

SERFF Tracking Number: ARLH-126858375

State: Arkansas

Filing Company: US Able Life

State Tracking Number: 46847

Company Tracking Number: 44-01 R10/10

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: NA

Project Name/Number: /

Filing at a Glance

Company: US Able Life

Product Name: NA

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: ARLH-126858375 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 46847

Co Tr Num: 44-01 R10/10

State Status: Approved-Closed

Author:

Date Submitted: 09/20/2010

Reviewer(s): Rosalind Minor

Disposition Date: 10/13/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested:

State Filing Description:

General Information

Project Name:

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type:

Overall Rate Impact:

Filing Status Changed: 10/13/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type:

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 10/13/2010

Created By: Jennifer Newkirk

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Jennifer Newkirk

PPACA: Pre-PPACA Submission

Filing Description:

Company and Contact

Filing Contact Information

NA NA,

NA@NA.COM

NA, NA

123-555-4567 [Phone]

LITTLE ROCK, AR 00000

Filing Company Information

SERFF Tracking Number: ARLH-126858375

State: Arkansas

Filing Company: USAbLe Life

State Tracking Number: 46847

Company Tracking Number: 44-01 R10/10

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: NA

Project Name/Number: /

USAbLe Life
320 W. Capitol
Suite #500
P.O. Box 1151
Little Rock, AR 72203-1151
(501) 375-7200 ext. [Phone]

CoCode: 94358
Group Code:
Group Name:
FEIN Number: 71-0505232

State of Domicile: Arkansas
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:
Per Company: No

SERFF Tracking Number: ARLH-126858375

State: Arkansas

Filing Company: US Able Life

State Tracking Number: 46847

Company Tracking Number: 44-01 R10/10

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: NA

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/13/2010	10/13/2010
Approved-Closed	Rosalind Minor	10/13/2010	10/13/2010

SERFF Tracking Number: ARLH-126858375

State: Arkansas

Filing Company: US Able Life

State Tracking Number: 46847

Company Tracking Number: 44-01 R10/10

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: NA

Project Name/Number: /

Disposition

Disposition Date: 10/13/2010

Implementation Date:

Status: Approved-Closed

Comment: The filing is approved effective 9/21/10 and not 10/13/10.

Rate data does NOT apply to filing.

SERFF Tracking Number: ARLH-126858375

State: Arkansas

Filing Company: US Able Life

State Tracking Number: 46847

Company Tracking Number: 44-01 R10/10

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: NA

Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	ARLH-126858375	Approved-Closed	Yes

SERFF Tracking Number: ARLH-126858375

State: Arkansas

Filing Company: US Able Life

State Tracking Number: 46847

Company Tracking Number: 44-01 R10/10

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: NA

Project Name/Number: /

Disposition

Disposition Date: 10/21/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ARLH-126858375

State: Arkansas

Filing Company: US Able Life

State Tracking Number: 46847

Company Tracking Number: 44-01 R10/10

TOI: H21 Health - Other

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Product Name: NA

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State: Arkansas

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Company Tracking Number: 44-01 R10/10

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Product Name: NA

Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Unsatisfied - Item: Flesch Certification Comments:	Approved-Closed	10/13/2010
Unsatisfied - Item: Application Comments:	Approved-Closed	10/13/2010
Unsatisfied - Item: Health - Actuarial Justification Comments:	Approved-Closed	10/13/2010
Unsatisfied - Item: Outline of Coverage Comments:	Approved-Closed	10/13/2010
Unsatisfied - Item: PPACA Uniform Compliance Summary Comments:	Approved-Closed	10/13/2010
Satisfied - Item: ARLH-126858375 Comments: Attachment: ARLH-126858375.pdf	Approved-Closed	10/13/2010



**GROUP HEALTH
INSURANCE DIVISION**

320 W. Capitol, Suite #500
P. O. Box 1151
Little Rock, AR 72203-1151

NAIC 94358
RECEIVED
SEP 20 2010
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

September 20, 2010

Ms. Rosalind D. Minor, Policy Analyst
Life and Health Division
Arkansas Insurance Department
1200 West Third
Little Rock, Arkansas 72201-1904

S# ARLH-126858375
46847
ak # 0000180056
\$ 150.00

RE: USABLE Life
Employee Group Health Coverage Application (2-100)
Form No. 44-02 R10/10 – USABLE SGAPP
Employee Group Health Coverage Application
Form No. 44-02 R10/10 – USABLE LGAPP
Medical Questionnaire for Late Enrollees
Form No. 44-03 R10/10 - USABLE LGAPPMED

APPROVED
SEP 21 2010
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Dear Rosalind,

Enclosed please find duplicate copies of the above mentioned form for your review and approval if indicated.

These applications have been revised to delete the student status information.

Also enclosed is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d). Please also note, we have scored the amendment as part of the benefit certificates with which it will be used as provided by Arkansas Code Annotated §23-80-206(e).

By way of this letter, I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.

I certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 are incorporated in the benefit certificates.

In accordance with Rule and Regulation 57, a check in the amount of \$150.00, payable to the State Insurance Department Trust is enclosed.

Please feel free to contact my analyst, Christi Kittler at 378-2967, with any questions you may have.

Cordially yours,

Frank B. Sewall
FBS/el

Enclosures



**EMPLOYEE
GROUP HEALTH COVERAGE
APPLICATION (2-100)**

Please check the appropriate box and fill in blanks below in ink.		GROUP ADMINISTRATOR USE ONLY
Group No.:	I.D. No.:	Class:

Is the Employee waiving coverage in the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete Sections 1, 3 & 8 only.		<div style="border: 2px solid black; padding: 5px; transform: rotate(-5deg);"> APPROVED SEP 21 2010 LIFE AND HEALTH <small>ARKANSAS INSURANCE DEPARTMENT</small> </div>
<input type="checkbox"/> US Able Life group health coverage		
<input type="checkbox"/> Life Only (complete Sections 1,2, 3, 5 & 8)		
<input type="checkbox"/> New Enrollee <input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Add a Family Member: <input type="checkbox"/> Newborn — Date of Birth: _____ <input type="checkbox"/> Marriage — Marriage Date: _____	

Date of Full-Time Employment			<input type="checkbox"/> COBRA Effective Date			<input type="checkbox"/> COBRA Termination Date			Reason for COBRA:
Mo.	Day	Year	Mo.	Day	Year	Mo.	Day	Year	

SECTION 1. EMPLOYEE INFORMATION									
First Name:		Middle Name:		Last Name:		Marital Status:		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Home Address:				City:		State:		Zip Code:	
Home Phone No.:		Work Phone No.:		Employer:			Job Title:		
Coverage <input type="checkbox"/> Employee Only			<input type="checkbox"/> Employee & Child(ren)			Employment <input type="checkbox"/> Hourly		Hours Worked Weekly: _____	
Desired: <input type="checkbox"/> Employee & Spouse			<input type="checkbox"/> Employee, Spouse & Child(ren)			Status: <input type="checkbox"/> Salaried		<input type="checkbox"/> Other	

SECTION 2. (Complete this section on all members to be covered.)									
Social Security Number	First Name	M. I.	Last Name	Birth Date Mo/Day/Yr	Sex M or F	Height/Weight	\$ Amt/Yrs Deductible Credit Submitted*		
Employee ____-____-____						Ht. _____ Wt. _____			
Spouse ____-____-____						Ht. _____ Wt. _____			
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. ____-____-____						Ht. _____ Wt. _____			
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. ____-____-____						Ht. _____ Wt. _____			
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. ____-____-____						Ht. _____ Wt. _____			
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. ____-____-____						Ht. _____ Wt. _____			

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS						FOR OFFICE USE ONLY		
To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.						C/T	PKG	WWP
1. Medical Coverage Declined for:						Eff Date _____ IMP _____		
<input type="checkbox"/> Myself		<input type="checkbox"/> Covered by spouse's group coverage — Carrier Name and ID :				Life _____ AD&D _____		
<input type="checkbox"/> Spouse		<input type="checkbox"/> Enrolled in other Insurance Carrier Plans — Carrier Name and ID:				Timely _____ UND _____ Date _____		
<input type="checkbox"/> Dependents		<input type="checkbox"/> Medicare		<input type="checkbox"/> Covered by TRICARE or CHAMPVA		Late _____		
<input type="checkbox"/> Other (Explain): _____						OTHER		

*Deductible Credit is available for new group enrollments but only if the individual requests it on this initial application

2

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS (continued)

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I may be enrolled as a Late Enrollee or my request may be deferred until open enrollment.

Special Enrollment Period. If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other insurance coverage, in order to enroll yourself and/or your dependents in your employer's plan in the future without being considered a Late Enrollee you must: (1) Indicate on this application form that the reason you or your dependent(s) are declining coverage now is because you or your dependent(s) have coverage under another group health plan; and (2) Submit a Group Enrollment Form to enroll yourself or your dependent(s) within 30 days after coverage ends under the other group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and/or your new dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

SECTION 4. OTHER MEDICAL INSURANCE

(This section must be completed to process your enrollment application.)

Yes No On the day coverage begins will any family members be covered by other health or dental insurance or Medicare, including continuation of coverage? If yes, answer all questions below. (Use additional paper if necessary)

Yes No Is the continuing coverage Medicare? If so, complete the following:

Reason for Medicare coverage: Over 65 Disabled Kidney Disease

Medicare Beneficiary Name:

Medicare Health Identification Contract (HIC) Number:

Relationship of Beneficiary to Policyholder:

Type of Medicare Coverage (check all that apply) Medicare Part A – Effective Date:

Medicare Part B – Effective Date:

Yes No Is the continuing coverage other than Medicare? If so, complete the following: (if covered by more than one insurance plan, attach paper)

Name of Insurer:

Address:

Phone:

Policyholder Name:

Date of Birth:

Member ID #:

List the following information for all family members covered by this policy (indicate those not residing in your household with a check ✓ mark)

First Name	Last Name	Relationship	✓	Effective Date of Coverage

For members listed above, are you responsible for providing primary health insurance coverage? Yes No – Please name responsible party:

SECTION 5. LIFE INSURANCE (Issued for any employer with 2-100 employees)

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.

First Name	M.I.	Last Name	Date of Birth	Relationship

SECTION 6. PROOF OF PRIOR COVERAGE

Yes No Do you or any dependent listed in this application currently have or have you (they) had any health coverage within the past 63 days? If YES, please provide the coverage history for the past 18 months in the spaces below.

If the insurance coverage for which you are making application contains a pre-existing condition limitation period, you may be able to offset part of all of such period by attaching a Certificate of Creditable Coverage to this application. Federal and state law require your prior health plan(s) or health insurance company(ies) to provide you such Certificate(s) of Creditable Coverage upon request. If for some reason you are unable to attach such a Certificate of Creditable Coverage, please include whatever documents you have (i.e. explanation of benefits forms, correspondence from your former health plan or health insurer, former identification card, or benefit certificate) which will assist us to corroborate your prior creditable coverage.

Name of Persons Covered	Name, Address, Phone No. & Policy No. of Prior Health Insurance Co.	Effective Date	Termination Date	Reason for Termination

SECTION 7. MEDICAL QUESTIONNAIRE

All of the following questions must be answered in ink in the employee's own handwriting for each person applying for coverage. Use a separate sheet, if necessary; sign, date, and attach to the questionnaire. **YOUR COVERAGE CANNOT BE DECLINED BASED ON HEALTH CONDITIONS.** However, **FAILURE TO REVEAL ALL MEDICAL INFORMATION IN A MANNER CONSTITUTING FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT MAY RESULT IN RESCISSION OF COVERAGE.**

1. **Yes** **No** Has any person to be insured ever been declined, surcharged, rescinded or restricted for the issuance of life, health or accident insurance? If "Yes," Member: _____ Reason: _____
2. **Yes** **No** Has any person to be insured ever been insured with USABLE Life? If "Yes," Member: _____
3. **Yes** **No** Has any person to be insured used tobacco in the last 12 months? If "Yes," Member: _____ What type? _____

In the past 10 years, has any person to be insured ever been diagnosed or been advised to have treatment or care for any of the following conditions? **Check the appropriate box(es) below and explain in the Additional Medical Information section.**

<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">Y N</td> <td style="width: 50%; text-align: center;">Y N</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 4. Heart Condition</td> <td><input type="checkbox"/> <input type="checkbox"/> 15. Cyst or Tumor</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 5. Circulatory Disorder</td> <td><input type="checkbox"/> <input type="checkbox"/> 16. AIDS or HIV positive</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 6. Pancreatic Disorder</td> <td><input type="checkbox"/> <input type="checkbox"/> 17. Immune Disorder</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 7. Lung Problem</td> <td><input type="checkbox"/> <input type="checkbox"/> 18. Digestive Disorder</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 8. COPD or Asthma</td> <td><input type="checkbox"/> <input type="checkbox"/> 19. Kidney Disorder</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 9. Brain Disorder</td> <td><input type="checkbox"/> <input type="checkbox"/> 20. Bladder/Prostate Disorder</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 10. Mental Disorder</td> <td><input type="checkbox"/> <input type="checkbox"/> 21. Recurrent Pain</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 11. Depression</td> <td><input type="checkbox"/> <input type="checkbox"/> 22. Reproductive Disorder</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 12. Anxiety</td> <td><input type="checkbox"/> <input type="checkbox"/> 23. Liver Disorder</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 13. Alcohol Abuse</td> <td><input type="checkbox"/> <input type="checkbox"/> 24. Diabetes or high blood sugar</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 14. High Blood Pressure</td> <td style="text-align: center;">Type: _____ and _____</td> </tr> </table> <p>If yes provide last 3 readings: _____ ; _____ ; _____</p>	Y N	Y N	<input type="checkbox"/> <input type="checkbox"/> 4. Heart Condition	<input type="checkbox"/> <input type="checkbox"/> 15. Cyst or Tumor	<input type="checkbox"/> <input type="checkbox"/> 5. Circulatory Disorder	<input type="checkbox"/> <input type="checkbox"/> 16. AIDS or HIV positive	<input type="checkbox"/> <input type="checkbox"/> 6. Pancreatic Disorder	<input type="checkbox"/> <input type="checkbox"/> 17. Immune Disorder	<input type="checkbox"/> <input type="checkbox"/> 7. Lung Problem	<input type="checkbox"/> <input type="checkbox"/> 18. Digestive Disorder	<input type="checkbox"/> <input type="checkbox"/> 8. COPD or Asthma	<input type="checkbox"/> <input type="checkbox"/> 19. Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> 9. Brain Disorder	<input type="checkbox"/> <input type="checkbox"/> 20. 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Stroke or Seizure</td> <td># of episodes: _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 26. Drug Abuse</td> <td>Name of Drug: _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 27. Cancer</td> <td>Type: _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 28. Arthritis</td> <td>Type: _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 29. Hepatitis</td> <td>Type: _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 30. Currently Pregnant</td> <td>Due Date: _____</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> 31. Any Condition not listed above?</td> <td></td> </tr> </table>	Y N	Y N	<input type="checkbox"/> <input type="checkbox"/> 25. Stroke or Seizure	# of episodes: _____	<input type="checkbox"/> <input type="checkbox"/> 26. Drug Abuse	Name of Drug: _____	<input type="checkbox"/> <input type="checkbox"/> 27. 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APPROVED
 SEP 21 2010
 LIFE AND HEALTH
 ARKANSAS INSURANCE DEPARTMENT

32. **Yes** **No** In the past 10 years, has any person to be insured ever been hospitalized, received hospital services or had surgery? (If "Yes" give full details in the Additional Medical Information Section below.)
33. **Yes** **No** In the past 10 years, has any person to be insured ever seen, or been advised to see a health care provider, surgeon, chiropractor, counselor, psychiatrist, social worker, pain specialist, physical therapist, speech therapist, rehabilitation therapist, occupational therapist, oncologist, or endocrinologist? (Circle each provider and give details in the Additional Medical Information Section below.)

ADDITIONAL MEDICAL INFORMATION List below full details to questions answered "Yes." (Additional space available on the next page.)

Question Number	Person Treated	Condition & Type of Treatment	Date Occurred	Last Date of Treatment	Current Status	Complete Name and Address of Physician

34. **Yes** **No** In the past 2 years, has any person to be insured discontinued or failed to take medication prescribed by a physician? If "yes" list full details below. (Additional space available on the next page.)
35. **Yes** **No** Has any person to be insured been prescribed or taken any prescription medication for more than a total of 30 days in the past 2 years? If "yes" list full details below. (Additional space available on the next page.)

PRESCRIPTION INFORMATION

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Complete Name & Address of Physician



EMPLOYEE GROUP HEALTH COVERAGE APPLICATION

(For employer groups with 51 or more employees)

Please check the appropriate box and fill in blanks below in ink.		GROUP ADMINISTRATOR USE ONLY	
Group No.:		I.D. No.:	
		Class:	
Is the Employee waiving coverage in the plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete Sections 1, 3 & 7 only.			FOR OFFICE USE ONLY
<input type="checkbox"/> USable Life group health coverage		<input type="checkbox"/> USable Life HSA	
<input type="checkbox"/> USable Life HRA		<input type="checkbox"/> Life Only (complete Sections 1, 5 & 7)	
<input type="checkbox"/> New Enrollee		<input type="checkbox"/> Add a Family Member:	
<input type="checkbox"/> Loss of Other Coverage		<input type="checkbox"/> Newborn — Date of Birth: _____	
		<input type="checkbox"/> Marriage — Marriage Date: _____ (Submit copy of marriage certificate.)	
Date of Full-Time Employment		<input type="checkbox"/> COBRA Effective Date	
		<input type="checkbox"/> COBRA Termination Date	
Reason for COBRA:			
Mo.	Day	Year	
Mo.	Day	Year	
Mo.	Day	Year	

SECTION 1. EMPLOYEE INFORMATION

First Name:		Middle Name:		Last Name:		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
						<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Home Address:				City:		State:	Zip Code:
Home Phone No.:		Work Phone No.:		Employer:		Job Title:	
Coverage <input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee & Child(ren)		Employment <input type="checkbox"/> Hourly		Hours Worked Weekly: _____	
Desired: <input type="checkbox"/> Employee & Spouse		<input type="checkbox"/> Employee, Spouse & Child(ren)		Status: <input type="checkbox"/> Salaried <input type="checkbox"/> Other			

SECTION 2. (Complete this section on all members to be covered.)

Social Security Number	First Name	M. I.	Last Name	Birth Date Mo/Day/Yr	Sex M or F	Height/ Weight	\$ Amt/Yrs Deductible Credit Submitted*
Employee ____ - ____ - ____			APPROVED			Ht. _____ Wt. _____	
Spouse ____ - ____ - ____			SEP 21 2010			Ht. _____ Wt. _____	
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. ____ - ____ - ____			LIFE AND HEALTH			Ht. _____ Wt. _____	
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. ____ - ____ - ____			ARKANSAS INSURANCE DEPARTMENT			Ht. _____ Wt. _____	
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. ____ - ____ - ____						Ht. _____ Wt. _____	
Child - <input type="checkbox"/> Nat. <input type="checkbox"/> Step <input type="checkbox"/> Adop. ____ - ____ - ____						Ht. _____ Wt. _____	

FOR OFFICE USE ONLY

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS		C/T	PKG	WWP
<i>To be completed if coverage is declined or refused by an eligible employee and/or their eligible family members.</i>				
		Eff Date		IMP
1. Medical Coverage Declined for:		Life		
<input type="checkbox"/> Myself		AD&D		
<input type="checkbox"/> Spouse		Timely	UND	Date
<input type="checkbox"/> Dependents		Late		
		OTHER		
<input type="checkbox"/> Covered by spouse's group coverage — Carrier Name and ID :				
<input type="checkbox"/> Enrolled in other Insurance Carrier Plans — Carrier Name and ID:				
<input type="checkbox"/> Medicare		<input type="checkbox"/> Covered by TRICARE or CHAMPVA		
<input type="checkbox"/> Other (Explain):				

*Deductible Credit is available for new group enrollments but only if the individual requests it on this initial application

SECTION 3. WAIVER OF ENROLLMENT/SPECIAL ENROLLMENT RIGHTS (continued)

I hereby certify that: (1) I have been given the opportunity to apply for the coverage made available through my employer under the applicable policy. The coverages and the policy have been thoroughly explained to me, and I decline to apply for coverage for myself and/or my dependent(s) as listed above; and (2) I understand that if I refuse to apply now and I apply for coverage at a later date, I may be enrolled as a Late Enrollee or my request may be deferred until open enrollment.

Special Enrollment Period. If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other insurance coverage, in order to enroll yourself and/or your dependents in your employer's plan in the future without being considered a Late Enrollee you must: (1) Indicate on this application form that the reason you or your dependent(s) are declining coverage now is because you or your dependent(s) have coverage under another group health plan; and (2) Submit a Group Enrollment Form to enroll yourself or your dependent(s) within 30 days after coverage ends under the other group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse and/or your new dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

SECTION 4. OTHER MEDICAL INSURANCE

(This section must be completed to process your enrollment application.)

Yes No On the day coverage begins will any family members be covered by other health or dental insurance or Medicare, including continuation of coverage? If yes, answer all questions below. (Use additional paper if necessary)

Yes No Is the continuing coverage Medicare? If so, complete the following:

Reason for Medicare coverage: Over 65 Disabled Kidney Disease

Medicare Beneficiary Name:

Medicare Health Identification Contract (HIC) Number:

Relationship of Beneficiary to Policyholder:

Type of Medicare Coverage (check all that apply) Medicare Part A – Effective Date:

Medicare Part B – Effective Date:

Yes No Is the continuing coverage other than Medicare? If so, complete the following: (if covered by more than one insurance plan, use additional paper)

Name of Insurer:

Address:

Phone:

Policyholder Name:

Date of Birth:

Member ID #:

List the following information for all family members covered by this policy (indicate those not residing in your household with a check ✓ mark)

First Name	Last Name	Relationship	✓	Effective Date of Coverage

For members listed above, are you responsible for providing primary health insurance coverage? Yes No – Please name responsible party:

SECTION 5. LIFE INSURANCE (Issued for any employer with 51-100 employees)

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.

First Name	M.I.	Last Name	Date of Birth	Relationship

SECTION 6. PROOF OF PRIOR COVERAGE

Yes No Do you or any dependent listed in this application currently have or have you (they) had any health coverage within the past 63 days? If YES, please provide the coverage history for the past 18 months in the spaces below.

If the insurance coverage for which you are making application contains a pre-existing condition limitation period, you may be able to offset part of all of such period by attaching a Certificate of Creditable Coverage to this application. Federal and state law require your prior health plan(s) or health insurance company(ies) to provide you such Certificate(s) of Creditable Coverage upon request. If for some reason you are unable to attach such a Certificate of Creditable Coverage, please include whatever documents you have (i.e. explanation of benefits forms, correspondence from your former health plan or health insurer, former identification card, or benefit certificate) which will assist us to corroborate your prior creditable coverage.

Name of Persons Covered	Name, Address, Phone No. & Policy No. of Prior Health Insurance Co.	Effective Date	Termination Date	Reason for Termination

SECTION 7. UNDERSTANDINGS, REPRESENTATIONS AND AGREEMENTS (PLEASE READ BEFORE SIGNING IN INK.)

I understand that the benefits for which I (we) will be eligible are those described in the USABLE Life group policies with my employer as may from time to time be amended. I understand that coverage will not become effective before the approved effective date. I understand that in addition to other exclusions and limitations provided in the USABLE Life group policies, **NO BENEFITS WILL BE AVAILABLE TO COVERED PERSONS AGE 19 OR OLDER DURING THE APPLICABLE PRE-EXISTING CONDITION EXCLUSION PERIOD FOR TREATMENT OF ANY CONDITION FOR WHICH A COVERED PERSON RECEIVED MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WITHIN THE SIX (6) MONTH PERIOD ENDING ON THE EFFECTIVE DATE OR THE FIRST DAY OF THE WAITING PERIOD, WHICHEVER IS EARLIER.**

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company or any third party engaged by USABLE Life to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me, or any member of my family (if applicable), to give USABLE Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources 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; (d) understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage and that this information shall also be used by USABLE Life, its reinsurers, or its legal representative may disclose this information to others as required or permitted by law and as set out in its Notice of Privacy Practices; (e) understand that I may terminate this authorization by sending a written revocation to USABLE Life, 320 W. Capitol, Suite 500, Little Rock AR 72203; (f) unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

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.

Print Name of Applicant

Signature of Applicant

Date

Print Employer/Group Administrator*

Signature Employer/Group Administrator*

Date

**Required for new hires and additions only.*

APPROVED
SEP 21 2010
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

MEDICAL QUESTIONNAIRE FOR LATE ENROLLEES

Applicant: _____

SSN: _____

All of the following questions must be answered in ink in the employee's own handwriting for each person applying for coverage. Use a separate sheet, if necessary; sign, date, and attach to the questionnaire. **YOUR COVERAGE CANNOT BE DECLINED BASED ON HEALTH CONDITIONS.** However, **FAILURE TO REVEAL ALL MEDICAL INFORMATION IN A MANNER CONSTITUTING FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT MAY RESULT IN RESCISSION OF COVERAGE.**

- Yes No Has any person to be insured ever been declined, surcharged, rescinded or restricted for the issuance of life, health or accident insurance? If "Yes," Member: _____ Reason: _____
- Yes No Has any person to be insured ever been insured with US Able Life? If "Yes," Member: _____
- Yes No Has any person to be insured used tobacco in the last 12 months? If "Yes", Member: _____ What type? _____

In the past 10 years, has any person to be insured ever been diagnosed or been advised to have treatment or care for any of the following conditions? Check the appropriate box(es) below and explain in the Additional Medical Information section.

Y	N	Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Heart Condition	15.	Cyst or Tumor	25.	Stroke or Seizure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Circulatory Disorder	16.	AIDS or HIV positive		# of episodes: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Pancreatic Disorder	17.	Immune Disorder	26.	Drug Abuse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Lung Problem	18.	Digestive Disorder		Name of Drug: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	COPD or Asthma	19.	Kidney Disorder	27.	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Brain Disorder	20.	Bladder/Prostate Disorder		Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Mental Disorder	21.	Recurrent Pain	28.	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Depression	22.	Reproductive Disorder		Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Anxiety	23.	Liver Disorder	29.	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Alcohol Abuse	24.	Diabetes or high blood sugar		Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	High Blood Pressure		Type: _____ and	30.	Currently Pregnant
<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
					Due Date: _____
				<input type="checkbox"/>	<input type="checkbox"/>
					31. Any Condition not listed above?

- Yes No In the past 10 years, has any person to be insured ever been hospitalized, received hospital services or had surgery? (If "Yes" give full details in the Additional Medical Information Section below.)
- Yes No In the past 10 years, has any person to be insured ever seen, or been advised to see a health care provider, surgeon, chiropractor, counselor, psychiatrist, social worker, pain specialist, physical therapist, speech therapist, rehabilitation therapist, occupational therapist, oncologist, or endocrinologist? (Circle each provider and give details in the Additional Medical Information Section below.)

ADDITIONAL MEDICAL INFORMATION List below full details to questions answered "Yes." (Additional space available on the next page.)

Question Number	Person Treated	Condition & Type of Treatment	Date Occurred	Last Date of Treatment	Current Status	Complete Name and Address of Physician

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SEP 21 2011

LIFE AND HEALTH
ARKANSAS INSURANCE COMPANY

- Yes No In the past 2 years, has any person to be insured discontinued or failed to take medication prescribed by a physician? If "yes" list full details below. (Additional space available on the next page.)
- Yes No Has any person to be insured been prescribed or taken any prescription medication for more than a total of 30 days in the past 2 years? If "yes" list full details below. (Additional space available on the next page.)

PRESCRIPTION INFORMATION

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Complete Name & Address of Physician

