

SERFF Tracking Number: LSVX-G128026018 State: Arkansas
Filing Company: USAbLe Life State Tracking Number:
Company Tracking Number: AR001680100002
TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Small Group Applications, SG2-APP & VSG2-APP
Project Name/Number: Small Group Application, SG2-APP/AR001680100002

Filing at a Glance

Company: USAbLe Life
Product Name: Small Group Applications, SG2- SERFF Tr Num: LSVX- State: Arkansas
APP & VSG2-APP G128026018
TOI: L04G Group Life - Term SERFF Status: Closed-Approved- State Tr Num:
Closed
Sub-TOI: L04G.103 Renewable - Single Life - Co Tr Num: AR001680100002 State Status: Approved-Closed
Fixed/Indeterminate Premium
Filing Type: Form Reviewer(s): Linda Bird
Author: SPI Life and Specialty Disposition Date: 02/03/2012
Ventures
Date Submitted: 02/01/2012 Disposition Status: Approved-
Closed
Implementation Date Requested: 03/01/2012 Implementation Date:
State Filing Description:

General Information

Project Name: Small Group Application, SG2-APP Status of Filing in Domicile:
Project Number: AR001680100002 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 02/03/2012
State Status Changed: 02/03/2012 Deemer Date:
Created By: SPI Life and Specialty Ventures Submitted By: SPI Life and Specialty Ventures
Corresponding Filing Tracking Number:
Filing Description:
This application will be used in conjunction with our Group Life and AD&D Policy, GRP-P (5-09) which was approved for use on 02/18/2009. Please Reference SERFF Tracking #LSVX126016440.

It will also be used with our Long Term Disability Policy, LTD-P (5-09) which was approved on 03/17/2009. Please reference SERFF Filing #LSVX126075574.

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The application may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document, but we assure that its content will not change and its readability compliance will not be affected. Also, at some point, we anticipate utilizing electronic signatures in a form compliant with your laws and regulations.

Company and Contact

Filing Contact Information

Rae Lynn Craig, Regulatory Resource Analyst rcraig@usablelife.com
 PO Box 1650 501-375-7200 [Phone] 8932 [Ext]
 Little Rock, AR 72203-1650 501-235-8484 [FAX]

Filing Company Information

USable Life CoCode: 94358 State of Domicile: Arkansas
 PO Box 1650 Group Code: 876 Company Type: Life & Health
 Little Rock, AR 72203-1650 Group Name: Life and Speciality State ID Number:
 Ventures (LSV)
 (501) 375-7200 ext. [Phone] FEIN Number: 71-0505232

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
USable Life	\$200.00	02/01/2012	55980571

SERFF Tracking Number: LSVX-G128026018 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	02/03/2012	02/03/2012

SERFF Tracking Number: LSVX-G128026018 *State:* Arkansas
Filing Company: US Able Life *State Tracking Number:*
Company Tracking Number: AR001680100002
TOI: L04G Group Life - Term *Sub-TOI:* L04G.103 Renewable - Single Life -
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Product Name: Small Group Applications, SG2-APP & VSG2-APP
Project Name/Number: Small Group Application, SG2-APP/AR001680100002

Disposition

Disposition Date: 02/03/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LSVX-G128026018 State: Arkansas
 Filing Company: USable Life State Tracking Number:
 Company Tracking Number: AR001680100002
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
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 Product Name: Small Group Applications, SG2-APP & VSG2-APP
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form	Small Group Insurance Application (GIIM)		Yes
Form	Small Group Insurance Application (GIIP)		Yes
Form	Voluntary Life and AD&D Enrollment Form for Small Group		Yes
Form	Voluntary Life, AD&D and LTD Enrollment Form for Small Group		Yes

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 Product Name: Small Group Applications, SG2-APP & VSG2-APP
 Project Name/Number: Small Group Application, SG2-APP/AR001680100002

Form Schedule

Lead Form Number: SG2-APP-AR (5-09)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SG2-APP-AR (5-09)	Application/ Small Group Enrollment Form	Insurance Application (GIIM)	Initial		43.500	SG2-APP-AR (5-09).PDF
	SG2-APP-DL-AR (5-09)	Application/ Small Group Enrollment Form	Insurance Application (GIIP)	Initial		41.300	SG2-APP-DL-AR (5-09).PDF
	VSG2-APP (5-09)	Application/ Voluntary Life and Enrollment Form	AD&D Enrollment Form for Small Group	Initial		54.100	VSG2-APP (5-09).PDF
	VSG2-APP2 (5-09)	Application/ Voluntary Life, AD&D Enrollment Form	and LTD Enrollment Form for Small Group	Initial		50.300	VSG2-APP2 (5-09).PDF



SMALL GROUP INSURANCE APPLICATION (GIIM)

P.O. Box 1650
Little Rock, Arkansas 72203

Type or Print in Black Ink

SECTION I. GROUP INFORMATION:

1. Legal Name of Policyholder:		2. Taxpayer ID#:		3. Effective 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. Name of Subsidiary or Affiliate Companies to be Covered		8. SIC Code/Affiliate
9. Mailing Address of Policyholder			City	State	Zip+4
10. Contact Information at Company: <input type="checkbox"/> Benefits or <input type="checkbox"/> Billing Contact Person _____ Phone/Fax Number () _____ E-mail Address _____ Web Address _____					

[11. Class Definitions. Small Group is limited to three classes with a minimum of 5 employees/class. *Voluntary plans are limited to one class.*

Class	Life	LTD	Grp.	Vol.	Description of Class	Waiting Period, if Different
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

12. 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 _____		13. Billing Method: <input type="checkbox"/> Credit Card/Bank draft <input type="checkbox"/> Billed by Blue Plan <input type="checkbox"/> Self Administered <input type="checkbox"/> On-Line Billing <input type="checkbox"/> List Bill	
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14. Total number of eligible employees: Group: _____ [Voluntary: _____]		15. Total number of employees enrolled: Group: _____ [Voluntary: _____]		16. Employer contribution: Group: _____ [Voluntary: _____]	
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17. Do you allow Domestic Partner Coverage under the existing Medical Plan? Yes No

18. Waiting Period: <input type="checkbox"/> First of the following month after completion of _____ days, or <input type="checkbox"/> Day following Hire Date [(VLTD requires a 30 day minimum waiting period.)]		19. Minimum hours per week: Group: _____ [Voluntary: _____]	
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20. Eligible Waiting Period Applies to: <input type="checkbox"/> Future Employees Only <input type="checkbox"/> Present & Future Employees <i>Does the waiting period apply to employees rehired within [12] months of their termination date</i> <input type="checkbox"/> Yes <input type="checkbox"/> No			[20a. Annual Enrollment date for Voluntary Coverage: _____]
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21. Replacement: Are any of the following a replacement of similar coverage? *If prior coverage, please include a copy of the prior carrier's plan.*

Yes	No	[Grp.]	[Vol.]	Coverage	If Yes, Previous Carrier	Termination Date
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Life & AD&D Insurance		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Long Term Disability		

SECTION II. EMPLOYER BENEFIT OPTIONS: FOR GROUPS WITH [5 TO 50] ELIGIBLE EMPLOYEES

SELECT COVERAGES THAT BEST MEET THE GROUP'S NEEDS. [Term Life/AD&D is required for LTD purchase.]

[STEP 1: Select the Life/AD&D and LTD Coverage for the Employees and the Class Applicable for that Amount]

[Group Term Life and AD&D Insurance]				Group Long Term Disability					
Choice	Class (Circle one)	No. of ee's	Term Life and AD&D Benefit	Choice	Class (Circle one)	No. of ee's	LTD Benefit	[Elimination Period]	
								[30] Day	[60] Day
<input type="checkbox"/>	1, 2, 3	_____	[\$25,000	<input type="checkbox"/>	1, 2, 3	_____	[\$500	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	1, 2, 3	_____	\$35,000	<input type="checkbox"/>	1, 2, 3	_____	\$750	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	1, 2, 3	_____	\$40,000*	<input type="checkbox"/>	1, 2, 3	_____	\$1,000	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	1, 2, 3	_____	\$50,000*]	<input type="checkbox"/>	1, 2, 3	_____	\$1,500*	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	1, 2, 3	_____	\$2,000*]	<input type="checkbox"/>	<input type="checkbox"/>

[*Requires a minimum of 10 eligible employees participating.] [Amounts between classes may not exceed 2x the lower amount.]

[STEP 2: Select Enhancements to the [Group] Coverages]			
<input type="checkbox"/>	Dependent Life Coverage: Spouse/child: \$5,000/\$2,000 (<i>Child coverage from 14 days to 6 months is limited to \$100</i>)	<input type="checkbox"/>	Double the amount of the AD&D benefit.]
[SECTION III. EMPLOYEE BENEFIT OPTIONS (VOLUNTARY PLANS): FOR GROUPS WITH [10 TO 50] ELIGIBLE EMPLOYEES			
<i>Instructions: Group must elect Group Term Life/ADD if VGTL/VAD&D or VLTD is desired. The employer cannot offer both group LTD and voluntary LTD.</i>			
<input type="checkbox"/> Voluntary* Term Life & AD&D		Benefits	
Employee (Life & AD&D)		Available amounts from [\$20,000 to \$50,000] in [\$10,000] increments	
Dependent (Life only - spouse/child)		Available amounts of \$[10,000/\$5,000 or \$20,000/\$10,000]	
<input type="checkbox"/> Voluntary* LTD		[<input type="checkbox"/> 30 or <input type="checkbox"/> 60] Day Elimination Period	
Available Monthly Benefit Amounts		[<input type="checkbox"/> \$500; <input type="checkbox"/> \$750; <input type="checkbox"/> \$1,000; <input type="checkbox"/> \$1,500]	
<i>The employer elects one elimination period and one monthly benefit amount for all employees. The employee elects to purchase.</i>			
<i>*All voluntary plans require a minimum of 10 eligible employees, with a minimum of 5 participating or 25%, whichever is greater]</i>			
TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT FEATURES:			
Group [and Voluntary] AD&D Riders		Benefits reduce by the following amounts on the insured's birthday*	
<i>Group [& Voluntary] Plans</i>	<i>[Voluntary Plans]</i>	Reduction at Age of Employee	
<input checked="" type="checkbox"/> Seat Belt /Air Bag	<input checked="" type="checkbox"/> Special Education	Age 65	Age 70
<input checked="" type="checkbox"/> Coma	<input checked="" type="checkbox"/> Spouse Training]	<input checked="" type="checkbox"/> 35%	<input checked="" type="checkbox"/> 50%
<input checked="" type="checkbox"/> Repatriation		* Benefits for the covered person(s) terminate when no longer eligible or at retirement, whichever comes first.	
<input checked="" type="checkbox"/> Exposure and Disappearance			
LONG TERM DISABILITY FEATURES:			
Disability Definition: Earnings / Occupation Test (80/20);[24] month own occupation		Drug & Mental Illness Limitation: 24 Month Lifetime Benefits	
Benefits Duration: [24 months] [(Group & Voluntary)]		Benefit Percentage: Flat benefit not to exceed [60%] of pre-disability earnings	
Pre-existing Condition:[Group LTD: 3/12; Voluntary LTD: 12/6/24]		Integration: non-integrated; Voluntary amounts above [\$1,000] are integrated.	
W-2 Service Options for Long Term Disability			
<input type="checkbox"/> Option 1: Withhold Federal income Taxes and the employee's portion of FICA. Prepare and File W-2 Forms.			
<input type="checkbox"/> Option 2: Withhold Federal income Taxes and the employee's portion of FICA. Policyholder waives W-2 Forms Services.			
A detailed description of the W-2 services elected by the Policyholder pursuant to this application will be sent to the Policyholder by mail. Such services will be performed in accordance with the above election and established standard procedures.			
SECTION III. 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: 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.			

_____	_____	_____		
Dated at (City & State)	Date	Signature of Policyholder and Title		
_____	_____			
Name of Licensed Agent	Signature of Licensed Agent			
<table border="1" style="width: 200px; margin-left: auto; margin-right: auto;"> <tr style="background-color: #cccccc;"> <td style="text-align: center;">For Home Office Use Only</td> </tr> <tr> <td style="text-align: center;">Group #</td> </tr> </table>			For Home Office Use Only	Group #
For Home Office Use Only				
Group #				



SMALL GROUP INSURANCE APPLICATION (GIIP)

P.O. Box 1650
Little Rock, Arkansas 72203

Type or Print in Black Ink

SECTION I. GROUP INFORMATION:										
1. Legal Name of Policyholder:			2. Taxpayer ID#:			3. Effective 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. Name of Subsidiary or Affiliate Companies to be Covered			8. SIC Code/Affiliate		
9. Mailing Address of Policyholder					City		State		Zip+4	
10. Contact Information at Company: <input type="checkbox"/> Benefits or <input type="checkbox"/> Billing Contact Person _____ Phone/Fax Number () _____ E-mail Address _____ Web Address _____										
11. Class Definition. <i>[All active full-time employees working a minimum of [25] hours or more per week.]</i>										
12. 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 _____					13. Billing Method: <input type="checkbox"/> Credit Card/Bank draft <input type="checkbox"/> Billed by Blue Plan <input type="checkbox"/> Self Administered <input type="checkbox"/> On-Line Billing <input type="checkbox"/> List Bill					
14. Total number of eligible employees:			15. Total number of employees enrolled:			16. Employer contribution:				
17. Do you allow Domestic Partner Coverage under the existing Medical Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No										
18. Eligibility waiting Period: <input type="checkbox"/> First of the following Policy month after completion of _____ days, or <input type="checkbox"/> Day following Hire Date										
19. Eligible Waiting Period Applies to: <input type="checkbox"/> Future Employees Only <input type="checkbox"/> Present & Future Employees <i>Does the waiting period apply to employees rehired within 12 months of their termination date</i> <input type="checkbox"/> Yes <input type="checkbox"/> No										
20. Replacement: Are any of the following a replacement of similar coverage? <i>If prior coverage, please include a copy of the prior carrier's plan.</i>										
Yes	No	Coverage			If Yes, Previous Carrier			Termination Date		
<input type="checkbox"/>	<input type="checkbox"/>	Life & AD&D Insurance								
<input type="checkbox"/>	<input type="checkbox"/>	Long Term Disability								
SECTION II. BENEFIT OPTIONS:										
THIS APPLICATION IS MADE FOR THE FOLLOWING OPTION. CHECK ONLY ONE BOX										
[Benefits]	Groups of [5 to 50] Employees					Groups of [10 to 50] Employees				
	Option A	Option B		Option C		Option D	Option E		Option F	
Life Insurance	\$35,000	\$25,000		\$35,000		\$50,000	\$40,000		\$50,000	
Waiver of Premium*	Yes	Yes		Yes		Yes	Yes		Yes	
Accelerated Benefit*	75% of Life	75% of Life		75% of Life		75% of Life	75% of Life		75% of Life	
Dependent Life	Yes	Yes		Yes		Yes	Yes		Yes	
Spouse	\$5,000	\$5,000		\$5,000		\$5,000	\$5,000		\$5,000	
Children	\$2,000	\$2,000		\$2,000		\$2,000	\$2,000		\$2,000	
14 days – 6 months	\$100	\$100		\$100		\$100	\$100		\$100	
Accidental Death & Dismemberment	\$35,000	\$25,000		\$35,000		\$50,000	\$40,000		\$50,000	
Long Term Disability	No	Yes		Yes		No	Yes		Yes	
Monthly Benefit	N/A	\$750		\$1,000		N/A	\$1,500		\$2,000	
Benefit Duration	N/A	2YR/RBD**		2YR/RBD**		N/A	2YR/RBD**		2YR/RBD**	
Elimination Period	N/A	60 Day	30 Day	60 Day	30 Day	N/A	60 Day	30 Day	60 Day	30 Day
Total Monthly Insurance Premium	\$12.00	\$16.00	\$19.00	\$21.00	\$25.00	\$15.00	\$26.00	\$34.00	\$34.00	\$44.00
Select one Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Waiver of premium and Accelerated benefits are only applicable to Life insurance. **Reducing Benefit Duration]										

TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT FEATURES:			
AD&D Riders	Benefits for Life and AD&D reduce by the following amounts on the insured's birthday*		
<input checked="" type="checkbox"/> Seat Belt /Air Bag	Reduction at Age of Employee		
<input checked="" type="checkbox"/> Coma	Age 65	Age 70	
<input checked="" type="checkbox"/> Repatriation	<input checked="" type="checkbox"/> 35%	<input checked="" type="checkbox"/>	50%
<input checked="" type="checkbox"/> Exposure and Disappearance	* Benefits for the covered person(s) terminate when no longer eligible or at retirement, whichever comes first.		
LONG TERM DISABILITY FEATURES:			
Disability Definition: Earnings / Occupation Test (80/20);[24] month own occupation		Drug & Mental Illness Limitation: 24 Month Lifetime Benefits	
Benefits Duration: [24] months RBD		Benefit Percentage: Flat benefit not to exceed [60%] of pre-disability earnings	
Pre-existing Condition: [3/12]		Integration: [non-integrated]	
W-2 Service Options for Long Term Disability			
<input type="checkbox"/> Option 1: Withhold Federal income Taxes and the employee's portion of FICA. Prepare and File W-2 Forms. <input type="checkbox"/> Option 2: Withhold Federal income Taxes and the employee's portion of FICA. Policyholder waives W-2 Forms Services. A detailed description of the W-2 services elected by the Policyholder pursuant to this application will be sent to the Policyholder by mail. Such services will be performed in accordance with the above election and established standard procedures.			
SECTION III. AUTHORIZATION:			
REMARKS OR SPECIAL PROVISIONS:			
<p>The undersigned employer and /or authorized representative hereby request that it be approved for insurance coverage through US Able Life and agrees to comply with all terms and provisions of the Group Policy (ies) issued in response to this application.</p> <p>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 US Able Life.</p> <p>Warning: 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.</p>			

_____ Dated at (City & State)

_____ Date

_____ Signature of Policyholder and Title

_____ Name of Licensed Agent

_____ Signature of Licensed Agent

For Home Office Use Only
Group #

INSTRUCTIONS – How to Complete Section II

Initial Enrollment – Adding Coverage:

Check “Yes” by each coverage you want. Check “No” by each coverage you do not want.

If you checked “Yes” by a coverage, check the “Add New” box, and complete the “Total Amount of Coverage” for which you are applying.

For example, you are applying for

- Voluntary Group Life/AD&D: \$50,000 on yourself, \$20,000/\$10,000 on your spouse and children

Section II. Voluntary Coverage(s)								
Coverage's	Insured	Indicate new or any changes to existing					Total Amount of Coverage	Premium (Completed by Employer)
		Indicate	Add New	Delete	Increase Increase	Decrease Existing		
Voluntary Group Life & Voluntary AD&D	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input checked="" type="checkbox"/> \$50,000	
Dependent Life Only	Spouse/Child	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$10,000/\$5,000 <input checked="" type="checkbox"/> \$20,000/\$10,000	

How to change or Delete Coverage:

If you are changing any of your coverage, please complete the information for all the coverage you have, so that we are sure we have everything correct. Be sure to check the appropriate “Add”, “Delete”, “Increase”, or “Decrease” box.

For example, you **currently** have:

- Voluntary Group Life/AD&D: \$30,000 on yourself, \$20,000/\$10,000 on your spouse and your children

You want to **change** your coverage to:

- Voluntary Group Life/AD&D: \$40,000 on yourself (increase), and decrease coverage for spouse and children to \$10,000/\$5,000

Section II. Voluntary Coverage(s)								
Coverage's	Insured	Indicate new or any changes to existing					Total Amount of Coverage	Premium (Completed by Employer)
		Indicate	Add New	Delete	Increase Increase	Decrease Existing		
Voluntary Group Life & Voluntary AD&D	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input checked="" type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000	
Dependent Life Only	Spouse/Child	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> \$10,000/\$5,000 <input type="checkbox"/> \$20,000/\$10,000	

<input type="checkbox"/> New Enrollee		<input type="checkbox"/> Change		<input type="checkbox"/> Decline all coverage		Group #:		
Employer: If Evidence of Insurability (EOI) is required, please submit the Evidence of Insurability form along with this enrollment form to us.								
Employer's Name:								
SECTION 1. EMPLOYEE INFORMATION								
Employee's Legal Name (First, MI, Last)						Social Security No.		
Home Address				City	State	Zip	Phone No.	
Date of Birth	Age	Gender	<input type="checkbox"/> M <input type="checkbox"/> F	Salary \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual			
Occupation (Be Exact)				Dept/Location				
Hours Worked Weekly				Date Employed Full-time				
Plan Information - Ask your employer for the details about the cost, if any, and whether you will be required to complete Evidence of Insurability (EOI).								
Section II. Voluntary Coverage(s) – See Instructions on Reverse or Page 2.								
Coverage's	Insured	Indicate new or any changes to existing					Total Amount of Coverage	Premium (Completed by Employer)
		Indicate	Add New	Delete	Increase Increase	Decrease Existing		
Voluntary Group Life & Voluntary AD&D	Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000	
Dependent Life	Spouse/Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$10,000/\$5,000 <input type="checkbox"/> \$20,000/\$10,000	
Voluntary LTD	Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>			Elected by your employer for all employees and will be indicated on your certificate	
Do you presently have other disability coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you intend to replace existing coverage with this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, give monthly amount \$								
Dependents to be covered (Life/AD&D)		Gender	Relationship	Social Security No.	Date of Birth			
		<input type="checkbox"/> M <input type="checkbox"/> F						
		<input type="checkbox"/> M <input type="checkbox"/> F						
		<input type="checkbox"/> M <input type="checkbox"/> F						
		<input type="checkbox"/> M <input type="checkbox"/> F						
Are you actively at work on the date of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No								
SECTION 2. EMPLOYEE BENEFICIARY DESIGNATION <input type="checkbox"/> Check if Change Only								
This will revoke any existing beneficiary designations you may have for these benefits.								
PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):								
Name (Last, First, MI)	Address	SSN	Birth Date	Relationship	Percentage			
Total must equal 100% =								
CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):								
Name (Last, First, MI)	Address	SSN	Birth Date	Relationship	Percentage			
Total must equal 100% =								
New Voluntary LTD plans and benefit increases: During the first year of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage.								
I represent that the information provided above is true and correct to the best of my knowledge and belief. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For those coverages I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability may be required. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.								
Warning: 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.							Date Received – Home Office	

Employee's Signature

Date

INSTRUCTIONS – How to Complete Section II

Initial Enrollment – Adding Coverage:

Check “Yes” by each coverage you want. Check “No” by each coverage you do not want.

If you checked “Yes” by a coverage, check the “Add New” box, and complete the “Total Amount of Coverage” for which you are applying.

For example, you are applying for

- Voluntary Group Life/AD&D: \$50,000 on yourself, \$20,000/\$10,000 on your spouse and your children
- Voluntary LTD: You are electing to add VLTD

Section II. Voluntary Coverage(s) – See Instructions on Reverse or Page 2.								
Coverage’s	Insured	Indicate new or any changes to existing					Total Amount of Coverage	Premium (Completed by Employer)
		Indicate	Add New	Delete	Increase Increase	Decrease Existing		
Voluntary Group Life & Voluntary AD&D	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input checked="" type="checkbox"/> \$50,000	
Dependent Life Only	Spouse/Child	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$10,000/\$5,000 <input checked="" type="checkbox"/> \$20,000/\$10,000	
Voluntary LTD	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>			Elected by your employer for all employees and will be indicated on your certificate	

How to change or Delete Coverage:

If you are changing any of your coverage, please complete the information for all the coverage you have, so that we are sure we have everything correct. Be sure to check the appropriate “Add”, “Delete”, “Increase”, or “Decrease” box.

For example, you **currently** have:

- Voluntary Group Life/AD&D: \$30,000 on yourself, \$20,000/\$10,000 on your spouse and your children
- Voluntary LTD

You want to **change** your coverage to:

- Voluntary Group Life/AD&D: \$40,000 on yourself (increase), decrease coverage for your spouse and children to \$10,000/\$5,000
- Voluntary LTD: Remove VLTD (delete)

Section II. Voluntary Coverage(s) – See Instructions on Reverse or Page 2.								
Coverage’s	Insured	Indicate new or any changes to existing					Total Amount of Coverage	Premium (Completed by Employer)
		Indicate	Add New	Delete	Increase Increase	Decrease Existing		
Voluntary Group Life & Voluntary AD&D	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input checked="" type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000	
Dependent Life Only	Spouse/Child	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> \$10,000/\$5,000 <input type="checkbox"/> \$20,000/\$10,000	
Voluntary LTD	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input checked="" type="checkbox"/>			Elected by your employer for all employees and will be indicated on your certificate	

SERFF Tracking Number: LSVX-G128026018 State: Arkansas
 Filing Company: USable Life State Tracking Number:
 Company Tracking Number: AR001680100002
 TOI: L04G Group Life - Term Sub-TOI: L04G.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: Small Group Applications, SG2-APP & VSG2-APP
 Project Name/Number: Small Group Application, SG2-APP/AR001680100002

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR - READABILITY CERTIFICATION.PDF		

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Attached to forms tab		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: SG2-APP Variables.PDF		

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: USAble Life

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
SG2-APP-AR (5-09)	43.5
SG2-APP-DL-AR (5-09)	41.3
VSG2-APP (5-09)	54.1
VSG2-APP2 (5-09)	50.3

Signed: 
Name: Connie Phillips
Title: Assistant General Counsel & Assistant Secretary
Date: 2/1/2012

STATEMENT OF VARIABILITY

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

Small Group Insurance Application, SG2-APP

Section I. Group Information

1. Item #11. Increase the number of classes based on the groups requirements. 2 employees can range from 2 to 50 and reference to Grp and Vol can come in or out.
2. Item #13. Billing methods to come in or out
3. Item #14. Voluntary in or out
4. Item #15. Voluntary in or out
5. Item #16. Voluntary in or out
6. Item #18. Voluntary reference in or out
7. Item #19. Voluntary in or out
8. Item #20. The 12 month period is 6 or 12 months
9. Item 20a. In or out
10. Item 21. Grp and Vol can come in or out

Section II. Employer Benefit Options

1. All reference to number of employees (i.e., 2 to 50) is variable from 2 to 100
2. First sentence. In or out
3. Starting at step one, the entire section is variable
 - a. Group Term Life and AD&D Insurance. Amounts range from \$10,000 to \$100,000
 - b. Group Long Term Disability. LTD benefit range from \$500 to \$5,000
 - i. Elimination period range from 30 to 180 days
 - c. Ability to add a duration period from 2 to age 65 RBD
4. Footnotes
 - a. Requires a minimum of 5 eligible employees participating. In or out and the range is from 2 to 25
 - b. Amounts between classes In or out and the range is 2 to 3
5. Step 2. The entire section is in our out
 - a. Group can be in or out
 - b. Dependent Life
 - i. Spouse from \$5,000 to \$10,000
 - ii. Children from \$2,000 to \$10,000

Section III. Employee Benefit Options

1. The entire section in our out
 - a. Employee Life/ADD range from \$20,000 to \$100,000
 - b. Dependents
 - i. Spouse range from \$10,000 to \$50,000
 - ii. Child range from \$5,000 to \$10,000
 - c. LTD elimination period from 30 to 180 days
 - d. LTD benefit range from \$500 to \$3,000
2. Term Life and Accidental Death & Dismemberment Features. Voluntary reference in or out
 - a. Voluntary plan riders in or out
3. Long Term Disability Features
 - a. Disability Definition range from 24 to 60 month own occ
 - b. Benefit duration range from 2 to age 65 RBD, group & voluntary in or out
 - c. Pre-existing condition: 3 to 24 months
 - d. Benefit Percentage range from 50% to 66 2/3%
 - e. Integration from \$500 to \$3,000

Small Group Insurance Application, SG2-APP-DL

Section I. Group Information

1. Item #11. Increase the number of classes based on the groups requirements. 2 employees can range from 2 to 5 and reference to Grp and Vol can come in or out.
2. Item #13. Billing methods to come in or our
3. Item #14. Voluntary in or out
4. Item #15. Voluntary in or out
5. Item #16. Voluntary in or out
6. Item #18. Voluntary reference in or out
7. Item #19. Voluntary in or out
8. Item #20. The 12 month period is 6 or 12 months
9. Item 20a. In or out
10. Item 21. Grp and Vol can come in or out

Section II. Employer Benefit Options

1. All reference to number of employees (i.e., 2 to 50) is variable from 2 to 100
2. Any one of the 6 plans can be removed
 - a. Additional plans can be added based on the variables
3. The benefits within the plans are variable as follows:
 - a. Life Insurance: \$10,000 to \$100,000
 - b. Accelerated Death Benefit: 50% to 100%
 - c. Dependent Life
 - i. Spouse: \$5,000 to \$10,000
 - ii. Child
 1. 6 months and over: \$2,000 to \$10,000
 - d. AD&D:\$25,000 to \$100,000
 - e. LTD benefit
 - i. Amount: \$500 to \$3,000
 - ii. Duration: 2 year to full RBD
 - iii. Elimination period 30 to 180 day
4. Long Term Disability Features
 - a. Disability Definition: 24 month to 60 month
 - b. Duration: 24 months to full RBD
 - c. Pre-x: 5-09 limits
 - d. Benefit Percentage: 50% to 66 2/3%
 - e. Integration: integrated and non-integrated