

**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 Y O P Q				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 <input type="checkbox"/> Vol. Group Term Life <input type="checkbox"/> Amount over Guarantee Issue <input type="checkbox"/> Late Enrollee											
Name (First, MI, Last)							Social Security No.				
Home Address				City		State	Zip	County			
Date of Birth	Birth State or Country	Gender <input type="checkbox"/> M <input type="checkbox"/> 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?										<input type="checkbox"/>	<input type="checkbox"/>
2. Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised?										<input type="checkbox"/>	<input type="checkbox"/>
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years?										<input type="checkbox"/>	<input type="checkbox"/>
4. Has anyone to be covered consulted a physician in the past one (1) year for any reason?										<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/> <input type="checkbox"/>		f. Emotional, nervous system, eating disorder, or mental health problems?				<input type="checkbox"/> <input type="checkbox"/>			
b. Disease of the heart or blood vessels, or had a stroke?		<input type="checkbox"/> <input type="checkbox"/>		g. Ulcer, stomach or digestive disorder?				<input type="checkbox"/> <input type="checkbox"/>			
c. Kidney disease or diabetes?		<input type="checkbox"/> <input type="checkbox"/>		h. Arthritis, back, bones or joint disorder?				<input type="checkbox"/> <input type="checkbox"/>			
d. Alcohol or drug abuse?		<input type="checkbox"/> <input type="checkbox"/>		i. Bladder, urinary system or reproductive organs disorder?				<input type="checkbox"/> <input type="checkbox"/>			
e. Lung, asthma, liver or blood disorder?		<input type="checkbox"/> <input type="checkbox"/>									
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")?										<input type="checkbox"/>	<input type="checkbox"/>
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.										<input type="checkbox"/>	<input type="checkbox"/>
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4.										<input type="checkbox"/>	<input type="checkbox"/>
9. Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8?										<input type="checkbox"/>	<input type="checkbox"/>
10a. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		10b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?								<input type="checkbox"/>	<input type="checkbox"/>
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.										<input type="checkbox"/>	<input type="checkbox"/>
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: <input type="checkbox"/> 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
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## 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/Producer's Signature	Employee's Signature

**Date Received Home Office**