**USAble Life**
P.O. Box 1650 • Little Rock, Arkansas 72203

**EVIDENCE OF INSURABILITY (Please Print)**
*A completed Enrollment Form must accompany this form.*

**SECTION 1 Completed By Employer**

| Group Name | Date of Hire | Telephone # (include area code) | Group Number |
|---|---|---|---|
| | | | |

Amount of Insurance Applying for:
Employee Life: $ Dependent Life $ Disability $ Other:

Employee's Annual Salary

**SECTION 2 Completed by Employee** ☐ **Vol. Group Term Life** ☐ **Amount over Guarantee Issue** ☐ **Late Enrollee**

| Name (First, MI, Last) | | | Social Security No. | |
|---|---|---|---|---|
| Home Address | City | State | Zip | County |
| | | | | |

| Date of Birth | Birth State or Country | Gender ☐ M ☐ F | Height (ft-in.) | Weight (lbs.) | Work Phone | Home Phone |
|---|---|---|---|---|---|---|
| | | | | | | |

**Spouse & Children Information** – Complete if Applying for Dependent's Coverage.

| Person Proposed for Insurance Show first, middle, last name | Occupation | Date of Birth & Place | | | | Height | Weight | Marital Status | Sex |
|---|---|---|---|---|---|---|---|---|---|
| | | Month | Day | Year | State or Country | | | | |
| (Spouse) | | | | | | | | | |
| (Child) | | | | | | | | | |
| (Child) | | | | | | | | | |
| (Child) | | | | | | | | | |
| (Child) | | | | | | | | | |

Spouse's Social Security No.: Spouse's Work Telephone #:

**SECTION 3 Insurability Questionnaire**

| | Yes | No |
|---|---|---|
| 1. Has anyone to be covered used any tobacco products in the past year? | ☐ | ☐ |
| 2. Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised? | ☐ | ☐ |
| 3. Has anyone to be covered been hospitalized for any reason during the past five (5) years? | ☐ | ☐ |
| 4. Has anyone to be covered consulted a physician in the past one (1) year for any reason? | ☐ | ☐ |

5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| a. Cancer, cancer related disease or benign tumor? | ☐ | ☐ | f. Emotional, nervous system, eating disorder, or mental health problems? | ☐ | ☐ |
| b. Disease of the heart or blood vessels, or had a stroke? | ☐ | ☐ | g. Ulcer, stomach or digestive disorder? | ☐ | ☐ |
| c. Kidney disease or diabetes? | ☐ | ☐ | h. Arthritis, back, bones or joint disorder? | ☐ | ☐ |
| d. Alcohol or drug abuse? | ☐ | ☐ | i. Bladder, urinary system or reproductive organs disorder? | ☐ | ☐ |
| e. Lung, asthma, liver or blood disorder? | ☐ | ☐ | | | |

| | | |
|---|---|---|
| 6. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")? | ☐ | ☐ |
| 7. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4. | ☐ | ☐ |
| 8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4. | ☐ | ☐ |
| 9. Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8? | ☐ | ☐ |
| 10a. Are you now pregnant? ☐ Yes ☐ No<br>10b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section? | ☐ | ☐ |
| 11. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If No, give full details in Section 4. | ☐ | ☐ |

12. Names, addresses, and phone numbers of the personal physicians of all applicants:

_____

**SECTION 4 Give Details to "Yes" answers to questions 2 through 10 include dates of treatment:** ☐ **Separate Sheet Attached**

| Ques. No.& Individual | Illness/Reason for Checkup or Medication & Dosage or Doctor's Treatment/Consultation | Date & Duration | Full Name, Complete Address and Telephone Number of Doctors & Hospitals |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Be Sure to Read the Important Disclosures and sign on Page 2/Reverse**

| Employee's Name (First, MI, Last) | Social Security # | Employer Name |
|---|---|---|
| | | |

# NOTICE FOR PROPOSED INSURED

## IMPORTANT NOTICE FOR DISABILITY COVERAGE

Acceptance of your application for disability income insurance will be based upon the information contained in the Evidence of Insurability, including the medical information disclosed and information obtained from your medical providers. **Your insurance coverage may not be issued as applied for.** If not, an "Exclusion of Coverage Amendment" will be attached to your certificate of coverage.

**PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT.**

## IMPORTANT NOTICE CONCERNING YOUR EFFECTIVE DATE

1. Insurance will not be effective until the application is approved by USAble Life.
2. Insurance will not be effective if there has been a change in the health of the proposed insured(s) after the date of the application and prior to the effective date.
3. For benefits sheltered under a Section 125 Cafeteria plan: To satisfy premium deduction requirements of your employer and dating requirements of the Section 125 Plan, your coverage will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) of the Section 125 agreement 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.

In signing below, I: (a) represent that the statements and answers given in this application, are true, complete and correctly recorded; (b) understand that the insurance applied for is not effective until the application is approved by USAble Life; (c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medical facility, insurance or reinsurance company, or MIB, Inc., formerly known as 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; (e) 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; (f) agree that this authorization shall be valid for two (2) years from the date the authorization is signed; (g) 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; (h) acknowledge I have read and understand all disclosures on this form; and (i) acknowledge receipt of written notification describing the use of the MIB as required by the Fair Credit Reporting Act and the Notice of Information Practices. I have read and understand the above statements and agreements.

**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: _____ Date of Application _____

City and State — Month, Day, Year

X _____ X _____

Agent's Signature — Employee's Signature

**Date Received Home Office**