USAble Life
P.O. Box 1650 • Little Rock, Arkansas 72203

EVIDENCE OF INSURABILITY (Please Print)
A completed Enrollment Form must accompany this form.

SECTION 1 –Completed By Employer

Group Name	Date of Hire	Telephone # (include area code)	Group Number

Amount of Insurance Applying for:
Employee Life: $ Dependent Life $ Disability $ Other:

Employee's Annual Salary

SECTION 2 – Completed by Employee ☐ Vol. Group Term Life ☐ Amount over Guarantee Issue ☐ Late Enrollee

Name (First, MI, Last)			Social Security No.	
Home Address	City	State	Zip	County

Date of Birth	Birth State or Country	Gender ☐ M ☐ F	Height (ft-in.)	Weight (lbs.)	Work Phone(	Home Phone

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

Person Proposed for Insurance Show first, middle, last name	Occupation	Date of Birth & Place: Month	Day	Year	State or Country	Height	Weight	Marital Status	Sex
(Spouse)									
(Child)									
(Child)									
(Child)									
(Child)									

Spouse's Social Security No.: Spouse's Work Telephone #:

SECTION 3 – Insurability Questionnaire

	Yes	No
1. Has anyone to be covered used any tobacco products in the past year?	☐	☐
2. Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised?	☐	☐
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years?	☐	☐
4. Has anyone to be covered consulted a physician in the past one (1) year for any reason?	☐	☐

5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for:

	Yes	No		Yes	No
a. Cancer, cancer related disease or benign tumor?	☐	☐	f. Emotional, nervous system, eating disorder, or mental health problems?	☐	☐
b. Disease of the heart or blood vessels, or had a stroke?	☐	☐	g. Ulcer, stomach or digestive disorder?	☐	☐
c. Kidney disease or diabetes?	☐	☐	h. Arthritis, back, bones or joint disorder?	☐	☐
d. Alcohol or drug abuse?	☐	☐	i. Bladder, urinary system or reproductive organs disorder?	☐	☐
e. Lung, asthma, liver or blood disorder?	☐	☐			

6. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")?	☐	☐
7. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4.	☐	☐
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4.	☐	☐
9. Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8?	☐	☐
10a. Are you now pregnant? ☐ Yes ☐ No — 10b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section?	☐	☐
11. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If No, give full details in Section 4.	☐	☐

12. Names, addresses, and phone numbers of the personal physicians of all applicants:

SECTION 4 – Give Details to "Yes" answers to questions 2 through 10 include dates of treatment: ☐ Separate Sheet Attached

Ques. No.& Individual	Illness/Reason for Checkup or Medication & Dosage or Doctor's Treatment/Consultation	Date & Duration	Full Name, Complete Address and Telephone Number of Doctors & Hospitals

Be Sure to Read the Important Disclosures and sign on Page 2/Reverse

EOI-A (1-13)

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

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.