

SERFF Tracking Number: ANTX-125697601 State: Arkansas  
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 39374  
Company Tracking Number:  
TOI: H13G Group Health - Short Term Care Sub-TOI: H13G.002 Nursing Home  
Product Name: 2089C-0806-AR  
Project Name/Number: 2089C-0806-AR/2089C-0806-AR

## Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: 2089C-0806-AR	SERFF Tr Num: ANTX-125697601	State: ArkansasLH
TOI: H13G Group Health - Short Term Care	SERFF Status: Closed	State Tr Num: 39374
Sub-TOI: H13G.002 Nursing Home	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status: Submitted	Reviewer(s): Rosalind Minor
	Author: Sherry Wiegman	Disposition Date: 06/25/2008
	Date Submitted: 06/23/2008	Disposition Status: Approved-Closed
		Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: 2089C-0806-AR	Status of Filing in Domicile: Authorized
Project Number: 2089C-0806-AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 06/25/2008	
State Status Changed: 06/25/2008	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	
short term nursing facility coverage	

## Company and Contact

### Filing Contact Information

Sherry Wiegman, Sr. Compliance Analyst	sherry.wiegman@anico.com
One Moody Plaza 17th Floor	(409) 621-7779 [Phone]

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Galveston, TX 77550 (409) 766-2950[FAX]

**Filing Company Information**

Standard Life and Accident Insurance Company CoCode: 86355 State of Domicile: Oklahoma  
One Moody Plaza 17th Floor Group Code: 408 Company Type: Health Insurance  
Galveston, TX 77550 Group Name: State ID Number:  
(409) 621-7779 ext. [Phone] FEIN Number: 73-0994234  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? Yes  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	\$50.00	06/23/2008	21036583

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/25/2008	06/25/2008

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## Disposition

Disposition Date: 06/25/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form	Enrollment Application	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** 2089C-0806-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	2089C-0806-AR	Certificate	Certificate	Initial		45	AR GROUP CERTIFICATE.pdf
Approved-Closed	RCAPP08AR	Application/Enrollment Form	Enrollment Application	Initial		45	AR Application.pdf
Approved-Closed	RCCIR-0805	Certificate Amendment, Insert Page, Endorsement or Rider	Rider	Initial		45	GROUP CIP RIDER.pdf
Approved-Closed	RCSIR-0805	Certificate Amendment, Insert Page, Endorsement or Rider	Rider	Initial		45	GROUP SIP RIDER.pdf

## SHORT-TERM NURSING FACILITY CERTIFICATE OF COVERAGE

This is Your Certificate of Coverage (Certificate) while You are insured under the Master Group Policy (Policy). It explains the rights and benefits that are determined by the Policy. The Policy alone constitutes the agreement under which payments are made. Benefit payment is governed by all the terms, conditions and limitations of the Policy. A copy of the Policy is kept at the principal office of the Policyholder. You may inspect it during regular business hours.

**CONSIDERATION** Coverage is issued in consideration of the statements made in the application and payment of the initial premium. Coverage is not provided until You pay the first full premium. The first premium pays for the initial term of coverage. The initial term of coverage begins at 12:01 a.m. in the state where you live on the Effective Date shown on the Certificate Schedule of Benefits.

**PREMIUM DUE DATE** The initial premium is for the term shown on the Certificate Schedule of Benefits. The renewal premium for periods of coverage is due on the first day of the next term. Coverage will end (lapse) on the due date if the renewal premium in effect is not paid before the end of the Grace Period.

**PREMIUMS ARE SUBJECT TO CHANGE** Please refer to the section titled Premiums for further information.

**RENEWAL PROVISION** The Company can refuse to renew coverage under the Policy as of any renewal premium due date for reasons stated in the Termination Provision. You will be given 90 days notice prior to the termination date of such non-renewal. The Company will not non-renew coverage just because of the claims You file or because of a change in Your health or Your type of work.

**YOUR 30 DAY RIGHT TO EXAMINE CERTIFICATE** Within 30 days after You get this Certificate, You may return it in person or by regular mail to the Company or the agent who sold it to You, if for any reason You decide You do not want it. The Company will return Your premium to You. Then You and the Company will be in the same position as if a Certificate had never been issued.

**IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION:** The issuance of the Certificate is based upon Your responses to the questions on Your Application to Standard Life. A copy is attached. Carefully check all documents. If Your answers are incorrect or untrue, the Company has the right to deny benefits or rescind Your Certificate. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of Your answers are incorrect, contact the Company at the address shown above within 30 days from receipt of the attached copy.

**NOTICE TO BUYER: This is a limited benefit health Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.**

**THIS IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If You are eligible for Medicare, You should review the guide *Medicare & You* available from the Company.**

**THIS CERTIFICATE DOES NOT PROVIDE LONG TERM CARE COVERAGE. This Certificate provides limited services for confinements of less than one year and does not provide long-term care coverage.**

**FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.**



Secretary



President

**THIS IS A LIMITED BENEFIT HEALTH COVERAGE CERTIFICATE OF COVERAGE  
PLEASE READ THIS CAREFULLY!**

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**CERTIFICATE SCHEDULE OF BENEFITS**

**Insured Information**

**Certificate Number:** [123-45-6789]  
**Insured Name:** [John A. Doe]  
**Date of Birth:** [April 15, 1968]

**Effective Date:** [June 1, 2004]  
**Issue Age:** [36]

**Initial Premium:**

**Initial Term:** [Annual][Semi-annual][Quarterly][COM]

**Annual Premium**

[\$000.00]

**Elimination Period** [None][20 Days of Care (once per lifetime)]

**Lifetime Maximum Benefit** [[180][270][360] Days of Care]

**Maximum Daily Benefit Amounts**

Nursing Facility [\$50.00 - \$300.00]  
Assisted Living Facility [\$37.50 - \$225.00]

**Bed Reservation Benefit** [21 days per calendar year]

**Restoration Benefit** [[180][270][360] Days of Care]

**[Optional Attached Riders**

Simple Inflation Protection Rider [\$00.00]

Compound Inflation Protection Rider [\$00.00]

**[Applicable Premium Discounts:**

Spouse [10%]  
Preferred Underwriting [20%]

**[Other Premium Modes:** [Annual] [Semi-annual] [Quarterly] [Monthly (COM)]

**Certificate Fee:** [\$20.00]

**[Total Annual Premium \$000.00 ]**

**Group Policyholder:** [National Consumers Advantage Association]

**Group Policy Number:** [xxxxxxxx]

**State of Issue:** [Nebraska]

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## SECTION I – DEFINITIONS

The terms listed below, when used in this Certificate, will have the following meanings:

Activities of Daily Living (ADLs) refer to certain basic daily tasks necessary to maintain Your health and safety. In the Certificate, ADLs refers to the activities described below:

1. Bathing means washing yourself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.
2. Continence means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
3. Eating means feeding yourself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously. Eating does not include meal preparation.
4. Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
5. Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. Transferring means the ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment. Transferring does not include the task of getting into or out of the tub or shower.

Age means Your Age on Your last birthday.

Application means the form required by the Company that You signed to apply for coverage under the Certificate. It also includes any other document that You use to change coverage under the Certificate.

Assisted Living Facility means a legally licensed Assisted Living Facility where shelter, food and care are provided for remuneration for a period of more than 24 consecutive hours to four or more persons residing at such facility who require or request such services due to age, illness or physical disability.

Assisted Living Facility does not include a home, apartment, or facility where: a) casual care is provided at irregular intervals, or b) a competent person residing in such home, apartment, or facility provides for or contracts for his or her own personal or professional services if no more than 25% of persons residing in such home, apartment, or facility receive such services.

These requirements are typically met by Assisted Living Facilities that are either free standing facilities or part of a lifecare community. They may also be met by some personal care and adult congregate care facilities. They are generally NOT met by individual homes or independent living units.

An Assisted Living Facility does not mean a Nursing Facility, Hospital or clinic, boarding home, or a place which operates primarily for the treatment of alcoholism or drug addiction. It also does not mean Your home.

Assisted Living Facility Care means care received in an Assisted Living Facility.

Certificate Year means the 365 days (366 in a leap year) beginning with the Effective Date of the Certificate; and each year thereafter beginning with the anniversary of the Effective Date of the Certificate.

Cognitive Impairment means a deterioration or Loss in intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in: (a) short-term or long-term memory; (b) orientation to people, places, or time; and (c) deductive or abstract reasoning. Such deterioration or Loss must place You in jeopardy of harming yourself, therefore requiring another person's supervision or verbal cueing. Determination of Cognitive Impairment will be made by a Licensed Health Care Practitioner.

Custodial Care means that level of care which is mainly for the purpose of meeting the ADLs. It may be provided by persons without professional skills or training. Such care is intended to: (a) maintain and support Your existing level of health; and (b) preserve Your health from further decline. It is not primarily for Your own or Your family's convenience.

Daily Benefit means the amount payable for each Day of Care. The Daily Benefit payable for each type of facility covered under the Policy is shown on the Certificate Schedule of Benefits page. Only one Daily Benefit will be payable for each Day of Care.

Day(s) of Care means a calendar day during which You were confined as a resident bed-patient in a Nursing Facility or Assisted Living Facility.

Effective Date means the day upon which Your coverage under the Certificate begins. It is shown in the Certificate  
2089C-0806-AR

## Schedule of Benefits.

Elimination Period means the number of Days of Care necessary before benefits are payable under the Policy. No payment will be made for Days of Care during the Elimination Period. Any day of confinement that does not meet the requirements of a Day of Care cannot be used to satisfy the Elimination Period.

The Elimination Period begins with the first Day of Care that occurs after the Effective Date of this Certificate. The Elimination Period can be met by any combination of Days of Care in a Nursing Facility or Assisted Living Facility .

Any days applied toward satisfaction of the Elimination Period need not be consecutive but must be met before any Daily Benefits are payable. The Elimination Period applies only once during the entire time You are insured under the Certificate. The Elimination Period (if any) is shown in the Certificate Schedule of Benefits.

Emergency means the sudden onset of an Injury or Sickness or an abrupt change in health status, which requires immediate medical services, the lack of which may mean risk of permanent damage to Your health.

Grace Period means the 31 day period immediately following each renewal Premium Due Date during which Premium payments must be made. Coverage will continue in force during the Grace Period.

Hands-on Assistance means the physical assistance of another person without which You would be unable to perform the Activity of Daily Living (ADL).

Hospital means an institution that:

1. Is licensed to operate as a Hospital pursuant to law;
2. Is primarily and continuously engaged in providing or operating, on its premises and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis; and
3. Provides twenty-four-hour nursing service by or under the supervision of registered nurses.

“Hospital” does not include:

1. Convalescent homes or convalescent, rest or Nursing Facilities; or
2. An Inpatient Rehabilitation Facility or facilities affording primarily educational or rehabilitative care, including rehabilitation services rendered in a separate section of an acute care facility; or
3. Facilities for the aged, drug addicts or alcoholics; or
4. A Long-term Acute Care Facility.

Immediate Family Members means a person who is related to You in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother and stepsister), or child (includes legally adopted or stepchild).

Injury or Injuries means accidental bodily Injury sustained by You that:

1. is the direct cause of the condition for which benefits are provided,
2. is independent of disease or bodily infirmity or any other cause, and
3. occurs while the insurance is in force.

All Injuries sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Inpatient Rehabilitation Facility means a Hospital, clinic, or other facility or part thereof whose primary function is comprehensive or work-specific integrated inpatient rehabilitation. The facility’s primary objective is restoration of physical and cognitive abilities to persons who have suffered disabling sickness or injury. Physicians direct the integration and application of services. The services consist primarily of physical, occupational, speech, and cognitive therapies.

The definitions of Hospitals and Nursing Facilities do not include Inpatient Rehabilitation Facilities.

Insured means the person named as “Insured” in the Certificate Schedule of Benefits for whom an Application is received and accepted by Us and proper premium payment has been made.

Intermediate Care means a degree of nursing care and evaluation that is less than that provided for Skilled Nursing Care, but greater than that provided for Custodial Care. This level of care provides a planned, continuous program of nursing care that is preventive or rehabilitative in nature.

Licensed Health Care Practitioner or Physician means a person who is a practitioner of the healing arts that is:

1. licensed by the proper authorities in the jurisdiction in which he or she practices;
2. operating within the scope of his or her license in rendering or prescribing medical care or treatment;

3. not You or Your Immediate Family Members; and
4. not a court-appointed representative.

Lifetime Maximum Benefit means the total number of Days of Care that could be paid to You for any combination of Nursing Facility Care or Assisted Living Facility Care that You have received while insured under the Policy. The Lifetime Maximum Benefit is shown in the Certificate Schedule of Benefits. Once the Lifetime Maximum Benefit is met, no further benefits are payable and coverage terminates.

Long-Term Acute Care Facility means an institution that:

1. Is licensed to operate as a Hospital pursuant to law;
2. Is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of fully licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis;
3. Provides twenty-four-hour nursing service by or under the supervision of registered nurses; and
4. Has an average inpatient length of stay greater than 25 days or is defined by Medicare as a Long-Term Acute Care Hospital.

The definitions of Hospitals and Nursing Facilities do not include Long-Term Acute Care Facilities.

Loss means any of the following:

1. You are unable to perform, without Hands-on-Assistance, at least two (2) ADLs, due to Loss of functional capacity; or
2. You have suffered a Cognitive Impairment and require Substantial Supervision; or
3. You require Nursing Facility Care or Assisted Living Facility care, due to Medical Necessity.

Maximum Daily Benefit means the maximum daily amount payable for Covered Services covered by the Policy. In no event, however, will the Maximum Daily Benefit payable for such Covered Services exceed the actual daily charge. The Maximum Daily Benefit for each type of service covered under the Policy is shown in the Certificate Schedule of Benefits.

Medical Necessity or Medically Necessary means that Your Physician has certified that admission to a Nursing Facility or Assisted Living Facility is necessary and consistent with generally accepted standards of medical practice (i.e., diagnosis, care, treatment) for Your medical condition. Periodic recertification by Your Physician of the need for continued Nursing Facility or Assisted Living Facility confinement may be required.

Medical Necessity or Medically Necessary does not mean care or services that: (a) are designed primarily for the comfort or convenience of You or Your family, or any person who cares for You; or (b) could be safely and adequately provided in a setting other than a Nursing Facility or Assisted Living Facility.

Medicare means the Health Insurance for the Aged Act set forth in Title XVIII of the United States Social Security Amendments of 1965, as then constituted or as later amended.

Mental or Nervous Disorder means: (a) neurosis; (b) psychoneurosis; (c) psychopathy; (d) psychosis; or (e) a mental or nervous disorder of any kind. It does not mean senility or Alzheimer's disease.

Nurse means a legally qualified person who is either: (a) a Registered Nurse (R.N.); (b) a Licensed Practical Nurse (L.P.N.); (c) a Licensed Vocational Nurse (L.V.N.); or (d) a Licensed Public Health Nurse (L.P.H.N.).

Nursing Facility means a legally licensed Nursing Facility that provides medical care, nursing care, rehabilitation, or related services and associated treatment for a period of more than 24 consecutive hours to persons residing in such facility who are ill, injured, or disabled.

“Nursing Facility” does not mean:

1. a Hospital, clinic, Long-Term Acute Care Facility, or Inpatient Rehabilitation Facility; or
2. an institution that is operated mainly for the treatment and care of alcoholism or drug addiction; or
3. any home, facility or part thereof used primarily for rest; or
4. a home or facility for the aged; or
5. a soldiers' home.

Nursing Facility Care means care or treatment received in a Nursing Facility.

Plan of Care means a written plan for confinement in a covered facility which must include, but not be limited to: (a) reason for confinement, including diagnosis, symptoms and reason for the need for continued care; (b) schedule of treatment, including level of care; (c) functional limitations, including deficiencies in Activities of Daily Living; and (d) objectives of the Plan of Care. The number of Days of Care specified in the Plan of Care cannot exceed the Lifetime Maximum Benefit. Your Plan of Care will end the earlier of when: (a) You are no longer receiving Nursing Facility Care or Assisted Living Facility Care due to a Loss;

or; (d) the Lifetime Maximum Benefit expires.

The Plan of Care must be developed by a Licensed Health Care Practitioner and approved by the Company and You or Your legally designated representative. The Plan of Care must be updated as Your condition changes.

After one Plan of Care has ended, if You suffer another Loss, this next Loss will require a new Plan of Care.

Rating Class means a population segment classified by actuaries as having similar insurance risks based on the following factors: (a) age; (b) sex; (c) marital status; (d) benefit options; (e) underwriting class; and (f) underwriting year.

Sickness means illness or disease that first manifests itself after the Effective Date and while the Policy is in force and is not otherwise excluded.

Skilled Nursing Care means that level of care which is provided by:

1. a licensed registered nurse for at least 8 consecutive hours per day, 7 days a week; and
  2. a licensed registered nurse or licensed practical nurse on a 24 hour basis, 7 days a week.
- Care must be prescribed by a Physician for the medical care of the patient and may not be provided by less skilled or less intensive care, such as Custodial Care or Intermediate Care.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect You from threats to Your health or safety (such as may result from wandering).

You, Your and Yours refers to the Insured named in the Certificate Schedule of Benefits, for whom an Application has been received and accepted by Us and proper premium payment has been made.

## **SECTION II - BENEFIT INFORMATION**

### **Eligibility for the Payment of Benefits**

While You are insured under the Policy, You will be eligible to receive the Daily Benefit amount shown in the Certificate Schedule of Benefits for each Day of Care that You receive Nursing Facility Care or Assisted Living Facility Care if:

1. You are unable to perform, without Hands-on-Assistance, at least two (2) ADLs, due to Loss of functional capacity; or
2. You have suffered a Cognitive Impairment and require Substantial Supervision; or
3. The Day of Care is Medically Necessary.

AND

1. the confinement is approved in Your Plan of Care;
2. the Day of Care for which benefits are eligible begins on or after the Effective Date of the Certificate.
3. the Elimination Period stated in the Certificate Schedule of Benefits has been met.

Each Day of Care must be:

1. Due to covered Injury or Sickness;
2. An overnight stay of 18 or more consecutive hours;
3. Approved by the Company and included in the Plan of Care;
4. At the direction of and under the supervision of a Physician; and
5. Medically Necessary.

Benefits are payable for each Day of Care beyond the Elimination Period up to the Lifetime Maximum Benefit shown in the

Certificate Schedule of Benefits. Once the Lifetime Maximum Benefit has been reached, no further benefits are payable under the Policy and the coverage terminates.

### **Nursing Facility Daily Benefit**

The Nursing Facility Care Daily Benefit, shown in the Certificate Schedule of Benefits, will be paid for each Day of Care in a Nursing Facility, if:

1. You are receiving Skilled Nursing Care, Intermediate Care, or Custodial Care; and
2. You have satisfied the other requirements described under "Eligibility for the Payment of Benefits".

The amount of Your benefit payment will be equal to the lesser of: 1) the Maximum Daily Benefit shown in the Certificate Schedule of Benefits for the type of facility in which Your Day of Care is received; or 2) the actual daily charge. You may receive Days of Care in any combination of Nursing Facility Care or Assisted Living Facility Care; however, only one Daily Benefit (whichever provides the greatest benefit) will be paid for each Day of Care.

The conditions of Eligibility for the Payment of Benefits must be met before You are eligible to receive benefit payments.

Total benefit payments will not be paid for a period longer than the Lifetime Maximum Benefit shown in the Certificate Schedule of Benefits. Payment of benefits is subject to all the stated conditions and provisions of the Policy. Refer to the Exclusions section for services that are not covered.

### **Assisted Living Facility Care Benefit**

The Assisted Living Facility Care Daily Benefit, shown in the Certificate Schedule of Benefits, will be paid for each Day of Care in an Assisted Living Facility if:

1. You are receiving Assisted Living Facility Care; and
2. You have satisfied the requirements described under "Eligibility for Benefit Payments."

The amount of Your benefit payment will be equal to the lesser of: 1) the Maximum Daily Benefit shown in the Certificate Schedule of Benefits for the type of facility in which Your Day of Care is received; or 2) the actual daily charge. You may receive Days of Care in any combination of Nursing Facility Care or Assisted Living Facility Care; however, only one Daily Benefit (whichever provides the greatest benefit) will be paid for each Day of Care.

The conditions of Eligibility for the Payment of Benefits must be met before You are eligible to receive benefit payments.

Total benefit payments will not be paid for a period longer than the Lifetime Maximum Benefit shown in the Certificate Schedule of Benefits. Payment of benefits is subject to all the stated conditions and provisions of the Policy. Refer to the Exclusions section for services that are not covered.

### **Bed Reservation Benefit**

If You are receiving Nursing Facility or Assisted Living Facility benefit payments and Your stay in such facility is interrupted because You are Hospitalized, the Company will continue to pay the Nursing Facility or Assisted Living Facility Daily Benefit if a charge is made to reserve Your accommodations in the facility. The maximum number of days for which benefits will be paid is equal to the Bed Reservation Benefit Limit shown in the Certificate Schedule of Benefits.

The Bed Reservation Benefit will not be payable if You have not satisfied the Elimination Period. However, the number of days a charge is made to reserve Your accommodations in the Nursing Facility or Assisted Living Facility will be applied to satisfy the Elimination Period.

Each day for which a Bed Reservation Benefit is paid will count toward the Lifetime Maximum Benefit. No benefits are payable if the Lifetime Maximum Benefit has been exhausted.

### **Restoration Benefit**

We will restore each of the paid Days of Care that were previously applied to the Lifetime Maximum Benefit up to the Restoration Benefit amount stated in the Certificate Schedule of Benefits. To receive this benefit, you must:

1. not be able to satisfy the requirements described under "Eligibility for the Payment of Benefits" above; and

2. have recovered for a period of at least 180 consecutive days; and
3. have not reached the Lifetime Maximum Benefit.

Your Physician must certify that You have recovered sufficiently such that You did not meet the "Eligibility for the Payment of Benefits" requirements for the 180 consecutive day period.

Each Day of Care that has been restored under this provision will reduce the Restoration Benefit. Days of Care payable will never exceed the Lifetime Maximum Benefit and the Restoration Benefit stated in the Certificate Schedule of Benefits.

### **SECTION III – EXCLUSIONS**

The Company will not pay a benefit for any Loss resulting from the following:

1. a Loss caused by or resulting from alcoholism or drug addiction;
2. a Loss caused by or resulting from illness, treatment, or medical condition arising out of any of the following:
  - a) war (whether declared or not) or any act of war;
  - b) participation in a felony, riot, or insurrection;
  - c) service in the armed forces or auxiliary units of the armed forces; or
  - d) attempted suicide (while sane or insane) for 2 years from the effective date, or intentionally self-inflicted injury;
3. confinement in a government facility, unless a charge is made that You are obligated to pay (except otherwise required by law);
4. confinement in a facility outside the United States of America, its possessions and territories;
5. confinement in a Hospital, except a Nursing Facility that is a distinct part of the Hospital;
6. a Loss for which benefits are reimbursable under Medicare (unless otherwise prohibited by law) or would be so reimbursable but for the application of a deductible or coinsurance amount; or other governmental program (except Medicaid, or a medical plan established by a government for its own employees), any state or Federal Workers' Compensation, employers' liability, occupational disease law, or the basic reparations benefits of a nofault motor vehicle insurance plan;
7. a Loss for which no charge is normally made in the absence of insurance; or
8. a Loss that is not included in or is inconsistent with Your Plan of Care.

### **SECTION IV – TERMINATION PROVISIONS**

The Extension of Benefits provision may apply when Your coverage would otherwise terminate in accordance with the terms of this section.

We or the Group Policyholder can terminate or non-renew coverage under the Policy under any of the following conditions:

1. The date You have exhausted the Lifetime Maximum Benefit;
2. The date of Your death;
3. The next premium due date after You have failed to pay premiums or contributions in accordance with the terms of the Policy or We have not received timely premium payments;
4. The date You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of the Policy, subject to the paragraph titled Time Limit On Certain Defenses under Section VI;
5. The next premium due date after We are ceasing to offer coverage in the association market in accordance with applicable state law; or
6. The next premium due date after We are discontinuing all health benefits plans offered to associations.

If We refuse to renew coverage under reason numbers 3 and 4 above, We will give You 30 days notice prior to the non-renewal effective date.

If We refuse to renew coverage under number 5 above, We will, within at least 90 days prior to the date of the discontinuation of coverage: a) provide notice to each association member covered under the Policy; b) offer to each member the option to purchase any other health benefit plan currently being offered by Us through the Association; and c) act uniformly without regard to any health status-related factor of covered members or dependents or new members or dependents who may become eligible for coverage.

If We discontinue offering all health insurance coverage in this market under number 6 above, We will give 180 days notice to the Commissioner of Insurance, the association, and each association member covered under the Policy.

At the time of coverage renewal, We may modify coverage under the Policy. However, the modification must be consistent with

State law and effective on a uniform basis among all individuals that We cover under the Policy.

Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in Your health or the type of work You perform; or
2. Just because of the claims filed by You or on Your behalf, unless the claims are fraudulent.

## SECTION V - CLAIMS PROVISIONS

**NOTICE OF CLAIM** You must give the Company written notice of a claim. It should be given within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You to Us at our Home Office, or to any authorized agent of the Company, with information sufficient to identify You, will be deemed notice to the Company.

**CLAIM FORMS** The Company will send You a claim form when Your notice of claim is received. If the form is not furnished within 15 days from the time You give notice, You may fulfill the proof of loss requirements by sending written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time set in Proof of Loss.

**PROOF OF LOSS** You should give the Company written proof of loss within 90 days after such loss. If it is not reasonably possible to do so, the Company will not reduce or deny Your claim for being late if proof is given as soon as reasonably possible. It must, however, be given within 15 months from the date of loss, unless You are not legally capable.

**TIME OF PAYMENT OF CLAIMS** All benefits due under the Policy will be paid as soon as due proof of loss is received.

**PAYMENT OF CLAIMS** All benefits due under the Policy will be paid to You or Your estate. If they are payable to Your estate, the Company may pay such benefits up to an amount not to exceed \$1,000 to any of Your relatives by blood or marriage who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company to the extent of such payment.

**ASSIGNMENT** Subject to any written direction of Yours in the application or otherwise, all or a portion of any benefits provided by the Policy may, at the Company's option and unless You request otherwise in writing not later than the time of filing proofs of loss, be paid directly to the facility rendering such services; but it is not required that the service be rendered by a particular facility.

**PHYSICAL EXAMINATIONS** The Company may have You examined at its own expense as often as it may reasonably require while a claim is pending under the Policy.

**LEGAL ACTIONS** No action at law or in equity shall be brought to recover under the Policy for at least 60 days after You have given the Company written proof of loss in accordance with the requirements of the Policy. You cannot start such action more than 3 years after the date proof of loss is required to be furnished.

## SECTION VI - ABOUT YOUR CERTIFICATE

**ENTIRE CONTRACT, CHANGES** The Policy, the Policyholder application, the individual applications and attached papers, if any, is the entire contract of insurance. It may not be changed in any way by any agent. Only an officer of the Company can approve a change. All statements made in the absence of fraud, made by the applicants will be deemed representations and not warranties. No such statement will void the insurance or reduce the benefits unless contained in a written application of which a copy will be attached to the Policy.

**TIME LIMIT ON CERTAIN DEFENSES** [After 3 years](#) from the Effective Date of the Certificate, no misstatements, except [2089C-0806-AR](#)

fraudulent misstatements, made by You in Your Application for coverage will be used to void the Policy or to deny a claim for Loss incurred commencing after the expiration of [such three-year period](#).

No claim for loss incurred commencing [after 3 years](#) from the Effective Date of coverage under the Certificate will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage under the Certificate.

**CONFORMITY WITH STATE STATUTES** Any provision which, on the Effective Date, is in conflict with the laws of the state where You then live is automatically amended to conform to the minimum requirements of those laws.

**TIME PERIODS** Each Certificate term will begin and end at 12:01 A.M. in the state where You live.

**PREMIUM REFUND AT DEATH** [If Your coverage terminates due to death, the Company will refund the pro rata unearned portion of any premium paid. Unearned premiums will be paid in lump sum no later than thirty \(30\) days after We receive proof of Your death.](#)

**MISSTATEMENT OF AGE** If Your Age as shown in the Application is incorrect, all amounts payable under the Policy will be the amounts the premium actually paid would have purchased at the correct Age. The Company's liability will be limited to a refund of the premium paid for You if, according to Your correct Age, coverage under the Policy would not have been issued.

**UNPAID PREMIUM** Any due and unpaid premium for the Policy may be deducted from its benefits then payable.

**RIGHT OF RECOVERY** The Company has the right to recover any overpayment made because of an error in the processing of a claim. Any amounts which have not been recovered at the time another benefit is payable, may be recovered by offset against the benefit amount then due. We will not withhold any portion of any benefit payable unless:

1. We have written authorization from the claimant permitting such withholding procedure, or
2. We have clear, documented evidence that:
  - a. The overpayment was clearly erroneous under the provisions of the Policy; and
  - b. The error which resulted in the overpayment is not a mistake of law; and
  - c. We have notified the claimant within six (6) months of the date of the error, except in instances or error prompted by representations or modifications or nondisclosures of claimants, We have notified the claimant within fifteen (15) days after the date that clear, documented evidence of discovery of such error is included in our file; and
  - d. Such notice states clearly the nature of the error and the amount of the overpayment.

We will not adjust an overpayment no later than three (3) years after the date of the error. For purposes of this section, the date of the error will be the day on which the draft for benefits is issued.

## SECTION VII – PREMIUMS

The required Premium must be paid on each Premium Due Date or prior to the end of the Grace Period.

**PREMIUM CHANGES** Your premium rate will not be changed due to Your Age or use of coverage under the Policy. Any change will be made only on a Rating Class basis. The Premium rate for the Certificate is guaranteed not to change for the first year the Certificate is in force, unless the terms of the Certificate are changed.

[Rate changes will be effective on the next Premium Due Date after the Company has provided 60 days advance written notice. Premium rates will not be changed more frequently than once in any 12 month period.](#)

If Your benefit levels are changed at Your request, Your premium may, at such time, be changed to reflect the change in benefits. Premiums for additional, increased or terminated coverage may cause a pro-rata adjustment on the next Premium Due Date. Premiums for additional or increased coverage will be based upon Your current attained Age at the time You apply for such additional or increased coverage.

**WAIVER OF PREMIUM** Once benefits become payable for a covered Loss, Premium payments which become due while receiving Nursing Facility Care or Assisted Living Facility Care benefits will not be required to continue Your coverage. Premium payments will resume in accordance with the Policy provisions when you are discharged from the Nursing Facility or Assisted Living Facility.

## SECTION VIII - HOW TO KEEP YOUR CERTIFICATE IN FORCE

**GRACE PERIOD** There will be a grace period for payment of each renewal premium. It will be 31 days from the date the premium is due. This Certificate will stay in force during the 31 days. The coverage will lapse if the premium is not paid before the end of the grace period.

**REINSTATEMENT** Coverage lapses if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or acceptance of premium by one of Our authorized agents) without requiring an Application for reinstatement, reinstates coverage under the Policy.

We will require an Application for reinstatement. We will subject all representations made in this Application to all of the provisions of the Policy, including Time Limit on Certain Defenses. If We approve the Application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval within 45 days, We must reinstate coverage. The reinstatement will take place on the forty-fifth 45th day following the date of the reinstatement Application .

The reinstated plan only covers:

1. Loss that results from an Injury that You sustain after reinstatement; or
2. A Sickness that begins ten days or more after the date of reinstatement.

In all other respects, Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date. **We will not consider a request for reinstatement that You make more than 180 days after coverage has lapsed.**

**ELECTRONIC ACCOUNT DEBIT AUTHORIZATION** If You have chosen Electronic Account Debit as Your method of premium payment, You agree that:

1. We are authorized to debit Your named account for premium payments;
2. The account debit will be made electronically without the signature of any officer or employee of the Company; We will not provide a receipt for any account debit;
3. The Company will not incur any liability because of dishonor of the account debit;
4. Upon refusal of the financial institution to honor any attempted debit of the named account, We will cease to debit Your account. We will send You written notice, requesting payment in full of the required premium. Upon Your payment of the required premium, We will again begin to debit Your account. However, if You do not pay the required premium, Your coverage will lapse in accordance with the Grace Period provision; and
5. Except as provided in (4) above, the authorization remains effective unless either party ends the authorization. Before ending the authorization, a party must provide the other party at least 30 days advance written notice. We are not liable for amounts debited from Your account prior to Our receipt of written notification to end coverage.

**RECOVERY CARE II APPLICATION - ASSOCIATION MEMBER** *(Please Print - Black Ink)*

**SECTION A**

1. Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
First Name Middle Initial Last Name  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_ Best Time to Call \_\_\_\_\_ Email \_\_\_\_\_
2. Billing Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Height \_\_\_\_\_ Weight \_\_\_\_\_

**SECTION B**

- New Policy     Reinstatement
4.  Male     Female
  5. **I, AS A MEMBER OF THE NCAA, AM APPLYING FOR:**  
 a) Daily Benefit \$ \_\_\_\_\_    b) Lifetime Maximum Benefit Period (days):     180     270     360  
 c) Elimination Period (days):     0     20    d) Inflation Protection Rider:     Compound     Simple
  6. **Payment Mode:**     Annual     Semi-Annual     Quarterly     Monthly COM
  7. **Requested Effective Date:** \_\_\_\_\_

**SECTION C**

**If the answer to any question in Section C (8-11h) is Yes, the application should not be submitted.**

8. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency? .....  Yes     No
9. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection? .....  Yes     No
10. Within the past **2 years**, have you:
  - a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given? .....  Yes     No
  - b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip? .....  Yes     No
  - c) required the use of a wheelchair, walker or cane? .....  Yes     No
  - d) been advised to have cataract surgery or other eye surgery that has not been performed? .....  Yes     No

11. Do you now have or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:
- a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission? .....  Yes  No
  - b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement?.....  Yes  No
  - c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene? .....  Yes  No
  - d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?.....  Yes  No
  - e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment? .....  Yes  No
  - f) Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder?.....  Yes  No
  - g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse? .....  Yes  No
  - h) incontinence, any ostomy present due to disease, an organ transplant other than corneal?.....  Yes  No
12. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack?.....  Yes  No
- If Yes, give information regarding diagnosis or condition. (use additional sheet if necessary) \_\_\_\_\_

### SECTION D

Will any health, recovery short term, long term, or home health care insurance be replaced with this certificate? .....  Yes  No

If Yes, which company? \_\_\_\_\_ Policy Number \_\_\_\_\_

If Yes, read and complete the Notice to Applicant Regarding Replacement.

### SECTION E

**AGREEMENT** — I have read or had read to me my completed application. My answers are true and complete to the best of my knowledge and belief. I understand my coverage, if issued, will begin on the date of issue shown in my certificate. I realize any false statement or misrepresentation in my application may result in loss of coverage under my certificate.

**FRAUD WARNING** — 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.

**ACKNOWLEDGMENT** — If age 65 or older, I have received the guide *Medicare & You* and a Duplication of Medicare Coverage form from the Agent.

**The certificate provides limited benefits. Review your certificate carefully.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**A TELEPHONE INTERVIEW WILL BE CONDUCTED.**

**What will be the best time to contact the Applicant for the telephone interview?** \_\_\_\_\_

**AUTHORIZATION TO OBTAIN, RELEASE  
AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. any authorized representative of the Proposed Insured is entitled to receive a copy of this authorization upon request.

(continued on side 2)

**AUTHORIZATION TO OBTAIN, RELEASE  
AND DISCLOSE MEDICAL INFORMATION (continued)**

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian-in-fact, guardian, payee representative or other



# AGENT'S STATEMENT

I certify that: 1) I saw the Applicant; 2) I asked the Applicant the questions in the application and truthfully and accurately recorded the answers; 3) the answers did not conflict with my observations and knowledge of the Applicant; 4) I witnessed the Applicant's signature; and 5) If applicable, I gave the guide *Medicare & You* and a copy of the appropriate form(s) and/or disclosure(s) to the Applicant.

I also certify that: 1) the Applicant has read, or had read to him or her, the completed application; and 2) the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the certificate.

I certify that I have verified the Applicant's identity by viewing a U.S. federal or state government-issued I.D.:

Driver's License     Passport     Government-issued Identification Card     Other

The Company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"): \_\_\_\_\_

The Company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the past 5 years and which are not currently in force are (if none, write "NONE"): \_\_\_\_\_

## AGENT INFORMATION

Name (printed) \_\_\_\_\_ Signature \_\_\_\_\_

Agent Code \_\_\_\_\_ Date Signed \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Premium Quoted \$ \_\_\_\_\_

Premium Collected \$ \_\_\_\_\_

Receipt Given:  Yes     No

No money collected. Initial premium is to be drafted.

Mail Policy to:  Insured     Agent

Special Requests: \_\_\_\_\_

\_\_\_\_\_

## RECEIPT

**IF PREMIUM IS COLLECTED, CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY.** If coverage is not issued, the initial premium will be refunded to the Applicant. If coverage is issued, coverage will begin on the date of issue shown in the certificate.

Received from \_\_\_\_\_

on \_\_\_\_\_  
Date

an application for Recovery Care II

and a Check  Money Order

for \$ \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Agent's Signature



**Standard Life and Accident Insurance Company**  
Administrative Office:  
P.O. Box 1850, Galveston, Texas 77553-1850  
888.519.5819

## DISCLOSURE NOTICE

In connection with your application, Standard Life and Accident Insurance Company (Standard Life), or its reinsurers, may obtain medical and other information for evaluation purposes. Standard Life may obtain that information from the Medical Information Bureau, Inc. or any medical professional, medically related facility, insurance support organization or insurance company who possesses information about the care, treatment or advice given you or your family. That information could concern drugs, alcoholism or mental illness. Standard Life may also obtain an investigative consumer report on you.

Information regarding your insurability will be treated as confidential. Standard Life or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Standard Life or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

If an investigative consumer report is prepared in connection with your application, you may request to be interviewed for that report. Also, you have the right to review and note any corrections concerning reported personal information in Standard Life's file, unless the information is privileged.

This notice is only a summary. You may request additional information about Standard Life's information collection practices and your rights by contacting Standard Life.

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY**  
P.O. Box 1820, Galveston, Texas 77553-1820  
888.350.1488

# AUTHORIZATION TO MY BANK

## CHECK-O-MATIC AUTHORIZATION

Attach Voided Check or Deposit Ticket Here  
and Sign Authorization

Checking       Savings

### Bank Information

\_\_\_\_\_  
Name

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree that should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

\_\_\_\_\_  
Date Signed



\_\_\_\_\_  
Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number \_\_\_\_\_

Routing Number \_\_\_\_\_



## COMPOUND INFLATION PROTECTION RIDER

### Providing Increases in Benefit Amounts of 5% Compounded Annually

In consideration of the timely payment of the additional required premium, this Compound Inflation Protection Rider is added to and made a part of Your Certificate of Coverage (Certificate) on the Effective Date of the Certificate; subject to all the terms and conditions stated in the Certificate and those stated in this Rider. The additional required premium for the coverage provided by this Rider is shown in the Schedule.

**BENEFIT INCREASE** On the first anniversary date of [the Certificate](#) and on each subsequent Certificate anniversary date, we will automatically increase the Maximum Daily Benefit Amounts (for Nursing Facility Care and the Assisted Living Facility Care) listed in the Certificate's Schedule of Benefits. Each increase will be five percent (5%) of the Maximum Daily Benefit Amount in effect on the most recent anniversary.

The increases will occur annually and continue while the Certificate and this Rider are in force. Increases to the Maximum Daily Benefit Amounts will continue while the Insured is receiving benefits on a continuing claim. The increase does not apply to any other amount shown in the Certificate.

**TERMINATION** This Rider will terminate on the earliest of the following dates: 1) the date the Certificate terminates or lapses; or 2) the date this Rider is cancelled.

In the event of any conflict between this Rider and Your Certificate, this Rider will prevail. This Rider will not vary, alter, waive, or extend any of the terms, conditions, provisions, or limitations of Your Certificate, other than as stated herein.

Signed for Standard Life and Accident Insurance Company by:

Secretary

President



## SIMPLE INFLATION PROTECTION RIDER

### Providing Increases in Benefit Amounts of 5% Annually

In consideration of the timely payment of the additional required premium, this Simple Inflation Protection Rider is added to and made a part of Your Certificate of Coverage (Certificate) on the Effective Date of the Certificate; subject to all the terms and conditions stated in the Certificate and those stated in this Rider. The additional required premium for the coverage provided by this Rider is shown in the Schedule.

**BENEFIT INCREASE** On the first anniversary date of [the Certificate](#) and on each subsequent Certificate anniversary date, we will automatically increase the Maximum Daily Benefit Amounts (for Nursing Facility Care and Assisted Living Facility Care) listed in the Certificate's Schedule of Benefits. The automatic annual increase will be equal to 5% of the initial Maximum Daily Benefit Amounts shown in the Schedule of Benefits on the Date of Issue of Your Certificate. Annual increases will not be compounded.

After the first 20 years from the Date of Issue, the amounts will remain level at 200% of the initial Maximum Daily Benefit Amounts shown in the Schedule of Benefits on the Date of Issue of Your Certificate.

The increases will occur annually and continue while the Certificate and this Rider are in force. Increases to the Maximum Daily Benefit Amounts will continue while the Insured is receiving benefits on a continuing claim. The increase does not apply to any other amount shown in the Certificate. The premium will not increase due to the automatic increase in benefit amounts.

**TERMINATION** This Rider will terminate on the earliest of the following dates: 1) the date the Certificate terminates or lapses; or 2) the date this Rider is cancelled.

In the event of any conflict between this Rider and Your Certificate, this Rider will prevail. This Rider will not vary, alter, waive, or extend any of the terms, conditions, provisions, or limitations of Your Certificate, other than as stated herein.

Signed for Standard Life and Accident Insurance Company by:

Secretary

President

SERFF Tracking Number: ANTX-125697601 State: Arkansas  
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 39374  
Company Tracking Number:  
TOI: H13G Group Health - Short Term Care Sub-TOI: H13G.002 Nursing Home  
Product Name: 2089C-0806-AR  
Project Name/Number: 2089C-0806-AR/2089C-0806-AR

## Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: ANTX-125697601 State: Arkansas  
Filing Company: Standard Life and Accident Insurance Company State Tracking Number: 39374  
Company Tracking Number:  
TOI: H13G Group Health - Short Term Care Sub-TOI: H13G.002 Nursing Home  
Product Name: 2089C-0806-AR  
Project Name/Number: 2089C-0806-AR/2089C-0806-AR

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice

**Review Status:**

Approved-Closed

06/25/2008

**Comments:**

**Attachment:**

AR Certificate of Compliance slaico.pdf



A MEMBER OF THE AMERICAN NATIONAL FAMILY OF COMPANIES

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY**

## STATE OF ARKANSAS

# COMPLIANCE CERTIFICATION

Regarding:

2089C-0806-AR, RCAPP08AR, RCCIR-0805, RCSIR-0805

I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify that they are in compliance with the applicable statutes, regulations, and bulletins of the State of Arkansas. I further certify that they will be revised and/or discontinued in the event of future changes in the statutes, regulations, or bulletins which would prohibit the use of such forms.

A handwritten signature in black ink, appearing to read "James P. Stelling". The signature is fluid and cursive.

---

James P. Stelling  
Asst. Vice President, Health Compliance

06/20/08

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Date of Signature