

Beneficiary Change Form

| Date f | Received Home Office |
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P.O. Box 1650 Little Rock, Arkansas 72203-1650

| Insured Name (First, MI, Last) | | | Birthdate | | Social Security Number | | |
|---|---|------------|---------------------|----------|------------------------|---------------------------------------|----------------------------|
| Address Street | City | S | tate ZIP | | Daytime Telephor | Daytime Telephone | |
| Employer Name (if applicable) Policy Number | | | | | | Policy Number | |
| For Individual Life Police If the Policyowner is differ complete this form. | cies Only: erent from the insure | d, the pol | icy owner <i>mu</i> | st | Policyowner N | lame (if other than Ins | ured) |
| I hereby designate the for existing beneficiary(ies): | bllowing beneficiary(i | es) under | the following | cove | rage(s) and re | evoke the appointm | ent of any |
| Policy Number | | | Type of Pol | icy/C | ertificate | | |
| | 1, 20 E A 1 | | | | | | |
| | | | | | | · · · · · · · · · · · · · · · · · · · | |
| PRIMARY BENEFICIAR | V/IES) Will rocci | vo proce | ode if living | n at i | death of Inc | ured: | |
| PRIMARY BENEFICIAN | (1(1ES) - WIII Tecel | | Social | | | | |
| Last Name | First Name | MI | Security # | E | Birthdate | Relationship | Percentage |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | 1 | | | | | Total = | (Total must equal 100%) |
| CONTINGENT BENEFIC | CIARY(IES) - Will r | eceive p | roceeds if F | rim | ary Benefici | ary(ies) are also | |
| at death of Insured: | | <u> </u> | Social | | ~~ | | |
| Last Name | First Name | MI | Security # | <u>E</u> | Birthdate | Relationship | Percentage |
| | | | | | | | |
| | | | | - | | | |
| | | | | | | | |
| | | | 1 | | www.latebitT | Total = | (Total must equal 100%) |
| Dated at | | , this the | day | of | | 1 | |
| Cianak | re of Insured | <u></u> | | anati | ire of Policyou | vner (if other than Ir | nsured) |
| THIS BENEFICIARY D | | T VALIE | | - | - | | |

HOME OFFICE.

See Page 2/Reverse Side For Instructions

INSTRUCTIONS

- 1. The signature of the Insured and Policyowner (if other than Insured), is required.
- 2. This form must be completed, signed, and forwarded to Your Employer's Home Office.
- 3. Give full legal name of each beneficiary and relationship to the Insured.

SAMPLE BENEFICIARY DESIGNATIONS

- 1. UNNAMED CHILDREN AS BENEFICIARIES: The legal, natural or adopted child or children of the Insured.
- 2. PARTNERSHIP AS BENEFICIARY: Doe & Company, 100 North Main, Anytown, USA, a partnership composed of John H. Doe and Richard A. Doe.
- 3. CORPORATION AS BENEFICIARY: Doe & Company, 100 North Main, Anytown, USA, a corporation organized under the laws of the State of Arkansas.
- TRUST AS BENEFICIARY: John H. Doe, Trustee under Trust Agreement dated ________
- 5. CHARITY: American Cancer Society, 234 Main, Anytown, USA.

| Complete of a blamp (Clest till I ant) | Social Security # | Employer Name |
|--|-------------------|----------------|
| Employee's Name (First, Mi, Last) | Social Geodity # | English trains |
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NOTICE FOR PROPOSED INSURED

IMPORTANT NOTICE FOR DISABILITY COVERAGE

Acceptance of your application for disability income insurance will be based upon the information contained in the Evidence of Insurability, including the medical information disclosed and information obtained from your medical providers. Your insurance coverage may not be issued as applied for. If not, an "Exclusion of Coverage Amendment" will be attached to your certificate of coverage.

PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT.

IMPORTANT NOTICE CONCERNING YOUR EFFECTIVE DATE

- 1. Insurance will not be effective until the application is approved by USAble Life.
- Insurance will not be effective if there has been a change in the health of the proposed insured(s) after the date of the application and prior to the effective date.
- 3. For benefits sheltered under a Section 125 Cafeteria plan: To satisfy premium deduction requirements of your employer and dating requirements of the Section 125 Plan, your coverage will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) of the Section 125 agreement or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

In signing below, I: (a) represent that the statements and answers given in this application, are true, complete and correctly recorded to the best of my knowledge and belief; (b) understand that the insurance applied for is not effective until the application is approved by USAble Life; (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 medical facility, insurance or reinsurance company, or MIB, Inc., formerly known as 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 date the authorization is signed; (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 I have read and understand all disclosures on this form; and (l) acknowledge receipt of written notification describing the use of the MIB as required by the Fair Credit Reporting Act and the Notice of Information Practices. I have read and understand the above statements and agreements.

| Insurance Frat insurance comp and denial of ins | Date Received Home Office | | | |
|---|---------------------------|---------------------|----------------------|--|
| Signed at: | | Date of Application | | |
| | City and State | | Month, Day, Year | |
| X | | x | | |
| | Agent's Signature | | Employee's Signature | |

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MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

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

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

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