Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8416

Application for Extended Insurance Benefits
(Waiver of Premium)

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

(To Avoid Delay Please Answer All Questions)

EMPLOYER'S STATEMENT

Employee's Name	Policy/Certificate Number	Group Policy Number

Employee's Date of Hire	Employee's Effective Date of Ins.	Last Day Worked	Reason for Stopping Work	Returned to Work On

Occupation at Time of Disability	Employer's Fax Number

Employee Works:
Mon_____ Tue_____ Wed_____ Thurs_____ Fri_____ Sat_____ Sun_____

Hours Worked Per Day: ___________________

Employee's Annual Salary	Effective Date of Annual Salary

Briefly describe the general duties of the Employee's Occupation:

Does this job require any of the following?

	Yes	No	If yes, please specify how often it is required
Standing	☐	☐	_____ Hours _____% of the time require in an average 8 hour day
Sitting	☐	☐	_____ Hours _____% of the time require in an average 8 hour day
Walking	☐	☐	_____ Hours _____% of the time require in an average 8 hour day
Lifting	☐	☐	_____ Hours _____% of the time require in an average 8 hour day
Carrying	☐	☐	_____ Hours _____% of the time require in an average 8 hour day

Does this job require driving or business travel? ☐ Yes ☐ No

If yes; a) What is the average distance per day? ___________________

b) How often is travel required? ___________________________

How many pounds must he or she be able to lift? ______________ How Often? _____________

How often are the following required in an 8 hour day?
(Use the abbreviations R = Rarely O = Occasionally F = Frequently C = Continuously)

Bending _________ Reaching _________ Kneeling _________

Squatting ________ Climbing _________ Repetitive Tasks _________

What degree of dexterity is required? ☐ High ☐ Medium ☐ Low

Employer		Date
Signature	Title	E-mail Address
Name (Please Print or Type)		Telephone
Address		City, State, Zip

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EMPLOYEE'S STATEMENT

Full Name (Last, First)				Social Security Number
Address	City	State	Zip	Phone Number

Date of Birth	Sex ☐ Male ☐ Female	Occupation (List the duties of your occupation at the time of disability)
Height	Weight	

I have been unable to work because of this disability since Month ______ Day ______ Year ______	I returned to work on a part-time basis on Month ______ Day ______ Year ____	I returned to work on a full-time basis on Month ______ Day ______ Year ______
Date of your accident or the date you first noticed the symptoms of your illness Month ______ Day ______ Year ______	Is your accident or illness related to your occupation? ☐ Yes ☐ No	If yes, explain

Describe how and where accident occurred or describe the first symptoms of your illness:

Date you were first treated for your illness or injury Month ______ Day ______ Year ______	Treated by Hospital ____________ (Name, Address) Doctor ____________ (Name, Address)
Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, when? Month ______ Day ______ Year ______	Treated by Hospital ____________ (Name, Address) Doctor ____________ (Name, Address)

EDUCATIONAL BACKGROUND

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

☐ College ☐ Business ☐ Vocational

Other (specify) ____________

Degree(s) Received: ____________

Major Field(s) of Study: ____________

Were You in the Armed Forces? ☐ Yes ☐ No

Branch of Service: ____________ Highest Rank: ____________

WORK EXPERIENCE

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

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

Dates	Type of Work	Physical Requirements	Supervisory Experience, if any

Date: ____________ Employee's Signature: ____________

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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization must be fully completed as a condition of obtaining insurance coverage.

I hereby request and authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, other health care provider, healthcare clearinghouse, insurance company, reinsurer, the Medical Information Bureau ("MIB") or consumer reporting agency ("providers") that has provided payment, treatment or services to me and any member of my family who has applied for coverage ("family member"), or other person on whose behalf I am acting, to disclose the entire medical record and any other protected health information concerning me and any family member to USAble Life and its agents, employees, legal representatives, reinsurers, and the MIB. This includes information on the diagnosis of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information do not apply to this authorization, and I instruct any providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that USAble Life may: 1) underwrite an application for coverage; 2) make eligibility, risk rating, policy issuance and enrollment determinations; 3) obtain reinsurance; 4) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 5) administer coverage; and 6) conduct other legally permissible activities that relate to any coverage I or any family member, or other person whom I represent has or has applied for with USAble Life.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I or my family member, or other person whom I represent has the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Privacy Officer, USAble Life, PO Box 1650, Little Rock, AR 72203-1650, or to privacyofficer@usablelife.com. I understand that a revocation is not effective to the extent that any of the providers have relied on this authorization or to the extent that USAble Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the providers may not refuse to provide treatment if I refuse to sign this authorization. However, I further understand that if I refuse to sign this authorization to release complete medical records, USAble Life may deny my application or claim for benefits. I acknowledge that I have received a copy of this authorization.

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

Except as otherwise noted below, it is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

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

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

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

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

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

________________________________ ____________________

Applicant's Name (please print) Date

____

Applicant's Signature

Application for Extended Insurance Benefits

ATTENDING PHYSICIAN'S STATEMENT

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

Patient's Name:

1. DIAGNOSIS

(a) Diagnosis (including any complications): ______________________ ICD-9 Code(s) ______________

(b) Subjective symptoms:

(c) Objective findings (Including current X-rays, EKG's Laboratory Data and any clinical findings):

2. DATES OF TREATMENT

(a) Date of first visit ______________________

(b) Date of last visit______________________

(c) Frequency of visits______________________

3. NATURE OF TREATMENT
(Including surgery, medication, physical therapy, etc.)

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

(a) Are you aware of the main duties patient performs in his/her usual work or business? ☐ Yes ☐ No

(b) Are you aware of patient's background (education, training, experience, etc.)? ☐ Yes ☐ No

(c) Describe any restrictions (what patient SHOULD NOT do):

(d) Describe any limitations (what patient CANNOT do):

5. CARDIAC (If Applicable)

(a) Functional capacity (American Heart Ass'n).. ☐ Class 1 (No Limitations) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

(b) Blood Pressure (last visit).. ______________________
Systolic/Diastolic

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

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

(b) Remarks:

7. MENTAL/NERVOUS IMPAIRMENT (If applicable)

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

(b) Remarks:

8. PROGRESS

(a) Has patient: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
If recovered, date able to return to work______________________

(b) Is Patient: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

(c) Has patient been hospital confined? ☐ Yes ☐ No Admitted______________
If yes, give name and Address of Hospital ______________________ Discharged ______________

(d) Do you expect any significant improvement in the future? ☐ Yes ☐ No

1. If yes, when will patient recover sufficiently to perform the duties of:
   a) Patient's regular occupation: ______________ or ☐ 1 Month ☐ 1 –3 Months ☐ 3 – 6 Months ☐ Never
   b) Any other type of work: ______________ or ☐ 1 Month ☐ 1 –3 Months ☐ 3 – 6 Months ☐ Never
2. If No, please explain: ______________________

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

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Retain for your records.