



Attention: Claims Department
P.O. Box 1650
Little Rock, Arkansas 72203-1650
Telephone (800) 370-5856
Fax (501) 235-8417
Email: claims@usablelife.com

DISABILITY UPDATE FORM INSURED'S STATEMENT

IMPORTANT READ CAREFULLY

1. Please answer ALL questions on Insured's Statement.
2. Authorization and Fraud Notice must be currently signed and dated.
3. Have your physician complete the Attending Physician's Statement.
4. This form is to be completed without expense to US Able Life, and returned by: _____ to avoid interruption of your disability benefits.

Name & Address

Claim Number:
Policy Number:
Home or Daytime Phone Number:

1. Describe conditions AND symptoms currently causing disability.	
2. Have you received medical attention since your last report?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please list: a) Names of Doctors: b) Dates of Treatment:
3. Have you been hospitalized or undergone surgery since your last report?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please list: a) Name of Hospital: b) Dates of Confinement: c) Type of Surgery:
4. Briefly describe your present daily activities.	
5. Are you still totally disabled? (Unable to perform any of the duties of your regular occupation)	<input type="checkbox"/> Yes When do you expect to return to your regular occupation? Month ____ Day ____ Year ____ <input type="checkbox"/> No When were you able to return to your regular occupation? Month ____ Day ____ Year ____
6. If not totally disabled, are you partially disabled? (Able to perform only part of the duties of your regular occupation)	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes": a) When did you begin partial disability employment? Month ____ Day ____ Year ____ b) What important occupational duties have you been unable to perform during partial disability?
7. Are you now gainfully employed in other than your regular occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes": a) When did such employment begin? Month ____ Day ____ Year ____ b) Briefly describe the job and nature of duties performed:
8. Identify other income sources and amount of income which you are receiving or may be entitled to receive during this disability	
Your Social Security: (disability or retirement)	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Mo. V.A. Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Mo.
Dependent Social Security:	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Mo. Worker's Compensation: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Wk.
Sick Leave or Wage Continuation:	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Wk. Other Disability Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Wk.
Retirement: (normal, early or disability)	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Mo. (identify) _____
State Disability Income:	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Wk. Include a copy of your award or denial letter for any source in which one has been received.
Unemployment:	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ ____ Wk.

Please have your attending physician complete the Attending Physician's Statement.



P.O. Box 1650 · Little Rock, Arkansas 72203-1650

FRAUD NOTICE

For your protection, the laws of some states may require us to furnish you with the following notice:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act. Please see below for special notice required by state law.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

AR, LA, MD, RI, and WV: 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.

CA: For your protection California law requires the following to appear on this form: 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: 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 respect to a settlement or award from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies to the extent required by applicable law.

DE: Any person knowingly and with the intent to injure, defraud or deactivate any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

HI: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

ID: Any person knowingly and with the intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

IN: A person knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KY: Any person who knowingly and with the 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: 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 or a denial of insurance benefits.

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

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

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

NM: 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 civil fines and criminal penalties.

OH: A 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 false or deceptive statement is guilty of insurance fraud.

OK: WARNING: any person who knowingly and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR: A person who knowingly and with the intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud.

PA: 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.

TN, VA and WA: 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.

TX: 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.

Date

Signature



P.O. Box 1650
Little Rock, AR 72203-1650

Authorization to Disclose, Obtain and Use Personal Information

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 Medical Information Bureau, 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 US Able 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.

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

(Date)

Signature

Printed Name

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

