



Mail to:
US Able Life
Group Health Division
320 W. Capitol, Suite 900
P. O. Box 1151
Little Rock, AR 72203-1151
(800) 519-2583

APPLICATION FOR REINSTATEMENT

Legal Name of Firm, Group Number, Telephone, Firm Address, City, State, Zip Code, County, Firm's Executive Contact, Firm's Administrative Contact

Business Type (Please check appropriate box): Sole Proprietor, Corporation, Government Entity

Federal Tax I.D. Number

Group Information:

Total Number of full time employees?

Total Number of eligible employees currently enrolled?

Number of full time employees not currently covered?

List the names of those not currently covered that have no other insurance coverage:

Blank lines for listing names of those not currently covered.

Employer contribution % Dependent contribution %

IMPORTANT NOTE: If Employer Contribution is 100%, all eligible employees must be enrolled.

To the best of your knowledge and belief, are any employees or dependents now disabled, unable to or not at work, hospital confined, on leave of absence, handicapped, contemplating hospital confinement or otherwise incapacitated as of this date? (If yes, please list names and details on the following lines).

Blank lines for providing details of disabled employees or dependents.

I hereby certify that all of the information contained in this application for reinstatement is correct.

Group Administrator

Date