USAble Life
Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8417
Email: claims@usablelife.com

Name & Address

DISABILITY UPDATE FORM
INSURED'S STATEMENT

IMPORTANT READ CAREFULLY

1. **Please answer ALL questions on Insured's Statement.**
2. **Authorization and Fraud Notice must be currently signed and dated.**
3. **Have your physician complete the Attending Physician's Statement.**
4. **This form is to be completed without expense to USAble Life, and returned by: _____ to avoid interruption of your disability benefits.**

IMPORTANT NOTE:

	Claim Number:
	Policy Number:
	Home or Daytime Phone Number:

1. Describe conditions AND symptoms currently causing disability. If pregnancy, indicate delivery date and/or estimated delivery date.	
2. Have you received medical attention since your last report?	☐ Yes ☐ No If "Yes", please list: a) Names of Doctors: b) Dates of Treatment:
3. Have you been hospitalized or undergone surgery since your last report?	☐ Yes ☐ No If "Yes", please list: a) Name of Hospital: b) Dates of Confinement: c) Type of Surgery:
4. Briefly describe your present daily activities.	
5. Are you still totally disabled? (Unable to perform any of the duties of your regular occupation)	☐ Yes When do you expect to return to your regular occupation? Month _____ Day _____ Year _____ ☐ No When were you able to return to your regular occupation? Month _____ Day _____ Year _____
6. If not totally disabled, are you partially disabled? (Able to perform only part of the duties of your regular occupation)	☐ Yes ☐ No If "Yes": a) When did you begin partial disability employment? Month _____ Day _____ Year ____ b) What important occupational duties have you been unable to perform during partial disability?
7. Are you now gainfully employed in other than your regular occupation?	☐ Yes ☐ No If "Yes": a) When did such employment begin? Month _____ Day _____ Year ____ b) Briefly describe the job and nature of duties performed:

8. Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability

Your Social Security: (disability or retirement)	☐ Yes ☐ No $_____ Mo.	V.A. Benefits:	☐ Yes ☐ No $_____ Mo.
Dependent Social Security:	☐ Yes ☐ No $_____ Mo.	Worker's Compensation:	☐ Yes ☐ No $_____ Wk.
Sick Leave or Wage Continuation:	☐ Yes ☐ No $_____ Wk.	Other Disability Coverage:	☐ Yes ☐ No $_____ Wk.
Retirement: (normal, early or disability)	☐ Yes ☐ No $_____ Mo.	(identify) _____	
State Disability Income:	☐ Yes ☐ No $_____ Wk.	Include a copy of your award or denial letter for any source in which one has been received.	
Unemployment:	☐ Yes ☐ No $_____ Wk.		

Please have your attending physician complete the Attending Physician's Statement.

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FRAUD NOTICE

AZ Residents Only: Upon written request, we will provide you with information regarding the benefits and provisions of the annuity contract for which you are applying. If you are not satisfied with this contract, you may return it within 10 days, or 30 days if the owner is age 65 or over, after the date you receive it. Any premium paid will be refunded without interest.

AR, LA, NM, and OK Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, submits an application for insurance containing any materially false, incomplete, or misleading information, or conceals for the purpose of misleading, any material fact, is guilty of insurance fraud, which is a crime in certain states, a felony. Penalties may include imprisonment.

CA Residents Only: § 789.8 The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties. You or your agent may wish to consult independent legal or financial advice before selling or liquidating any assets prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

District of Columbia Residents Only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL Residents Only: 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.

KY and PA Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MD Residents Only: "Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

ME and TN Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

OH Residents Only: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Rhode Island Residents Only: 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 is guilty of a crime and may be subject to fines and confinement in prison."

VA Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WA Residents Only: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

_____ _____

Date Signature

USAble Life

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Authorization to Disclose, Obtain and Use Personal Information

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the Medical Information Bureau, benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

I have executed this authorization intending that it will be effective on and after

_____
(Date)

_____ _____
Signature Printed Name

Return original with your claim & retain a copy of this authorization and claim form for your records.

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ATTENDING PHYSICIAN'S STATEMENT

Must be completed IN FULL by physician

Patient's Name:	Patient's Date of Birth:

1. DIAGNOSIS
   a) Diagnosis (including any complications):_____ ICD-9 Code(s) _____
   b) If pregnancy, indicate delivery date _____ ☐ Actual ☐ Estimated
   c) Subjective Symptoms:
   d) Objective findings (include current x-rays, EKGs, laboratory data and any clinical findings):

2. DATES OF TREATMENT
   a) Date of first visit _____ c) Date of Next visit _____
   b) Date of most recent visit _____ d) Frequency of visits _____

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

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 Association) ☐ 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 capability; capable of clerical/administrative (sedentary*) activity (60-70%)
   ☐ Class 5 - Severe limitation of functional capability; 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:
   c) Do you believe patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

8. PROGRESS
   a) Has patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed If recovered, date able to return to work_____
   b) Is patient: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined
   c) Has Patient been hospital confined since last report? ☐ Yes ☐ No Admitted _____
   If Yes, Name & 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
      Date if known
      b) Any other type of work: _____ or ☐ 1 Month ☐ 1–3 Months ☐ 3–6 Months ☐ Never
      Date if known
   2. If no, please explain: _____
   e) Do you support candidacy for Social Security Benefits? ☐ Yes ☐ No

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

FRAUD WARNING: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act.