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USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

HOSPITAL CARE PLAN APPLICATION

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES

☐ **By checking this box, I confirm my understanding that this hospital care plan does not meet the federal government requirement for minimum essential health coverage.**

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 MEDICAL 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. Are YOU currently pregnant or undergoing treatment for infertility; confined in a penal institution; in a hospital or nursing home; unable to engage in regular and customary activities due to an injury or illness; or has confinement been recommended by a licensed medical professional?

2. Within the past 12 months, have YOU been confined in a hospital or nursing home because of disease, disorder or illness related to the Heart; Lungs; Liver; Kidney; Cerebral, Coronary or Peripheral Vascular system; Blood or Bone Marrow; Cancer; Rheumatoid Arthritis; Multiple Sclerosis or Parkinson's Disease?

3. In the past 10 years have YOU been diagnosed with, treated by a licensed medical professional for, or taken medication for: Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection, or other sickness or condition derived from such infection; Alzheimer's disease or Dementia; Diabetes (except during pregnancy); Kidney or Renal Failure; Systemic Lupus Erythematosus; Muscular Dystrophy; Cystic Fibrosis; High Blood Pressure requiring treatment with more than 2 medications, or with readings in the past three months exceeding 149/94; alcohol or substance abuse, or been convicted of DUI?

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.

Height (ft-in)Primary Ins	Weight (lbs.)Primary Ins	**STOP HERE. If your weight is significantly higher (or lower) than normal for your height, your application will not be processed.**
Height (ft-in) Spouse	Weight (lbs) Spouse	**STOP HERE. If your spouse's weight is significantly higher (or lower) than normal for height, your application for them will not be processed.**

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

Hospital Care Plan: **PREMIUM**

☐ Plan I ☐ Plan II

TOTAL MONTHLY PREMIUM: $_____

*"Spouse" includes your Domestic Partner

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 and Secondary	Indicate Percentage
			Primary	
			Secondary	
			Total must equal 100% =	

SECTION 7 – AUTHORIZATION

OUTLINE: 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, the applicant, hereby attest that I currently have other health coverage in force that qualifies as minimum essential coverage, as defined by Section 5000A(f) of the Internal Revenue Code. ☐ Yes ☐ No I understand that by checking "no" this hospital care policy will not be issued.

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