

USable Life

P.O. Box 1650 · Little Rock, Arkansas 72203

GROUP INSURANCE APPLICATION (BASIC AND VOLUNTARY)

Type Or Print In Black Ink

1. Legal Name of Policyholder		Taxpayer ID#		Group #	
2. Mailing Address of Policyholder		City		State	
3. Street Address of Policyholder (if different from above)		City		State	
4. Name of CEO, President or Owner of Company		Fax Number of Policyholder		Phone Number of Policyholder	
5. Correspondence/Phone Contact at Company Name: _____ Email: _____		Billing Contact at Company Name: _____ Email: _____			
6. Claims Contact at Company Name: _____ Email: _____		Renewal Contact at Company Name: _____ Email: _____			
7. Name of Subsidiary or Affiliate Companies to be Covered				Billing Method <input type="checkbox"/> Online Bill <input type="checkbox"/> List Bill	
8. Nature of Business & SIC code		Effective Date as of 12:01 a.m.	First Renewal Date	Number of Employees Eligible _____ Enrolled _____	
9. Do you have any employees located in states other than the policyholder's main address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list states.					
10a. Waiting Period: <input type="checkbox"/> Premium Due Date following completion of _____ days <input type="checkbox"/> Day following completion of _____ days			10b. Waiting Period applies to: <input type="checkbox"/> Future Employees Only <input type="checkbox"/> Present & Future Employees		
NOTE: For VIP and VLTD coverage, the waiting period will never be less than 30 days for present and future employees without prior approval from USable Life.			10c. Employer Contribution: Life and AD&D _____% Dep Life _____% Hosp. Indemnity _____% STD _____% _____ % _____ %		
11. Class Descriptions for Basic Coverage(s): If more than one class, descriptions must be specific. Class 1 _____ Class 2 _____ Class 3 _____ Class 4 _____					
Employees working less than 30 hours per week are not eligible for coverage unless otherwise noted above and approval received.					
12. Selection of Coverage: Check all that apply and fill in all applicable blanks.					
Class	<input type="checkbox"/> Life Insurance Amount of Insurance	<input type="checkbox"/> AD&D Principal Sum	Supplemental <input type="checkbox"/> Life <input type="checkbox"/> AD&D Amount of Insurance	Short Term Disability <input type="checkbox"/> Salary Multiple <input type="checkbox"/> Flat Schedule Maximum Weekly Benefit*	
1	_____	_____	_____	_____	
2	_____	_____	_____	_____	
3	_____	_____	_____	_____	
4	_____	_____	_____	_____	
* Weekly STD benefit is subject to a maximum of : _____% of employee's basic weekly earnings.					
13. If the Life and AD&D benefit is a multiple of salary amount should be rounded to: <input type="checkbox"/> the next higher <input type="checkbox"/> the next lower <input type="checkbox"/> the nearest Multiple of \$ _____, if not already a multiple. Not to exceed a maximum of \$ _____.					
14. Guaranteed Issue (Life and AD&D amounts over Guaranteed Issue are subject to evidence of insurability.)		Changes in benefit amounts in accordance with the Schedule shown above will become effective on: <input type="checkbox"/> the first day of the policy month following the date of change; or <input type="checkbox"/> the policy anniversary date coincident with or next following the date of change; or <input type="checkbox"/> on the date of change; or <input type="checkbox"/> other (give details): _____			
15. Dependent Life Insurance (Benefit amounts are limited in some states) <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse \$ _____ Children: (select one age range) <input type="checkbox"/> from birth to 6 months <input type="checkbox"/> from 15 days to 6 months \$ _____ (select one age range) <input type="checkbox"/> 6 months to 19 years* <input type="checkbox"/> 6 months to age _____* \$ _____ *To age _____ if full-time student.					

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Legal Name of Policyholder

Taxpayer ID#

16. Reductions & Termination (Benefit reduction due to age will be effective on the insured's birthday.)

- Employee Life and AD&D benefits reduce by the following percent or to the amount shown and terminate at retirement unless an earlier termination age is shown.
at age 65: at age 70: at age 75: at age 80: Terminates at:
Dependent Life benefits reduce 50% at the spouse's age 65. Terminate at the employee's retirement.
Other:

17. Short Term Disability (Employer pays all or some of the premium) (non-occupational) (Not Available in some states)

Accident Benefits Sickness Benefits Maximum Period
Begin Day Begin Day Weeks
Yes No

18. Hospital Indemnity Benefit

(Not Available in some states) Units Available: 1 unit only or 1 or 2 unit(s) as elected by employee
Yes No Dependent Coverage Available: Yes No Employer Contribution:

19. Voluntary Group Term Life

Yes No Smoker Distinct Rates: Yes No Guaranteed Issue: No Yes \$
Portability Provision Industry Class: # Enrolled If Yes, required employee participation %

20. Voluntary Accidental Death & Dismemberment

Yes No # Enrolled

21. Voluntary Short Term Disability Income Protection (VIP): Weekly benefit selected by employee in \$10 increments from \$100 to \$750.

(non-occupational) Benefit Plan: (select one) Benefit Percentage: Industry Class:
Yes No 1-8-13 1-8-26 1-8-52 # Enrolled:
8-8-13 8-8-26 8-8-52 Employer Contribution:
15-15-13 15-15-26 15-15-52

- a. Reductions & Termination (Benefit reduction due to age will be effective on the anniversary following the insured's birthday). Benefits reduce 33 1/3% at age 65, and terminate at age 70 or upon retirement, whichever occurs first.
b. Do you currently have an employer-paid disability income plan? Yes No
c. Do you want Continuity of Coverage? Yes No Prior Carrier Date Terminated
If yes, copy of prior plan required for claims administration.
d. Are premiums sheltered under a Section 125 Cafeteria plan? Yes No

22. Voluntary Long Term Disability (VLTD)

Yes No Employer Contribution: # Enrolled:
Industry Class:
Elimination Period: 90 Days 180 Days
Maximum Benefit Period: 5 years Accident/2 years Sickness
5 years Sickness or Accident
Age 65 Sickness or Accident

- a. Amount of Insurance: Selected by the employee in increments of \$100 not to exceed 60% of monthly salary.
b. Pre-existing Conditions Exclusions/Limitations: 12/6/24 (unless state law requires otherwise)
c. The Minimum Monthly Benefit is \$ 50.00 or 10% of the Monthly Disability Benefit, whichever is less (unless state law requires otherwise)
d. Policy Features include: • 24 Month Own Occupation • Three month Survivor Benefit • 24 Month Mental Illness, Alcohol & Drug Limitation
• Progressive Partial Disability • Waiver of Premium • \$50,000 Human Organ Transplant • Primary and Family Social Security Integration
e. Is this a replacement of similar coverage? Yes No
If yes, Prior Carrier Date Terminated
Also if there was a prior carrier, a copy of prior plan is required for claims administration.
f. Are premiums sheltered under a Section 125 Cafeteria plan? Yes No

REMARKS OR SPECIAL PROVISIONS

For Voluntary Products: Full-time means working at least 20 hours per week unless otherwise noted .

COMPLIANCE NOTICE: US Able Life does not provide legal or tax advice. Based upon information you have provided us about your group, we will notify you if we perceive any obvious deficiency in your plan, but you must consult your own legal counsel for definitive advice and opinions regarding your plan's compliance.

WARNING: It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines or a denial of insurance benefits in accordance with applicable state law.

It is understood and agreed that this application shall be made a part of the policy or policies applied for and that no insurance shall be effective until approved by the Company at its Home Office.

Dated and Signed at (City, State)

Date

Signature of Policyholder and Title

Signature of Marketing Representative

Signature of Marketing Manager

Signature of Broker, if applicable