

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		Telephone Number of Policyholder			
5. Name of Insurance Contact at Company		E-mail Address of Insurance Contact		Fax Number of Policyholder	
6. Name of Subsidiary or Affiliate Companies to be Covered				Billing Method	
				<input type="checkbox"/> Online Bill <input type="checkbox"/> List Bill	
7. Nature of Business		Effective as of 12:01 a.m.		First Renewal Date	
				Number of Employees	
				Eligible _____ Enrolled _____	
8. Do you have any employees located in states other than the policyholder's main address? Yes No					
If yes, please list states.					
9a. Waiting Period:			9b. Waiting Period applies to:		
Premium Due Date following completion of _____ days Day following completion of _____ days			Future Employees Only 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.			9c. Employer Contribution:		
			Life and AD&D _____% Dep Life _____% Hosp. Indemnity _____% STD _____% _____% _____%		
10. Class Definitions for Basic Coverage(s): If more than one class, definitions 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.					
11. Selection of Coverage: Check all that apply and fill in all applicable blanks.					
Class	Life Insurance Amount of Insurance	AD&D Principal Sum	Supplemental Life AD&D Amount of Insurance	Short Term Disability Salary Multiple Flat Schedule Maximum Weekly Benefit*	
1	_____	_____	_____	_____	
2	_____	_____	_____	_____	
3	_____	_____	_____	_____	
4	_____	_____	_____	_____	
* Weekly STD benefit is subject to a maximum of : _____% of employee's basic weekly earnings.					
If the Life and AD&D benefit is a multiple of salary amount should be rounded to:					
the next higher the next lower the nearest Multiple of \$ _____, if not already a multiple.					
Not to exceed a maximum of \$ _____.					
12. Guaranteed Issue		Changes in benefit amounts in accordance with the Schedule shown above will become effective on:			
(Life and AD&D amounts over Guaranteed Issue are subject to evidence of insurability.)		the first day of the policy month following the date of change; or the policy anniversary date coincident with or next following the date of change; or on the date of change; or other (give details):			
13. Dependent Life Insurance (Benefit amounts are limited in some states)					
Yes No Spouse \$ _____					
Children: (select one age range) from birth to 6 months from 15 days to 6 months \$ _____					
(select one age range) 6 months to 19 years* 6 months to age _____* \$ _____					
*To age _____ if full-time student.					

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Legal Name of Policyholder	Taxpayer ID#
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14. 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: _____

15. Short Term Disability (non-occupational)
(Not Available in some states)

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

16. 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: _____

17. Voluntary Group Term Life

	Yes No	Standard	OR	Select		Guaranteed Issue:	No	Yes	\$ _____
		# Enrolled _____				If Yes, required employee participation _____%			
		Portability Provision							

18. Voluntary Accidental Death & Dismemberment

	Yes No	# Enrolled _____
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19. Voluntary STD Income Protection Weekly Benefit (VIP): Selected by employee in \$10 increments from \$100 to \$750.
(non-occupational)

	Benefit Plan: (select one)		Industry Class: _____	# Enrolled: _____
Yes No	1-8-13 1-8-26 1-8-52			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

20. Voluntary Long Term Disability (VLTD)

	Yes No	Industry Class: _____	Employer Contribution: _____	# Enrolled: _____
			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.
 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

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.

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. Penalties may include imprisonment, fines or a denial of insurance benefits.

_____	_____	_____
Dated at (City, State)	Date	Signature of Policyholder and Title
_____	_____	_____
Signature of Marketing Representative	Signature of Marketing Manager	Signature of Broker, if applicable