



**USABLE LIFE**  
 Group Health Division  
 320 West Capitol, Suite 900  
 Little Rock, Arkansas 72203-1151  
 (800) 519-2583

**APPLICATION FOR  
 CONVERSION POLICY**

**CONVERSION APPLICATION**

Please check the appropriate box and fill in blanks below in ink.

**SECTION 1. PERSON APPLYING FOR COVERAGE** (Complete this section on all members to be covered.)

Social Security Number	First Name	M. I.	Last Name	Relationship	Birth Date Mo/Day/Yr	Sex M or F
Oldest Person _____-_____-_____				APPLICANT (Age 0-64)		
Spouse, if applying _____-_____-_____				SPOUSE		
Child - Under age 19 _____-_____-_____						
Child - Under age 19 _____-_____-_____						
Child - Under age 19 _____-_____-_____						

Do all dependents listed above reside at the same address as employee?  Yes  No

If NO, list dependent(s) name and address:

**SECTION 2. PERSONAL INFORMATION**

APPLICANT'S MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOWED

Applicant's Employer:	Job Duties:
Spouse's Employer:	Job Duties:

**SECTION 3. RESIDENCE ADDRESS**

Home Address:	City	State	Zip Code
Home Phone No. ( )	Work Phone No. ( )	Best Time to Call: ____AM ____PM	[ ] Home [ ] Work

**SECTION 4. TYPE OF COVERAGE**

**SECTION 5. BILLING MODE**

<input type="radio"/> Individual <input type="radio"/> Family	<input type="radio"/> Monthly Bank Draft	<input type="radio"/> Semi-Annually
	<input type="radio"/> Quarterly	<input type="radio"/> Annually

**SECTION 6. CURRENT INSURANCE**

Name of Current Insurance Company ID No. Group No.

Will you, your spouse or dependents be continuing any other health insurance coverage, including Medicare?  Yes  No

If Medicare, reason for coverage:  Over 65  Disabled  Kidney Disease

If you answered YES to the question above, complete next section. (Use additional paper if necessary.)

Name of Persons Covered	Name, Addr & Phone No. of Health Insurance Company	Insurance or Medicare No.	Effective Date	Employer Providing Coverage

Have you or anyone to be covered previously had a USABLE Life health policy?

Yes  No (If yes, please provide the ID# and approximate dates of coverage.)

**SECTION 7. SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)**

I understand (1) This application may be rejected if it is incomplete. (2) If accepted, coverage will not become effective before the date shown on my identification card. (3) In addition to other exclusions and limitations, NO USABLE LIFE BENEFITS WILL BE AVAILABLE FOR UP TO 12 MONTHS FROM MY EFFECTIVE DATE OF MY ORIGINAL COVERAGE (4) If my application is accepted relying on my representations on this document, any coverage that may be issued to me shall be invalid if based on false information. (5) Knowingly presenting a false or fraudulent claims for payment of a loss or benefit or knowingly presenting false information in an application for insurance is a crime, conviction of which may result in fines or imprisonment.

In signing below, I: (a) represent that the statements and answers given in this application are true, complete and correctly recorded; (b) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company having information with respect to any physical or mental condition treatment or any member of my family (if applicable), to give USABLE Life, their respective agents, or any subsidiaries, their reinsurers or their legal representative any and all such information to use for underwriting purposes; (c) authorize all said sources 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 a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request. I understand that any material misrepresentations, omission or intentional fraudulent statement may result in cancellation or rescission of any coverage issued in reliance thereon, and that USABLE Life may recover any monies and damages incidental and consequential that result.

_____	_____	_____
Print Name of Applicant	Signature of Applicant	Date
_____	_____	_____
Print Name of Spouse	Signature of Spouse	Date
_____	_____	_____
Print Parent / Guardian (if policy is for a minor)	Signature of Parent / Guardian	Date

**THIS APPLICATION IS VALID ONLY WHEN COMPLETED AND SIGNED.**

**FOR OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE.)**

ID No.	Group No.	Effective Date	Plan	Pkg	WWP
--------	-----------	----------------	------	-----	-----