Name of Patient	Date of Birth

Nature of Injury or illness (Include ICD Codes)	When Did it Occur

Date Patient First Consulted You	Date symptoms first appeared	Has Patient Ever Had Same of Similar Condition? ☐ No ☐ Yes If Yes, When: _____

If hospitalized, date _____ ☐ In Patient ☐ Outpatient

Hospital Name: _____

City, State _____

If loss of limb, was it through or above wrist or ankle Joint? ☐ Yes ☐ No

If loss of sight, is it permanent or irrecoverable? ☐ Yes ☐ No

If Yes, on what date did it become so? Date: _____

If No, what percentage of sight remains? _____

Was the loss of sight or dismemberment solely due to accidental bodily injury without other causes? ☐ Yes ☐ No

If No, Please explain:

Were any surgical procedures involved? ☐ Yes ☐ No Please Describe:	Date Performed

If loss due to burn, specify degree and size:

☐ First Degree
☐ Second Degree _____ Percentage of Body Surface Burned
☐ Third Degree _____ Square Inches of Body Surface Burned

If loss due to dislocation, complete separation? ☐ Yes ☐ No ☐ Open Reduction ☐ Closed Reduction

If loss due to fracture:

☐ Simple ☐ Compound ☐ Open Reduction ☐ Closed Reduction

If loss due to Laceration:

Total Length:

☐ Less than 5.08 cm
☐ 5.08 – 15.24 cm
☐ Greater than 15.24 cm

Type of Repair:

☐ Stitches ☐ Glue
☐ Staples ☐ Other

I certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Physician's Signature	**Date**

Physician's Name	**Degree**

Address	**Telephone ( )**	**Fax ( )**

City	**State**	**Zip**

FRAUD WARNING: Except as noted in separate Fraud Notice, 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, and denial of insurance benefits in accordance with applicable state law.

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.

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.