USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

CANCER APPLICATION & CHANGE FORM

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

☐ New Business ☐ Change Form ☐ Replace USAble Policy No. _____ ❑ Policy Lost ❑ Policy Attached

SECTION 1 - APPLICANT INFORMATION

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

SECTION 2 – SPOUSE & CHILDREN INFORMATION

Person Proposed for Insurance Show first, middle, last name	Relationship	Date of birth mo.	day	yr.	Birth State or Country	Marital Status	Age	Sex
a.								
b.								
c.								
d.								
e.								

SECTION 3 – PLAN SELECTION ■ New Applicant ■ Application for Change

I hereby apply for the following coverage: ☐ Applicant ☐ Applicant & Children ☐ Applicant, Spouse & Children

CEP Policy

☐ Plan I – ($100 Hosp. Confinement, $5,000 Radiation/Chemo/Blood, $1,000 Surgical/Anesthesia, and Specified Disease Benefit)

☐ Plan II - ($250 Hosp. Confinement, $10,000 Radiation/Chemo/Blood, $2,000 Surgical/Anesthesia, and Specified Disease Benefit)

☐ Plan III - ($300 Hosp. Confinement, $15,000 Radiation/Chemo/Blood, $4,000 Surgical/Anesthesia, and Specified Disease Benefit)

Add Delete Elective Rider(s):

☐ ☐ $_____ Cancer Diagnosis Rider

☐ ☐ $_____ Monthly Disability Rider:
Spouse Coverage ☐ Yes ☐ No

Total Monthly Premium: $ _____

1. Is every person to be insured covered by a Health Plan? ☐ Yes ☐ No **If "No", this policy will not be issued.**
2. REPLACEMENT: Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____
3. Is any person to be insured currently covered under any other specified disease policy that is not going to be replaced? ☐ Yes ☐ No Does anyone have specified disease applications pending with this or any other company? ☐ Yes ☐ No If "yes" to either question, provide the following: Number of policies in force? _____ Number of applications pending? _____
4. OUTLINE: Have you received the Outline of Coverage and Disclosure Statement? ☐ 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" 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. 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 Medical Information Bureau 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 state no person to be insured is covered by any Title XIX program – Medicaid or any similar name. **Caution: If your answers are incorrect or untrue, USAble Life has the right to deny benefits or rescind your policy.**

Be sure to complete the 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

NOTIFICATION FOR THE PROPOSED INSURED— Please read carefully and detach for your records.

INSURANCE FRAUD WARNING. Any person who knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

Notice of Insurance Information Practices - In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

USAble Life
Little Rock, Arkansas

Name (First, MI, Last)	Social Security #	Employer

CANCER MONTHLY PREMIUM(S)

	Individual	1 Parent Family	Full Family
Policy Benefits:			
Plan I	$12.70	$15.60	$23.46
Plan II	18.14	22.12	33.54
Plan III	21.72	26.62	42.74
Monthly Disability Rider for 1 year:			
$250	$1.20	$1.20	$2.16
$500	2.40	2.40	4.32

	Individual	1 Parent Family	Full Family
Cancer Diagnosis Rider:			
$1,000	$0.84	$1.02	$1.56
$2,000	1.68	2.04	3.12
$3,000	2.52	3.06	4.68
$4,000	3.36	4.08	6.24
$5,000	4.20	5.10	7.80

SECTION 4 – MEDICAL INFORMATION

	Yes	No
1. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: cancer or any malignancy, which includes carcinoma; sarcoma; Hodgkins Disease; leukemia; lymphoma; or malignant tumor? If "Yes," list person(s), and condition(s): Person(s)_____ Condition(s)_____	☐	☐
2. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: Addison's Disease, Brucellosis, Budd-Chiari Syndrome, Cystic Fibrosis, Diphtheria, Encephalitis, Histoplasmosis, Legionnaires' Disease, Lou Gehrig's Disease, Malaria, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Osteomyelitis, Poliomyelitis, Q-Fever, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Spinal Meningitis, Systemic Lupus Erythematosus, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Trichinosis, Tuberculosis, Tularemia, Typhoid Fever, Whooping Cough? If "Yes," list person(s), and condition(s): Person(s)_____ Condition(s)_____	☐	☐
3. Has any person to be insured ever been diagnosed or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or the Human Immunodeficiency Virus (HIV)? If "Yes," list person(s), and condition(s): Person(s)_____ Condition(s)_____	☐	☐

The person(s) named above in questions 1, 2, or 3 may be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy issuance.

4. Name, address, and phone number of your personal physician(s):

_____

_____

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.

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MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

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

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Braintree, Massachusetts 02184-8734. USAble Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

FEDERAL FAIR CREDIT REPORTING ACT NOTICE

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.