

SERFF Tracking Number: FHLA-125632477 State: Arkansas
Filing Company: Family Heritage Life Insurance Company of America State Tracking Number: 38855
Company Tracking Number: A5ARPOL
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: Accident Only Policy
Project Name/Number: /

Filing at a Glance

Company: Family Heritage Life Insurance Company of America

Product Name: Accident Only Policy SERFF Tr Num: FHLA-125632477 State: ArkansasLH
TOI: H02I Individual Health - Accident Only SERFF Status: Closed State Tr Num: 38855
Sub-TOI: H02I.000 Health - Accident Only Co Tr Num: A5ARPOL State Status: Approved-Closed
Filing Type: Form/Rate Co Status: Reviewer(s): Rosalind Minor
Authors: Kevin Wicktora, Ruth Campanelli Disposition Date: 05/06/2008
Date Submitted: 05/02/2008 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Authorized
Project Number: Date Approved in Domicile: 04/25/2008
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 05/06/2008 Deemer Date:
State Status Changed: 05/06/2008
Corresponding Filing Tracking Number:
Filing Description:
Please see the cover letter attached under the Supporting Documentation tab.

Company and Contact

Filing Contact Information

SERFF Tracking Number: FHLA-125632477 State: Arkansas
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Kevin Wicktora, Compliance Manager kevin.wicktora@familyheritagelife.com
6001 East Royalton Road (440) 922-5134 [Phone]
Cleveland, OH 44147

Filing Company Information

Family Heritage Life Insurance Company of America CoCode: 77968 State of Domicile: Ohio
6001 East Royalton Road Group Code: Company Type: Life & Health
Suite 200
Cleveland, OH 44147 Group Name: State ID Number:
(440) 922-5200 ext. [Phone] FEIN Number: 34-1626521

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Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: \$50 For the Policy and \$50 for the Rates. Will be mailed to the Department along with SERFF Tracking Number.
Per Company: No

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/06/2008	05/06/2008

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Disposition Date: 05/06/2008

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
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Accident Only Policy	Approved-Closed	Yes
Form	Application for Accident Only Policy	Approved-Closed	Yes
Form	Accident Claim Form	Approved-Closed	Yes
Form	Accident Policy Change Form	Approved-Closed	Yes

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Form Schedule

Lead Form Number: A5POLCAR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	A5POLCA R	Policy/Contract/Fraternal Certificate	Accident Only Policy	Initial			A5POLCAR.pdf
Approved-Closed	A5APP-RP	Application/Enrollment Form	Application for Accident Only Policy	Initial			A5APP-RP.pdf
Approved-Closed	A5CLM-ST	Other	Accident Claim Form	Initial			A5CLM-ST.pdf
Approved-Closed	A5CHG-ST	Other	Accident Policy Change Form	Initial			A5CHG-ST.pdf

FAMILY HERITAGE

Life Insurance Company Of America

Executive Office: P.O. Box 470608
Cleveland, Ohio 44147
(440) 922-5222

ACCIDENT ONLY POLICY

**THIS IS AN ACCIDENT ONLY POLICY AND IT DOES NOT PAY
BENEFITS FOR LOSS FROM ANY OTHER CAUSE
PLEASE READ IT CAREFULLY**

POLICY INDEX

Policy Schedule.....	Attached
Definitions.....	Section 1
Benefits.....	Section 2
Limitations and Exclusions.....	Section 3
General Provisions.....	Section 4
Claim Provisions.....	Section 5
Riders, Endorsements, Amendments, if any.....	Attached
Application.....	Attached

This policy is a legal contract between the Policyowner and Family Heritage Life Insurance Company of America. We agree to insure You against loss from Accidental Injury resulting from a Covered Accident in return for Your Premium payments.

RIGHT TO EXAMINE THE POLICY: If, for any reason, You are not satisfied with this policy, it can be returned to an authorized agent of the Company or to Our Executive Office within 10 days after You receive it for a complete refund of Premium and cancellation of the policy. IT IS IMPORTANT that You read Your entire policy, including the application, and write to Us within 10 days if any information shown in the application is incorrect or incomplete.

GUARANTEED RENEWABILITY: This policy is continuously renewed during the Policyowner's lifetime by the payment of Premiums when due. We reserve the right to change Premium rates upon 60 days prior written notice. Such changes may only be made for all policies of this kind issued in the same state. You cannot be singled out for a rate change.

This policy is signed on behalf of FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA by its Secretary and President.



Secretary



President

SECTION 1: DEFINITIONS

When the terms below are used in this policy, the following definitions apply:

WE, US, OUR: Means Family Heritage Life Insurance Company of America.

POLICYOWNER: Means the person named on the Policy Schedule as the Policyowner.

YOU, YOUR: If this is an Individual Policy, You means only the Policyowner. If this is a Family Policy, You means the Policyowner and the Policyowner's Spouse and Children. If this is a Single Parent Policy, You means the Policyowner and the Policyowner's Children. If this is a Married Couple Policy, You means the Policyowner and the Policyowner's Spouse.

The Policyowner may be able to add coverage for a Spouse and/or Children to this policy after the Effective Date. To do so, We must receive an application for the person along with evidence satisfactory to Us that the person is eligible and insurable. If the application is approved, We will notify the Policyowner of the date the added person's coverage becomes effective. We retain the discretion whether to allow You to add coverage for a Spouse or Child to this policy.

SPOUSE: Means the insurable person named as Spouse on the application and married to the Policyowner as evidenced by a government issued license.

CHILD, CHILDREN: Means the Policyowner's natural children, step-children, legally adopted children, children placed with You for adoption, children petitioned for adoption or children for whom the Policyowner has permanent legal custody. Each Child must be insurable, unmarried, dependent on the Policyowner or the Policyowner's Spouse for a majority of the Child's support, and younger than age 23. A Child will be considered dependent if he or she qualifies as a legal dependent of You or Your Spouse for tax exemption purposes under the U.S. Internal Revenue Service (IRS) Tax Code. The insurance on any Child will terminate at 12:00 noon (Eastern Standard Time) on the Child's 23rd birthday, the Child's marriage or when the Child no longer qualifies as a legal dependent for tax exemption purposes, whichever occurs first. Terminations will not affect previously incurred claims (for continuation of coverage, see SECTION 4: GENERAL PROVISIONS – CONVERSION).

Adopted Children: The Policyowner's adopted Children are covered from the moment of adoption, and Children placed with You for adoption are covered from the moment of petition or placement. If this is a Family or Single Parent Policy, no notice or additional Premium is required.

If this is an Individual or Married Couple Policy, coverage shall begin on the date of the filing of a petition for adoption if coverage is applied for within 60 days after the filing of the petition for adoption. Newborn Children are covered from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the Child's birth and You pay the additional premium to continue coverage beyond 60 days.

Handicapped Children: If this is a Family or Single Parent Policy, Children also includes dependent Children, regardless of age, who are mentally or physically handicapped, and became or become handicapped prior to age 23, and cannot support themselves because of their handicap. Proof of continued handicap and dependency must be provided upon Our request, but not more often than annually, after two years following the Child's 23rd birthday.

Newborn Children: If this is a Family or Single Parent Policy, the Policyowner's newborn Children are covered from the moment of live birth, and no notice or additional Premium is required.

If this is an Individual or Married Couple Policy, the Policyowner's newborn Children are covered from the moment of live birth for the next 30 days. We must be notified within 30 days after the date of birth and receive payment of the required Premium in order to have coverage continue beyond the 30 day period.

ACCIDENT: A sudden, unexpected and unintended event, which results in bodily injury to You.

ACCIDENTAL INJURY: Means bodily injuries caused solely by and resulting from a Covered Accident. Accidental Injury does not include injury that is a direct or indirect result of:

- a mental infirmity;
- medical treatment that is unrelated to an Accident;
- an adverse reaction to medication;
- a disease or its treatment; or
- a degenerative or chronic condition including a condition of the back, neck, bones or joints.

COVERED ACCIDENT: Means an Accident:

- that occurs after You become insured under this policy;
- that occurs while this policy is in force;
- for which benefits are provided; and
- which is not excluded in this policy.

PHYSICIAN: Means a person, other than You or a member of Your family, who is a Doctor of Medicine or Doctor of Osteopathy, licensed by the state, and performs services which are allowed by his or her license.

CHIROPRACTOR: Means a person, other than You or a member of Your family, who is licensed by the state to practice Chiropractic and performs services which are allowed by his or her license.

FRACTURE: Means a break or breaks in a bone which is diagnosed by an x-ray.

CHIP FRACTURE: Means a break that results in a bone fragment.

STRESS FRACTURE: Means a small sliver or hairline break in a bone.

HOSPITAL: Means a medical facility which is legally licensed and operated as an acute care Hospital, provides overnight care of injured and sick people, is supervised by a Physician, provides 24-hour-a-day nursing services by or under the supervision of a registered professional nurse, provides on-site or prearranged use of x-ray equipment, laboratory facilities and surgical units, and maintains permanent medical history records.

A Hospital is not a bed, unit or facility that functions as a clinic, urgent care center, nursing home, hospice, skilled nursing facility, extended care facility, convalescent home, a place for rehabilitation, rest home or a home for the aged, a place for the treatment of substance abuse, a sanatorium or a mental institution.

EMERGENCY ROOM: Means a specified area of a Hospital that is designated solely for emergency care of patients. This area must:

- be staffed and equipped to treat trauma;
- be supervised and provide treatment by Physicians; and
- provide comprehensive emergency medical services 24 hours a day, seven days a week.

ACCREDITED INSTITUTION OF POST-SECONDARY EDUCATION: Means a school which provides education beyond high school and is identified in the U.S. Department of Education Database of Accredited Institutions and Programs.

PROOF OF ENROLLMENT: Means a Bursar's receipt, tuition receipt, or any other proof acceptable to Us that the student is enrolled and tuition has been paid.

CLAIMS INCURRED: Means the amount paid and payable to You under this policy and any rider(s) as a result of a Covered Accident. A claim is considered incurred on the date of a Covered Accident regardless of the dates of service or the dates of claim payment.

MATURITY DATE: Means the date on which the Cash Value Period ends and You become entitled to a Cash Value Benefit.

CASH VALUE PERIOD: Means the period of time from the Effective Date to the first Maturity Date or from one Maturity Date to the next Maturity Date. The Policyowner's age at the beginning of a Cash Value Period determines the length of the Cash Value Period as follows:

- Ages 50 or under: The Cash Value Period is 25 years.
- Ages 51 through 65: The Cash Value Period is the number of years from the beginning of the Cash Value Period to the first Policy Anniversary Date after the Policyowner reaches age 75.
- Ages 66 and over: The Cash Value Period is 10 years.

The Cash Value Period will be based on the Policyowner's age, even if the Policyowner dies and the policy is continued by the covered Spouse as described under the Continuation provision.

COMPLETED YEARS OF PREMIUM PAYMENT: Means the number of complete years for which premiums are paid from the beginning of the Cash Value Period to the date on which a Cash Value Benefit is calculated.

POLICY ANNIVERSARY DATE: Means the annual occurrence of the Effective Date shown on the Policy Schedule.

PREMIUM: Means the amount of money You pay Us in return for the insurance provided by this policy and any rider(s).

SECTION 2: BENEFITS

OUR PROMISE TO PAY: Subject to the terms, conditions, limitations and exclusions of this policy, We will pay the following benefits:

EMERGENCY TREATMENT BENEFIT: We will pay charges up to **[\$300/\$200/\$100]** if, within 7 days after a Covered Accident, You receive emergency treatment for an Accidental Injury. This benefit is payable only if: (1) treatment for an Accidental Injury is received in an Emergency Room, or (2) one of the following is received to treat an Accidental Injury:

- x-ray;
- MRI;
- CT scan;
- digital motion x-ray;
- surgical procedure;
- needle aspiration;
- laceration or puncture wound repair;
- administration of prescription medication;
- tetanus shot;
- antivenom therapy;
- treatment for poisoning (except food poisoning);
- repair of damaged tooth;
- removal of a foreign object from eye;
- casts, splint and orthotic devices;
- crutches; or
- second degree (partial thickness) or third degree (full thickness) burn treatment.

The amount shown is for all emergency treatments combined and is the maximum amount payable per Covered Accident.

Benefits for covered Children will be paid at 50% of the stated amount.

HOSPITAL INPATIENT BENEFIT: We will pay **[\$450/\$300/\$150]** for each day You are admitted to a Hospital as an inpatient for treatment of an Accidental Injury, up to 180 days per Covered Accident. This benefit will be calculated based on the number of days the Hospital charges You as an inpatient for the room. This benefit is not payable for observation rooms or if You are only admitted as an outpatient.

Hospital Inpatient benefits for Covered Accidents being treated outside the United States will be based on the average length of stay for a similar Accident in a U.S. Hospital.

Benefits for covered Children will be paid at 50% of the stated amount.

HOSPITALIZATION PLUS BENEFIT: We will pay **[\$900/\$600/\$300]** if You are admitted to a Hospital and charged for at least one day as an inpatient for treatment of an Accidental Injury sustained in a Covered Accident. For each person insured by this policy, this benefit is payable only once per calendar year and only once per Covered Accident.

Benefits for covered Children will be paid at 50% of the stated amount.

AMBULANCE BENEFIT: We will pay charges up to **[\$600/\$400/\$200]** if a licensed professional ambulance service transports You by ground transportation to a Hospital for treatment of an Accidental Injury received in a Covered Accident.

Ambulance transportation must be within 48 hours after the Covered Accident. The amount shown is the maximum amount payable per Covered Accident.

Benefits for covered Children will be paid at 50% of the stated amount.

AIR AMBULANCE BENEFIT: We will pay charges up to **[\$1,200/\$800/\$400]** if a licensed professional air ambulance service transports You by air to a Hospital for treatment of an Accidental Injury received in a Covered Accident.

Ambulance transportation must be within 48 hours after the Covered Accident. The amount shown is the maximum amount payable per Covered Accident.

Benefits for covered Children will be paid at 50% of the stated amount.

FRACTURE BENEFIT: We will pay the amount shown below if You Fracture a bone in one or more places in a Covered Accident and it is diagnosed and treated by a Physician within 30 days after the Accident.

	<u>Policyowner & Spouse</u>	<u>Covered Children</u>
Head		
Skull - depressed	[\$6,000/\$4,000/\$2,000]	[\$3,000/\$2,000/\$1,000]
Skull - linear	[\$3,000/\$2,000/\$1,000]	[\$1,500/\$1,000/\$500]
Skull - simple	[\$3,000/\$2,000/\$1,000]	[\$1,500/\$1,000/\$500]
Upper jaw	[\$3,000/\$2,000/\$1,000]	[\$1,500/\$1,000/\$500]
Facial bones (other than teeth)	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Lower jaw	[\$2,100/\$1,400/\$700]	[\$1,050/\$700/\$350]
Collar Bone – clavicle	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Sternum	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Rib	[\$900/\$600/\$300]	[\$450/\$300/\$150]
Shoulder Blade – scapula	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Spine		
Compression fracture	[\$3,000/\$2,000/\$1,000]	[\$1,500/\$1,000/\$500]
Wedge fracture	[\$3,000/\$2,000/\$1,000]	[\$1,500/\$1,000/\$500]
Process fracture	[\$3,600/\$2,400/\$1,200]	[\$1,800/\$1,200/\$600]
Laminar fracture	[\$4,800/\$3,200/\$1,600]	[\$2,400/\$1,600/\$800]
Vertebral body fracture	[\$4,800/\$3,200/\$1,600]	[\$2,400/\$1,600/\$800]
Axial burst fracture	[\$4,800/\$3,200/\$1,600]	[\$2,400/\$1,600/\$800]
Coccyx	[\$1,200/\$800/\$400]	[\$600/\$400/\$200]
Upper Arm – humerus shaft	[\$3,000/\$2,000/\$1,000]	[\$1,500/\$1,000/\$500]

	<u>Policyowner & Spouse</u>	<u>Covered Children</u>
Elbow		
Radial head	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Olecranon	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Distal humerus	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Forearm – radius or ulna shaft	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Wrist		
Navicular	[\$2,100/\$1,400/\$700]	[\$1,050/\$700/\$350]
Carpal	[\$2,100/\$1,400/\$700]	[\$1,050/\$700/\$350]
Hand – metacarpal	[\$1,500/\$1,000/\$500]	[\$750/\$500/\$250]
Finger	[\$300/\$200/\$100]	[\$150/\$100/\$50]
Pelvis	[\$6,000/\$4,000/\$2,000]	[\$3,000/\$2,000/\$1,000]
Hip – femoral head or neck	[\$6,000/\$4,000/\$2,000]	[\$3,000/\$2,000/\$1,000]
Thigh – femoral shaft	[\$7,500/\$5,000/\$2,500]	[\$3,750/\$2,500/\$1,250]
Lower Leg – fibula or tibia shaft	[\$3,000/\$2,000/\$1,000]	[\$1,500/\$1,000/\$500]
Knee		
Patella	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Femoral condyle	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Fibula head	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Tibial tuberosity	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Tibial plateau	[\$2,400/\$1,600/\$800]	[\$1,200/\$800/\$400]
Ankle		
Malleolus	[\$2,100/\$1,400/\$700]	[\$1,050/\$700/\$350]
Talus	[\$2,100/\$1,400/\$700]	[\$1,050/\$700/\$350]
Foot – tarsal or metatarsal	[\$1,800/\$1,200/\$600]	[\$900/\$600/\$300]
Toe	[\$300/\$200/\$100]	[\$150/\$100/\$50]

If more than one bone is Fractured in any one Covered Accident, We will pay up to 150% of the benefit amount for the Fracture which has the largest dollar value. If a Physician diagnoses the Fracture as a Chip Fracture, We will pay 10% of the amount shown above. If a Physician diagnoses the Fracture as a Stress Fracture, We will pay 20% of the amount shown above.

Any Fracture Benefit for a subsequently dismembered hand or foot resulting from the same Covered Accident will be deducted from the Dismemberment Benefit. If this benefit is paid and You later die as a result of the same Covered Accident, We will reduce the Accidental Death Benefit by any amounts paid under the Fracture Benefit.

OUTPATIENT PHYSICAL THERAPY BENEFIT: We will pay charges up to **[\$75/\$50/\$25]** for each day that You receive the outpatient services of a licensed Physiotherapist or Physical Therapist that is prescribed by a Physician for the treatment of an Accidental Injury sustained in a Covered Accident. We will pay this benefit up to a maximum of 6 therapy sessions per calendar year. Treatment must begin within 90 days after the Covered Accident or Your discharge date from the Hospital, whichever is later.

Benefits for covered Children will be paid at 50% of the stated amount.

CHIROPRACTIC CARE BENEFIT: This benefit is payable when You are charged for the services of a Chiropractor to treat an Accidental Injury. Treatment must be received within 7 days after the Covered Accident. We will pay:

- **[\$75/\$50/\$25]** for x-rays; and
- **[\$75/\$50/\$25]** for all other chiropractic treatment.

This benefit is payable only for one x-ray and one chiropractic treatment per calendar year for each person insured by this policy. This is the only benefit payable under this policy for treatment by a Chiropractor.

Benefits for covered Children will be paid at 50% of the stated amount.

DISMEMBERMENT BENEFIT: We will pay the appropriate amount below if an Accidental Injury causes the dismemberment of Your hand, foot or eye within one year after a Covered Accident, irrespective of total disability.

- Single Dismemberment: **[\$15,000/\$10,000/\$5,000]**
- Multiple Dismemberment: **[\$30,000/\$20,000/\$10,000]**

Dismemberment means:

- Hand: the hand is completely severed at or above the wrist joint.
- Foot: the foot is completely severed at or above the ankle joint.
- Eye: the central visual acuity of the eye becomes irrevocably incapable of being corrected to better than 20/200.

Any Fracture Benefit for a subsequently dismembered hand or foot resulting from the same Covered Accident will be deducted from the Dismemberment Benefit.

If this benefit is paid and You later die as a result of the same Covered Accident, We will reduce the Accidental Death Benefit by any amounts paid under the Dismemberment Benefit.

Benefits for covered Children will be paid at 50% of the stated amount.

ACCIDENTAL DEATH BENEFIT: We will pay **[\$30,000/\$20,000/\$10,000]** if You are injured in a Covered Accident and the injury causes You to die within 90 days after the Accident, irrespective of total disability.

We will reduce the Accidental Death Benefit by any amounts paid under the Fracture and Dismemberment Benefits for that person for the same Covered Accident.

Benefits for covered Children will be paid at 50% of the stated amount.

FAMILY LODGING BENEFIT: We will pay charges up to **[\$75/\$50/\$25]** for Your lodging in a hotel or motel while a covered person is admitted to a Hospital as an inpatient for treatment of an Accidental Injury sustained in a Covered Accident. This benefit is not available for an Individual Policy.

This benefit is limited to payment for one room for each day of the hospitalization up to a maximum of 60 days per Covered Accident.

FAMILY EDUCATION BENEFIT: This benefit is payable when the first Accidental Death Benefit is paid for the Policyowner or the covered Spouse and there are covered Children under this policy at the time of the Accident. We will pay for Post-secondary Education tuition up to **[\$3,000/\$2,000/\$1,000]** per calendar year for up to 5 covered Children. This benefit will be paid up to a lifetime maximum of **[\$12,000/\$8,000/\$4,000]** for each of the 5 covered Children that qualify for the benefit. This benefit is not available for an Individual Policy or Married Couple Policy.

To receive payment under this benefit, a covered Child must submit annually to the Company, Proof of Enrollment at an Accredited Institution of Post-secondary Education. Benefits will not be payable for any covered Child after that Child attains age 25. The company must be notified of the identity of covered Children within 90 days following the payment of the Accidental Death Benefit.

CASH VALUE BENEFIT: This benefit will be equal to the total premiums paid during the Cash Value Period, multiplied by the applicable percentage shown in the TABLE OF CASH VALUE PERCENTAGES, minus any Claims Incurred during the Cash Value Period.

You will be eligible for a Cash Value Benefit if You keep your policy in force until a Maturity Date. You are not required to surrender Your policy at the Maturity Date to receive this benefit.

You will be eligible for a Cash Value Benefit if after five Completed Years Of Premium Payments and prior to the Maturity Date You:

- Cancel Your policy or allow it to lapse; or,

- die, and the policy is not continued by Your covered Spouse as described under the Continuation provision. The policy will cease to be in effect as of the date to which the Cash Value Benefit is calculated, and the policy may not be reinstated after this date.

If You allow the policy to terminate within the first five years, and it is later reinstated, the calculation of all Cash Value Benefit amounts will be deferred by the period of time that the policy was inactive.

TABLE OF CASH VALUE PERCENTAGES:

**COMPLETED
YEARS OF
PREMIUM
PAYMENT**

AGE AT BEGINNING OF CASH VALUE PERIOD

	50 and Under	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66 and Over
1	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
2	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
3	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
4	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
5	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
6	15%	15%	16%	16%	17%	18%	19%	19%	20%	22%	23%	23%	22%	22%	21%	30%	20%
7	19%	20%	21%	22%	23%	24%	26%	27%	29%	31%	33%	33%	33%	34%	38%	45%	29%
8	22%	23%	25%	26%	28%	30%	32%	34%	37%	39%	42%	44%	46%	48%	58%	70%	36%
9	26%	27%	29%	31%	33%	35%	38%	40%	44%	47%	51%	54%	58%	63%	76%	87%	43%
10	29%	31%	33%	35%	38%	40%	43%	47%	50%	54%	59%	64%	69%	78%	88%	100%	50%
11	32%	34%	37%	39%	42%	45%	49%	53%	57%	62%	67%	72%	80%	89%	100%		
12	35%	38%	41%	44%	47%	50%	54%	59%	63%	69%	75%	83%	90%	100%			
13	39%	41%	45%	48%	52%	56%	60%	65%	70%	76%	83%	91%	100%				
14	42%	45%	49%	52%	56%	61%	66%	71%	77%	84%	91%	100%					
15	46%	49%	53%	57%	62%	67%	72%	78%	84%	92%	100%						
16	50%	54%	58%	62%	67%	72%	78%	85%	92%	100%							
17	54%	58%	63%	67%	73%	79%	85%	92%	100%								
18	58%	63%	68%	73%	79%	85%	92%	100%									
19	63%	68%	73%	79%	85%	92%	100%										
20	68%	73%	79%	86%	92%	100%											
21	74%	79%	86%	93%	100%												
22	79%	86%	93%	100%													
23	86%	93%	100%														
24	93%	100%															
25	100%																

SECTION 3: LIMITATIONS AND EXCLUSIONS

The payment of benefits is subject to all the terms and conditions of this policy including any limitations and exclusions described in specific benefits.

We will not pay benefits for an Accidental Injury or death contributed to, caused by, or resulting from:

WAR: Your participating in war or any act of war, declared or not. We will return the prorated Premium for any period not covered by this policy for any excluded periods.

SUICIDE: Your committing or attempting to commit suicide, regardless of mental capacity.

INTENTIONAL INJURIES: Your injuring or attempting to injure yourself or a covered Spouse or Child intentionally, regardless of mental capacity.

SICKNESS: Your having any disease or bodily/mental illness or degenerative condition. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

RACING: Your riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test, or while testing any vehicle on any race course or speedway.

AVIATION: Your operating, learning to operate, serving as a crew member on, or jumping from any aircraft, including those which are not motor-driven.

INTOXICATION: Your being legally intoxicated or being under the influence of any narcotic or other illegal substance, unless such narcotic or substance is taken on the advice of a Physician and according to the Physician's instructions. Having a blood alcohol level that exceeds the level permitted by the laws of the state where the Accident occurs which pertain to driving a motor vehicle will be presumptive proof of intoxication.

ILLEGAL ACTS: Your participating or attempting to participate in a felony or working at an illegal job.

SPORTS: Your participating in professional or semi-professional sports.

RODEO: Your participating for money in a rodeo event.

SECTION 4: GENERAL PROVISIONS

ENTIRE CONTRACT: The entire contract of insurance consists of all applications, the policy, the Policy Schedule, and any attached riders, amendments, or endorsements.

CONTRACT CHANGES: No change in this policy is valid unless provided in writing by Our Executive Office and such approval is endorsed by one of Our officers and attached to this policy. No one else has the authority to change this policy or to waive any of its provisions.

TERM: This policy becomes effective at 12:00 noon (Eastern Standard Time) on the Effective Date shown on Your Policy Schedule. Each renewal term ends at 12:00 noon (Eastern Standard Time) on the date to which Your Premium is paid. Renewal dates are determined by mode of payment. Your initial mode of payment is shown on Your Policy Schedule.

CANCELLATION OF INSURANCE: The Policyowner may cancel this policy at any time. The Policyowner's request to cancel must be in writing and sent to Us at Our Executive Office. Cancellation will become effective on the day We receive the request, or on a later date specified in the request. In the event of cancellation, We will promptly return the unearned portion of any Premium paid. This will be calculated using the pro-rata portion of any Premium paid. If any claim originated prior to the effective date of cancellation, We will pay the appropriate benefits due. We cannot cancel this policy for any reason other than nonpayment of Premium.

PREMIUMS: The first Premium is due on the Effective Date. Each Premium after the first is due on the last day of the term for which the most recent Premium was paid and must be paid to Us at Our Executive Office.

This policy will not be in force until Your application is approved and the first Premium is accepted by Us. If We accept subsequent Premium, this policy will continue in force until the end of the term for which the Premium is due.

The amount of the first Premium for the initial mode of payment is shown on the Policy Schedule. The amount of each Premium after the first is based on Your then current mode of payment.

GRACE PERIOD: If You do not pay a Premium when it is due, You can pay it during the next 31 days. This period is known as the Grace Period. During this Grace Period the policy will stay in force but will terminate if You do not pay the Premium by the end of the 31 days.

REINSTATEMENT: If this policy terminates because You do not pay the Premium by the end of the Grace Period, You may be able to put Your insurance back in force.

If We or Our authorized agent accept Your Premium and We do not require a reinstatement application, this policy will be reinstated as of 12:00 noon (Eastern Standard Time) on the date We receive the Premium. If We require a reinstatement application at the time We accept the Premium, We will issue You a conditional receipt for the Premium. Upon Our receipt and approval of the reinstatement application, this policy will be reinstated as of 12:00 noon (Eastern Standard Time) on the date the reinstatement application is approved. If We do not mail written notice of disapproval of the reinstatement application within 45 days after Our receipt of the Premium, then this policy will automatically be reinstated as of 12:00 noon (Eastern Standard Time) on the 45th day.

The reinstated policy will only cover loss resulting from an Accidental Injury that takes place after the reinstatement date. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium was due but not to a period of more than 60 days prior to the reinstatement date.

We reserve the right to make changes to this policy before We reinstate it. Any changes will be noted on or attached to the reinstated policy. In every other way, Your rights and Our rights will be the same.

CONTINUATION: If the Policyowner's Spouse is covered under this policy, he or she can elect to continue insurance under this policy if the Policyowner dies. A written request for continuation and the appropriate Premium must be sent to Us within 60 days of the Policyowner's death.

UNEARNED PREMIUM: If the Policyowner dies and the policy is not continued by the covered Spouse as described under the Continuation provision, any proceeds payable to the Policyowner's estate will include premiums paid for any period beyond the end of the policy month in which the death occurred. Unearned premiums shall be paid in lump sum on a date no later than 30 days after the proof of the Policyowner's death has been furnished to Us.

CONVERSION: If the Policyowner's Spouse is covered under this policy and would lose insurance because of divorce, annulment, or the Policyowner's death, or a covered dependent Child would lose insurance because of marriage, attainment of the limiting age or the Policyowner's death, then Your Spouse and/or Child may convert to a separate policy. A written request for conversion, along with the appropriate Premium, must be sent to Our Executive Office within 60 days after the date insurance would otherwise end. We will issue, without evidence of insurability, an equal or similar policy. The converted insurance will be limited by any exclusions which applied under this policy. Additionally, any benefit amounts paid for a person under this policy will be applied to benefit limits under that person's converted policy.

MISSTATEMENTS OF AGE: If any age or date of birth is misstated in the application, benefit amounts will be determined based on the appropriate age at the time coverage was purchased. If, based on the correct ages, We would not have issued this policy or insured certain members of Your family under this policy, then Our only responsibility will be to refund any excess Premium paid.

TIME LIMIT ON CERTAIN DEFENSES: We rely on the statements the Policyowner made in the application when issuing this insurance. After this insurance has been in force for three years, We cannot cancel the policy or refuse to pay benefits for losses after such time because of any misstatements, except fraudulent misstatements, made in the application.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on the Effective Date, is in conflict with the laws of the state in which Your policy was issued, will be amended to conform to the minimum requirements of those laws.

SECTION 5: CLAIM PROVISIONS

NOTICE OF CLAIM: Written notice of a claim must be given within 60 days after the start of a covered loss or as soon as reasonably possible. The notice must be sent to Us at Our Executive Office or to an authorized agent of the Company. The notice should include the Policyowner's name and policy number.

CLAIM FORMS: When We receive notice of a claim, We will send forms for filing Proof of Loss. If these forms are not sent within 15 days, You will meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section.

PROOFS OF LOSS: Written Proof of Loss must be furnished to the Company in English at Our Executive Office within 90 days after the loss for which You are seeking benefits. If it is not possible to give written proof in the time required, We will not reduce or deny benefits for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the date proof is otherwise required, unless You were legally incapacitated during that time.

One or more of the following together with Your written statement may be required as Proof of Loss:

- completed Company claim forms;
- adoption papers;
- birth, marriage, and death certificates;
- a Physician's statement;
- Hospital, medical and Physician records;
- itemized bills for services rendered;
- a police or accident report;
- an autopsy report; and
- other documentation.

TIME PAYMENT OF CLAIMS: Benefits for any loss covered by this policy will be paid immediately upon Our receipt of due written Proof of Loss.

BENEFICIARY: The person named in the application as the Beneficiary is the person to whom any Accidental Death Benefits will be payable. If there is no Beneficiary designation in effect when an Accidental Death Benefit is payable or if all named Beneficiaries have died, then the benefit will be paid to the Policyowner's estate.

CHANGING YOUR BENEFICIARY: The Policyowner can ask Us to change the Beneficiary at any time. The request must be in writing and the change must be approved by Us. If approved, it will go into effect the day the Policyowner signs the request. The change will not have any bearing on payments made before We approved the request.

PAYMENT OF CLAIMS: Benefits other than the Accidental Death Benefit and Family Education Benefit will be paid to the Policyowner. We will not be bound by any assignment of benefits request or authorization form unless We have given Our prior consent. Any benefits unpaid at the time of Your death will be paid in the following order: to any approved assignee, to the Beneficiary, or to the Policyowner's estate.

EXTENSION OF BENEFITS: Termination of the policy shall be without prejudice to any continuous loss which commenced while the policy was in force but the extension of benefits beyond the period the policy was in force may be predicated upon the payment of the maximum benefits.

UNPAID PREMIUM: When a claim is paid, any Premium due and unpaid may be deducted from the claim payment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have You examined as often as reasonably necessary while a claim is pending. We can require an autopsy where allowed by law. Either will be done at Our expense.

LEGAL ACTION: You cannot take legal action against Us for benefits under this policy:

- within 60 days after You have sent Us written Proof of Loss; or
- more than three years from the time written proof is required to be given.

Application To: FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA
Executive Office: P.O. Box 470608, Cleveland, OH 44147

[INJURCARE PLUS]

Applicant's Name (Please Print: First, Middle Initial, Last)					<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Spouse's Name (If Family or Married Couple Coverage)					<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Applicant's Address: Number and Street		City	County	State	Zip	Phone Number
Applicant's Employer's Name and Address			Applicant's Occupation		Spouse's Occupation	
Beneficiary's Name and Address					Relationship:	
Names of all children proposed to be insured* (Please Print: First, Middle Initial, Last):					Gender	Date of Birth
_____					<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____					<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____					<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____					<input type="checkbox"/> M <input type="checkbox"/> F	_____

*Subject to Policy Terms & Conditions. List any additional children proposed to be insured on the back in the space provided.

Do you give Family Heritage permission to use your name for marketing purposes? YES NO
 Have you ever purchased any other insurance with Family Heritage Life Insurance Company of America? YES NO
 Will this coverage replace any other accident and sickness insurance presently in force? YES NO
 If "YES" please sign a Replacement Form.

ACCIDENT INSURANCE			
COVERAGE LEVEL	COVERAGE TYPE	PAYMENT MODE	MODAL PREMIUM
<input type="checkbox"/> Elite <input type="checkbox"/> Preferred <input type="checkbox"/> Standard	<input type="checkbox"/> Individual <input type="checkbox"/> Single Parent <input type="checkbox"/> Married Couple <input type="checkbox"/> Family	<input type="checkbox"/> A/C <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	Total \$ _____
EXECUTIVE OFFICE USE			Amount Collected \$

IMPORTANT NOTICE: Any person who knowingly facilitates a fraud or has intent to defraud an insurer, or submits an application or files a claim containing false or deceptive statements, is guilty of insurance fraud.

APPLICANT'S STATEMENT: I have read, or have had read to me, the completed application. The above representations are true to the best of my knowledge and belief. I understand: that any false statements or misrepresentations in this application may result in loss of coverage; that the agent has no authority to approve the application, change the policy or waive any policy provisions; and, that no insurance will be effective until the date stated in my policy.

Date: _____ Signature of Applicant: _____

THIS SECTION TO BE COMPLETED BY AGENT: I hereby certify that I have explained to the applicant all limitations and exclusions pertaining to the coverage(s) applied for. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the applicant. I further certify that I am a licensed agent in the state where this application is being signed.

Date: _____ Signature of Agent: _____ Agent #: _____

Signed in: _____
City State

FORM A5APP-RP



APPLICATION RECEIPT

Family Heritage Life Insurance Company of America • P.O. Box 470608 • Cleveland, Ohio 44147 • (440) 922-5222

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from _____ the sum of \$ _____ which has been tendered as payment of the first _____ premium for the policy which has been applied for with Family Heritage Life Insurance Company of America. It is understood that, if issued, the policy will be in force as of the effective date shown in the policy. If the application is declined by the Company, no insurance shall begin and the above payment will be returned to the applicant.

Date: _____ Licensed Company Representative: _____

IF YOU DO NOT HEAR FROM THE COMPANY OR RECEIVE YOUR POLICY WITHIN 30 DAYS, CALL OR WRITE TO THE COMPANY, GIVING THE NAME OF THE PERSON WHO SIGNED THIS RECEIPT, THE TYPE OF POLICY APPLIED FOR, THE AMOUNT PAID AND THE DATE.

FORM A5APP-RP

**AUTHORIZATION TO HONOR DEDUCTIONS DRAWN BY
FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA**

Checking Savings Third Party

Name of Bank Depositor _____
(Print Name as Shown on Bank Documents)

To: _____ Routing # _____
(Name of Bank and Branch)

_____ Account # _____
(Address of Bank or Branch where Account is Maintained)

I hereby request and authorize you to honor and charge to my account deductions drawn on my account by and payable to Family Heritage Life Insurance Company of America, and to honor credit entries made to my account by Family Heritage Life Insurance Company of America. The signatures on such deductions may be either typed or printed. If any such deductions are dishonored, either 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.

This authorization shall continue in force until revoked by me in writing and received by you, a copy of which revocation shall be sent by me to Family Heritage Life Insurance Company of America, at the Executive Office in Cleveland, Ohio. Family Heritage Life Insurance Company of America is instructed to forward authorization to you.

I request that such deductions be drawn on my account on the _____ day of the month.
(Note: the 29th, 30th, and 31st are not available dates)

Date _____ Signature of Bank Depositor _____

To: The Bank Named Above

So that you may comply with your depositor's request this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, deduction, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, deduction, draft or order shall be dishonored whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which might be brought by any depositor, policyowner, beneficiary or any other persons because of your actions taken pursuant to the foregoing plan of premium collection.

Family Heritage Life Insurance Company of America
Cleveland, Ohio 44147

Harold L. Lewis
President

Names of additional children proposed to be insured*: (Please Print: First, Middle Initial, Last)	Gender	Date of Birth
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
*Subject to Policy Terms & Conditions.		



FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA

P.O. Box 470608, Cleveland, OH 44147, (440) 922-5151

Policyowner's Name: _____ Policy #: _____

ACCIDENTAL INJURY CLAIM FORM

Instructions: Have the Patient/Claimant answer all questions on Side 1 and have the treating Physician complete Side 2. If filing an **accidental injury claim** submit one claim form completed by the Claimant and the Physician for each accident along with copies of all itemized hospital and medical bills that apply and accident report, if applicable. If filing an **accidental death claim** submit one claim form completed by the Spouse/Executor and the Physician along with copies of the Claimant's death certificate and accident report, if applicable.

1. Patient's name: _____ 2. Social Security No.: _____

3. Address: _____ 4. Phone number: (____) _____

_____ 5. Date of birth: _____

6. Relationship to Policyowner: Self Spouse Son Daughter Other _____

7. Date of accident: _____ 8. Date first consulted physician: _____

9. Place of accident: _____

10. Describe how illness/injury occurred: _____

11. Nature of injury: _____

12. List all treating physicians. Include name and phone number: _____

13. If hospitalized, when? From _____ to _____ Hospital phone: (____) _____

14. Hospital name: _____

City

State

IMPORTANT NOTICE: Any person who, knowingly facilitates a fraud or has intent to defraud an insurer, or submits an application or files a claim containing false or deceptive statements is guilty of insurance fraud.

AUTHORIZATION MUST BE SIGNED BEFORE CLAIM CAN BE PROCESSED

I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish any information with respect to any illness or accident, medical history or medical records for the Patient to Family Heritage Life Insurance Company of America (FHLICoA) or its representative for the purpose of evaluating claims for benefits. I understand that this authorization is voluntary and I may revoke it at any time by submitting a written revocation to FHLICoA. If I do revoke this authorization, it will not have any affect on any information released before FHLICoA's receipt of the revocation, including any action taken by the individual/entity that received the health information. I further understand that I may request to see and copy the information described in this Authorization and that I am entitled to a signed copy of this Authorization. I acknowledge that unless an earlier date is specified under applicable law, this Authorization will expire 90 days from the date signed.

Signed _____ Date _____

Patient, Parent (If Child) or Executor

IF THE CLAIMANT IS UNABLE TO PROVIDE A SIGNATURE, PLEASE INCLUDE A COPY OF A
POWER OF ATTORNEY, LETTER OF EXECUTOR AND/OR DEATH CERTIFICATE

SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN

Physician's name: _____ Phone number: (____) _____

Specialty: _____

Address: _____

1. Diagnosis: _____ 2. Diagnosis code(s): _____

3. Was this condition due to an accidental injury? Yes No 4. Date accident occurred: _____

5. Nature of the injury: _____

6. Where did the injury happen? _____

7. Date patient first consulted you for this condition: _____ Date of most recent exam: _____

8. Has the patient ever had the same or similar condition? Yes No If Yes, when? _____

9. Describe any other disease or infirmity affecting the present condition: _____

10. Referring physician's name, address and phone number: _____

11. Was the patient under the influence of any intoxicant or narcotic at the time of the accident? Yes No

If Yes, was it taken under the direction of a physician? Yes No If Yes, please explain: _____

Did it contribute to the injury? Yes No If Yes, please explain: _____

12. Was the patient hospitalized solely due to this condition? Yes No

If hospitalized, name and address of the facility: _____

Date admitted: _____ Date discharged: _____

13. List any applicable procedure codes: A) _____ B) _____ C) _____

14. Do you have records on the patient's past medical history? Yes No

Completed by (please print)

Position

Physician's Signature

Date

ACCIDENT POLICY CHANGE FORM

FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA
P.O. BOX 470608, CLEVELAND, OH 44147

Policy # _____

Policyowner's Name (Please Print: First, Middle Initial, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Policyowner's Soc. Sec. #
Spouse's Name (If Family or Married Couple Coverage)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Spouse's Soc. Sec. #
Policyowner's Address: Number and Street	City	County	State Zip Phone Number

Beneficiary's Name and Address	Relationship:
--------------------------------	---------------

Names of all Children (Please Print: First, Middle Initial, Last):	Gender	Date of Birth
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____

SECTION 1: TYPE OF CHANGE REQUESTED (check all that apply)

- Reinstatement*
 Level Increase*
 Level Decrease
 Add Family Member*
 Remove Family Member

COVERAGE LEVEL	COVERAGE TYPE	PAYMENT MODE	MODAL PREMIUM
<input type="checkbox"/> Elite <input type="checkbox"/> Preferred <input type="checkbox"/> Standard	<input type="checkbox"/> Individual <input type="checkbox"/> Single Parent <input type="checkbox"/> Married Couple <input type="checkbox"/> Family	<input type="checkbox"/> A/C <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	Total \$ _____

- Are you requesting the removal of a family member because of the death of the Policyowner?
If YES, please include a copy of the death certificate.
 YES NO
- Are you requesting the removal of a family member because of divorce from the Policyowner?
If YES, please indicate date of divorce _____.
 YES NO
- After removing family member(s) from coverage, are there any dependent children who will remain under your coverage?
 YES NO

*Medical records may be required for any person(s) covered or to be covered under this policy. The company reserves the right to reject any coverage changes or reinstatements based on existing or previous medical conditions.

IMPORTANT NOTICE: Any person who, knowingly facilitates a fraud or has intent to defraud an insurer, or submits an application or files a claim containing false or deceptive statements, is guilty of insurance fraud.

SECTION 2: NAMES OF FAMILY MEMBERS (List the names, relationship and birthdates of all family members)

Name	Relationship (Child, Spouse)	Date of Birth	Remove/Add
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 3: APPLICANT'S STATEMENT

I have read, or have had read to me, the completed application. The above representations are true to the best of my knowledge and belief. I understand that:

For all changes:

- any false statements or misrepresentations in the application may result in loss of coverage;
- the agent has no authority to approve the application, change the policy or waive any of its policy provisions; and
- the Company will notify me of any adjustment in premium.

For changes in coverage:

- if I am adding a family member to my coverage, the family member will not be covered until this application is approved by the Company, I have paid the appropriate premium, and the family member has satisfied the waiting period, if any;
- my existing coverage will remain in effect until the Company issues a change in coverage and its Effective Date; and
- any Return of Premium or Cash Value Benefit will be based on the age of the original Policyowner.

For reinstatements:

- unless the Company disapproves this application, the coverage will be reinstated either as of the date that this application is approved, or after the 45th day following the date we received your premium payment; and
- the reinstated coverage will cover loss that results from accidental injuries sustained after the reinstatement date.

AUTHORIZATION: I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau to furnish any information with respect to any illness or accident, medical history or medical records to Family Heritage Life Insurance Company of America (FHLICoA) or its representative to review for underwriting purposes. I understand that this authorization is voluntary and I may revoke it at any time by submitting a written revocation to FHLICoA. If I do revoke this authorization, it will not have any affect on any information released before FHLICoA's receipt of the revocation, including any action taken by the individual/entity that received the health information. I further understand that I may request to see and copy the information described in this Authorization and that I am entitled to a signed copy of this Authorization. I acknowledge that unless an earlier date is specified under applicable law, this Authorization will expire 90 days from the date signed.

Date: _____ Signature of Applicant: _____

**AUTHORIZATION TO HONOR DEDUCTIONS DRAWN BY
FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA**

Checking Savings Third Party

Name of Bank Depositor _____
(Print Name as Shown on Bank Documents)

To: _____ Routing # _____
(Name of Bank and Branch)

_____ Account # _____
(Address of Bank or Branch where Account is Maintained)

I hereby request and authorize you to honor and charge to my account deductions drawn on my account by and payable to Family Heritage Life Insurance Company of America, and to honor credit entries made to my account by Family Heritage Life Insurance Company of America. The signatures on such deductions may be either typed or printed. If any such deductions are dishonored, either 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.

This authorization shall continue in force until revoked by me in writing and received by you, a copy of which revocation shall be sent by me to Family Heritage Life Insurance Company of America, at the Executive Office in Cleveland, Ohio. Family Heritage Life Insurance Company of America is instructed to forward authorization to you.

I request that such deductions be drawn on my account on the _____ day of the month.
(Note: the 29th, 30th, and 31st are not available dates)

Date _____ Signature of Bank Depositor _____

To: **The Bank Named Above**

So that you may comply with your depositor's request this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, deduction, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, deduction, draft or order shall be dishonored whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which might be brought by any depositor, policyowner, beneficiary or any other persons because of your actions taken pursuant to the foregoing plan of premium collection.

Family Heritage Life Insurance Company of America
Cleveland, Ohio 44147



President

SERFF Tracking Number: FHLA-125632477 State: Arkansas
Filing Company: Family Heritage Life Insurance Company of America State Tracking Number: 38855
Company Tracking Number: A5ARPOL
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: Accident Only Policy
Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 05/06/2008

Comments:

The Certification for Rule & Regulation is attached.
Form AR-GUAR approved by the Department on 8/6/1999 (attached) is the form issued to all Arkansas policyholders pursuant to Rule & Regulation 49.
The Flesch Readability Certification is attached.
Form AR-LTR approved by the Department on 8/6/1999 (attached) is our Consumer Information Notice and will be issued to all Arkansas policyholders.

Attachments:

Rule 19 Cert.pdf
Ar-guar.pdf
Readability Cert.pdf
AR-LTR.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 05/06/2008

Comments:

Application form A5POL-RP is new and attached under the Form Schedule tab.

Satisfied -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 05/06/2008

Comments:

Premium rates for the policy are included in the memorandum as the last page.

Attachment:

ActMemo-ICP-C2.pdf

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 05/06/2008

Comments:

Attachment:

A5OCCST.pdf

SERFF Tracking Number: FHLA-125632477 State: Arkansas
Filing Company: Family Heritage Life Insurance Company of State Tracking Number: 38855
America
Company Tracking Number: A5ARPOL
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: Accident Only Policy
Project Name/Number: /

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 05/06/2008
Comments:
Attachment:
Cover letter - AR.pdf

FAMILY HERITAGE[®]
Life Insurance Company Of America

Certification of Compliance with Rule and Regulation 19

I hereby certify that to the best of my knowledge, information and belief that this submission (Form A5POLCAR, et al) meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance Department.



Signature

Henry G. Grendell

Name

Vice President & General Counsel

Title

May 2, 2008

Date

P.O. Box 470608 • Cleveland, Ohio 44147

(440) 922-5200

FAX: (440) 922-5201

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rates yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or a similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

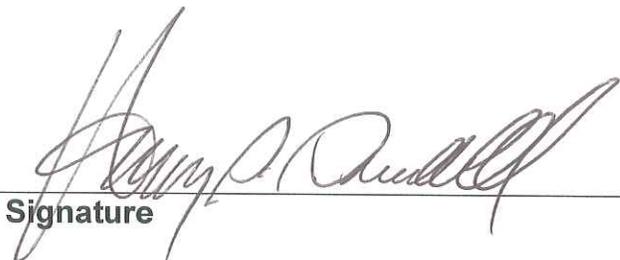
LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy of contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Family Heritage Life Insurance Company of America

I hereby certify that Policy Form A5POLCAR meets the minimum reading ease score on the Flesch Reading Ease Test and that it complies with the requirements of ACA 23-80-206, cited as the Life and Accident and Health Insurance Policy Language Simplification Act.



Signature

Henry G. Grendell

Name

Vice President & General Counsel

Title

May 2, 2008

Date

FAMILY HERITAGE

Life Insurance Company of America

A Southwestern/Great American Company

Dear Insured,

We are here to serve you...

As our policyholder, your satisfaction is very important to us. If you have a question about your policy, if you need assistance with a problem, or if you have a claim, you should contact our Home Office at (440) 922-5222 or write to us at P.O. Box 470608, Cleveland, OH 44147. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

Should you feel you are not being treated fairly with respect to a claim, you may contact the Arkansas Department of Insurance with your complaint.

To contact the Department, write or call:

Consumer Services Division
Arkansas Insurance Department
1200 W. 3rd Street
Little Rock, AR 72201-1904
(501) 371-2640 or 1-800-852-5494

(440) 922-5222

FAX: (440) 922-5223

P.O. Box 470608 • Cleveland, Ohio 44147

FAMILY HERITAGE

Life Insurance Company Of America

P.O. Box 470608, Cleveland, Ohio 44147

OUTLINE OF COVERAGE

ACCIDENT ONLY INSURANCE

Elite/Preferred/Standard Benefit Levels

Policy Form A5POLC

"THIS IS NOT A MEDICARE SUPPLEMENT POLICY"

SECTION 1: PLEASE READ YOUR POLICY CAREFULLY

This Outline of Coverage provides a brief description of the main features of the policy, along with all levels of coverage. This is not the contract. Only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and us. **PLEASE READ YOUR POLICY CAREFULLY!**

SECTION 2: ACCIDENT ONLY COVERAGE

Policies of this nature are designed to provide, to persons insured, coverage for specific losses resulting from an accidental injury. Benefits are outlined in Section 3 and may be subject to the Limitations and Exclusions contained in Section 4.

SECTION 3: BENEFITS PROVIDED UNDER THIS POLICY

EMERGENCY TREATMENT BENEFIT: Charges up to **\$300/\$200/\$100** if, within 7 days after a covered accident, emergency treatment is received for an accidental injury. The amount shown is for all emergency treatments combined and is the maximum amount payable per covered accident. Benefits for covered children will be paid at 50% of the stated amount. This benefit is payable only if: (1) treatment for an accidental injury is received in an emergency room, or (2) one of the following is received to treat an accidental injury:

- x-ray;
- MRI;
- CT scan;
- digital motion x-ray;
- surgical procedure;
- needle aspiration;
- laceration or puncture wound repair;
- administration of prescription medication;
- tetanus shot;
- antivenom therapy;
- treatment for poisoning (except food poisoning);
- repair of damaged tooth;
- removal of a foreign object from eye;
- casts, splint and orthotic devices;
- crutches; or,
- second degree (partial thickness) or third degree (full thickness) burn treatment.

HOSPITAL INPATIENT BENEFIT: **\$450/\$300/\$150** for each day you are admitted to a hospital as an inpatient for treatment of an accidental injury, up to 180 days per covered accident. The benefit will be calculated based on the number of days the hospital charges you as an inpatient for the room. This benefit is not payable for observation rooms or if you are only admitted as an outpatient. Hospital Inpatient benefits for covered accidents being treated outside the United States will be based on the average length of stay for a similar accident in a U.S. hospital. Benefits for covered children will be paid at 50% of the stated amount.

PLEASE RETAIN THIS FOR YOUR RECORDS

HOSPITALIZATION PLUS BENEFIT: \$900/\$600/\$300 if you are admitted to a hospital and charged for at least one day as an inpatient for treatment of an accidental injury sustained in a covered accident. For each person insured by this policy, this benefit is payable only once per calendar year and only once per covered accident. Benefits for covered children will be paid at 50% of the stated amount.

AMBULANCE BENEFIT: Charges up to **\$600/\$400/\$200** if a licensed professional ambulance service transports you by ground transportation to a hospital for treatment of an accidental injury received in a covered accident. Ambulance transportation must be within 48 hours after the covered accident. The amount shown is the maximum amount payable per covered accident. Benefits for covered children will be paid at 50% of the stated amount.

AIR AMBULANCE BENEFIT: Charges up to **\$1,200/\$800/\$400** if a licensed professional air ambulance service transports you by air to a hospital for treatment of an accidental injury received in a covered accident. Ambulance transportation must be within 48 hours after the covered accident. The amount shown is the maximum amount payable per covered accident. Benefits for covered children will be paid at 50% of the stated amount.

FRACTURE BENEFIT: The amount shown below if you fracture a bone in one or more places in a covered accident and it is diagnosed and treated by a physician within 30 days after the accident. If more than one bone is fractured in any one covered accident, this benefit will pay up to 150% of the benefit amount for the fracture which has the largest dollar value. If a physician diagnoses the fracture as a chip fracture, this benefit will pay 10% of the amount shown. If a physician diagnoses the fracture as a stress fracture, this benefit will pay 20% of the amount shown.

If this benefit is paid and you later die as a result of the same covered accident, we will reduce the Accidental Death Benefit by any amounts paid under the Fracture Benefit.

	<u>Policyowner & Spouse</u>	<u>Covered Children</u>
Head		
Skull - depressed	\$6,000/\$4,000/\$2,000	\$3,000/\$2,000/\$1,000
Skull - linear	\$3,000/\$2,000/\$1,000	\$1,500/\$1,000/\$500
Skull - simple	\$3,000/\$2,000/\$1,000	\$1,500/\$1,000/\$500
Upper jaw	\$3,000/\$2,000/\$1,000	\$1,500/\$1,000/\$500
Facial bones (other than teeth)	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Lower jaw	\$2,100/\$1,400/\$700	\$1,050/\$700/\$350
Collar Bone – clavicle	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Sternum	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Rib	\$900/\$600/\$300	\$450/\$300/\$150
Shoulder Blade – scapula	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Spine		
Compression fracture	\$3,000/\$2,000/\$1,000	\$1,500/\$1,000/\$500
Wedge fracture	\$3,000/\$2,000/\$1,000	\$1,500/\$1,000/\$500
Process fracture	\$3,600/\$2,400/\$1,200	\$1,800/\$1,200/\$600
Laminar fracture	\$4,800/\$3,200/\$1,600	\$2,400/\$1,600/\$800
Vertebral body fracture	\$4,800/\$3,200/\$1,600	\$2,400/\$1,600/\$800
Axial burst fracture	\$4,800/\$3,200/\$1,600	\$2,400/\$1,600/\$800
Coccyx	\$1,200/\$800/\$400	\$600/\$400/\$200
Upper Arm – humerus shaft	\$3,000/\$2,000/\$1,000	\$1,500/\$1,000/\$500
Elbow		
Radial head	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Olecranon	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Distal humerus	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Forearm – radius or ulna shaft	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Wrist		
Navicular	\$2,100/\$1,400/\$700	\$1,050/\$700/\$350
Carpal	\$2,100/\$1,400/\$700	\$1,050/\$700/\$350

	<u>Policyowner & Spouse</u>	<u>Covered Children</u>
Hand – metacarpal	\$1,500/\$1,000/\$500	\$750/\$500/\$250
Finger	\$300/\$200/\$100	\$150/\$100/\$50
Pelvis	\$6,000/\$4,000/\$2,000	\$3,000/\$2,000/\$1,000
Hip – femoral head or neck	\$6,000/\$4,000/\$2,000	\$3,000/\$2,000/\$1,000
Thigh – femoral shaft	\$7,500/\$5,000/\$2,500	\$3,750/\$2,500/\$1,250
Lower Leg – fibula or tibia shaft	\$3,000/\$2,000/\$1,000	\$1,500/\$1,000/\$500
Knee		
Patella	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Femoral condyle	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Fibula head	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Tibial tuberosity	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Tibial plateau	\$2,400/\$1,600/\$800	\$1,200/\$800/\$400
Ankle		
Malleolus	\$2,100/\$1,400/\$700	\$1,050/\$700/\$350
Talus	\$2,100/\$1,400/\$700	\$1,050/\$700/\$350
Foot – tarsal or metatarsal	\$1,800/\$1,200/\$600	\$900/\$600/\$300
Toe	\$300/\$200/\$100	\$150/\$100/\$50

OUTPATIENT PHYSICAL THERAPY BENEFIT: Charges up to **\$75/\$50/\$25** for each day that you receive the outpatient services of a licensed physiotherapist or physical therapist that is prescribed by a physician for the treatment of an accidental injury sustained in a covered accident. We will pay this benefit up to a maximum of 6 therapy sessions per calendar year. Treatment must begin within 90 days after the covered accident or your discharge date from the hospital, whichever is later. Benefits for covered children will be paid at 50% of the stated amount.

CHIROPRACTIC CARE BENEFIT: **\$75/\$50/\$25** for x-rays and **\$75/\$50/\$25** for all other chiropractic treatment when you are charged for the services of a chiropractor as the direct result of a covered accident. Treatment must be received within 7 days after the accident. This benefit is payable only for one x-ray and one chiropractic treatment per calendar year for each person insured by this policy. This is the only benefit payable under this policy for treatment by a chiropractor. Benefits for covered children will be paid at 50% of the stated amount.

DISMEMBERMENT BENEFIT: **\$15,000/\$10,000/\$5,000** if an accidental injury causes single dismemberment of your hand, foot or eye within one year of a covered accident. **\$30,000/\$20,000/\$10,000** if an accidental injury causes multiple dismemberment of two or more hands, feet or eyes within one year after a covered accident. Any Fracture Benefit for a subsequently dismembered hand or foot resulting from the same covered accident will be deducted from the Dismemberment Benefit. If this benefit is paid and you later die as a result of the same covered accident, we will reduce the Accidental Death Benefit by any amounts paid under the Dismemberment Benefit. Benefits for covered children will be paid at 50% of the stated amount.

Dismemberment means:

- Hand: the hand is completely severed at or above the wrist joint.
- Foot: the foot is completely severed at or above the ankle joint.
- Eye: the central visual acuity of that eye becomes irrevocably incapable of being corrected to better than 20/200.

ACCIDENTAL DEATH BENEFIT: **\$30,000/\$20,000/\$10,000** if you are injured in a covered accident and the injury causes you to die within 90 days after the accident. We will reduce the Accidental Death Benefit by any amounts paid under the Fracture and Dismemberment Benefits for that person for the same covered accident. Benefits for covered children will be paid at 50% of the stated amount.

FAMILY LODGING BENEFIT: Charges up to **\$75/\$50/\$25** for lodging in a hotel or motel while a covered person is admitted to a hospital as an inpatient for treatment of an accidental injury sustained in a covered accident. This benefit is not available for an individual policy. This benefit is limited to payment for one room for each day of the hospitalization up to a maximum of 60 days per covered accident.

FAMILY EDUCATION BENEFIT: This benefit is payable when the first Accidental Death Benefit is paid for the Policyowner or covered spouse. Up to **\$3,000/\$2,000/\$1,000** per calendar year for up to 5 covered children for post-secondary education tuition. Children must be covered under the policy at the time of the accident that caused the accidental death. This benefit will be paid up to a lifetime maximum of **\$12,000/\$8,000/\$4,000** for each of the 5 covered children that qualify for the benefit.

To receive payment under this benefit, a covered child must submit annually to the company, proof of enrollment at an accredited institution of post-secondary education. Benefits will not be payable for any covered child after that child attains age 25. The company must be notified of the identity of covered children within 90 days following the payment of the Accidental Death Benefit. This benefit is not available for an Individual Policy or Married Couple Policy.

CASH VALUE BENEFIT: This benefit will be equal to the total premiums paid during the Cash Value Period, multiplied by the applicable percentage shown in the Table of Cash Value Percentages included in the policy, minus any Claims Incurred during the Cash Value Period.

You will be eligible for a Cash Value Benefit if you keep your policy in force until a Maturity Date. You are not required to surrender the policy at the Maturity Date to receive this benefit.

You will be eligible for a Cash Value Benefit if after five completed years of premium payments and prior to a Maturity Date you:

- Cancel the policy or allow it to lapse; or,
- die, and the policy is not continued by your covered spouse as described under the policy continuation provision. The policy will cease to be in effect as of the date to which the Cash Value Benefit is calculated, and the policy may not be reinstated after this date.

The Maturity Date is the date on which a Cash Value Period ends and you become entitled to a Cash Value Benefit. Claims incurred means the amount paid and payable to you under this policy and any rider(s) as a result of a covered accident. A claim is considered incurred on the date of a covered accident regardless of the dates of service or the dates of claim payment.

The Cash Value Period is the period of time from the policy Effective Date to the Maturity Date or from one Maturity Date to the next. The Policyowner's age at the beginning of a Cash Value Period determines the length of the Cash Value Period as follows:

- Ages 50 or under: The Cash Value Period is 25 years.
- Ages 51 through 65: The Cash Value Period is the number of years from the beginning of the Cash Value Period to the first Policy Anniversary Date after the Policyowner reaches age 75.
- Ages 66 and over: The Cash Value Period is 10 years.

The Cash Value Period will be based on the Policyowner's age, even if the Policyowner dies and the policy is continued by the covered spouse as described under the continuation provision.

SECTION 4: LIMITATIONS AND EXCLUSIONS

The payment of benefits is subject to all the terms and conditions of the policy including any limitations and exclusions described in specific benefits. We will not pay benefits for an accidental injury or death contributed to, caused by, or resulting from:

WAR: Participating in war or any act of war, declared or not. We will return the prorated premium for any period not covered by this policy for any excluded periods.

SUICIDE: Committing or attempting to commit suicide, regardless of mental capacity.

INTENTIONAL INJURIES: Injuring or attempting to injure yourself or a covered spouse or child intentionally, regardless of mental capacity.

SICKNESS: Having any disease or bodily/mental illness or degenerative condition. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.

RACING: Riding in or driving any motor-driven vehicle in an organized race, stunt show or speed test, or while testing any vehicle on any race course or speedway.

AVIATION: Operating, learning to operate, serving as a crew member on, or jumping from any aircraft, including those which are not motor-driven.

INTOXICATION: Being legally intoxicated or being under the influence of any narcotic or other illegal substance, unless such narcotic or substance is taken on the advice of a physician and according to the physician's instructions. Having a blood alcohol level that exceeds the level permitted by the laws of the state where the accident occurs which pertain to driving a motor vehicle will be presumptive proof of intoxication.

ILLEGAL ACTS: Participating or attempting to participate in a felony or working at an illegal job.

SPORTS: Participating in professional or semi-professional sports.

RODEO: Participating for money in a rodeo event.

SECTION 5: RENEWABILITY OF THIS POLICY

This policy is guaranteed renewable for life. Rates may be changed only if changed on all policies of this kind in your state.

SECTION 6: PREMIUM AND COVERAGE LEVEL

After the first premium, if you do not pay a premium when it is due, you can pay it during the next 31 days. These 31 days are called the grace period. During this period, the policy will stay in force.

Benefit dollar amounts are stated throughout this Outline of Coverage in the following order from left to right: **Elite Level/Preferred Level/Standard Level** .

You have applied for the **Elite** **Preferred** **Standard** benefit level.

Your premium for the benefit level selected is: \$ _____

THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED. YOU SHOULD CONSULT THE POLICY ITSELF TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

PLEASE RETAIN THIS FOR YOUR RECORDS

FAMILY HERITAGE[®]
Life Insurance Company Of America

May 2, 2008

Rosalind Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201-1904

**RE: Family Heritage Life Insurance Company of America
NAIC # 77968 FEIN # 34-1626521
Accident Only Policy - FORM A5POLCAR
SERFF Tracking Number: FHLA-125632477**

Dear Ms. Minor:

Family Heritage Life Insurance Company of America would like to file the following forms for review and approval in the State of Arkansas.

<u>Form Number</u>	<u>Description</u>
A5POLCAR	Accident Only Policy
A5OCCAR	Outline of Coverage
A5APP-RP	Application
A5CLM-ST	Claim Form
A5CHG-ST	Policy Change Form

These forms are new and will not replace any previously approved forms. This is an individual accident only policy series with benefits for loss due to accidental injury. It will be marketed by licensed agents on a direct basis.

The applicant will choose between three benefit levels: Elite, Preferred or Standard. Benefit dollar amounts for each of the levels appear throughout the submitted policy within brackets and in the following order from left to right: [Elite Level/Preferred Level/Standard Level]. The policy issued will include only the benefit dollar amounts for the selected benefit level.

To the best of my knowledge, this filing is complete and intended to comply with the insurance laws of Arkansas.

This filing was approved by our state of domicile (Ohio) on April 25, 2008.

P.O. Box 470608 • Cleveland, Ohio 44147

(440) 922-5200

FAX: (440) 922-5201

Included in this filing are the following:

- This cover letter;
- Each of the referenced forms;
- An actuarial memorandum and premium rates for the policy;
- A Flesch Certification;
- A Certification of Compliance with Rule & Regulation 19; and
- Copies of previously approved forms we issue to satisfy Rule & Regulation 49 and the Consumer Information Notice requirement.

The Company's check in the amount of \$100.00 for the filing fee will be mailed to the Department along with a SERFF document that includes the SERFF Tracking Number.

If you have any questions or need additional information, please call 440-922-5134 or e-mail kevin.wicktora@familyheritagelife.com. Thank you for your assistance with this filing.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kevin Wicktora', written in a cursive style.

Kevin Wicktora
Compliance Manager