USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

Life Application

Office Use Only	
Policy #	
Eff Date	
Group #	
Dept./Loc	

A. Proposed Insured

Primary ☐ Employee ☐ Spouse ☐ Child

Insured's Name (First, MI, Last)				Sex	Social Security #
Date of Birth	Age	Birth State/Country	Height	Weight	Occupation

If over age 17, have you used any tobacco products within the past 12 months? ☐ Yes ☐ No
If, Yes, list tobacco products used:

If the Policyowner is other than Employee, indicate Owner and relationship to Insured*

**** The Employee will be the owner unless otherwise specified above.***

B. Residence

Street	City	State	Zip Code	Phone No.

C. Employer Information

1. Employer	Employment Date	Base Annual Salary

2. Is the Employee/Applicant actively at work on the date of this application and has he / she been actively at work for the 31 days prior to such date? Employee/Applicant ☐ Yes ☐ No Spouse ☐ Yes ☐ No
If "No", give full details.

3. Employee's Name (if other than Primary Insured):	Social Security #

D. Plan Selection

Complete Benefits, Amount Applied For, and Monthly Premium
Term Life coverage available in $20,000 increments beginning with $20,000 to a total maximum of $300,000 per person.
Whole Life coverage available beginning with $5,000 to a total maximum of $300,000 per person.
Total Life coverage available is maximum $300,000 per person.

1. Does any person to be insured have any existing life insurance policies or annuity contracts? ☐ Yes ☐ No
If Yes, the ***Important Notice Regarding Replacement of Life Insurance*** must be completed.

2. Base Policy Plan (Choose One)	Amount Applied for	Monthly Premium
☐ Whole Life ☐ 15 Year Term ☐ 30 Year Term ☐ 10 Year Term ☐ 20 Year Term ☐ Term to 80	$ _____	$ _____

3. Whole Life Only: Automatic Premium Loan Provision will be included unless this box is checked. ☐ No

4. Optional Benefits With Whole Life or Term Life

☐ Accidental Death Rider		Amount Applied for same as Base Policy	$ _____
☐ Family Term Rider Or ☐ Children Term Rider (1 unit = $2,000 on each child)	***Complete Section E if applying for one of these riders***	_____ Unit(s) Maximum of 5	_____

5. Optional Benefit With Whole Life Only

Term Life Rider

☐ 10 Year Term ☐ 20 Year Term ☐ 15 Year Term ☐ 30 Year Term	☐ Term to 80	$ _____	$ _____

6. Optional Benefit With Term Life Only

☐ Return of Premium Rider (Available with 15, 20 and 30 Year Term policy)	$ _____
TOTAL EMPLOYEE POLICY PREMIUM	$ _____

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

E. Spouse and/or Children (Complete only if applying for Family Term or Children Term Rider)

Full Name (First, MI, Last)	Relationship	Date of Birth mo.	day	yr.	Sex	Birth State or Country	Height	Weight
a.								
b.								
c.								
d.								
e.								

F. Beneficiary

Name	Relationship	Date of Birth	Primary or Secondary	Indicate % Distribution Primary	Secondary
			☐ Primary		
			☐ Primary or ☐ Secondary		
			☐ Primary or ☐ Secondary		
			Total (Primary and Secondary Distribution Must Each Total 100%)		

G. General Information – All Insureds	**Yes**	**No**
1. Has anyone to be insured :		
a. In the past 12 months been hospitalized or treated by a member of the medical profession, including medication, because of sickness or injury (excluding pregnancy, colds, flu, allergies, and back problems)?	☐	☐
b. Had a blood pressure reading in the past 2 years of greater than 150 over 100? (If yes, list medications taken, medication dosage, and two current blood pressure readings with dates in Additional Data section.)	☐	☐
c. Been hospitalized for any reason during the past 5 years?	☐	☐

2. Has anyone to be insured ever been diagnosed or treated by a member of the medical profession for any of the following (If Yes, give details in Additional Data Section):

	Yes	No		Yes	No
a. Disease of the heart, blood vessels, or stroke?	☐	☐	f. Chronic hepatitis?	☐	☐
b. Lung, liver, pancreas, or blood disorder?	☐	☐	g. Disease of the nervous system including epilepsy, myasthenia gravis, paralysis, multiple sclerosis, or Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)?	☐	☐
c. Cancer, leukemia or any cancer related disease?	☐	☐	h. Systemic Lupus Erythematosus Disease (SLE)?	☐	☐
d. Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	☐	☐	i. Asthma, emphysema, chronic obstructive pulmonary disease (COPD)?	☐	☐
e. Kidney disease, genitourinary disease or disorder, insulin-dependent diabetes, or diabetes diagnosed prior to age 40?	☐	☐	j. Manic depressive disorder (bipolar) or schizophrenia?	☐	☐
			k. Gastrointestinal or digestive disease disorder?	☐	☐
			l. Skin, bone, muscle or joint disorder?	☐	☐

3. Within the past 5 years, had any disease, disorder, operation or injury other than as stated above?	☐	☐
4. In the past 5 years, been treated for alcoholism or drug abuse?	☐	☐
5. In the past 2 years, been put on probation or convicted of: a felony; a misdemeanor; driving under the influence (DUI); or driving while intoxicated (DWI)?	☐	☐
6. Have either your parents, brothers, or sisters been diagnosed or treated for cancer, heart trouble, stroke, or diabetes? If "yes", list relative, disorder, age of onset, and age at death in the Additional Data Section.	☐	☐
7. Within the past 24 months, have you engaged in hang gliding, mountain climbing, flying ultralights, parachuting, sky diving ballooning, or scuba diving to depths of more than 75 feet? If yes, provide details in the Additional Data Section.	☐	☐
8. Within the past 24 months, have you flown as a student pilot or private pilot; engaged in auto, motorcycle, or boat racing; or participated in any similar sport or avocation? If, yes, provide: Type of avocation _____ Number of times per year_____ Number of hours per year_____	☐	☐

9. Primary Physician's Name: _____ Address: _____

City, State, Zip: Phone #

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

Additional Data: Give details to any "Yes" answers to Questions 1 through 7.

Item#	Person	Diagnosis	Date/Duration	Treatment/Result	Name & Address of Physician and/or Hospital

H. Agreement Section

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 read and understood the "Important Note" on page 3 of this application; (c) authorize any physician, medical; practitioner, hospital, clinic, or other medical 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 date the authorization is signed; (f) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (g) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

Insurance Fraud Warning – It is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Signed at _____ (City) _____ (State) on _____ (Month Day Year)

X _____ (Signature of Proposed Insured) X _____ (Signature of Applicant, Owner, if other than Proposed Insured)

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; and (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. I understand that my policy will be dated and become effective on the first day of the month following the 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.

I. Agent's Statement

To the best of your knowledge, does any person to be insured have any existing life insurance policies or annuity contracts?
☐ Yes ☐ No If Yes, the ***Important Notice Regarding Replacement of Life Insurance*** must be completed.

I have explained to any person to be insured(s) all exceptions and limitations pertaining to the coverage(s) applied for. I hereby certify that I know nothing affecting the insurability of any person to be insured(s), which is not fully set forth as requested in this application. I have not made, not agreed to make, any rebate for insurance. I further certify that I am a licensed agent in the state where this application is taken. I have truly and accurately recorded the information supplied by the applicant.

Agent	Code No.	Date	Agency	Phone Number