USAble Life℠

LIFE INSURANCE | CLAIM FORM

FOR QUESTIONS, CONTACT CUSTOMER SERVICE AT 1-800-370-5856, MONDAY THROUGH FRIDAY, 8:00 AM TO 5:00 PM CST.

WHERE TO SUBMIT YOUR CLAIM:
Attention: Claims Department
Mail: PO Box 1650 | Little Rock | AR | 72203
Email: claims@usablelife.com | **Fax:** 501-235-8416

EMPLOYEE INFORMATION

INFORMATION FOR INSURED EMPLOYEE

LAST NAME, FIRST NAME, MI | ☐ **FEMALE** ☐ **MALE** GENDER | SOCIAL SECURITY NUMBER | BIRTH DATE (MM/DD/YY)

ADDRESS | CITY | STATE | ZIP CODE

INSURED INFORMATION

INFORMATION FOR COVERED INDIVIDUAL WHO SUFFERED THE LOSS

LAST NAME, FIRST NAME, MI | ☐ **FEMALE** ☐ **MALE** GENDER | SOCIAL SECURITY NUMBER | BIRTH DATE (MM/DD/YY)

☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** RELATIONSHIP EMPLOYEE

☐ **YES** *IF YES, SUBMIT POLICE AND TOXICOLOGY REPORTS* ☐ **NO** WAS LOSS DUE TO ACCIDENT?

DATE OF LOSS (MM/DD/YY)

EMPLOYER STATEMENT

EMPLOYER NAME | USABLE LIFE POLICY NUMBER | EMPLOYER TELEPHONE NUMBER | EMPLOYER FAX NUMBER

EMPLOYER ADDRESS | CITY | STATE | ZIP CODE

HIRE DATE (MM/DD/YY) | EMPLOYEE MOST RECENT JOB TITLE | ☐ **YES** *IF YES, PROVIDE SALARY INFORMATION* ☐ **NO** IS BENEFIT BASED ON SALARY MULTIPLE? | $ EMPLOYEE SALARY

SALARY EFFECTIVE DATE (MM/DD/YY) | DATE LAST PHYSICALLY AT WORK (MM/DD/YY) | ☐ **DEATH** ☐ **DISABILITY** ☐ **RETIREMENT** ☐ **EMPLOYMENT TERMINATED** REASON EMPLOYEE WAS NOT ACTIVELY AT WORK AT TIME OF LOSS

☐ **GROUP LIFE** $_____ ☐ **VOLUNTARY GROUP/SUPPLEMENTAL LIFE** $_____ ☐ **ACCIDENTAL DEATH** $_____ ☐ **DEPENDENT LIFE** $_____
WHAT BENEFITS IS THE INSURED ENROLLED IN? *PROVIDE BENEFIT DOLLAR AMOUNTS IN SPACES BESIDE APPLICABLE BENEFITS*

☐ **YES** ☐ **NO** *IF NO, GIVE DATE DISCONTINUED:* ARE PREMIUMS PAID-TO-DATE FOR THIS INSURED?

☐ **YES** *IF YES, SUBMIT BENEFICIARY DESIGNATION FORM* ☐ **NO** WAS A BENEFICIARY DESIGNATED?

☐ **SPOUSE** ☐ **MINOR** ☐ **TRUST** ☐ **ESTATE** ☐ **OTHER** BENEFICIARY TYPE

▼ SIGN AND DATE BELOW

I attest to the fact that the information furnished above is to the best of my knowledge, complete and accurate.

LAST NAME, FIRST NAME, MI *(PRINTED)* | JOB TITLE | SIGNATURE | TODAY'S DATE (MM/DD/YY)

⚠ **FRAUD WARNING:** EXCEPT AS NOTED IN THE SEPARATE FRAUD NOTICE, 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.

BENEFICIARY STATEMENT

ADDITIONAL BENEFICIARY STATEMENTS ON NEXT PAGE

BENEFICIARY LAST NAME, FIRST NAME, MI

☐ **FEMALE** ☐ **MALE**
GENDER

SOCIAL SECURITY NUMBER

BIRTH DATE (MM/DD/YY)

ADDRESS

CITY

STATE

ZIP CODE

☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** _____
RELATIONSHIP INSURED EMPLOYEE

DAYTIME TELEPHONE

FAX NUMBER OR EMAIL ADDRESS

▼ **SIGN AND DATE BELOW**

I attest to the fact that the information furnished above is to the best of my knowledge, complete and accurate.

BENEFICIARY/REPRESENTATIVE LAST NAME, FIRST NAME, MI *(PRINTED)*

SIGNATURE

TODAY'S DATE

AUTHORIZATION TO OBTAIN INFORMATION

▼ **SIGN AND DATE BELOW**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, health maintenance organization, the Medical Information Bureau (MIB), government entity (federal, state, or local), reinsurer, or other organization, institution or person that has information, records or knowledge of me or my health, past or present, to furnish such information to USAble Life (the "Company"), or its agents. I understand that the Company may disclose the information to MIB, other insurance carriers, reinsurers, claim management/investigation firms, agents, employees and others who have a legitimate business interest in obtaining the information in connection with underwriting or claim processing. A photocopy of this Authorization shall be as valid as the original.

NEAREST RELATIVE LAST NAME, FIRST NAME, MI *(PRINTED)*

RELATIONSHIP TO INSURED

SIGNATURE

TODAY'S DATE

CLAIM SUBMISSION CHECKLIST

BEFORE SUBMITTING YOUR CLAIM, PLEASE REVIEW THE LIST BELOW FOR ITEMS THAT MAY BE REQUIRED FOR PROCESSING:

FOR ALL CLAIMS: ☐ COMPLETED CLAIM FORM ☐ SIGNED FRAUD NOTICE ☐ EMPLOYEE BENEFIT APPLICATION ☐ BENEFICIARY DESIGNATION FORM ☐ DEATH CERTIFICATE*

FOR ACCIDENTAL DEATH CLAIMS: ☐ POLICE REPORT ☐ AUTOPSY REPORT ☐ TOXICOLOGY REPORT

FOR CLAIMS NAMING MINORS AS THE BENEFICIARY: ☐ LETTERS OF GUARDIANSHIP ☐ BIRTH CERTIFICATE AND SOCIAL SECURITY CARD OF BENEFICIARY

FOR CLAIMS WITHOUT APPOINTED BENEFICIARY OR NAMING AN ESTATE AS THE BENEFICIARY: ☐ LETTERS OF ADMINISTRATION OR TESTAMENTARY

FOR CLAIMS NAMING A TRUST AS THE BENEFICIARY: ☐ COPIES OF TRUST AND LETTERS OF ACCEPTANCE FROM THE TRUSTEE WITH THE TRUST ID NUMBER

**DEATH CERTIFICATE MUST CONTAIN ORIGINAL SEAL FOR CLAIMS EXCEEDING $50,000*

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ADDITIONAL BENEFICIARY STATEMENT

BENEFICIARY LAST NAME, FIRST NAME, MI

GENDER ☐ **FEMALE** ☐ **MALE**

SOCIAL SECURITY NUMBER

BIRTH DATE (MM/DD/YY)

ADDRESS

CITY

STATE

ZIP CODE

RELATIONSHIP INSURED EMPLOYEE ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** ___________________

DAYTIME TELEPHONE

FAX NUMBER OR EMAIL ADDRESS

SIGN AND DATE BELOW

I attest to the fact that the information furnished above is to the best of my knowledge, complete and accurate.

BENEFICIARY/REPRESENTATIVE LAST NAME, FIRST NAME, MI *(PRINTED)*

SIGNATURE

TODAY'S DATE

ADDITIONAL BENEFICIARY STATEMENT

BENEFICIARY LAST NAME, FIRST NAME, MI

GENDER ☐ **FEMALE** ☐ **MALE**

SOCIAL SECURITY NUMBER

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CITY

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ZIP CODE

RELATIONSHIP INSURED EMPLOYEE ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** ___________________

DAYTIME TELEPHONE

FAX NUMBER OR EMAIL ADDRESS

SIGN AND DATE BELOW

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BENEFICIARY/REPRESENTATIVE LAST NAME, FIRST NAME, MI *(PRINTED)*

SIGNATURE

TODAY'S DATE

ADDITIONAL BENEFICIARY STATEMENT

BENEFICIARY LAST NAME, FIRST NAME, MI

GENDER ☐ **FEMALE** ☐ **MALE**

SOCIAL SECURITY NUMBER

BIRTH DATE (MM/DD/YY)

ADDRESS

CITY

STATE

ZIP CODE

RELATIONSHIP INSURED EMPLOYEE ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** ___________________

DAYTIME TELEPHONE

FAX NUMBER OR EMAIL ADDRESS

SIGN AND DATE BELOW

I attest to the fact that the information furnished above is to the best of my knowledge, complete and accurate.

BENEFICIARY/REPRESENTATIVE LAST NAME, FIRST NAME, MI *(PRINTED)*

SIGNATURE

TODAY'S DATE

USAble Life℠

AUTHORIZATION | To Disclose, Obtain and Use Personal Information

Read and sign below.

In signing below, I represent the statements I may have provided for claim review are true, complete and correct. I hereby authorize third persons, including, without limitation: any financial institution, consumer reporting agency, insurance company or reinsurer, insurance service organization such as the MIB, Inc., benefit plan administrator, health plan, hospital, health care provider, pharmacy, laboratory, business associate, governmental entity (federal, state, or local), or any other organization or individual (collectively "Third Parties"); to disclose the minimum necessary personal, financial and health information, including physical, psychological, psychiatric, drug or substance use and communicable disease diagnosis or treatment information ("Personal Information") to USAble Life (the "Company"), its representatives or agents in connection with underwriting, claim evaluation or processing, medical or disability assessment and management, or treatment, payment, and operations related activities (the "Permitted Activities"). The Company may possess and further disclose Personal Information obtained from me, Third Parties, or developed by the Company to other Third Parties, claim or medical management organizations, investigative firms, agents, employees, consultants and others who have a legitimate business interest in obtaining the minimum necessary Personal Information in connection with the Permitted Activities. If any provision of this authorization is or becomes invalid or unenforceable pursuant to applicable Federal or State laws, it shall be ineffective only to the extent of such invalidity or unenforceability, and the remaining provisions of this authorization shall not be affected.

This authorization is valid for the lesser of: the period that my coverage from the Company remains in effect or; if this authorization is given in connection with the Company's consideration of a claim for benefits, for the duration of the Company's consideration of that claim. I have the right to revoke this authorization, in writing, at any time or to refuse to sign this authorization. I acknowledge that if I do so, that revocation may adversely affect the completion of the Permitted Activities, including the denial of a claim for benefits. Any written revocation of this authorization shall become effective upon receipt by the Company, but shall not apply retroactively as to Personal Information that has been previously disclosed, obtained or used in accordance with this authorization. A photocopy of this form is as valid as the original. A copy of this authorization will be provided to me or my authorized representative upon request.

Signature

Sign and date this form.

I have executed this authorization intending that it will be effective on and after:

Date

•

Signature

•

Printed name

•

Return original with your claim and retain a copy of this authorization and claim form for your records.

⚠ USABLE LIFE℠ | FRAUD NOTICE

FOR YOUR PROTECTION, THE LAWS OF SOME STATES MAY REQUIRE US TO FURNISH YOU WITH THE FOLLOWING NOTICE:
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. Please see below for special notices required by state law.

AL Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AK Residents Only: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

AZ Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA Residents Only: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO Residents Only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE, ID, IN, OK Residents Only: Any person who knowingly, and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC Residents Only: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL Residents Only: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KS Residents Only: 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 as determined by a court of law.

KY Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

ME and TN Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

MD, RI, TX Residents Only: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MN Residents Only: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NH Residents Only: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ Residents Only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OH Residents Only: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OR Residents Only: 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.

PA Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VT Resident Only: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

VA and WA Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

▼ SIGN AND DATE BELOW

I have read and understand the Fraud Warning that applies to my state of residence.

LAST NAME, FIRST NAME, MI *(PRINTED)*	SIGNATURE	TODAY'S DATE