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## ACCIDENT POLICY APPLICATION & CHANGE FORM

Office Use Only						
Policy Number						
Group Number						
Effective Date						
Dept./Loc.						
Class						

P.O. Box 1650 Little Rock, Arkansas 72203

Agent Name/Number		New Appl	ication			Change	e Form		Class					
	☐ Re	einstateme	nt Polic	y #	‡		F	Repla	ices Pol	icy #				
SECTION 1 PERSONAL	IDENTIF	ICATION												
Name (First, MI, Last)	F	For Name Change, Give Prior Last Name Social Security No.												
Home Address				C	City		State Zip		County					
Date of Birth	Age	Birth State	or Countr	ry		Male Female	Work Ph	none		Home Phone				
Type of Business					Applicant's ema				nail addre	ail address (if any)				
Name of Employer			D	Date Employed Full-Time			Occupation				Hours Worked Weekly			
DEPENDENT INFORMATI	ON - Coi	mplete if A	Applyin	ıg 1	for Depen	dent's C	Coverag	e.						
									Date o	of Birth		Rint	h State	
Full Name (First,	MI, Last)			F	Relationship		Sex		o. Da	ay Yr.		or Country		
SECTION 2 PLAN SELEC	CTION				■ New A	pplicar	it		Applio	cation	for Cha	nge		
CHECK COVERAGE DESI	RED:													
Applicant	] Applica	int & Spou	se		☐ Appl	icant &	Children		□ A	pplican	t, Spou	se &	Children	
Applying for Accident Policy Plan:  Basic (3 units of Modules 1, 3, 5, 6 and 7 and 4 units of Modules 2, 4, and 8)  Select (4 units of all Modules)  Ultra (4 units of Module 6, 5 units of Module 8, and 6 units of all other Modules)														
Optional Accidental Disabilit	y Rider*:													
☐ Off-The Job or ☐ 24-Hour ☐ \$400 ☐ \$600 ☐ \$800 \$						\$								
Optional Sickness Disabi	lity Rider	*	\$400		□ \$6	00				\$				
					TOTA	L MON	THLY P	REM	IUM	\$				
Industry Class		Class A			3	Class		C	С		Clas		s D	
Monthly Premiums	3	Basic	Selec	ct	Ultra	Basic	Sele	ct	Ultra	Bas	ic Se	lect	Ultra	
Applicant		\$15.80	\$19.3		\$27.88	\$23.36	\$28.6	34	\$41.32	\$27.8	30 \$3	4.08	\$49.12	
Applicant & Spouse		22.48	27.52		39.68	29.88			52.80	33.9		.60	60.00	
Applicant & Children		26.28	32.16		46.40	30.28			53.52	34.2		.92	60.44	
Applicant, Spouse & Childre	en <u> </u>	32.96	40.32		58.20	36.80	45.1		65.00	40.3		.44	71.32	
Optional Rider(s) Off-The-Job		-Job	b 24-Hour		Off-Th	ne-Job	24	24-Hour		Off-The-Job		24-Hour		
Accident Disability Rider*:		_			<b>#5.50</b>			<b>C47.00</b>		N1/2		N 1 / A		
\$400 \$3.12			\$8.40		\$5.52			\$17.92		N/A		N/A		
\$600 4.68				12.60			8.28		6.88	N/A		+	N/A	
\$800 6.24					16.80	11	11.04 35.84			N/A N/A				
Sickness Disability Rider* Class \$400 \$7.4					)				<b>Class C</b> \$8.08			Class D N/A		
\$600			11.10				ან.0 12.1			+		1/A 1/A		
*Coverage applies to prim	arv insu	red only.	11.10	<u> </u>			12.1			1	'	<b>1</b> / / \		

Employee's Name (Last, First, M.I.)			So	ocial Security #	Employer							
SE	CTION 3 PERSONAL INFORMATION (Only Com	nplete If	laaA	vina	for ANY Disability Rider.)							
						Yes	No					
1.	Do you have other short-term disability coverage? salary. Weekly Benefit Weekly Sa			ekly								
2.	2. Within the past three years, have you been the driver in a motor vehicle accident or charged with a moving violation, including driving under the influence of drugs or alcohol? Has your driver's license ever been suspended?											
3.	Are you currently disabled?											
	Answer questions 4 through 7 if applying for Sickness Disability Rider.											
4. Have you 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)	Lung, Liver or Blood Disorder? Emotional, Nervous System							
	(b) Disease of the Heart or Blood Vessels, or had a Stroke?			(9)	(including Muscular Dystrophy Multiple Sclerosis), Eating Disc							
	(c) Kidney Disease or Diabetes?			4. \	or Mental Health Problems?							
	(d) Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or			(h)	Ulcer, Stomach or Digestive Disorder?							
	Human Immunodeficiency Virus ("HIV")?			(i)	Arthritis, Bones or Joint Disorde	er?						
	(e) Alcohol or Drug Abuse?	Ш	Ш	(j)	Bladder, Urinary System or Reproductive Organs Disorder	?						
	pressure)?  Yes No If "Yes," list person(s), medications taken, medication dosage and last two blood pressure readings.  Medication, Dosage, Readings with Dates:											
6.	Are you currently pregnant?  Yes No H	lave vou	ever	had	a problem pregnancy?  Yes	□ No						
7.	Primary Physician's Name:	•			Address:							
	<u> </u>	City, State, Zip:										
	Give details for "yes" answers to an	y questi	ions a	and i	indicate to whom answers rela	nte.						

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Employee's Name (Last, First, M.I.)	Social Sec	curity #	Employer						
SECTION 4 BENEFICIARY ■ Na	ame Benefic	ciary ■ Cha	ange of Beneficiary						
I hereby revoke the appointment of any existing	g beneficiary	and designate t	he following beneficiary (	under thi	s policy.				
Name	Birthdate	Relationship	Primary or Second	ary	Indicate Percentage				
			☐ Primary or ☐ Sec	condary					
			☐ Primary or ☐ Sec	condary					
SECTION 5 AUTHORIZATION									
<ol> <li>Is this insurance to replace or change other name of company.</li> </ol>	r insurance?	☐ Yes ☐ 1	No If "Yes", give details	includin	g				
2. Have you received the Outline of Coverage	(in those sta	ates where requi	ired by law)?	No (cho	eck one)				
In signing below, I (a) represent that the statements correctly recorded; (b) authorize USAble Life or its (c) authorize any physician, medical practitioner, he company, or Medical Information Bureau, Inc. having applied for coverage on this application) regarding activities, character, general reputation, finances, an any and all such information to use for underwriting in knowledge to any agency employed by the compassibmission; (e) agree that this authorization shall be of this authorization shall be as valid as the original request; (g) acknowledge receipt of written notification Fair Credit Reporting Act and the Information Praction necessary payroll deductions to pay for my insurance condition may void the policy.	reinsurer to rospital, clinic ing information gour mental and vocation to insurance; (d) any to collect evalid for two and I underson describing ces Notice. I	make a brief rep c, or other medic on on me or any all and physical had give to USAble authorize all sai at and transmit so (2) years from to stand that a copy of the use of the Manapplying for in-	poort of my personal healt cally related facility, insured member of my family (health, other insurance explicitly be Life, its reinsurers, or its id sources, except MIB, to such information in order the application date; (f) again is available to me or my Medical Information Bure issurance, I authorize my explicitly insurance, I authorize my explicitly insurance.	th information in inf	ation to MIB; reinsurance se who have e, hazardous epresentative ch records or tate its rapid a photocopy entative upon quired by the r to make the				
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 primary insured; (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.									
Insurance Fraud Warning – It is or may be a crim insurance company for the purpose of defrauding the and denial of insurance benefits in accordance with	the company	or other person	•	•					
I have read and understand the above statements an	nd agreement	ts.							
X Applicant's Signature	Sig	igned at:							
			(City and State	:)					
<b>Agent's Statement:</b> I have accurately recorded the information supplied by the applicant.		te of Application							
V		(Month, Day, Year)							
XAgent's Signature									
			Date Rec	ceived Hor	me Office				