Please Print Using Dark Ink

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

CRITICAL ILLNESS PLAN APPLICATION

SECTION 1 – ARE YOU ELIGIBLE FOR COVERAGE?		
Are you currently able to perform your regular and customary activities at home or work on a full-time basis and not limited by an injury or illness? If applying, is any dependent currently unable to engage in regular and customary activities due to an injury or sickness?	☐ Yes ☐ No ☐ Yes ☐ No	**STOP HERE. We are not able to provide coverage to anyone who is limited as described by an injury or sickness.**
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 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?

☐ 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. Do YOU currently have, or in the past 10 years, have YOU been diagnosed with, been treated by a licensed medical professional, or taken medication for:

- Any form of Cancer,
- Any chronic or progressive disease or disorder of the Heart, Circulatory System, Lungs, Liver, Pancreas, Kidney, Blood or Bone Marrow, Brain or Immune System,
- Stroke or Transient Ischemic Attack (TIA), or Cerebral Vascular Disease,
- Diabetes (except during pregnancy only); or any blood pressure readings in the past three months exceeding 149/94, or requiring treatment with more than 2 medications,
- Quadriplegia, or other Nervous System Disease or Disorder,
- Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection, or other sickness or condition derived from such infection?

2. Do YOU currently have:

- scheduled, or have YOU been advised to have any consultation, diagnostic tests, medical or surgical procedures, or are YOU awaiting results? (annual wellness exams, routine mammogram, pap smear, prostate exam, or colonoscopy recommended due to age only are excluded)
- any cysts, growths, lumps, or any mole or freckle that has bled, become painful, changed color or increased in size, which have not yet been medically evaluated?

3. In the past 5 years have YOU been diagnosed with, treated or counseled by a licensed medical professional for, or taken medication for alcohol or substance abuse, or been convicted of DUI, or are YOU currently confined to a penal institution?

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.

Height (ft-in) Primary Insured	Weight (lbs.) Primary Insured	**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		Tobacco or Nicotine use in the past 36 months	☐ Yes ☐ No
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

Critical Illness Coverage: **PREMIUM**

☐ With Cancer ☐ Without Cancer

☐ You	☐ 5,000	☐ 10,000	☐ 15,000	☐ 20,000	$_____
☐ Spouse	☐ 5,000	☐ 10,000	☐ 15,000	☐ 20,000	$_____
☐ Child(ren)	☐ 5,000	☐ 10,000			$_____

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	0.00%
			Secondary	0.00%
			Total must equal 100% =	0.00%

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 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