



P. O. Box 1650
Little Rock, AR 72203

Please Print Using Dark Ink

ARKANSAS PUBLIC SCHOOL EMPLOYEES GROUP

Application, Change Form & Beneficiary Change Form

For Office Use Only		
Class	Dep	SIC
Eff. Date		
Group #		

- Instructions:**
1. For \$5,000 Basic Life/AD&D **ONLY** – complete rows 1, 2, 3, 4, 5, 7, 8, 9 and sign as well as date the form.
 2. For \$5,000 Basic Life/AD&D **AND/OR** Supplemental Life/AD&D, Dependent Life – **complete all areas.**
 3. Return Completed Form to Your School District Payroll Office.

New Applicant
 Benefit Change
 Name Change
 Beneficiary Change

APPLICANT INFORMATION

1. Employer (Agency /School District Name)		Group Number AS004404-		Product(s) <input checked="" type="checkbox"/> Basic Life/AD&D <input type="checkbox"/> Supplemental Life/AD&D <input type="checkbox"/> Dependent Life	
2. Employee Social Security #	Employee Last Name		First Name	Middle Initial	Date of Birth Mo _____ Date _____ Year _____
3. Home Address		Street	City	State	Zip
4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Height (ft.-in.)	Weight (lbs)	Marital Status	Date of Hire (Include Month/Day/Year)
5. Home Phone #		Work Phone #		Annual Salary	

6. Spouse & Children Information – Complete if Applying for Dependent's Coverage

Person Proposed for insurance Show first, middle, last name	Social Security #	Occupation	Date of Birth & Place				Height	Weight	Marital Status	Sex
			Mo.	Day	Yr.	State or Country				
(spouse)										
(child)										
(child)										
(child)										

BASIC/SUPPLEMENTAL/DEPENDENT LIFE

Supplemental Employee Life and AD&D				Dependent Life		Monthly Premium	
Are you currently enrolled in one of the Arkansas Public School Employees qualified health plans? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No		\$5,000 Basic Employee Life \$0.56	
Classification By Basic Annual Earnings	Insurance Amount	Check One	Monthly Premium	Spouse: \$2,500 Your spouse/child will not be covered for Dep. Life if also covered as an employee of the AR Public School Group.		Supplemental Employee Life \$ _____	
\$10,000 or less	\$20,000	<input type="checkbox"/>	\$ 4.60	Child(ren): \$2,500 - 3 years of age and over \$1,000 - 14 days of age to 3 years of age		Dependent Life \$ _____	
\$10,001 - \$15,000	\$30,000	<input type="checkbox"/>	\$ 6.90	Monthly Premium \$0.48		Total Monthly Premium \$ _____	
\$15,001 - \$20,000	\$40,000	<input type="checkbox"/>	\$ 9.20				
\$20,001 - \$25,000	\$50,000	<input type="checkbox"/>	\$11.50				
\$25,001 - \$30,000	\$60,000	<input type="checkbox"/>	\$13.80				
\$30,001 and above	\$70,000	<input type="checkbox"/>	\$16.10				

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) 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; (c) 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; (d) agree that this authorization shall be valid for two (2) years from the application date; (e) 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; (f) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act; and (g) acknowledge receipt of the Insurance Fraud Warning. 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.

Insurance Fraud 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 may be guilty of a crime and subject to fines and confinement in prison.

DATE OF APPLICATION

MONTH/DAY/YEAR

EMPLOYEE SIGNATURE

SIGNATURE OF EMPLOYER/WITNESS

PRINTED NAME OF EMPLOYER/WITNESS

7. Employee Name (Last, First, M.I.)	Social Security #	Employer	Group # AS004404-_____
--------------------------------------	-------------------	----------	---------------------------

BASIC AND SUPPLEMENTAL LIFE/AD&D BENEFICIARY DESIGNATION

I hereby designate the following (beneficiaries) under this Plan and revoke any existing beneficiary designation I may have made for basic and/or supplemental life/AD&D insurance benefits. I understand that this change must be on a form acceptable to USABLE Life and received at our Home Office. I further acknowledge that any designation or change will be effective the date made, subject to any payment USABLE Life may have made before it is received.

PRIMARY BENEFICIARY(IES) [Will receive proceeds if living at death of Employee.]:

8. Last Name	First Name	MI	SSN	Birthdate	Relationship	Percentage
Total						= (Total must equal 100%)

CONTINGENT BENEFICIARY(IES) [Will receive proceeds if Primary Beneficiary(ies) are not living.]:

9. Last Name	First Name	MI	SSN	Birthdate	Relationship	Percentage
Total						= (Total must equal 100%)

Complete this section only if applying for Supplemental Life or Dependent Life more than 31 days after your hire date.
Complete the information below on yourself (if applying for Supplemental Life)
and on your dependents (if applying for Dependent Life).

- Have you, your spouse or children been hospitalized for any reason during the past five (5) years? No Yes
 If yes, give date, reason hospitalized and name of person hospitalized:

- Have you, your spouse or children consulted a physician in the past one (1) year? No Yes
 If yes, give name of person seen by doctor, reason seen, and name(s) of doctors seen:

- Have you, your spouse, or children ever been diagnosed by or received treatment from a member of the medical profession for:

	No	Yes		No	Yes
1) Cancer or any cancer related disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	6) Lung, Liver or Blood Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
2) Disease of the heart or blood vessels, or had a stroke?...	<input type="checkbox"/>	<input type="checkbox"/>	7) Emotional, Nervous System or Mental Health Problems?	<input type="checkbox"/>	<input type="checkbox"/>
3) Kidney disease or diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>	8) Hypertension (high blood pressure)? (Give last two blood pressure readings, dates, medication taken, and medication dosage below)?.....	<input type="checkbox"/>	<input type="checkbox"/>
4) AIDS or AIDS Related Complex, Immune Deficiency Disorder, or tested positive for antibodies to HIV?.....	<input type="checkbox"/>	<input type="checkbox"/>			
5) Alcohol or Drug Abuse?.....	<input type="checkbox"/>	<input type="checkbox"/>			

GIVE DETAILS TO ANY "YES" ANSWERS TO QUESTION 3 above, including name of person, diagnosis, and dates of treatment:

- Do you, your spouse or children have any impairments, diseases or illnesses not covered in questions 1, 2, or 3? No Yes
 If yes, give details, including name of person, diagnosis, and dates of treatment:

- Are you, your spouse or children currently taking medication(s)? No Yes If yes, give name of person, medication(s) and dosage:

- Name, address, and phone number of personal physician(s):



P.O. Box 1650
Little Rock, AR 72203

NOTICE FOR PROPOSED INSURED

Notice of Insurance Information Practices

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

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

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

Insurance Fraud 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 may be guilty of a crime and subject to fines and confinement in prison.

Federal Fair Credit Reporting Act Notice

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

Medical Information Bureau Disclosure Notice

Information regarding your insurability will be treated as confidential. US Able Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (Bureau), a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Toll-Free Tel. (866) 692-6901 [TTY (866) 346-3642 for hearing impaired].

US Able Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.