

USable Life

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

EVIDENCE OF INSURABILITY (Please Print)

A completed Enrollment Form must accompany this form.

SECTION 1 Completed By Employer										
Group Name				Date of Hire		Telephone # (include area code)		Group Number		
Amount of Insurance Applying for: Employee Life: \$ Dependent Life \$ Disability \$ Other:								Employee's Annual Salary		
SECTION 2 Completed by Employee <input type="checkbox"/> Vol. Group Term Life <input type="checkbox"/> Amount over Guarantee Issue <input type="checkbox"/> Late Enrollee										
Name (First, MI, Last)							Social Security No.			
Home Address				City		State	Zip	County		
Date of Birth	Birth State or Country		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (ft-in.)	Weight (lbs.)	Work Phone		Home Phone		
Spouse & Children Information – Complete if Applying for Dependent's Coverage.										
Person Proposed for Insurance Show first, middle, last name		Occupation		Date of Birth & Place			Height	Weight	Marital Status	Sex
				Month	Day	Year				
(Spouse)										
(Child)										
(Child)										
(Child)										
(Child)										
Spouse's Social Security No.:					Spouse's Work Telephone #:					
SECTION 3 Insurability Questionnaire										
								Yes	No	
1. Has anyone to be covered used any tobacco products in the past year?								<input type="checkbox"/>	<input type="checkbox"/>	
2. Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised?								<input type="checkbox"/>	<input type="checkbox"/>	
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years?								<input type="checkbox"/>	<input type="checkbox"/>	
4. Has anyone to be covered consulted a physician in the past one (1) year for any reason?								<input type="checkbox"/>	<input type="checkbox"/>	
5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for:										
		Yes No						Yes No		
a. Cancer, cancer related disease or benign tumor?		<input type="checkbox"/> <input type="checkbox"/>		f. Emotional, nervous system, eating disorder, or mental health problems?				<input type="checkbox"/> <input type="checkbox"/>		
b. Disease of the heart or blood vessels, or had a stroke?		<input type="checkbox"/> <input type="checkbox"/>		g. Ulcer, stomach or digestive disorder?				<input type="checkbox"/> <input type="checkbox"/>		
c. Kidney disease or diabetes?		<input type="checkbox"/> <input type="checkbox"/>		h. Arthritis, back, bones or joint disorder?				<input type="checkbox"/> <input type="checkbox"/>		
d. Alcohol or drug abuse?		<input type="checkbox"/> <input type="checkbox"/>		i. Bladder, urinary system or reproductive organs disorder?				<input type="checkbox"/> <input type="checkbox"/>		
e. Lung, asthma, liver or blood disorder?		<input type="checkbox"/> <input type="checkbox"/>								
6. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")?								<input type="checkbox"/>	<input type="checkbox"/>	
7. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4.								<input type="checkbox"/>	<input type="checkbox"/>	
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4.								<input type="checkbox"/>	<input type="checkbox"/>	
9. Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8?								<input type="checkbox"/>	<input type="checkbox"/>	
10a. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		10b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?						<input type="checkbox"/>	<input type="checkbox"/>	
11. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If No, give full details in Section 4.								<input type="checkbox"/>	<input type="checkbox"/>	
12. Names, addresses, and phone numbers of the personal physicians of all applicants:										
SECTION 4 Give Details to "Yes" answers to questions 2 through 10 include dates of treatment. <input type="checkbox"/> Separate Sheet Attached										
Ques. No. & Individual	Illness/Reason for Checkup or Medication & Dosage or Doctor's Treatment/Consultation				Date & Duration		Full Name, Complete Address and Telephone Number of Doctors & Hospitals			

Be Sure to Read the Important Disclosures and sign on Page 2/Reverse



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NOTICE FOR PROPOSED INSURED

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

Federal Fair Credit Reporting Act Notice

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

Medical Information Bureau Disclosure Notice

Information regarding your insurability will be treated as confidential. US Able Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

US Able Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.