USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

SMALL GROUP INSURANCE APPLICATION

(2–9 Lives)
Type or Print In Black Ink

For Home Office use only
Group #:

1. Legal Name of Policyholder				Taxpayer ID#
2. Type of Company: ☐ Corporation ☐ LLC ☐ PC ☐ S-Corp ☐ Sole Proprietor ☐ Partnership				
3. Mailing Address	City		State	Zip+4
4. Street Address (if different from above)	City		State	Zip+4
5. Name of CEO, President or Owner of Company	Nature of Business			SIC Code

6. Benefits Contact Person: ____________________

Phone Number: ( ) ____________ Fax Number: ( ) ____________

Email Address: ____________ Web Address: ____________

7. Effective as of 12:01 a.m.	Premium Deposit	Number of Employees Eligible ________ Enrolled ________	Billing Mode

8. Waiting Period
Life, AD&D, Dependent Life and STD:
☐ First of the month following completion of _____ days *(minimum 30 days for Life, AD&D, Dep Life, & STD)*
Long Term Disability:
☐ First of the month following completion of _____ days *(minimum 90 days for LTD)*
All effective dates must be first of the month.

9. Waiting Period applies to: ☐Future Employees Only ☐ Present & Future Employees

10. Life/AD&D
☐ Flat Amount $ ____________ per employee *(minimum $15,000; maximum $100,000, elected in $5,000 increments)*
☐ Multiple of annual salary to a maximum of $100,000: ☐ 1 times ☐ 2 times ☐ 3 times *(rounded to the next higher $1,000)*
☐ All employees according to the following occupational schedule:

Class	Job title, as shown on enrollment form	Life/AD&D Amount	STD Amount (if elected)
1.			
2.			
3.			

(No Class may have a benefit greater than 2 1/2 times the amount for the next lower class.)

11. Dependent Life *(available if Life/AD&D selected)* ☐ Yes ☐ No

	☐ Plan 1	☐ Plan 2
Spouse	$10,000	$5,000
Child (birth to 6 months)	$100	$100
Child (6 months to age 19*)	$5,000	$5,000

*to age 25 if full time student

12. Short Term Disability (STD) *(available if Life/AD&D or LTD selected)* ☐ Yes ☐ No

Elimination Period/Duration:
☐ 1-8-13 ☐ 1-8-26
☐ 8-8-13 ☐ 8-8-26
☐ 15-15-13 ☐ 15-15-26

Benefit Amount:
☐ Percentage of weekly income:
☐ 50% ☐ 60% ☐ 66 2/3% to maximum of $__________ *($50 – $750)*
☐ Flat Amount of $ ___________ *($50 increments to a maximum of $250)*
☐ Class Defined Plan *(fill in STD Amount column in number 10 above)*

Maximum: The maximum weekly STD benefit may not exceed 66 2/3% of an insured's weekly income.

Legal Name	Taxpayer ID#

13\. Long Term Disability (LTD) *(available if Life/AD&D or STD selected)* ☐ Yes ☐ No

Elimination Period: ☐ 90 Days ☐ 180 Days

Maximum Benefit Period: ☐ Social Security Normal Retirement Age (Sickness or Accident)
☐ 5 years or to age 70 (Sickness or Accident)

Amount of Insurance: ☐ 60% of monthly salary to a maximum of ☐ $4,000 ☐ $5,000 ☐ $6,000

Pre-existing Conditions Exclusions/Limitations: 12/6/24

The Minimum Monthly Benefit is $100.00 or 10% of the Monthly Disability Benefit, whichever is greater.

Policy Features include: • 24 Month Own Occupation • Three month Survivor Benefit • 24 Month Special Conditions Limitation • EDGE I • Waiver of Premium • Primary and Family Social Security Integration

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.

Are premiums sheltered under a Section 125 Cafeteria plan? ☐Yes ☐No

14\. Contributions *(Applies to all coverages unless otherwise stated. Employer must contribute at least 25% of cost.)*
☐ Non-contributory *(employer pays 100% of cost)* ☐ Contributory, employer pays ________% of cost

15\. ☐ I certify that all employees are actively at work at their usual place of business today.
☐ There are employees who are not actively at work at their usual place of business today. Please complete the following:

Name	Date Last Worked	Expected Return to Work Date	Reason for Absence

16\. General Conditions

- Eligibility: All full-time employees who work a minimum of 30 hours per week on a year round basis. Coverage does not include temporary, seasonal or retired employees.
- Employees must be actively at work on their effective date for coverage to be effective.
- Participation Requirement: 2 to 4 lives – 100%; 5 to 7 lives – All but 1 must enroll; 8 to 9 lives – All but 2 must enroll.
- Evidence of Insurability (EOI) is required on Life and AD&D and LTD amounts in excess of the guaranteed issue and on all late applications for contributory coverage.
- Life and AD&D insurance reduces to 65% at age 65; and to 50% of the original amount at age 70. All benefits terminate at retirement.

The undersigned employer and/or authorized representative hereby request that it be approved for insurance coverage through USAble Life and agrees to comply with all terms and provisions of the Group Policy(ies) issued in response to this application.

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.

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.

Applicant's Signature	Print Name and Title	Date
Representative's Signature (Must be resident licensed agent)	Print Representative's Name	Date