

State: Arkansas Filing Company: USAbLe Life  
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
Product Name: W2G Applications  
Project Name/Number: /

## Filing at a Glance

Company: USAbLe Life  
Product Name: W2G Applications  
State: Arkansas  
TOI: H21 Health - Other  
Sub-TOI: H21.000 Health - Other  
Filing Type: Form  
Date Submitted: 10/12/2012  
SERFF Tr Num: MWSG-128706516  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: W2GMAPP (5-12)  
  
Implementation: On Approval  
Date Requested:  
Author(s): June Stracener, Vickie McCarron, Reed Bates  
Reviewer(s): Rosalind Minor (primary)  
Disposition Date: 10/15/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

State: Arkansas  
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
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Filing Company: USAbLe Life

## General Information

Project Name: Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments: Arkansas is the domestic state.  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Group Market Type: Employer Overall Rate Impact:  
Filing Status Changed: 10/15/2012 Deemer Date:  
State Status Changed: 10/15/2012 Submitted By: June Stracener  
Created By: June Stracener  
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

USABLE LIFE

NAIC #: 94358; FEIN: 71-0505232

- Group Insurance Application W2GMAPP (5-12)
- Employee Insurance Application W2GEAPP (5-12)

On behalf of USAbLe Life (the "Company"), we respectfully submit the above-referenced forms for your review and approval. These forms are new and do not replace any previously approved forms.

Forms W2GMAPP (5-12) and W2GEAPP (5-12), the group and employee insurance applications, respectively, will be used to apply for the Company's group accident, hospital confinement, and critical illness products which have been previously approved by your Department. Note that these applications are being submitted under the SERFF TOI/Sub-TOI of H21.000 Health – Other pursuant to a telephone discussion with Rosalind Minor of your Department since the applications will be used with these three (3) different products. Approval information for the approved forms with which these applications will be used is set forth in the cover letter attached under the Supporting Documentation tab.

To the best of the Company's knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state, and contain no provisions previously disapproved by your Department.

These forms are in final print. The Company reserves the right to change the appearance, formatting and pagination, but not the text of these forms to comply with future changes in production, print systems or web site software and stylistic revisions. No font will be less than a 10-point font size. The Company also reserves the right to change the color and/or weight of hard-copy versions of this form and to correct typographical errors without refiling. In addition, the Company also reserves the right to change the Company logo, Company address and phone number, and Officers' signatures without refiling.

## Company and Contact

### Filing Contact Information

Derrick Smith, Attorney

dsmith@mwlaw.com

**State:** Arkansas **Filing Company:** USAbLe Life  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** W2G Applications  
**Project Name/Number:** /

425 West Capitol Avenue 501-688-8845 [Phone]  
 Suite 1800 501-918-7845 [FAX]  
 Little Rock, AR 72201-3525

**Filing Company Information**

(This filing was made by a third party - MWSGW01)

USAbLe Life	CoCode: 94358	State of Domicile: Arkansas
P.O. Box 1650	Group Code: 876	Company Type: Life & Health
Little Rock, AR 72203-1650	Group Name: Life & Specialty	State ID Number:
(501) 212-8877 ext. [Phone]	Ventures	
	FEIN Number: 71-0505232	

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: Arkansas, the domestic state, charges \$ 50/form. There are 2 forms included with this filing. Therefore, \$100.00 is being submitted via EFT.  
 Per Company: No

Company	Amount	Date Processed	Transaction #
USAbLe Life	\$100.00	10/12/2012	63794564

State: Arkansas Filing Company: US Able Life  
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
Product Name: W2G Applications  
Project Name/Number: /

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/15/2012	10/15/2012

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** W2G Applications  
**Project Name/Number:** /

**Filing Company:** US Able Life

## Disposition

Disposition Date: 10/15/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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	Statement of Variability	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form	Group Insurance Application	Approved-Closed	Yes
Form	Employee Insurance Application	Approved-Closed	Yes

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: W2G Applications  
 Project Name/Number: /

Filing Company: US Able Life

## Form Schedule

### Lead Form Number: W2GMAPP (5-12)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/15/2012	W2GMAPP (5-12)	AEF	Group Insurance Application	Initial:	50.300	Group Insurance Application W2GMAPP (5-12).pdf
2	Approved-Closed 10/15/2012	W2GEAPP (5-12)	AEF	Employee Insurance Application	Initial:	51.200	Employee Insurance Application W2GEAPP (5-12).pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



**[USABLE Life Group Insurance Application]**

[Home Office: P.O. Box 1650  
Little Rock, Arkansas 72203]

**For Home Office use only**  
**Group #:** \_\_\_\_\_

<input type="checkbox"/> Accident Plus	<input type="checkbox"/> Critical Illness Plus	<input type="checkbox"/> Cancer Plus	<input type="checkbox"/> Hospital Confinement Plus
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**SECTION I. GROUP INFORMATION:**

1. Legal Name of Policyholder: _____		2. Taxpayer ID#: _____	
3. Effective Date of Coverage: _____		4. Renewal Date of Coverage: _____	
4. Type of Company: <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> PC <input type="checkbox"/> S-Corp <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Government <input type="checkbox"/> Other _____			
5. Nature of Business: _____		6. SIC Code: _____	7. Subsidiary or Affiliate Companies <input type="checkbox"/> Yes <input type="checkbox"/> No (attached information)
8. SIC Code/Affiliate: _____			
9. Year Established: _____		10. Number of Employees: Total: _____ Eligible: _____ Enrolled: _____	
11. Contact Information at Company: Benefits Contact Person: _____ Phone/Fax Number: _____ Billing Contact Person: _____ Phone/Fax Number: _____ E-mail Address: _____ Web Address: _____			
12. Mailing Address of Policyholder _____		City _____	State _____ Zip+4 _____
13. Street Address of Policyholder (if different from above) _____		City _____	State _____ Zip+4 _____
14. Do you have any employees located in states other than the Policyholder's main address? (if yes, please indicate states below) <input type="checkbox"/> Yes <input type="checkbox"/> No _____			
15. Do you allow Domestic Partner Coverage under the existing Medical Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. Employer Contribution %: [ <input type="checkbox"/> Accident Plus _____%] [ <input type="checkbox"/> Critical Illness Plus _____%] [ <input type="checkbox"/> Cancer Plus _____%] [ <input type="checkbox"/> Hosp Confinement Plus _____%]			

**SECTION II. ENROLLMENT INFORMATION:**

[Initial Enrollment Effective Dates] _____		[Start Date (mm/dd/yyyy): _____]	[End Date (mm/dd/yyyy): _____]
<i>[Subsequent Open Enrollment Dates, if any, are subject to the agreement of the Policyholder and USABLE Life each year]</i>			
Eligibility Waiting Period <input type="checkbox"/> First of the month following: _____ <input type="checkbox"/> Day following: _____		(a) <input type="checkbox"/> Completion of _____ days (b) <input type="checkbox"/> Hire Date (a) <input type="checkbox"/> Completion of _____ days (b) <input type="checkbox"/> Hire Date]	Eligibility Waiting Period Applies to: <input type="checkbox"/> Future Employees Only <input type="checkbox"/> Present & Future Employees
<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Waiting period applies if rehired within [12] months of their termination date</i>			
Eligible Enrollment period after satisfying the Policyholder Waiting Period: [0 to 365] days			

**SECTION III. ELIGIBLE CLASS:**

Class	Min Hours	Description*	Product	Waiting Period
1			<input type="checkbox"/> Acc <input type="checkbox"/> CI <input type="checkbox"/> Cancer <input type="checkbox"/> Hosp	
2			<input type="checkbox"/> Acc <input type="checkbox"/> CI <input type="checkbox"/> Cancer <input type="checkbox"/> Hosp	
3			<input type="checkbox"/> Acc <input type="checkbox"/> CI <input type="checkbox"/> Cancer <input type="checkbox"/> Hosp	

\*A minimum of [20] hours per week is required and temporary and seasonal employees are excluded.

**SECTION IV. GROUP BILLING INSTRUCTIONS:**

Premium Mode:	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Annually	<input type="checkbox"/> Skip Month	[Which Month(s): _____]
Billed By:	<input type="checkbox"/> Blue Plan	<input type="checkbox"/> Self-Administered USAL		<input type="checkbox"/> List Bill	
Billing Method:	<input type="checkbox"/> Current Month	<input type="checkbox"/> Previous Month		<input type="checkbox"/> Other	
Date of First Deduction: _____	Other Instructions: _____				

**SECTION V. REPLACEMENT:**

Do you currently have insurance similar to the coverage applied for?  Yes  No If "yes" list the type of insurance, carrier, termination date and submit a W2GMAPP (5-12)

copy of the prior billing: \_\_\_\_\_  
 Will the insurance applied for replace any existing insurance?  Yes  No If "yes" list the type of insurance, carrier, termination date and submit a copy of the prior billing: \_\_\_\_\_

**SECTION VI. COVERAGES ELECTED FOR PACKAGED PLANS**

<input type="checkbox"/> Accident Plus		<input type="checkbox"/> Critical Illness Plus		<input type="checkbox"/> Cancer Plus	<input type="checkbox"/> Hospital Confinement Plus
<input type="checkbox"/> 24 hour Coverage	<input type="checkbox"/> Non-Occ Coverage]	<input type="checkbox"/> With Cancer	<input type="checkbox"/> Without Cancer]	<input type="checkbox"/> Standalone Cancer]	

**SECTION VII. COVERAGES ELECTED FOR CUSTOM PLANS**

*Instructions: This section is only to be completed if you have received a custom proposal, otherwise complete the section above for one of our package plans.*

[Accident Plus]			[Critical Illness Plus]		[Cancer Plus]	[Hospital Confinement Plus]				
<input type="checkbox"/> 24 hour Coverage <b>or</b> <input type="checkbox"/> Non-Occupational Coverage]			<input type="checkbox"/> With Cancer]	<input type="checkbox"/> Without Cancer]	<input type="checkbox"/> Standalone Cancer]	Module	Include	Number of Units		
								Plan 1	Plan 2	Plan 3
Module	Include	Number of Units		Benefit Amount	Benefit Amount	One	✓ Yes			
		Plan 1	Plan 2	Plan 3		Two	<input type="checkbox"/> Yes			
One	✓ Yes				Employee: [\$5,000 to \$_____]	Three	<input type="checkbox"/> Yes			
Two	✓ Yes				Spouse: [\$5,000 to \$_____]	Four	<input type="checkbox"/> Yes			
Three	<input type="checkbox"/> Yes				Child(ren): [\$5,000 or \$10,000]	Special Instructions:				
Four	<input type="checkbox"/> Yes				Child(ren): [\$5,000 or \$10,000]					
Five	<input type="checkbox"/> Yes									
Six	<input type="checkbox"/> Yes									

**SECTION VIII. AVAILABLE RIDERS FOR CUSTOM OR PACKAGE PLANS**

*Instructions: Elect the Riders to be added to your package plan or custom plan. Some riders may not be available for your custom plan. Review your proposal for the available riders.*

Available Riders							
[Accident Plus]	Max Units	[Critical Illness Plus]	Max Units	[Cancer Plus]	Max Units	[Hospital Confinement Plus]	Max Units
<input type="checkbox"/> AD&D		<input type="checkbox"/> AD&D		<input type="checkbox"/> AD&D		<input type="checkbox"/> AD&D	
<input type="checkbox"/> Accident only Disability		<input type="checkbox"/> Intensive Care Benefit		<input type="checkbox"/> Intensive Care Benefit		<input type="checkbox"/> Heart Attack & Stroke Benefit]	
<input type="checkbox"/> Hospital/ICU Daily Benefit		<input type="checkbox"/> Accumulation Benefit		<input type="checkbox"/> Accumulation Benefit			
<input type="checkbox"/> Sickness Hospital Daily Benefit		<input type="checkbox"/> Occupational HIV Benefit		<input type="checkbox"/> Occupational HIV Benefit			
<input type="checkbox"/> Sickness only Disability Benefit		<input type="checkbox"/> Recurrent Benefit		<input type="checkbox"/> Recurrent Benefit			
<input type="checkbox"/> Spouse Off-the-Job Disability Benefit]		<input type="checkbox"/> Quality of Life Benefit]		<input type="checkbox"/> Quality of Life Benefit]			

**SECTION IX. AUTHORIZATION:**

REMARKS OR SPECIAL PROVISIONS:

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 USABLE Life.

**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.

_____	_____	_____
Dated at (City & State)	Date	Signature of Policyholder and Title
_____	_____	_____
Name of Licensed and USAL Appointed Agent	Signature of Licensed and USAL Appointed Agent	USAL Agent Number



**[USABLE Life Employee Insurance Application**

Home Office: P.O. Box 1650  
Little Rock, Arkansas 72203]

**For Home Office use only**

**Date Received:** \_\_\_\_\_

<b>Group #:</b> _____	<b>REASON FOR REQUEST:</b>	<b>Class:</b> _____
-----------------------	----------------------------	---------------------

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> New Hire/Enrollee        | <input type="checkbox"/> Decline Coverage | <input type="checkbox"/> Other: _____                               |
| <input type="checkbox"/> Initial Enrollment Event | <input type="checkbox"/> Change Request   | <input type="checkbox"/> Qualifying Event; Date: _____ Event: _____ |

**SECTION I. EMPLOYEE INFORMATION (please print)**

Employer Name		Employer Address		Dept/Location	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms (Check one) <input type="checkbox"/> Other: _____	Employee's Legal Name (First, MI, Last)			<input type="checkbox"/> M <input type="checkbox"/> F	Social Security No.
Height:	Weight:	Have you used any tobacco products within the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mailing Address			City	State	Zip
Day Phone:	Evening Phone:	Work Phone:	Email Address:		
Birth Day:	Date of Hire:	Age:	Birth State:		
Occupation/Job Title		Regular Weekly Hours	Salary <input type="checkbox"/> Monthly <input type="checkbox"/> Annual \$ _____	Employee ID	

**SECTION II. SPOUSE & CHILDREN INFORMATION**

[Full Name] [First] [Middle] [Last]	[Domestic Partner]	Occupation	Gender	Birth Date (Mo/day/Yr)	Height ft /in	Weight Lbs	Social Security #
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> M <input type="checkbox"/> F				
Child			<input type="checkbox"/> M <input type="checkbox"/> F				
Child			<input type="checkbox"/> M <input type="checkbox"/> F				
Child			<input type="checkbox"/> M <input type="checkbox"/> F				

Has your spouse used any tobacco products within the past 36 months?  Yes  No Children over age 18?  Yes  No  
Spouse includes your legal married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the policyholder and the Insurer.

**SECTION III. CITIZENSHIP INFORMATION:**

No.	Question	Employee	Spouse
1.	Are you a US or Canadian citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	If no to question 1, have you been issued a permanent residency VISA?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	If yes to question 2, have you lived continuously in the US or Canada for the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION IV. BENEFICIARY**

Name Beneficiary  Change of Beneficiary

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Date of Birth	Relationship	Primary or Secondary <input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	Indicate % Distribution	
				Primary	Secondary
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary		
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary		
Total must equal 100%				100%	100%

**SECTION V ELIGIBILITY QUESTIONS (required for all applicants)**

No.	Question	Answer
1.	Are you actively at work on a full time/part time basis and able to perform the regular duties of your occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled? If "yes", List name(s) _____ who will be excluded from coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Is anyone proposed for coverage covered under Title XIX program (e.g. Medicaid)? If "yes", List name(s) _____ who will be excluded from coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

[Accident Coverage Only:  
 4. Within the past 3 years, has any applicant had their driver's license suspended or revoked?  Yes  No  
 If "yes", List name(s) \_\_\_\_\_ who will be excluded from coverage.

**SECTION VI. PLAN SELECTION**

Type of Election:  Add New  Delete  Increase  Decrease Change to:  Employee  Spouse  Child(ren)

<b>[Accident Plus+</b> <input type="checkbox"/> Yes <input type="checkbox"/> No]	<u>[Plan Selection]</u> <input type="checkbox"/> Basic <input type="checkbox"/> Select <input type="checkbox"/> Ultra]	<u>[Individual Coverage]</u> <input type="checkbox"/> Employee only]	<u>[Family Coverage]</u> <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family]
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[Additional Riders: (Only available if included in the plan selected by the policyholder)]

[Optional Riders for Employee & Family]	Amount Per Unit	Available Units	Elected Units
<input type="checkbox"/> Accidental Death & Dismemberment	\$20,000/\$30,000	[5]	_____ Units
<input type="checkbox"/> Accident Hospital/ICU Daily Benefit	\$25/\$75	[10]	_____ Units
<input type="checkbox"/> Sickness Hospital Daily Benefit	\$25	[4]	_____ Units

Optional Riders for Employee

<input type="checkbox"/> Accident only Disability	\$100	[10]	_____ Units
<input type="checkbox"/> Sickness only Disability	\$100	[10]	_____ Units

Optional Riders for Spouse

<input type="checkbox"/> Spouse Off-the-Job Disability*	\$50	[10]	_____ Units
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\*Available when only one of the family plans are elected that includes spouse coverage. The insured spouse must be working 20 hours or more per week and earning an income.

[Type of Election:  Add New  Delete  Increase  Decrease Change to:  Employee  Spouse  Child(ren)]

<b>[Critical Illness Plus]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No]	<u>[Individual Coverage]</u> <input type="checkbox"/> Employee only]	<u>[Family Coverage]</u> <input type="checkbox"/> Employee Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family]	<b>Cancer Plus</b> <input type="checkbox"/> Yes <input type="checkbox"/> No]	<u>[Individual Coverage]</u> <input type="checkbox"/> Employee only]	<u>[Family Coverage]</u> <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family]
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<u>[Elected Benefit Amount:</u> <input type="checkbox"/> Employee (\$5,000 to \$50,000 in \$5,000 increments) \$ _____ <input type="checkbox"/> Spouse* (\$5,000 to \$50,000 in \$5,000 increments) \$ _____ <input type="checkbox"/> Child(ren)* <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000]	<u>[Elected Benefit Amount:</u> <input type="checkbox"/> Employee (\$5,000 to \$50,000 in \$5,000 increments) \$ _____ <input type="checkbox"/> Spouse* (\$5,000 to \$50,000 in \$5,000 increments) \$ _____ <input type="checkbox"/> Child(ren)* <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000]
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[Additional Riders: (Only available if included in the plan selected by the policyholder)]

[Optional Riders for Employee & Spouse]	Amount Per Unit	Available Units	Elected Increments / Units
<input type="checkbox"/> Accidental Death & Dismemberment	\$20,000/\$30,000	[5]	_____ Units
<input type="checkbox"/> Intensive Care Benefit	\$200/Day	[5]	_____ Units
<input type="checkbox"/> Accumulation Benefit	Indicate Yes or No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Occupational HIV Benefit (employee only)	Indicate Yes or No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Recurrent Benefit	Indicate Yes or No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Quality of Life Benefit	Indicate Yes or No		<input type="checkbox"/> Yes <input type="checkbox"/> No

[\*Dependent amounts cannot exceed the employee amount.]

[Type of Election:  Add New  Delete  Increase  Decrease Change to:  Employee  Spouse  Child(ren)]

<b>[Hospital Confinement Plus]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No]	<u>[Plan Selection]</u> <input type="checkbox"/> Basic <input type="checkbox"/> Select <input type="checkbox"/> Ultra]	<u>[Individual Coverage]</u> <input type="checkbox"/> Employee only]	<u>[Family Coverage]</u> <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family]
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[Additional Riders: (Only available if included in the plan selected by the policyholder)]

[Optional Riders for Employee & Spouse]	Amount Per Unit	Available Units	Elected Units
<input type="checkbox"/> Accidental Death & Dismemberment	\$20,000/\$30,000	[5]	_____ Units
<input type="checkbox"/> Heart & Stroke	\$500	[5]	_____ Units

**SECTION VII. REPLACEMENT**

Do you currently have insurance like or similar to the coverage applied for?  Yes  No If "yes" list the type of insurance, carrier, termination date and

submit a copy of the prior billing: \_\_\_\_\_

Will the insurance applied for replace any existing insurance?  Yes  No If "yes" list the type of insurance, carrier, termination date and submit a copy of the prior billing: \_\_\_\_\_

**SECTION VIII. UNDERWRITING AND MEDICAL QUESTIONS**

Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering YES on the line provided in that area.

**[Conditional Guaranteed Questions]**

Applies to	Applicable Questions	Applicant	Spouse	Child(ren)
[Disability Riders; Sickness Riders; Critical Illness; Hospital Confinement; Cancer]	Have you or anyone proposed for coverage been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Disability Riders; Sickness Riders; Critical Illness; Hospital Confinement; Cancer]	Are you or anyone proposed for coverage currently disabled, or in the past 12 months have you been confined to a hospital, nursing home or rehab center, or has confinement been recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**[Simplified Issue Questions]**

[In addition to the questions above, the following questions must be completed. Any person answering YES to the following questions is not eligible for coverage. If multiple children are to be covered, please list the first name of any child answering YES on the line provided in that area.]

[Disability Riders; Sickness Riders; Critical Illness; Hospital Confinement; Cancer]	[Have you or anyone proposed for coverage, in the <b>past [10 years]</b> , been diagnosed or treated by a member of the medical profession for:]			
	1. [Cancer or any malignancy which includes: carcinoma, sarcoma, melanoma, Hodgkins disease, leukemia, lymphoma, malignant tumor, or a pre-leukemic or pre-malignant condition or a condition with malignant potential?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. [Heart disease, angina, heart attack, heart surgery, congestive heart failure, high blood pressure not controlled by medication or requiring more than two medications, any other abnormality of the heart or circulatory system including coronary artery disease, peripheral vascular disease, stroke, transient ischemic attack, or any other cerebrovascular disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. [Cerebral palsy, Parkinson's disease, paralysis, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease; muscular dystrophy, myasthenia gravis or any other neuromuscular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. [Kidney disease, Diabetes (except during pregnancy), Lung or Respiratory disease or disorder, Pulmonary or Cystic Fibrosis, Liver or Pancreatic disorder, any chronic or progressive disease or disorder of the Blood or Bone Marrow?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. [Multiple sclerosis, systemic lupus erythematosus or any other autoimmune disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Disability Riders; Sickness Riders; Critical Illness; Cancer]	6. [Do you or anyone proposed for coverage currently have scheduled, or been advised to have any screening tests, diagnostic tests, medical or surgical procedures, or are you awaiting results or being followed for any of the above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	7. [Memory loss, Alzheimer's disease, senile dementia or organic brain syndrome, or consulted a doctor or received advice for any of the above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Critical Illness; Cancer]	8. [Have you or anyone proposed for coverage been diagnosed or treated for alcohol or substance abuse in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	9. [Has any person to be insured or any two of their natural parents or siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION IX. AUTHORIZATION:

REMARKS OR SPECIAL PROVISIONS:

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" below; (c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, 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; (f) agree that this authorization shall be valid for two (2) years from the application date; (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 or my representative upon request; (h) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

**IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS:** (1) The policy is delivered to the Owner; (2) The first modal premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application. There is no coverage until the effective date of the policy.

**Insurance Fraud 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.

I have read and understand the above statements and agreements.

X \_\_\_\_\_  
Applicant's Signature

Signed at: \_\_\_\_\_  
(City and State)

Date of Application: \_\_\_\_\_  
(Month, Day, Year)

**Agent's Statement:** I have accurately recorded the information supplied by the applicant.

X \_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Agent's License ID Number

\_\_\_\_\_  
Agent's Printed Name

SERFF Tracking #:

MWSG-128706516

State Tracking #:

Company Tracking #:

W2GMAPP (5-12)

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: W2G Applications  
 Project Name/Number: /

Filing Company: US Able Life

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/15/2012
Comments:			
Attachment(s):	Flesch Score Certification for W2G Applications.pdf AR Certification of Compliance for W2G Applications (9-27-12).pdf		
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/15/2012
Comments:	The applications are attached to the Forms Schedule for approval.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	10/15/2012
Bypass Reason:	N/A/ This filing consists solely of two group applications.		
Comments:			
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/15/2012
Bypass Reason:	N/A. N/A/ This filing consists solely of two applications which are not PPACA related.		
Comments:			
		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	10/15/2012
Comments:			
Attachment(s):	Statement of Variability for Applications.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Authorization Letter	Approved-Closed	10/15/2012

**SERFF Tracking #:**

MWSG-128706516

**State Tracking #:**

**Company Tracking #:**

W2GMAPP (5-12)

**State:**

Arkansas

**Filing Company:**

USable Life

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

W2G Applications

**Project Name/Number:**

/

Comments:

Attachment(s):

Authorization Letter.pdf

## FLESCH SCORE CERTIFICATION

<b><u>Form Number</u></b>	<b><u>Form Name</u></b>	<b><u>Flesch Score</u></b>
W2GMAPP (5-12)	Group Insurance Application	50.3
W2GEAPP (5-12)	Employee Insurance Application	51.2

As an officer of US Able Life, I hereby certify that the above captioned forms achieve a Flesch score that meets or exceeds the requirements of your state insurance law. Defined terms and policy language required by law have been excepted.



\_\_\_\_\_  
Sally A. Murphy  
Senior Counsel and Assistant Secretary

September 27, 2012  
Date

## CERTIFICATION

I, Sally A. Murphy, Senior Counsel, Chief Compliance Officer and Assistant Secretary of USABLE Life, do hereby certify that the forms identified below comply with:

- Arkansas Rule and Regulation 19;
- Arkansas Rule and Regulation 49; and
- Arkansas Code Annotated § 23-79-138 as provided for in Bulletin 11-88.

### USABLE LIFE



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Sally A. Murphy  
Senior Counsel, Chief Compliance Officer and  
Assistant Secretary

Date: September 27, 2012

**Form Numbers:**

W2GMAPP (5-12)

W2GEAPP (5-12)

## STATEMENT OF VARIABILITY

***Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.***

### GENERAL VARIABLES

1. Company name may be changed as approved by the governing jurisdiction.
2. Company address, phone numbers, e-mail addresses, officer names, titles and signatures may be changed as necessary.
3. The words "employee," "individual," "employer," and "policyholder" are completely variable to incorporate the exact classes of employees and the exact eligible groups for a specific policyholder.

Example: Employee means any manager, supervisor or clerical staff in active employment with the ABC Company.

4. All letters and numbers (excluding form numbers) are variable subject to the laws of the governing jurisdiction.

### SPECIFIC GROUP APPLICATION VARIABLES W2GMAPP (5-12)

All references to coverage types and rider types may be included or excluded according to the types of coverage being offered to the Policyholder.

#### Section II. Enrollment Information:

1. Initial Enrollment Effective Dates, Start Date and End Dates will be excluded for policyholders providing 100% employer contribution.
2. Subsequent Open Enrollment Dates provision will be excluded for policyholders providing 100% employer contribution.
3. Eligibility waiting period is variable according to the plan selected by the policy holder.
4. Waiting period for rehires is variable according to the plan selected by the policyholder. The range is a minimum of 6 and a maximum of 12 months.
5. Eligible enrollment period after satisfying waiting period is variable according the policyholder.

#### Section III. Enrollment Information:

1. The product references are variable according to the types of coverage being offered to the Policyholder.
2. The minimum hour requirement ranges from 20 to 40 hours.

#### Section IV. Enrollment Information:

1. The individual Premium Mode, Billed By, and Billing Method options may be included or excluded according to the options offered to a particular policyholder.

**SPECIFIC GROUP APPLICATION VARIABLES  
W2GEAPP (5-12)**

All references to coverage types and rider types may be included or excluded according to the types of coverage being offered to the Policyholder.

**Section II. Spouse & Children Information:**

1. Either "Full Name" or First, Middle and Last Name will be requested.
2. Domestic Partner question will be asked if the plan purchased by the policyholder provides coverage for domestic partners.
3. Initial Enrollment Effective Dates, Start Date and End Dates will be excluded for policyholders providing 100% employer contribution.
4. Subsequent Open Enrollment Dates provision will be excluded for policyholders providing 100% employer contribution.
5. Eligibility waiting period is variable according to the plan selected by the policy holder.
6. Waiting period for rehires is variable according to the plan selected by the policyholder. The range is a minimum of 6 and a maximum of 12 months.
7. Eligible enrollment period after satisfying waiting period is variable according the policyholder.

**Section IV. Plan Selection:**

1. All references to coverage types and rider type may be included or excluded according to the plan(s) purchased by a particular policyholder.
2. All references to available benefits will vary according to the plan(s) purchased by a particular policyholder.

**Section VII. Underwriting and Medical Questions:**

1. Individual underwriting and medical questions will be included or excluded according to the plan(s) purchased by a particular policyholder.



April 25, 2012

INSURANCE COMMISSIONER

This letter, or a copy thereof, will authorize Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C. to represent US Able Life in any matters related to the submission of policy forms and/or rates to your state.

Very truly yours,

A handwritten signature in cursive script that reads "Sally A. Murphy".

Sally A. Murphy  
Senior Counsel, Chief Compliance Officer  
and Assistant Secretary