Please Print Using Dark Ink

P.O. Box 1650
Little Rock, Arkansas 72203

ACCIDENT ELITE PLAN APPLICATION

SECTION 1 – ARE YOU ELIGIBLE FOR COVERAGE?	
A. Are you a US citizen?	☐ Yes ☐ No
B. Have you been issued a permanent residency VISA and lived continuously in the US for the last 6 months?	☐ Yes ☐ No

IF YOU ANSWER NO TO BOTH OF A & B ABOVE, WE ARE NOT ABLE TO PROVIDE YOU WITH THIS INSURANCE.

SECTION 2 – DOES ANYONE HAVE PERSONAL HISTORY WHICH EXCLUDES THEM FROM COVERAGE? REVIEW CAREFULLY.

☐ By checking this box, I am verifying that the answers to the following questions are "No" for anyone named on this application.

In the following questions, "YOU" refers to yourself and anyone you included on this application.

1. Within the past 5 years, have YOU had your driver's license suspended or revoked?
2. Are YOU currently unable to engage in your regular and customary activities due to an injury or sickness?

STOP HERE. DO NOT APPLY FOR YOURSELF IF ANY OF THE ABOVE QUESTIONS ARE TRUE. DO NOT INCLUDE ANYONE IN YOUR FAMILY FOR WHOM ANY OF THE ABOVE QUESTIONS ARE TRUE.

SECTION 3 – TELL US ABOUT YOU

First Name	Middle Initial	Last Name		Social Security No.
Home Address		City	State / Zip	Date of Birth
U.S. Birth State / OR Birth Country		Sex ☐ Male ☐ Female		
Email Address		Primary Phone ( )	Cell Phone (if different) ( )	
Type of Work you do			Employer	

SECTION 4 - TELL US ABOUT YOUR FAMILY MEMBERS YOU WANT COVERED

First Name (and Last Name if different from yours)	Occupation	Sex	Date of Birth mo	day	yr	U.S. Birth State	OR Birth Country
Spouse*							
Child							
Child							
Child							
Child							

SECTION 5 – CONFIRM YOUR COVERAGE SELECTION

☐ You ☐ You & Your Spouse* ☐ You & Your Child/ren ☐ You, Your Spouse & Your Child/ren

Accident Elite Plan: **PREMIUM**

☐ Plan I ☐ Plan II

Accidental Death & Dismemberment** ☐ Yes ☐ No

TOTAL MONTHLY PREMIUM: $______________

*"Spouse" includes your Domestic Partner **AD&D may be purchased alone or in addition to a Plan

In the event of your death, who should we pay any remaining benefits to? (i.e. Your "Beneficiary")

SECTION 6 – BENEFICIARY

Name	Birthdate	Relationship	Primary or Secondary	Indicate Percentage	
				Primary	Secondary
			☐ Primary or ☐ Secondary		
			☐ Primary or ☐ Secondary		
			Total must equal 100% =	100%	100%

SECTION 7 – AUTHORIZATION

Have you received the Outline of Coverage? ☐ Yes ☐ No (check one)

In signing below, I represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" below; authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or MIB having information on me or any member of my family applying for coverage) regarding our mental and physical health, other insurance coverage or hazardous activities to give to USAble Life, its reinsurers, or its legal representative any information to use for underwriting insurance; 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; agree that this authorization shall be valid for two (2) years from the application date; 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; acknowledge receipt of written notification describing the use of MIB Inc. as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. I understand failure to disclose the true health condition of anyone on this application may void this policy.

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE UNLESS: (1) The policy is delivered to the you; (2) The first month's premium is paid; (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. There is no coverage until the effective date of the policy.

Insurance Fraud Warning - 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.

I have read and understand the above statements and agreements.

X ______________________________ Signed at: ______________________________

Applicant's Signature (City and State)

X ______________________________ Date of Application: ______________________________

Spouse's Signature (Month, Day, Year)

Agent's Statement: I have truly and accurately recorded the information supplied by the applicant.

X ______________________________ ______________________________

Agent's Signature Agent's License ID Number

____

Agent's Printed Name

Date Received Home Office