USAble Lifesm

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 $ Short Term Disability $ Long Term Disability $

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	Height (ft-in.)	Weight (lbs.)	Work Phone	Home Phone
		☐ M ☐ F			( )	( )

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 (including vaping and e-cigarettes) in the past year?	☐	☐
2. Does anyone to be covered have any medical condition for which they consulted with a licensed member of the medical profession or for which treatment by a licensed member of the medical profession 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 with a licensed member of the medical profession in the past one (1) year for any reason?	☐	☐

5. Has anyone to be covered ever been diagnosed or treated by a licensed 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 tested positive for exposure to the Human Immunodeficiency Virus ("HIV") infection or been diagnosed by a licensed member of the medical profession as having Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐
7. Within the past ten (10) years, has anyone to be covered been diagnosed or treated by a licensed 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. Within the past ten (10) years, has anyone to be covered been diagnosed or treated by a licensed member of the medical profession for any diseases or illnesses, except HIV, not covered in questions 2 – 8?	☐	☐
10a. Are you now pregnant, as diagnosed by a licensed medical professional? ☐ Yes ☐ No 10b. Within the past five (5) years, have you been diagnosed or treated by a licensed member of the medical profession for 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:

_____

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

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

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

Doesn't apply to Question 6

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.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In signing below, I authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc., and any consumer reporting agency to release any information regarding me or my past or present health to USAble Life, its reinsurers and legal representatives for the purpose of evaluating this Enrollment Form for insurance. Information subject to this authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities, driving record; age; occupation; income; and my use of alcohol, drugs, and tobacco. This information will be used to determine eligibility for insurance. This authorization does not authorize the release of genetic screening or testing results. Information will not be shared with any non-affiliated third party except as permitted under Florida law.

I also authorize USAble Life or its reinsurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance. I authorize USAble Life, its reinsurers, and its legal representatives to make a brief report of my/our personal health information to MIB, Inc. All sources except MIB, Inc. may give these facts to any insurance support organization authorized by USAble Life to collect and transmit them.

This authorization shall remain valid for a period of two years from the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to USAble Life.

I understand that this authorization may be revoked at any time. Such revocation must be in writing, and will not be effective until USAble Life and the provider of the information receive it. My revocation will not be effective with respect to disclosures made by a covered entity in reliance on this authorization before it was revoked.

Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

I understand that statements contained in this application for insurance shall, in the absence of fraud, be deemed representations and not warranties. I understand that the insurance being applied for, if issued, shall be based on these statements. I understand that any insurance will not take effect unless and until USAble Life approves this request for coverage and according to the provisions of the insurance contract. If coverage is not issued as requested, I authorize USAble Life to issue reduced benefits and adjust premiums to match the coverage issued. I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am requesting allows for alternate methods to pay insurance premiums).

I have read and understand this form in its entirety and the notices, authorizations, and certifications contained within.

Insurance Fraud Warning – Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signed at: _____ Date of Application _____

City and State — Month, Day, Year

X _____ X _____

Agent's Signature — Applicant's Signature

_____ X _____

Agent's Printed Name — Spouse's Signature

_____

Agent's FL License Identification Number

Date Received Home Office

EOI18-FL (4-17)