

SERFF Tracking Number: HMRK-125652016 State: Arkansas
Filing Company: HM Life Insurance Company State Tracking Number: 39036
Company Tracking Number: HM-CI-308
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
Limited Benefit
Product Name: Critical Illness
Project Name/Number: /HM-CI 308

Filing at a Glance

Company: HM Life Insurance Company

Product Name: Critical Illness

SERFF Tr Num: HMRK-125652016 State: ArkansasLH

TOI: H07G Group Health - Specified Disease - Limited Benefit

SERFF Status: Closed

State Tr Num: 39036

Sub-TOI: H07G.001 Critical Illness

Co Tr Num: HM-CI-308

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Jennifer Bayich

Disposition Date: 05/23/2008

Date Submitted: 05/19/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number: HM-CI 308

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Exempt from filing in PA.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 05/23/2008

State Status Changed: 05/23/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

May 19, 2008

Arkansas Department of Insurance

120 West 3rd Street

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Thank you in advance for your attention to this filing.

Sincerely,

Jennifer L. Bayich, Esq.
Compliance Analyst III

Attachments

Company and Contact

Filing Contact Information

Jennifer Bayich, Compliance Analyst II
P.O. Box 535061
Pittsburgh, PA 15235-5061

jennifer.bayich@hminsurancegroup.com
(412) 544-0923 [Phone]
(412) 544-1138[FAX]

Filing Company Information

HM Life Insurance Company
PO Box 535065
Suite P6504
Pittsburgh, PA 15253-5065
(412) 544-1139 ext. [Phone]

CoCode: 93440 State of Domicile: Pennsylvania
Group Code: 812 Company Type:

Group Name: HM Insurance Group State ID Number:
FEIN Number: 06-1041332

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00

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Retaliatory? No
Fee Explanation: \$50 x 1 policy form
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HM Life Insurance Company	\$50.00	05/19/2008	20384799

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/23/2008	05/23/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	05/22/2008	05/22/2008	Jennifer Bayich	05/23/2008	05/23/2008

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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	Explanation of Variables	Approved-Closed	Yes
Form (revised)	Group Specified Critical Illness Policy	Approved-Closed	Yes
Form	Group Specified Critical Illness Policy	Withdrawn	No
Form (revised)	Group Specified Critical Illness Certificate	Approved-Closed	Yes
Form	Group Specified Critical Illness Certificate	Withdrawn	No
Form	Application for Group Insurance	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 05/22/2008
Submitted Date 05/22/2008

Respond By Date

Dear Jennifer Bayich,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Specified Critical Illness Policy (Form)
- Group Specified Critical Illness Certificate (Form)

Comment: Coverage must be provided for all minors for whom the insured has filed a petition to adopt. Please refer to ACA 23-79-137 and the 60-day period.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 05/23/2008
Submitted Date 05/23/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Dear Ms Minor,

Thank you for your response to this filing. As requested, a provision to provide coverage for a minor for whom a petition of adoption has been filed has been added to the policy and certificate in accordance with Arkansas law. Revised forms are attached.

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If you should have further questions or require further information, please contact me.

Thank you and have a good day.

Related Objection 1

Applies To:

- Group Specified Critical Illness Policy (Form)
- Group Specified Critical Illness Certificate (Form)

Comment:

Coverage must be provided for all minors for whom the insured has filed a petition to adopt. Please refer to ACA 23-79-137 and the 60-day period.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Specified Critical Illness Policy	HMP-CI 308		Policy/Contract/Fraternal Certificate	Initial		51	Microsoft Word - HM CI Policy 4.2.pdf
Previous Version							
Group Specified Critical Illness Policy	HMP-CI 308		Policy/Contract/Fraternal Certificate	Initial		51	Microsoft Word - HM CI Policy 4.2.pdf
Group Specified Critical Illness Certificate	HMC-CI 308		Certificate	Initial		51	Microsoft Word - HM CI Cert

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4.29.08-
C.pdf

Previous Version

Group Specified Critical HMC-CI Illness Certificate	308	Certificate	Initial	51	Microsoft Word - HM CI Cert 4.29.08- C.pdf
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SERFF Tracking Number: *HMRK-125652016* *State:* *Arkansas*
Filing Company: *HM Life Insurance Company* *State Tracking Number:* *39036*
Company Tracking Number: *HM-CI-308*
TOI: *H07G Group Health - Specified Disease -* *Sub-TOI:* *H07G.001 Critical Illness*
 Limited Benefit
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No Rate/Rule Schedule items changed.

Sincerely,
Jennifer Bayich

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	HMP-CI 308	Policy/Cont	Group Specified ract/Fratern Critical Illness Policy al Certificate	Initial		51	Microsoft Word - HM CI Policy 4.2.pdf
Approved-Closed	HMC-CI 308	Certificate	Group Specified Critical Illness Certificate	Initial		51	Microsoft Word - HM CI Cert 4.29.08-C.pdf
Approved-Closed	HMWA 308	Application/ Enrollment Form	Application for Group Insurance	Initial		0	HMWA 308 Application (for all products).pdf

HM Life Insurance Company

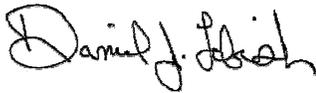
120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

POLICYHOLDER: [*]
[PARTICIPATING ORGANIZATION:] [*]
POLICY NUMBER: [*]
POLICY EFFECTIVE DATE: [*]
POLICY ANNIVERSARY DATE: [*]
STATE OF ISSUE: [*]

HM Life Insurance Company, herein called the Company or we, us or our, in consideration of the [Application for this Policy, if any, and the] timely payment of Premiums, agrees, subject to the terms and conditions of the Policy, to insure the [Policyholder]'s eligible [employee]s and their eligible dependents under this Policy. The [Policyholder] may add new [employee] s or dependents from time to time in accordance with the terms of the Policy. Subsequent anniversaries of the Policy will be the same date each year thereafter.

This Policy describes the terms and conditions of insurance. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Policy Effective Date shown above, at the [Policyholder]'s address. The laws of the State of Issue shown above govern this Policy. We and the [Policyholder] agree to all of the terms of this Policy

IN WITNESS WHEREOF **HM Life Insurance Company** has caused this Policy to be executed on the date of issue to take effect on the Policy Effective Date.



President



Secretary

• GROUP SPECIFIED CRITICAL ILLNESS POLICY • NON-PARTICIPATING

THIS POLICY PROVIDES LIMITED BENEFITS

NO RECOVERY FOR PRE-EXISTING CONDITIONS - READ CAREFULLY.

No benefits will be provided for the first twelve months a person is covered under the Policy for conditions for which medical advice or treatment was received or recommended during the [three] [six] [twelve] month period prior to the effective date of such person's coverage under the Policy.

Questions or Comments

We want to hear from you. If you have any questions about this Policy, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Policy. Thank you for your loyal patronage.

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[SCHEDULE OF AFFILIATES

The following Affiliates are covered under this Policy on the effective dates listed below. A newly-acquired Affiliate may be covered under this Policy on the first of the month following the date it is acquired as long as the [Policyholder] notifies us within [30] [45] [60] [90] [180] days of its acquisition and pays the required premium. If we are not notified within the required time period, the Affiliate will be covered on the date we agree in writing to provide coverage and receive the required premium. Individuals who are [employed by] [members of] [associated with] the Affiliate on its effective date of coverage are eligible for coverage on that date.

[Affiliate Name	Location	Effective Date
[*]	[*]	[*]

SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Policy provisions carefully.

Specified Critical Illness Benefits will be based on the Benefit Amount in effect when the loss begins. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

Eligibility Waiting Period

[For [employee]s hired [30] [31] [60] days [or more] before the Certificate Effective Date:] [None] [30] [31] [45] [60] [90] [days] [The period determined by the [Policyholder's] personnel practices]]

[For [employee]s hired after the Certificate Effective Date:] [None] [30] [31] [45] [60] [90] [days] [the [Policyholder's] next Open Enrollment Period] [The period determined by the [Policyholder's] personnel practices]]

Benefit Amount

[Employee]	[\$2,000 to \$500,000 in \$500 increments from \$2,000 to \$10,000; \$5000 increments from \$10,000 to \$100,000; \$10,000 increments from \$100,000 to \$200,000; and \$50,000 increments from \$200,000 to \$500,000]
[Spouse][Domestic Partner]	[Lesser of \$200,000 or] [50%] [75%] [100%] of [Employee] Amount]
[Child]	[Lesser of \$20,000 or] [10%] [25%] of [Employee] Amount]

[Guarantee Issue Benefit Amount

[Employee]	[\$2,000 to \$30,000 in \$500 increments]
[Dependent Spouse] [Domestic Partner]	[50%] [75%] [100%] of [Employee] Amount]
[Dependent Child]	[10%] [25%] of [Employee] Amount]]

You must provide satisfactory Evidence of Insurability to become insured for a Benefit Amount above the Guarantee Issue Amount. Thereafter, new Evidence of Insurability will be required for any further increase in your Benefit Amount. Coverage for any amount over the Guarantee Issue Amount will become effective on the later of the [day] [first of the month] following the date we approve the Covered Person's Evidence of Insurability.]

[Reduction Schedule

Rate	50%
Attained Age	70]

Specified Critical Illness Benefits**Percentage Payable**

[Cancer	
Invasive Cancer	100%
Carcinoma in situ	25%[*]
Skin Cancer	10%[*]]
[End Stage Renal Disease (Kidney Failure)	100%]
[Stroke	100%]
[Major Organ Transplant	100%]
[Coronary Artery Bypass	25%[*]]
[Myocardial Infarction (Heart Attack)	100%]
[Loss of Sight, Speech, Hearing	100%[*]]
[Coma	100%[*]]
[Paralysis	100%[*]]

[* Payable only once per lifetime, minimum benefit \$250]

[Health Screening Benefit

Amount per Screening	\$[25] [50] [100]
Number of Screenings per [Calendar] Year	1]

Minimum Participation Requirement

[5] [Employees] [and] [Dependents]]

Rates and Premiums**Mode of Premium Payment**

[Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual] [Annual]

Premium Due Dates

[Policy Effective Date and the first day of each month thereafter]

[Policy Effective Date and the first day of each calendar quarter thereafter]

Policy Effective Date and the first day [July] [and] [January] thereafter]

Contributions

The [entire] cost of this insurance is paid by [the] [[Policyholder]] [and] [Covered Persons].

Rates

Premium payable [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual] [Annual]

Issue Age	[Non-Tobacco Rate]	[Tobacco Rate]	[Uni-Smoker Rate]
18-24	[*]	[*]	[*]
25-29	[*]	[*]	[*]
30-34	[*]	[*]	[*]
35-39	[*]	[*]	[*]
40-44	[*]	[*]	[*]
45-49	[*]	[*]	[*]
50-54	[*]	[*]	[*]
55-59	[*]	[*]	[*]
60-64	[*]	[*]	[*]

65-69 [*] [*] [*]]

Composite Rate [*]

DEFINITIONS

Please note that certain words used in this Policy have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Policy have the meanings set forth below.

Active Service means that the [Employee] [or] [Dependent] is either:

1. at work on one of the [Employees] scheduled work days and is performing his regular duties on a [scheduled] basis, either at one of the [Employer's] usual places of business or at some other location to which the [Employer]'s business requires him to travel;
2. on a scheduled holiday[,] [or] vacation day [or period of [Employer]-approved paid leave of absence][, only if the [Employee] was in Active Service on the preceding scheduled workday].

A Covered Person is considered in Active Service if he is not one of the following:

1. an in-patient in a Hospital, skilled nursing facility, rehabilitation hospital, convalescent / personal care facility or receiving out-patient care and/or therapy that affects a Covered Person's ability to perform his regular duties on a scheduled basis;
2. confined at home under the care of a Physician or Doctor for a treatment of an injury or sickness; or
3. totally disabled.

Affiliate or Affiliated means a company, location, division, or organization while subsidiary to, affiliated with or controlled by the [Policyholder].

Cancer has the following meanings:

Invasive Cancer means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);
3. Skin Cancer, melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm), basal cell carcinoma and squamous cell carcinoma of the skin; and
4. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer.

Carcinoma in Situ means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Skin Cancer means melanoma that is diagnosed as Clark's level III, IV or Level V, or Breslow greater than .77 mm. Excluded are melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm), basal cell carcinoma and squamous cell carcinoma of the skin.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Cancer, and/or Carcinoma in Situ and/or Skin Cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. Clinical Diagnosis - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
 - a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
 - b. there is medical evidence to support the diagnosis; and
 - c. a doctor is treating a Covered Person for Cancer, Carcinoma in Situ and/or Skin Cancer.

Certificate means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

Coma means a profound state of unconsciousness that lasts for a period of 30 consecutive days and from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician. The Diagnosis of Coma must indicate that permanent neurological deficit is present.

Company or **we, us, our**, means HM Life Insurance Company, domiciled in Pennsylvania.

Coronary Artery Bypass means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, stents or other non-surgical procedures.

The diagnosis of the condition that necessitates the need for a Coronary Artery Bypass must be made by a cardiologist and based on angiographic evidence of the underlying disease.

Covered Person means an [Employee][,] [or] [Dependent] [Domestic Partner] , for whom an enrollment form has been accepted by us[, the required premium has been paid when due] and for whom coverage under this Policy remains in force. If [employee] is shown in the *Schedule of Benefits* we insure the [Employee]. Dependents are insured if either [Dependent spouse][,] [or] [Domestic Partner] or Dependent children is shown in the *Schedule of Benefits*.

Date of Diagnosis. The date of diagnosis is:

For cancer, carcinoma in situ and/or skin cancer: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.

For heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Myocardial Infarction (Heart Attack) definition.

For stroke: The date a stroke occurred must be determined by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

For end stage renal disease: The date that a physician recommends that a Covered Person qualifies for Medicare coverage for end stage renal disease.

For major organ transplant surgery: The date the surgery occurs for a transplant.

For coronary artery bypass open heart surgery: The date the surgery occurs for coronary artery bypass surgery.

For all other conditions: The date a Physician in the applicable field of medicine determines a Covered Critical Illness.

Dependent means the [Employee]'s:

1. Spouse, unless such spouse is eligible as a Covered [Employee] under this Policy; [and] [or]
- [2.] [Domestic Partner, unless such person is eligible as a Covered [Employee] under this Policy; and]
- [3.] Unmarried natural or step child, unless such child is eligible for medical coverage as a Covered [Employee] under this Policy and who:
 - [a.] is less than [19] [23] [25] [30] years old[; or
 - [b.] is unmarried, under [23] [25] [30] years of age and attends an accredited educational institution as a full-time student; or]
 - [c.] becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. This insurance will continue for as long as the Covered [Employee's] insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19.

This term includes a child who:

- [1.] [is living with the Covered [Employee] in a parent child relationship; or]
- [2.] is adopted by or placed for adoption with, or is party in a suit for adoption by, the Covered [Employee]; or
- [3.] is required to be provided coverage by the Covered Person or his [spouse] [Domestic Partner] under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]).

[Domestic Partner means a person of [the same] [or] [the opposite] sex who:

- [1.] [is not married or legally separated][;]
- [2.] [has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage][;]
- [3.] [Is not currently registered in a Domestic Partnership with a different domestic partner and has not been in such a relationship for at least six months][;]
- [4.] [occupies the same residence as the [Employee]][;]
- [5.] [has not entered into a Domestic Partnership relationship that is temporary, social, political, commercial or economic in nature][;] [and]
- [6.] [has entered into a Domestic Partnership Arrangement with the [Employee]].]

[Domestic Partnership Arrangement means the [Employee] and another person of [the same] [or] [the opposite] sex has any three of the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

1. joint lease, mortgage or deed;
2. joint ownership of a vehicle;
3. joint ownership of a checking account or credit account;
4. designation of the Domestic Partner as a beneficiary for the employee's life insurance or retirement benefits;

5. designation of the Domestic Partner as a beneficiary of the employee's will;
6. designation of the Domestic Partner as holding power of attorney for health care; or
7. shared household expenses].]

Eligibility Waiting Period means the period of time that must lapse before an [Employee][,] [Dependent] [or Domestic Partner] is eligible for insurance under the Policy. It will be extended by the number of days the [Employee][,] [Dependent] [or Domestic Partner] is not in Active Service. We will not pay benefits for a Specified Critical Illness that begins during the Eligibility Waiting Period or a Health Screening performed during such period.

[Provide **Evidence of Insurability** means a[n] [Employee][,] [and] [Dependent] [Domestic Partner] [Covered Person] must [upon request and at their expense]:

- [1.] complete and sign our [enrollment] [health and medical history] form[;]
- [2. sign our form authorizing us to obtain information about his health and other insurance coverage;
- [3.] provide any additional reasonable information about his insurability that we request; and
- [4.] undergo a physical examination and testing at our request].]

[Employee] means a [full-time] [employee] of the [Policyholder] [who works an average of [10] [15] [20] hours per week [or equivalent hours per month] [and who meets all of the requirements for one of the Covered Classes shown below].

- [[Class 1] [All [employee]s] of the [Policyholder] who are officers]
- [Class 2] [All [employee]s] of the [Policyholder] who are managers or supervisors]
- [Class 3] [All [employee]s] of the [Policyholder]] at [location]]
- [Class 4] All other [employee]s] of the [Policyholder]]]

End Stage Renal Disease (Kidney Failure) means end stage renal disease presenting as chronic, irreversible failure of one or both of kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or result in kidney transplantation. End stage renal disease is covered, provided it is not caused by a traumatic event, including surgical traumas.

The diagnosis of end stage renal disease must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.

[Guarantee Issue Benefit Amount means the maximum Benefit Amount available to a Covered Person without providing Evidence of Insurability].

He, him or his means an individual, male or female.

Hospital means an institution that meets all of the following:

1. it is licensed pursuant to applicable law; it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
2. it is managed under the supervision of a staff of legally licensed physicians;
3. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
4. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;

5. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent or custodial care; or
2. the aged.

Illness means a bodily disorder or disease that:

1. is first manifested while the Covered Person is insured under the Policy, and after any applicable Eligibility Waiting Period;
2. is not subject to the Pre-Existing Condition Limitation; and
3. is not otherwise excluded under the terms of this Policy.

Loss of Sight, Speech, or Hearing means the irreversible loss of sight in both eyes, the irreversible loss of the ability to speak, or the irreversible loss of hearing for all sounds in both ears.

The diagnosis of:

1. Loss of Sight, Speech, or Hearing must be made by a licensed professional or specialist in the applicable field of medicine.
2. Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 200 degrees in both eyes.
3. Loss of Speech must include documented evidence of the illness for the continuous 12- month period prior to the Diagnosis.
4. Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

This term does not include animal to human transplants; transplants of human to human organs other than a human heart, lung, liver, kidney, or pancreas; tissue transplants (corneas, skin, heart valves, bone, tendons, ligaments, cartilage and bone marrow), or a human to human transplant of a uterus, face or hand.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. The diagnosis must include at least three of the following criteria:

1. new and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction.
2. elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. chest pain.

Open Enrollment Period means a period of time agreed upon by the [Policyholder] and the Company, during which an [Employee] may apply for insurance.

Paralysis means complete and permanent loss of function of two or more limbs. Paralysis as a result of stroke is excluded. The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis. As used herein "limb" means an arm or leg.

Pathologist means a Physician, other than a Covered Person or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Physician or Doctor means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the [Policyholder]; or
2. living in the Covered Person's household; or
3. a parent, sibling, spouse[,] [Domestic Partner] or child of the Covered Person.

[Plan] Year or annual or annually means a period of twelve consecutive months beginning on the Policy Effective Date and subsequent Anniversary Dates.

[Policyholder] means the entity shown on the cover page of this Policy.

[Participating Organization] means the entity shown on the cover page of this Policy.]

Specified Critical Illness means such illness shown in the *Schedule of Benefits* and as defined in the Policy.

Stroke means a cerebrovascular incident caused by: infarction of brain tissue; cerebral hemorrhage; thrombosis, or embolization from an extra-cranial source lasting more than [24] hours that produces measurable evidence of permanent neurological deficit.

The following are not considered Strokes:

1. Transient Ischemic Attacks (TIAs)
2. Vertebro-Basilar Insufficiency
3. Incidental Findings on imaging studies
4. Head injury
5. Chronic cerebrovascular insufficiency
6. Reversible ischemic neurological deficits

“Transient Isechemic Attack (TIA)” means a neurological condition or event with the signs and symptoms of a stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.

ELIGIBILITY, EFFECTIVE DATE, TERMINATION AND CONTINUATION PROVISIONS

Policy Effective Date

We agree to provide Critical Illness Insurance Benefits described in this Policy in consideration of the [Policyholder]'s payment the premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied.

[Effective Date for Newly-Acquired Affiliates

Insurance becomes effective for any newly-acquired affiliate of the [Policyholder] on first of the month following the date it is acquired if we have been notified in writing within the time period specified in the *Schedule of Affiliates*, have agreed to provide insurance, and have received any additional premium due. If we are not so notified, insurance for the Affiliate will become effective on

the first of the month following the date we agree in writing to insure it and receive any additional premium due. Individuals who are [Employee]'s of an Affiliate on its effective date of insurance under this Policy will be eligible for insurance on that date.]

Eligibility

An [Employee][,][Dependent] [or][Domestic Partner] is eligible provided:

1. they meet the applicable definition shown in *Definitions*; and
2. they have completed the Eligibility Waiting Period, if any; and
- [3. in the case of an [Employee][,][Dependent spouse] [or] [Domestic Partner] they are under age 70 [on the Effective Date of the Certificate] [date they complete the Eligibility Waiting Period]; and]
- [4.] they meet the definition of Active Service in *Definitions*.

No person is eligible for insurance under this Policy as both an [Employee][,] [Dependent] [or Domestic Partner] at the same time.

Effective Date

The Effective Date of the Policy and Certificate is shown on the applicable cover page.

An eligible [Employee]'s insurance becomes effective on the [day] [first of the month] following the date he[:]

[1.] submits a complete enrollment form, if any [and we approve that form]; and]

[2.] has paid the required first contribution, if any].

An eligible Dependent's [or Domestic Partner]'s insurance becomes effective on the [day] [first of the month] following the date the [Employee] first becomes insured[, or the [day] [first of the month] following the date the person becomes eligible, if later][, provided[:]

[1.] [a completed enrollment form, if any, is submitted for the Dependent [and we approve that form];:] [and]

[2.] [the [Employee] has paid the required first contribution, if any, for the Dependent's coverage.

If either the [spouse] [or Domestic Partner] is eligible as an [Employee] the dependent children may be covered under only one [Employee].

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have no dependent children;

1. both will be insured as Covered Persons when a Covered Person is not required to contribute to the cost of his insurance; and
2. both may be insured as Covered Persons or one may elect to insure the other as a Dependent when a Covered Person is required to contribute to the cost of his insurance.

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have dependent children;

1. both will be insured as Covered Persons and dependent coverage will be provided via only the parent whose birthday occurs first during a Plan] Year, when an [Employee] is not required to contribute to the cost of his Dependents' insurance; and

2. both may be insured as an [Employee] but only one may elect dependent coverage to insure dependent children, when an [Employee] is required to contribute to the cost of his dependents' insurance.

A [spouse] [or Domestic Partner] that does not meet the definition of [Employee], or a dependent child may be insured as a Dependent provided one [spouse] [or Domestic Partner] meets the definition of [Employee] shown in *Definitions*.

[Newborn children of an [Employee] or spouse are automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. [Foster children [and other children living with the [Employee] or spouse in a parent child relationship] are eligible for coverage on the same basis upon placement in the home.]

[A child adopted by, or placed for adoption with, or who are a party in a suit for adoption by an [Employee] or spouse is covered automatically from birth provided we receive notification within 31 days after the birth of the newborn.]

[A minor under the charge, care, and control of the insured whom the insured has filed a petition to adopt shall be provided coverage the same as provided for other members of the insured's family. Coverage shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor]

Deferred Effective Date

The effective date of insurance will be deferred for any [Employee] who is not in Active Service on the [day] [first of the month] following the date he would otherwise have become eligible. Coverage will become effective on the later of the [day] [first of the month] following the date he returns to Active Service and the [day] [first of the month] following the date coverage would otherwise have become effective.

Late Enrollee

A person will be considered a late enrollee if he does not apply for insurance under this Policy within 31 days of the [day] [first of the month] following the date he is first eligible.

[Coverage for any late enrollee will become effective on the [day] [first of the month] following the date he [enrolls] [completes a [30] [60] [90] [120] [180] day late enrollee waiting period] [and submits the required premium].]

[If a person does not apply for insurance under this Policy within 31 days of the date he is first eligible, he must provide satisfactory Evidence of Insurability to become insured. Coverage for any late enrollee will become effective on the [first] day [of the month coinciding with or next] following the date we approve such person's Evidence of Insurability.]

[If a person does not apply for insurance under this Policy within 31 days of the date he is first eligible, he must wait until the [Policyholder]'s next Open Enrollment Period. Coverage for any late enrollee will become effective on the date specified by the [Policyholder].]

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from a change in benefits provided by this Policy or a change in the [Employee]'s Covered Class will take effect on the [day] [first of the month] following the date of such change. Increases will take effect subject to any Active Service and Evidence of Insurability requirement.

Termination of Insurance

Please read the *Continuation of Coverage* section of this Policy for information on continuation after eligibility for coverage would otherwise end.

The insurance on a Covered Person will end on the earliest date below:

1. first of the month following the date this Policy or insurance for a Covered Class is terminated;
2. the [day] [next premium due date after first of the month] following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
- [3.] [the [day] [next premium due date after first of the month] following the date the Covered Person attains age 70;]
- [4.] the last day of the last period for which premium is paid;
- [5.] the end of any period of continuation, as provided in the *Continuation of Coverage*; and
- [6.] with respect to an Eligible Dependent, the [day] [first of the month] following the date of the death of the Covered [Employee] or the [day] [first of the month] following the date of divorce from the Covered [Employee][, or termination of a Domestic Partnership Arrangement].

Termination will not affect a Specified Critical Illness Diagnosed or Health Screening incurred after the Eligibility Waiting Period while coverage was in effect.

Continuation of Coverage

If a Covered Person's insurance terminates for any reason other than non-payment of any required premium when due or termination of the Policy, such person may elect to continue coverage under the Policy provided he has not attained age 70. To elect continued coverage, the Covered Person must[

- [1.] [have been continuously insured for at least [6] [12] [24] months under this Policy and/or any plan it replaced just before the date their insurance terminates; and]
- [2.] make the election within 31 days of termination and pay all required premiums for the continued coverage.

Continued coverage is subject to all of the provisions and limitations of the Policy. The premium rate charged for the continued coverage will be 105% of the rate charged under the Policy based on the Covered Person's age at the time he elects to continue coverage.

Premiums for continued coverage will be collected from the terminated individual on a quarterly, semi-annual or annual basis, as elected by the Covered Person.

Coverage continued under this provision will end when [the Policy terminates][,] [the date such person attains age 70] or the last period for which premium is paid[, whichever occurs first].

Specified Critical Illness Benefit

We will pay this benefit if a Covered Person is diagnosed with one of the Specified Critical Illnesses shown in the *Schedule of Benefits* provided:

1. The first occurrence and the Date of Diagnosis is after the Eligibility Waiting Period; and
2. The Date of Diagnosis is while the Policy or the Certificate is in force; and
3. It is not excluded by name or specific description in the Policy.

[If the Date of Diagnosis of a Specified Critical Illness occurs during the Eligibility Waiting Period, the Certificate may be returned for a full refund of premium.]

The Benefit Amount is shown in the *Schedule of Benefits*. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.] Specified Critical Illness Benefits will be based on the Benefit Amount in effect when the loss begins. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

We will figure the benefits for each Specified Critical Illness by multiplying A times B minus C, where:

- A = The Benefit Amount in effect for the Covered Person's attained age when the loss begins.
- B = The Percentage Payable shown in the *Schedule of Benefits* for the applicable Specified Critical Illness and Covered Person's attained age.
- C = Any partial benefits paid for that Specified Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first Specified Critical Illness has been diagnosed unless the Date of Diagnosis is separated from the prior Specified Critical Illness by at least [30] [60] [90] [180] days [or in the case of Invasive Cancer, Carcinoma in Situ or Skin Cancer 12 months free of treatment].
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the Dates of Diagnosis are separated by at least [6] [9] [12] months.

[Health Screening Benefit

Subject to the terms and conditions of this Policy we will pay the benefit shown in the *Schedule of Benefits* for Health Screening Benefits incurred by a Covered Person. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.]

We will pay this benefit for the following Health Screening Tests performed after the Eligibility Waiting Period and while the Policy is in force. The amount we will pay per screening and number of screenings we will pay per Plan Year is shown in the *Schedule of Benefits*. Payment of this benefit will not reduce the Benefit Amount.

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill or the use of medication,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,

14. Mammography,
15. Pap test,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography,
19. Skin review by a dermatologist.

There is no limit to the number of years a Covered Person can receive benefits for Health Screening Tests, as long as the Policy or Certificate is in force.

We will pay this benefit regardless of a supporting Diagnosis or the results of the test.

No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.]

LIMITATIONS AND EXCLUSIONS

Limitations

1. Eligibility Waiting Period - No benefits are payable for any [Employee][,] [or] [Dependent] [or] [Domestic Partner] until the Eligibility Waiting Period shown in the *Schedule of Benefits* has been completed. If first diagnosed during the Eligibility Waiting Period, the Pre-Existing Condition Limitation will apply to any loss from that diagnosis. [At the [Policyholder]'s option, you may elect to void any coverage applied for and receive a full refund of premium. Any such request must be in writing and made prior to the end of the Eligibility Waiting Period.]
2. Pre-Existing Conditions - We will not pay benefits for any condition or illness starting within [3] [6] [12] months of the [Effective Date of the Certificate] [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] which is caused by, contributed to, or resulting from a Pre-Existing Condition. A claim for benefits for loss starting after 12 months from the Effective Date of the Certificate [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition.

A condition will no longer be considered Pre-Existing at the end of 12 consecutive months starting and ending after the Effective Date of the Policy [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance].

"Pre-Existing Condition" means a sickness or physical condition which, within the [3] [6] [12] month period prior to the Effective Date of the Policy [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] resulted in an insured receiving medical advice or treatment.

"Treatment" means consultation; care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

- [3. Reduction Schedule - The Benefit Amount [and Guarantee Issue Benefit Amount] payable for a Specified Critical Illness will be reduced by 50% if an Covered Person is age 70 or older on the date the benefit becomes payable. "Age" means the age of the Covered Person on such person's most recent birthday, regardless of the actual time of birth.]

Exclusions

We will not pay for:

1. Loss due to an accident, or any benefit for a diagnosis caused or contributed to by an accident. This includes any treatment received or expenses incurred for an accidental injury
2. Any benefit for a diagnosis the results in an experimental procedure, service or treatment, or a loss due to an experimental procedure, service or treatment;

3. Loss due to suicide or any attempt or threat to commit suicide, while sane or insane, or any intentionally self-inflicted injury or sickness;
4. Loss due to participation in a riot, civil commotion, civil disobedience, insurrection or unlawful assembly, unless a loss that occurs while a Covered Person is acting in a lawful manner within the scope of authority;
5. Loss due to committing, attempting to commit, or taking part in a felony or assault;
6. Loss due to the Covered Person being legally intoxicated as determined according to the laws of the United States of America;
7. Any benefit for a diagnosis of an illness resulting from the use of a controlled substance, or misuse of legal or illegal drugs, by a Covered Person that is not rendered by or at the direction of a Physician or Doctor;
8. Loss due to an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes an accidental injury or sickness contracted while in the service of any military, naval or air force of any country engaged in war (the Company will refund the pro rata unearned premium for any such period the Covered Person is not covered);
9. Loss due to an accident or sickness arising out of and in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made;
10. Any benefit for a diagnosis rendered by or at the direction of a Physician or Doctor during a period of time that insurance for a Covered Person is not in force;
11. Any benefit for a diagnosis rendered by or at the direction of a Physician or Doctor after this Policy has terminated;
12. Any diagnosis not rendered by or at the direction of a Physician or Doctor, or that is inconsistent with standards of medical practice for the applicable condition;
13. Benefits for a diagnosis rendered by or at the direction of a Physician or Doctor outside the United States or Canada;
14. Transportation; or
15. Benefits for a diagnosis rendered by any person who is:
 - a. employed or retained by the [Policyholder];
 - b. living in the Covered Person's household;
 - c. a parent, sibling, spouse[,] [Domestic Partner] or child of a Covered [Employee] or of His spouse; or
 - d. a Covered Person diagnosing himself.

CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Specified Critical Illness is Diagnosed or a Health Screening is performed or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent. Notice should include the [Policyholder]'s name, and the Covered Person's name, address, and Policy Number.

Claim Forms

We will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not sent within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

[Notice of Decision

We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;
2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours.]

Time of Payment of Claims

We will pay benefits due under this Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate.

If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

Claimant Cooperation Provision

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Claim Administration

For plans subject to the Employee Retirement Income Security Act (ERISA), the plan administrator of the employer's employee welfare benefit plan (the plan) has selected us as the plan fiduciary under federal law for the review of claims for benefits provided by this Policy and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact.

All decisions made by us in this capacity shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

We will have no fiduciary responsibility with respect to the administration of the plan except as described above. It is understood that our sole liability to the plan and to participants and beneficiaries under the plan shall be for the payment of benefits provided under this Policy.

We may contract with another entity to perform this function on our behalf.

Payment of Claims to Foreign [Employees]

The [Policyholder] may, in a fiduciary capacity, receive and hold any benefits payable to Covered [Employee]s whose place of employment is other than:

1. the United States and its possessions; or
2. the Dominion of Canada.

We will not be responsible for the application or disposition by the [Policyholder] of any such benefits paid. Our payments to the [Policyholder] will constitute a full discharge of our liability for those payments under this Policy.

Physical Examination and Autopsy

We, at our own expense, have the right and opportunity to examine the Covered Person when and as often as we may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

[Additional Coverage with the Company

We will only pay benefits for covered Illness, Condition or Procedure under one Specified Illness, Condition or Surgical Procedure Policy or Certificate if a Covered Person is covered by more than one of our Specified Illness, Condition or Surgical Procedure Policies or Certificates. A Covered Person may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Specified Illness, Condition or Surgical Procedure Policies or Certificates during the period there was more than one Policy or Certificate in force.]

Unpaid Premium - When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

ADMINISTRATIVE PROVISIONS

Cancellation

We or the [Policyholder] may cancel this Policy, after the first year as of any Premium Due Date, by giving the other party [31] [45] [60] [90] [120] [180] days advance written notice.

If a premium is not paid when due, we will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits*. The [Policyholder] has the sole responsibility to notify Covered Person's of such termination.

Grace Period

A Policy Grace Period of [30] [31] [60] [90] days will be granted for payment of required premiums due after the first premium, unless:

1. we do not intend to renew the coverage provided by the Certificate beyond the period for which premium has been accepted; and

2. written notice of our intention not to renew is delivered to the [Policyholder] at least [30] [45] [60] [90] [120] [180] days before the premium is due.

This Policy will be in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last day of the Grace Period. The [Policyholder] is liable to us for any unpaid premium for the time this Policy was in force.

An individual Grace Period of 31 days, applicable when a Covered Person remains eligible under this Policy under *Continuation of Coverage*, will be granted for payment of required premiums. A Covered Person's insurance under this Policy will remain in force during the Grace Period.

We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates, as set forth in the *Schedule of Benefits* or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits*. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the [Policyholder].

Premium Payment

The total premium for this Policy is the sum of premiums paid:

1. by the [Policyholder] for all Covered Persons other than those described in (2) below, including any amounts contributed toward the cost of this coverage by Covered Persons; and
2. by Covered Persons who remain eligible for coverage under one of the *Continuation of Coverage* of this Policy.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

Changes in Premium Rates

We may change the premium rates from time to time with at least 60 days advance written notice to the [Policyholder]. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. the number of [Employee]s eligible for coverage increases or decreases by more than 10% since the latter of the Policy Effective Date and the date of the last renewal of this Policy;
3. coverage is reinstated following failure to pay premium during the Grace Period;
4. acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible individuals;
5. a change in the number of eligible individuals which would, on a manual rate basis, require a change of 10% or more in the premium rate;
6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects our benefit obligations under this Policy; or
7. the [Policyholder] fails to provide sufficient information, as required by us, to confirm

adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

We will have the right to audit books and records of the [Policyholder] at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including [application (if any)][,] [individual enrollment forms (if any)][,] endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Misstatement of Age

If an age has been misstated on the enrollment form the Benefits will be those the premium paid would have purchased at the correct age.

Certificates

Where required by law, we will provide a Certificate of Insurance for delivery to the Covered Person. Each Certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

Assignment

The rights and benefits under this Policy may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his insurance should see the [Policyholder] for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's insurance (including an assignment on a form furnished by us or by the [Policyholder]).

Incontestability

1. Of This Policy

All statements made by the [Policyholder] to obtain this Policy are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the [Policyholder]. After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from a Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud.

Reporting Requirements

The [Policyholder] or its authorized agent must report all of the following to us by the premium due date:

1. the number of persons insured on the Policy Effective Date;
2. the number of persons who are insured after the Policy Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by us.

Clerical Error

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, we will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that applies to this Policy are automatically changed to satisfy the minimum requirements of such laws.

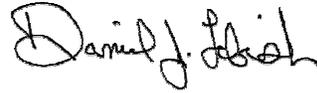
Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.

HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

HM Life Insurance Company certifies that you will be insured under the Policy Number issued to the Policyholder named below during the time, in the manner, and for the amounts provided in the Group Policy.



President

POLICYHOLDER:	[*]
POLICY NUMBER:	[*]
[PARTICIPATING ORGANIZATION:]	[*]
CERTIFICATE EFFECTIVE DATE:	[*]
STATE OF ISSUE:	[*]

Your coverage under the Policy **HM Life Insurance Company** issued to the Policyholder is shown in this Certificate. If your coverage is changed by an amendment to the Policy, we will provide the [Policyholder] with a revised Certificate or other notice to be given to you.

PLEASE READ THIS CERTIFICATE CAREFULLY

This Certificate of Insurance has a Table of Contents to help you find specific provisions. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Certificate Effective Date shown above, at the [Policyholder]'s address. The laws of the State of Issue shown above govern this Certificate.

"You" and "your" refer to the Covered Person. The "Company", we", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

• GROUP SPECIFIED CRITICAL ILLNESS • NON-PARTICIPATING

THE POLICY PROVIDES LIMITED BENEFITS

NO RECOVERY FOR PRE-EXISTING CONDITIONS - READ CAREFULLY.

No benefits will be provided for the first twelve months a person is covered under the Policy for conditions for which medical advice or treatment was received or recommended during the [three] [six] [twelve] month period prior to the effective date of such person's coverage under the Policy.

Questions or Comments

We want to hear from you. If you have any questions about this Certificate, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Certificate. Thank you for your loyal patronage.

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[SCHEDULE OF AFFILIATES

The following Affiliates are covered under this Certificate on the effective dates listed below. A newly-acquired Affiliate may be covered under this Certificate on the first of the month following the date it is acquired as long as the [Policyholder] notifies us within [30] [45] [60] [90] [180] days of its acquisition and pays the required premium. If we are not notified within the required time period, the Affiliate will be covered on the date we agree in writing to provide coverage and receive the required premium. Individuals who are [employed by] [members of] [associated with] the Affiliate on its effective date of coverage are eligible for coverage on that date.

[Affiliate Name	Location	Effective Date
[*]	[*]	[*]]

SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the provisions of this Certificate carefully.

Specified Critical Illness Benefits will be based on the Benefit Amount in effect when the loss begins. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

Eligibility Waiting Period

[For [employee]s hired [30] [31] [60] days [or more] before the Certificate Effective Date:] **[None]** **[30]** **[31]** **[45]** **[60]** **[90]** [days] [The period determined by the [Policyholder’s] personnel practices]]

[For [employee]s hired after the Certificate Effective Date:] **[None]** **[30]** **[31]** **[45]** **[60]** **[90]** [days] [the [Policyholder]’s next Open Enrollment Period] [The period determined by the [Policyholder’s] personnel practices]]

Benefit Amount

[Employee]	[\$2,000 to \$500,000 in \$500 increments from \$2,000 to \$10,000; \$5000 increments from \$10,000 to \$100,000; \$10,000 increments from \$100,000 to \$200,000; and \$50,000 increments from \$200,000 to \$500,000]
[Spouse][Domestic Partner]	[Lesser of \$200,000 or] [50%] [75%] [100%] of [Employee] Amount]
[Child]	[Lesser of \$20,000 or] [10%] [25%] of [Employee] Amount]

[Guarantee Issue Benefit Amount

[Employee]	[\$2,000 to \$30,000 in \$500 increments]
[Dependent Spouse] [Domestic Partner]	[50%] [75%] [100%] of [Employee] Amount]
[Dependent Child]	[10%] [25%] of [Employee] Amount]]

You must provide satisfactory Evidence of Insurability to become insured for a Benefit Amount above the Guarantee Issue Amount. Thereafter, new Evidence of Insurability will be required for any further increase in your Benefit Amount. Coverage for any amount over the Guarantee Issue Amount will become effective on the later of the [day] [first of the month] following the date we approve the Covered Person’s Evidence of Insurability.]

[Reduction Schedule

Rate	50%
Attained Age	70]

Specified Critical Illness Benefits**Percentage Payable**

[Cancer	
Invasive Cancer	100%
Carcinoma in situ	25%[*]
Skin Cancer	10%[*]]
[End Stage Renal Disease (Kidney Failure)	100%]
[Stroke	100%]
[Major Organ Transplant	100%]
[Coronary Artery Bypass	25%[*]]
[Myocardial Infarction (Heart Attack)	100%]
[Loss of Sight, Speech, Hearing	100%[*]]
[Coma	100%[*]]
[Paralysis	100%[*]]

[* Payable only once per lifetime, minimum benefit \$250]

[Health Screening Benefit

Amount per Screening	\$[25] [50] [100]
Number of Screenings per [Calendar] Year	1]

Minimum Participation Requirement

[5] [Employees] [and] [Dependents]]

[Rates and Premiums]

[Mode of Premium Payment	[Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual] [Annual]]
---------------------------------	---

Premium Due Dates [Certificate Effective Date and the first day of each month thereafter]

[Certificate Effective Date and the first day of each calendar quarter thereafter]

Certificate Effective Date and the first day [July] [and] [January] thereafter]

Contributions

The [entire] cost of this insurance is paid by [the] [[Policyholder]] [and] [Covered Persons].

[Rates

Premium payable [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual] [Annual]

Issue Age	[Non-Tobacco Rate]	[Tobacco Rate]	[Uni-Smoker Rate]
18-24	[*]	[*]	[*]
25-29	[*]	[*]	[*]
30-34	[*]	[*]	[*]
35-39	[*]	[*]	[*]
40-44	[*]	[*]	[*]
45-49	[*]	[*]	[*]
50-54	[*]	[*]	[*]

55-59	[*]	[*]	[*]
60-64	[*]	[*]	[*]
65-69	[*]	[*]	[*]
Composite Rate	[*]]	

DEFINITIONS

Please note that certain words used in this Certificate have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Active Service means that the [Employee] [or] [Dependent] is either:

1. at work on one of the [Employees] scheduled work days and is performing his regular duties on a [scheduled] basis, either at one of the [Employer's] usual places of business or at some other location to which the [Employer]'s business requires him to travel;
2. on a scheduled holiday[,] [or] vacation day [or period of [Employer]-approved paid leave of absence][, only if the [Employee] was in Active Service on the preceding scheduled workday].

A Covered Person is considered in Active Service if he is not one of the following:

1. an in-patient in a Hospital, skilled nursing facility, rehabilitation hospital, convalescent / personal care facility or receiving out-patient care and/or therapy that affects a Covered Person's ability to perform his regular duties on a scheduled basis;
2. confined at home under the care of a Physician or Doctor for a treatment of an injury or sickness; or
3. totally disabled.

Affiliate or Affiliated means a company, location, division, or organization while subsidiary to, affiliated with or controlled by the [Policyholder].

Cancer has the following meanings:

Invasive Cancer means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);
3. Skin Cancer, melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm), basal cell carcinoma and squamous cell carcinoma of the skin; and
4. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer.

Carcinoma in Situ means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Skin Cancer means melanoma that is diagnosed as Clark's level III, IV or Level V, or Breslow greater than .77 mm. Excluded are melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm), basal cell carcinoma and squamous cell carcinoma of the skin.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Cancer, and/or Carcinoma in Situ and/or Skin Cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. Clinical Diagnosis - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
 - a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
 - b. there is medical evidence to support the diagnosis; and
 - c. a doctor is treating a Covered Person for Cancer, Carcinoma in Situ and/or Skin Cancer.

Certificate means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

Coma means a profound state of unconsciousness that lasts for a period of 30 consecutive days and from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician. The Diagnosis of Coma must indicate that permanent neurological deficit is present.

Company or **we, us, our**, means HM Life Insurance Company, domiciled in Pennsylvania.

Coronary Artery Bypass means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, stents or other non-surgical procedures.

The diagnosis of the condition that necessitates the need for a Coronary Artery Bypass must be made by a cardiologist and based on angiographic evidence of the underlying disease.

[Employee] means a [full-time] [employee] of the [Policyholder] [who works an average of [10] [15] [20] hours per week [or equivalent hours per month] [and who meets all of the requirements for one of the Covered Classes shown below].

- [[Class 1] [All [employee]s] of the [Policyholder] who are officers]
- [Class 2] [All [employee]s] of the [Policyholder] who are managers or supervisors]
- [Class 3] [All [employee]s] of the [Policyholder]] at [location]]
- [Class 4] All other [employee]s] of the [Policyholder]]]

Covered Person means an [Employee][,] [or] [Dependent] [Domestic Partner] , for whom an enrollment form has been accepted by us[, the required premium has been paid when due] and for whom coverage under this Policy remains in force. If [employee] is shown in the *Schedule of Benefits* we insure the [Employee]. Dependents are insured if either [Dependent spouse][,] [or] [Domestic Partner] or Dependent children is shown in the *Schedule of Benefits*.

Date of Diagnosis- The date of diagnosis is:

For cancer, carcinoma in situ and/or skin cancer: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.

For heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Myocardial Infarction (Heart Attack) definition.

For stroke: The date a stroke occurred must be determined by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

For end stage renal disease: The date that a physician recommends that a Covered Person qualifies for Medicare coverage for end stage renal disease.

For major organ transplant surgery: The date the surgery occurs for a transplant.

For coronary artery bypass open heart surgery: The date the surgery occurs for coronary artery bypass surgery.

For all other conditions: The date a Physician in the applicable field of medicine determines a Covered Critical Illness.

Dependent means the [Employee]'s:

1. Spouse, unless such spouse is eligible as a Covered [Employee] under this Certificate; [and] [or]
- [2.] [Domestic Partner, unless such person is eligible as a Covered [Employee] under this Certificate; and]
- [3.] Unmarried natural or step child, unless such child is eligible for medical coverage as a Covered [Employee] under this Certificate and who:
 - [a.] is less than [19] [23] [25] [30] years old[; or
 - [b. is unmarried, under [23] [25] [30] years of age and attends an accredited educational institution as a full-time student; or]
 - [c.] becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. This insurance will continue for as long as the Covered [Employee's] insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19.

This term includes a child who:

- [1.] [is living with the Covered [Employee] in a parent child relationship; or]
- [2.] is adopted by or placed for adoption with, or is party in a suit for adoption by, the Covered [Employee]; or
- [3.] is required to be provided coverage by the Covered Person or his [spouse] [Domestic Partner] under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]).

[Domestic Partner means a person of [the same] [or] [the opposite] sex who:

- [1.] [is not married or legally separated][;]
- [2.] [has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage][;]
- [3.] [Is not currently registered in a Domestic Partnership with a different Domestic Partner and has not been in such a relationship for at least six months][;]
- [4.] [occupies the same residence as the [Employee]][;]
- [5.] [has not entered into a Domestic Partnership relationship that is temporary, social, political, commercial or economic in nature][;] [and]
- [6.] [has entered into a Domestic Partnership Arrangement with the [Employee]].]

[Domestic Partnership Arrangement] means the [Employee] and another person of [the same] [or] [the opposite] sex has any three of the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

1. joint lease, mortgage or deed;
2. joint ownership of a vehicle;
3. joint ownership of a checking account or credit account;
4. designation of the Domestic Partner as a beneficiary for the employee's life insurance or retirement benefits;
5. designation of the Domestic Partner as a beneficiary of the employee's will;
6. designation of the Domestic Partner as holding power of attorney for health care; or
7. shared household expenses].]

Eligibility Waiting Period means the period of time that must lapse before an [Employee][,] [Dependent] [or Domestic Partner] is eligible for insurance under this Certificate. It will be extended by the number of days the [Employee][,] [Dependent] [or Domestic Partner] is not in Active Service. We will not pay benefits for a Specified Critical Illness that begins during the Eligibility Waiting Period or a Health Screening performed during such period.

[Provide **Evidence of Insurability** means a[n] [Employee][,] [and] [Dependent] [Domestic Partner] [Covered Person] must [upon request and at their expense]:

- [1.] complete and sign our [enrollment] [health and medical history] form[;]
- [2. sign our form authorizing us to obtain information about his health and other insurance coverage;
1. provide any additional reasonable information about his insurability that we request; and
2. undergo a physical examination and testing at our request].]

End Stage Renal Disease (Kidney Failure) means end stage renal disease presenting as chronic, irreversible failure of one or both of kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or result in kidney transplantation. End stage renal disease is covered, provided it is not caused by a traumatic event, including surgical traumas.

The diagnosis of end stage renal disease must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.

[Guarantee Issue Benefit Amount] means the maximum Benefit Amount available to a Covered Person without providing Evidence of Insurability].

He, him or his means an individual, male or female.

Hospital means an institution that meets all of the following:

1. it is licensed pursuant to applicable law; it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
2. it is managed under the supervision of a staff of legally licensed physicians;
3. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);

4. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
5. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent or custodial care;
2. the aged.

Illness means a bodily disorder or disease that:

1. is first manifested while the Covered Person is insured under this Certificate, and after any applicable Eligibility Waiting Period;
2. is not subject to the Pre-Existing Condition Limitation; and
3. is not otherwise excluded under the terms of this Certificate.

Loss of Sight, Speech, or Hearing means the irreversible loss of sight in both eyes, the irreversible loss of the ability to speak, or the irreversible loss of hearing for all sounds in both ears.

The diagnosis of:

1. Loss of Sight, Speech, or Hearing must be made by a licensed professional or specialist in the applicable field of medicine.
2. Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 200 degrees in both eyes.
3. Loss of Speech must include documented evidence of the illness for the continuous 12- month period prior to the Diagnosis.
4. Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

This term does not include animal to human transplants; transplants of human to human organs other than a human heart, lung, liver, kidney, or pancreas; tissue transplants (corneas, skin, heart valves, bone, tendons, ligaments, cartilage and bone marrow), or a human to human transplant of a uterus, face or hand.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. The diagnosis must include at least three of the following criteria:

1. new and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction.
2. elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. chest pain.

Open Enrollment Period means a period of time agreed upon by the [Policyholder] and the Company, during which an [Employee] may apply for insurance.

Paralysis means complete and permanent loss of function of two or more limbs. Paralysis as a result of stroke is excluded. The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis. As used herein “limb” means an arm or leg.

Pathologist means a Physician, other than a Covered Person or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Physician or Doctor means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the [Policyholder]; or
2. living in the Covered Person’s household; or
3. a parent, sibling, spouse[,] [Domestic Partner] or child of the Covered Person.

[Plan] Year or annual or annually means a period of twelve consecutive months beginning on the Certificate Effective Date and subsequent Anniversary Dates.

[Policyholder] means the entity shown on the cover page of this Certificate.

Specified Critical Illness means such illness shown in the *Schedule of Benefits* and as defined in this Certificate.

Stroke means a cerebrovascular incident caused by: infarction of brain tissue; cerebral hemorrhage; thrombosis, or embolization from an extra-cranial source lasting more than [24] hours that produces measurable evidence of permanent neurological deficit.

The following are not considered Strokes:

1. Transient Ischemic Attacks (TIAs)
2. Vertebro-Basilar Insufficiency
3. Incidental Findings on imaging studies
4. Head injury
5. Chronic cerebrovascular insufficiency
6. Reversible ischemic neurological deficits

“Transient Isechemic Attack (TIA)” means a neurological condition or event with the signs and symptoms of a stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.

ELIGIBILITY, EFFECTIVE DATE, TERMINATION AND CONTINUATION PROVISIONS

Certificate Effective Date

We agree to provide Critical Illness Insurance Benefits described in this Certificate in consideration of the [Policyholder]'s payment the premium when due. Insurance coverage begins on the Certificate Effective Date shown on this Certificate's first page as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied.

[Effective Date for Newly-Acquired Affiliates

Insurance becomes effective for any newly-acquired affiliate of the [Policyholder] on first of the month following the date it is acquired if we have been notified in writing within the time period specified in the *Schedule of Affiliates*, have agreed to provide insurance, and have received any additional premium due. If we are not so notified, insurance for the Affiliate will become effective on the first of the month following the date we agree in writing to insure it and receive any additional premium due. Individuals who are [Employee]'s of an Affiliate on its effective date of insurance under this Certificate will be eligible for insurance on that date.]

Eligibility

An [Employee][,][Dependent] [or][Domestic Partner] is eligible provided:

1. they meet the applicable definition shown in *Definitions*; and
2. they have completed the Eligibility Waiting Period, if any; and
- [3. in the case of an [Employee][,][Dependent spouse] [or] [Domestic Partner] they are under age 70 [on the Effective Date of the Certificate] [date they complete the Eligibility Waiting Period]; and]
- [4.] they meet the definition of Active Service in *Definitions*.

No person is eligible for insurance under this Certificate as both an [Employee][,] [Dependent] [or Domestic Partner] at the same time.

Effective Date

The Effective Date of the Certificate is shown on the applicable cover page.

An eligible [Employee]'s insurance becomes effective on the [day] [first of the month] following the date he[:]

- [1.] submits a complete enrollment form, if any [and we approve that form]; and]
- [2.] has paid the required first contribution, if any].

An eligible Dependent's [or Domestic Partner]'s insurance becomes effective on the [day] [first of the month] following the date the [Employee] first becomes insured[, or the [day] [first of the month] following the date the person becomes eligible, if later][, provided[:]

- [1.] [a completed enrollment form, if any, is submitted for the Dependent [and we approve that form][;] [and]
- [2.] [the [Employee] has paid the required first contribution, if any, for the Dependent's coverage.

If either the [spouse] [or Domestic Partner] is eligible as an [Employee] the dependent children may be covered under only one [Employee].

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have no dependent children;

1. both will be insured as Covered Persons when a Covered Person is not required to contribute to the cost of his insurance; and
2. both may be insured as Covered Persons or one may elect to insure the other as a Dependent when a Covered Person is required to contribute to the cost of his insurance.

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have dependent children;

1. both will be insured as Covered Persons and dependent coverage will be provided via only the parent whose birthday occurs first during a Plan] Year, when an [Employee] is not required to contribute to the cost of his Dependents' insurance; and
2. both may be insured as an [Employee] but only one may elect dependent coverage to insure dependent children, when an [Employee] is required to contribute to the cost of his dependents' insurance.

A [spouse] [or Domestic Partner] that does not meet the definition of [Employee], or a dependent child may be insured as a Dependent provided one [spouse] [or Domestic Partner] meets the definition of [Employee] shown in *Definitions*.

[Newborn children of an [Employee] or spouse are automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. [Foster children [and other children living with the [Employee] or spouse in a parent child relationship] are eligible for coverage on the same basis upon placement in the home.]

[A child adopted by, or placed for adoption with, or who are a party in a suit for adoption by an [Employee] or spouse is covered automatically from birth provided we receive notification within 31 days after the birth of the newborn.]

[A minor under the charge, care, and control of the insured whom the insured has filed a petition to adopt shall be provided coverage the same as provided for other members of the insured's family. Coverage shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor]

Deferred Effective Date

The effective date of insurance will be deferred for any [Employee] who is not in Active Service on the [day] [first of the month] following the date he would otherwise have become eligible.

Coverage will become effective on the later of the [day] [first of the month] following the date he returns to Active Service and the [day] [first of the month] following the date coverage would otherwise have become effective.

Late Enrollee

A person will be considered a late enrollee if he does not apply for insurance within 31 days of the [day] [first of the month] following the date he is first eligible.

[Coverage for any late enrollee will become effective on the [day] [first of the month] following the date he [enrolls] [completes a [30] [60] [90] [120] [180] day late enrollee waiting period] [and submits the required premium].]

[If a person does not apply for insurance within 31 days of the date he is first eligible, he must provide satisfactory Evidence of Insurability to become insured. Coverage for any late enrollee will become effective on the [first] day [of the month coinciding with or next] following the date we approve such person's Evidence of Insurability.]

[If a person does not apply for insurance within 31 days of the date he is first eligible, he must wait until the [Policyholder]'s next Open Enrollment Period. Coverage for any late enrollee will become effective on the date specified by the [Policyholder].]

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from a change in benefits provided by this Certificate or a change in the [Employee]'s Covered Class will take effect on the [day] [first of the month] following the date of such change. Increases will take

effect subject to any Active Service and Evidence of Insurability requirement.

Termination of Insurance

Please read the *Continuation of Coverage* section of this Certificate for information on continuation after eligibility for coverage would otherwise end.

The insurance on a Covered Person will end on the earliest date below:

1. first of the month following the date this Certificate or insurance for a Covered Class is terminated;
2. the [day] [next premium due date after first of the month] following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Certificate;
- [3.] [the [day] [next premium due date after first of the month] following the date the Covered Person attains age 70;]
- [4.] the last day of the last period for which premium is paid;
- [5.] the end of any period of continuation, as provided in the *Continuation of Coverage*; and
- [6.] with respect to an Eligible Dependent, the [day] [first of the month] following the date of the death of the Covered [Employee] or the [day] [first of the month] following the date of divorce from the Covered [Employee][, or termination of a Domestic Partnership Arrangement].

Termination will not affect a Specified Critical Illness Diagnosed or Health Screening incurred after the Eligibility Waiting Period while coverage was in effect.

Continuation of Coverage

If a Covered Person's insurance terminates for any reason other than non-payment of any required premium when due or termination of this Certificate, such person may elect to continue coverage under this Certificate provided he has not attained age 70. To elect continued coverage, the Covered Person must[:

- [1.] [have been continuously insured for at least [6] [12] [24] months under this Certificate and/or any plan it replaced just before the date their insurance terminates; and]
- [2.] make the election within 31 days of termination and pay all required premiums for the continued coverage.

Continued coverage is subject to all of the provisions and limitations of this Certificate. The premium rate charged for the continued coverage will be 105% of the rate charged to the [Policyholder] for the coverage under this Certificate based on the Covered Person's age at the time he elects to continue coverage.

Premiums for continued coverage will be collected from the terminated individual on a quarterly, semi-annual or annual basis, as elected by the Covered Person.

Coverage continued under this provision will end when [the Certificate terminates][,] [the date such person attains age 70] or the last period for which premium is paid[, whichever occurs first].

Specified Critical Illness Benefit

We will pay this benefit if a Covered Person is diagnosed with one of the Specified Critical Illnesses shown in the *Schedule of Benefits* provided:

1. The first occurrence and the Date of Diagnosis are after the Eligibility Waiting Period; and
2. The Date of Diagnosis is while the Certificate is in force; and

3. It is not excluded by name or specific description in this Certificate.

[If the Date of Diagnosis of a Specified Critical Illness occurs during the Eligibility Waiting Period, the Certificate may be returned for a full refund of premium.]

The Benefit Amount is shown in the *Schedule of Benefits*. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.] Specified Critical Illness Benefits will be based on the Benefit Amount in effect when the loss begins. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

We will figure the benefits for each Specified Critical Illness by multiplying A times B minus C, where:

- A = The Benefit Amount in effect for the Covered Person's attained age when the loss begins.
- B = The Percentage Payable shown in the *Schedule of Benefits* for the applicable Specified Critical Illness and Covered Person's attained age.
- C = Any partial benefits paid for that Specified Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first Specified Critical Illness has been diagnosed unless the Date of Diagnosis is separated from the prior Specified Critical Illness by at least [30] [60] [90] [180] days [or in the case of Invasive Cancer, Carcinoma in Situ or Skin Cancer 12 months free of treatment].
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the Dates of Diagnosis are separated by at least [6] [9] [12] months.

[Health Screening Benefit

Subject to the terms and conditions of this Certificate we will pay the benefit shown in the *Schedule of Benefits* for Health Screening Benefits incurred by a Covered Person. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.]

We will pay this benefit for the following Health Screening Tests performed after the Eligibility Waiting Period and while this Certificate is in force. The amount we will pay per screening and number of screenings we will pay per Plan Year is shown in the *Schedule of Benefits*. Payment of this benefit will not reduce the Benefit Amount.

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill or the use of medication,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),

8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,
14. Mammography,
15. Pap test,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography,
19. Skin review by a dermatologist.

There is no limit to the number of years a Covered Person can receive benefits for Health Screening Tests, as long as this Certificate is in force.

We will pay this benefit regardless of a supporting Diagnosis or the results of the test.

No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.]

LIMITATIONS AND EXCLUSIONS

Limitations

1. Eligibility Waiting Period - No benefits are payable for any [Employee][,] [or] [Dependent] [or] [Domestic Partner] until the Eligibility Waiting Period shown in the *Schedule of Benefits* has been completed. If first diagnosed during the Eligibility Waiting Period, the Pre-Existing Condition Limitation will apply to any loss from that diagnosis. [At the [Policyholder]'s option, you may elect to void any coverage applied for and receive a full refund of premium. Any such request must be in writing and made prior to the end of the Eligibility Waiting Period.]
2. Pre-Existing Conditions - We will not pay benefits for any condition or illness starting within [3] [6] [12] months of the [Effective Date of the Certificate] [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] which is caused by, contributed to, or resulting from a Pre-Existing Condition. A claim for benefits for loss starting after 12 months from the Effective Date of the Certificate [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition.

A condition will no longer be considered Pre-Existing at the end of 12 consecutive months starting and ending after the Effective Date of the Certificate [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance].

"Pre-Existing Condition" means a sickness or physical condition which, within the [3] [6] [12] month period prior to the Effective Date of the Certificate [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] resulted in an insured receiving medical advice or treatment.

"Treatment" means consultation; care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

[3. Reduction Schedule - The Benefit Amount [and Guarantee Issue Benefit Amount] payable for a Specified Critical Illness will be reduced by 50% if an Covered Person is age 70 or older on the date the benefit becomes payable. "Age" means the age of the Covered Person on such person's most recent birthday, regardless of the actual time of birth.]

Exclusions

We will not pay for:

1. Loss due to an accident, or any benefit for a diagnosis caused or contributed to by an accident. This includes any treatment received or expenses incurred for an accidental injury
2. Any benefit for a diagnosis the results in an experimental procedure, service or treatment, or a loss due to an experimental procedure, service or treatment;
3. Loss due to suicide or any attempt or threat to commit suicide, while sane or insane, or any intentionally self-inflicted injury or sickness;
4. Loss due to participation in a riot, civil commotion, civil disobedience, insurrection or unlawful assembly, unless a loss that occurs while a Covered Person is acting in a lawful manner within the scope of authority;
5. Loss due to committing, attempting to commit, or taking part in a felony or assault;
6. Loss due to the Covered Person being legally intoxicated as determined according to the laws of the United States of America;
7. Any benefit for a diagnosis of an illness resulting from the use of a controlled substance, or misuse of legal or illegal drugs, by a Covered Person that is not rendered by or at the direction of a Physician or Doctor;
8. Loss due to an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes an accidental injury or sickness contracted while in the service of any military, naval or air force of any country engaged in war (the Company will refund the pro rata unearned premium for any such period the Covered Person is not covered);
9. Loss due to an accident or sickness arising out of and in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made;
10. Any benefit for a diagnosis rendered by or at the direction of a Physician or Doctor during a period of time that insurance for a Covered Person is not in force;
11. Any benefit for a diagnosis rendered by or at the direction of a Physician or Doctor after this Certificate has terminated;
12. Any diagnosis not rendered by or at the direction of a Physician or Doctor, or that is inconsistent with standards of medical practice for the applicable condition;
13. Benefits for a diagnosis rendered by or at the direction of a Physician or Doctor outside the United States or Canada;
14. Transportation; or
15. Benefits for a diagnosis rendered by any person who is:
 - a. employed or retained by the [Policyholder];
 - b. living in the Covered Person's household;
 - c. a parent, sibling, spouse[,] [Domestic Partner] or child of a Covered [Employee] or of His spouse;
or

- d. a Covered Person diagnosing himself.

CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Specified Critical Illness is Diagnosed or a Health Screening is performed or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent. Notice should include the [Policyholder]'s name, and the Covered Person's name, address, and [Policy] [Certificate] Number.

Claim Forms

We will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not sent within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Certificate for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable.

If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

[Notice of Decision

We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific certificate provisions, rules or guidelines on which the denial was based;

3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;
2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific certificate provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours.]

Time of Payment of Claims

We will pay benefits due under this Certificate for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under this Certificate, unless otherwise stated, will be payable to the Covered Person or to his estate.

If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

Claimant Cooperation Provision

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Claim Administration

For plans subject to the Employee Retirement Income Security Act (ERISA), the plan administrator of the employer's employee welfare benefit plan (the plan) has selected us as the plan fiduciary under federal law for the review of claims for benefits provided by this Certificate and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact.

All decisions made by us in this capacity shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

We will have no fiduciary responsibility with respect to the administration of the plan except as described above. It is understood that our sole liability to the plan and to participants and beneficiaries under the plan shall be for the payment of benefits provided under this Certificate.

We may contract with another entity to perform this function on our behalf.

Payment of Claims to Foreign [Employees]

The [Policyholder] may, in a fiduciary capacity, receive and hold any benefits payable to Covered [Employee]s whose place of employment is other than:

1. the United States and its possessions; or
2. the Dominion of Canada.

We will not be responsible for the application or disposition by the [Policyholder] of any such benefits paid. Our payments to the [Policyholder] will constitute a full discharge of our liability for those payments under this Certificate.

Physical Examination and Autopsy

We, at our own expense, have the right and opportunity to examine the Covered Person when and as often as we may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under the Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Certificate. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Certificate.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

[Additional Coverage with the Company]

We will only pay benefits for covered Illness, Condition or Procedure under one Specified Illness, Condition or Surgical Procedure Policy or Certificate if a Covered Person is covered by more than one of our Specified Illness, Condition or Surgical Procedure Policies or Certificates. A Covered Person may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Specified Illness, Condition or Surgical Procedure Policies or Certificates during the period there was more than one Policy or Certificate in force.]

Unpaid Premium - When a claim is paid, any premium due and unpaid by the [Policyholder] may be deducted from the claim payment.

ADMINISTRATIVE PROVISIONS

Cancellation

We or the [Policyholder] may cancel the coverage provided by this Certificate, after the first year as of any Premium Due Date, by giving the other party [31] [45] [60] [90] [120] [180] days advance written notice.

If a premium is not paid by the [Policyholder] when due, we will cancel this Certificate at the end of the last period for which premium was paid, subject to the Grace Period provision. The [Policyholder] has the sole responsibility to notify Covered Person's of such termination.

Grace Period

The [Policyholder] will be granted a Grace Period of [30] [31] [60] [90] days for payment of required premiums due after the first premium, unless:

1. we do not intend to renew the coverage provided by this Certificate beyond the period for which premium has been accepted; and
2. written notice of our intention not to renew is delivered to the [Policyholder] at least [30] [45] [60] [90] [120] [180] days before the premium is due.

This Certificate will be in force during the Grace Period. If the required premiums are not paid by the [Policyholder] during the Grace Period, insurance will end on the last day of the Grace Period. The [Policyholder] is liable to us for any unpaid premium for the time this Certificate was in force.

If a Covered Person's insurance under this Certificate in being continued under Continuation of Coverage, such person will be granted an individual Grace Period of 31 days for payment of required premiums due.

If the required premiums are not paid by the Covered Person during the individual Grace Period, such person's insurance will end on the last day of the individual Grace Period. A Covered Person's insurance under this Certificate will remain in force during the individual Grace Period. The Covered Person is liable to us for any unpaid premium for the time their coverage under this Certificate is being continued under Continuation of Coverage.

We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Certificate will be based on the rates, agreed to by the [Policyholder] or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected by the [Policyholder]. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the [Policyholder].

Premium Payment

The total premium for the insurance provided by this Certificate is the sum of premiums paid:

1. by the [Policyholder] for all Covered Persons other than those described in (2) below, including any amounts contributed toward the cost of this coverage by Covered Persons; and
2. by Covered Persons who remain eligible for coverage under the *Continuation of Coverage* provision of this Certificate.

If any premium is not paid when due, this Certificate will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

Changes in Premium Rates

We may change the premium rates from time to time with at least 60 days advance written notice to the [Policyholder]. No change in rates will be made until 12 months after the initial effective date of the coverage provided by this Certificate. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Certificate change;
2. the number of [Employee]s eligible for coverage increases or decreases by more than 10% since the latter of the initial effective date and the date of the last renewal of the coverage provided by this Certificate;
3. coverage is reinstated following failure to pay premium during the Grace Period;
4. acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible individuals;
5. a change in the number of eligible individuals which would, on a manual rate basis, require a change of 10% or more in the premium rate;
6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects our benefit obligations under this Certificate; or
7. the [Policyholder] fails to provide sufficient information, as required by us, to confirm adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

We will have the right to audit books and records of the [Policyholder] at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

GENERAL PROVISIONS

Entire Contract; Changes

The Policy [and this Certificate], including [application (if any)][,] [individual enrollment forms (if any)][,] endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in the Policy [or this Certificate] will be valid until approved by one of our executive officers and endorsed on or attached to the Policy or this Certificate. No agent has authority to change the Policy [or this Certificate], or to waive any of the Policy's [or Certificate's] provisions.

Misstatement of Age

If an age has been misstated on the enrollment form the Benefits will be those the premium paid would have purchased at the correct age.

Certificates

Where required by law, we will provide a Certificate of Insurance for delivery to the Covered Person. Each Certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment

The rights and benefits under this Certificate may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his insurance should see the [Policyholder] for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's insurance (including an assignment on a form furnished by us or by the [Policyholder]).

Incontestability

1. [Policyholder]

All statements made by the [Policyholder] to obtain the coverage provided by this Certificate are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of the coverage provided by this Certificate unless a copy of the instrument containing the statement is, or has been, furnished to the [Policyholder]. After two years from the initial effective date of the coverage provided by this Certificate, no such statement will cause the coverage provided by this Certificate to be contested except for fraud.

2. Covered Person

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from a Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud.

Reporting Requirements

The [Policyholder] or its authorized agent must report all of the following to us by the premium due date:

1. the number of persons insured on the Certificate Effective Date;
2. the number of persons who are insured after the Certificate Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by us.

Clerical Error

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Certificate. If such error or delay is found, we will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that applies to this Certificate are automatically changed to satisfy the minimum requirements of such laws.

Compensation Insurance

This Certificate is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.

No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage. All materials describing this coverage must be approved in writing by **HM Life** prior to distribution. Note: Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until notified.

Premium rates quoted were based on the data submitted to **HM Life**. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for **HM Life's** approval of the coverage requested.

Print Name of Applicant's Authorized Representative

Signature of Applicant's Authorized Representative

Date

Title

Signature of Witness and/or Agent

Location, City/State

Name of Witness and/or Agent

Agent License Number

FRAUD NOTICE *(Please read carefully)*

Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

In Arkansas, 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.

For your protection, California requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

In the District of Columbia, **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

In Kentucky, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Any application for insurance in writing by the applicant shall be altered solely by the applicant or by his written consent; except that insertions may be made by the insurer for administrative purposes only in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

In Maryland any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In Ohio, any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

In Washington, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SERFF Tracking Number: HMRK-125652016 State: Arkansas
Filing Company: HM Life Insurance Company State Tracking Number: 39036
Company Tracking Number: HM-CI-308
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
Limited Benefit
Product Name: Critical Illness
Project Name/Number: /HM-CI 308

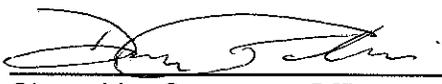
Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	05/23/2008
Comments:		
Attachment: Readability Cert 05.08.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	05/23/2008
Comments: Attached in form schedule.		
Satisfied -Name: Explanation of Variables	Review Status: Approved-Closed	05/23/2008
Comments:		
Attachment: Summary of Variables HM-CI 308.pdf		

STATE OF ARKANSAS
READABILITY CERTIFICATION

This is to certify that the following forms comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act and have achieved a Flesch Reading Ease Score of:

<u>FORM NO.</u>	<u>DESCRIPTION</u>	<u>FLESCH SCORE</u>
HMP-CI 308	Critical Illness	50.9
HMC-CI 308	Critical Illness	50.7



Signed by Company Officer

May 15, 2008
Date

Domenic Palmieri
Name

Senior Vice President – Finance
Title

VARIABLES, CUSTOMIZED PROVISIONS, AND FORMAT
HM Life Insurance Company
HMP- CI 308, et al

HM Life's policy forms are constructed in a way that allows us to select appropriate variables for each client either upon request or as required by applicable.

Policy forms will only be issued to eligible groups as defined by applicable law. Certificates of Insurance are issued to all group policyholders and/or participating employers for distribution to eligible members.

The enclosed policy form filing includes standard and variable provisions – there are several kinds of variables which are bracketed:

- Optional benefit provisions provided upon request and contract provisions, which are used in specific situations depending upon the requested plan design.
- Variable amounts, periods, and/or durations, all of which are shown in brackets. Such amount, period or duration used will depend on the product design requested by the client, subject to underwriting approval.
- Optional wording within a sentence or paragraph – where alternate wording is available, each variation is bracketed and shown in the enclosed policy forms.

An asterisk within bracket may be used to designate a form number, form type and/or applicable class in the footer; a name, number or date on the cover page; an affiliate name, location or effective date; or the dollar value of the premium due.

Common terms within the form may be substituted with similar terms, for example:

[Policyholder] – Employer, Participating Organization Association, Union, Indian Nation, etc. or similar term may be substituted for Policyholder provided benefits are provided on a group basis in a manner that precludes individual selection.

[Employee] – Associate, Member, Participant, etc. or similar term may be substituted for Employee

[Plan] – Calendar or Benefit may be substituted.

References to time periods, such as 180 days, may be converted to their monthly equivalent where practical upon request.

All exclusions and limitations may be included or deleted in their entirety. Optional wording within the exclusion or limitation is shown in brackets. Definitions that do not apply to the benefit description may be deleted in their entirety.

The policyholder generally determines eligibility and service waiting periods, if any, for their employees. Thus the definition of any insured person, and/or any service waiting period associated with such person's eligibility for benefits is subject to change. We will not agree to a definition of employee or a service waiting period that is not applied consistently to all employees within a given class.

Additional variations not shown in the enclosed policy form may be agreed upon as a result of negotiations between HM Life and the Policyholder. However, we will not agree to any provision, which is, to the best of our knowledge and belief, ambiguous or unclear, or inconsistent with any law or regulation of the state or federal government.

The attached forms are submitted in final printed form in 10-point type on 8 1/2 by 11 pages. The certificate may be printed in a booklet format (5 1/2 by 8 1/2 pages), if requested by the Policyholder. We may issue certificates in a foreign language, based on a direct translation of the filed wording.

HM Life Insurance Company

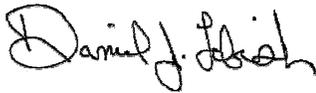
120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

POLICYHOLDER: [*]
[PARTICIPATING ORGANIZATION:] [*]
POLICY NUMBER: [*]
POLICY EFFECTIVE DATE: [*]
POLICY ANNIVERSARY DATE: [*]
STATE OF ISSUE: [*]

HM Life Insurance Company, herein called the Company or we, us or our, in consideration of the [Application for this Policy, if any, and the] timely payment of Premiums, agrees, subject to the terms and conditions of the Policy, to insure the [Policyholder]'s eligible [employee]s and their eligible dependents under this Policy. The [Policyholder] may add new [employee] s or dependents from time to time in accordance with the terms of the Policy. Subsequent anniversaries of the Policy will be the same date each year thereafter.

This Policy describes the terms and conditions of insurance. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Policy Effective Date shown above, at the [Policyholder]'s address. The laws of the State of Issue shown above govern this Policy. We and the [Policyholder] agree to all of the terms of this Policy

IN WITNESS WHEREOF **HM Life Insurance Company** has caused this Policy to be executed on the date of issue to take effect on the Policy Effective Date.



President



Secretary

• GROUP SPECIFIED CRITICAL ILLNESS POLICY • NON-PARTICIPATING

THIS POLICY PROVIDES LIMITED BENEFITS

NO RECOVERY FOR PRE-EXISTING CONDITIONS - READ CAREFULLY.

No benefits will be provided for the first twelve months a person is covered under the Policy for conditions for which medical advice or treatment was received or recommended during the [three] [six] [twelve] month period prior to the effective date of such person's coverage under the Policy.

Questions or Comments

We want to hear from you. If you have any questions about this Policy, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Policy. Thank you for your loyal patronage.

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[SCHEDULE OF AFFILIATES

The following Affiliates are covered under this Policy on the effective dates listed below. A newly-acquired Affiliate may be covered under this Policy on the first of the month following the date it is acquired as long as the [Policyholder] notifies us within [30] [45] [60] [90] [180] days of its acquisition and pays the required premium. If we are not notified within the required time period, the Affiliate will be covered on the date we agree in writing to provide coverage and receive the required premium. Individuals who are [employed by] [members of] [associated with] the Affiliate on its effective date of coverage are eligible for coverage on that date.

[Affiliate Name	Location	Effective Date
[*]	[*]	[*]

SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Policy provisions carefully.

Specified Critical Illness Benefits will be based on the Benefit Amount in effect when the loss begins. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

Eligibility Waiting Period

[For [employee]s hired [30] [31] [60] days [or more] before the Certificate Effective Date:] [None] [30] [31] [45] [60] [90] [days] [The period determined by the [Policyholder's] personnel practices]]

[For [employee]s hired after the Certificate Effective Date:] [None] [30] [31] [45] [60] [90] [days] [the [Policyholder's] next Open Enrollment Period] [The period determined by the [Policyholder's] personnel practices]]

Benefit Amount

[Employee]	[\$2,000 to \$500,000 in \$500 increments from \$2,000 to \$10,000; \$5000 increments from \$10,000 to \$100,000; \$10,000 increments from \$100,000 to \$200,000; and \$50,000 increments from \$200,000 to \$500,000]
[Spouse][Domestic Partner]	[Lesser of \$200,000 or] [50%] [75%] [100%] of [Employee] Amount]
[Child]	[Lesser of \$20,000 or] [10%] [25%] of [Employee] Amount]

[Guarantee Issue Benefit Amount

[Employee]	[\$2,000 to \$30,000 in \$500 increments]
[Dependent Spouse] [Domestic Partner]	[50%] [75%] [100%] of [Employee] Amount]
[Dependent Child]	[10%] [25%] of [Employee] Amount]]

You must provide satisfactory Evidence of Insurability to become insured for a Benefit Amount above the Guarantee Issue Amount. Thereafter, new Evidence of Insurability will be required for any further increase in your Benefit Amount. Coverage for any amount over the Guarantee Issue Amount will become effective on the later of the [day] [first of the month] following the date we approve the Covered Person's Evidence of Insurability.]

[Reduction Schedule

Rate	50%
Attained Age	70]

Specified Critical Illness Benefits**Percentage Payable**

[Cancer	
Invasive Cancer	100%
Carcinoma in situ	25%[*]
Skin Cancer	10%[*]]
[End Stage Renal Disease (Kidney Failure)	100%]
[Stroke	100%]
[Major Organ Transplant	100%]
[Coronary Artery Bypass	25%[*]]
[Myocardial Infarction (Heart Attack)	100%]
[Loss of Sight, Speech, Hearing	100%[*]]
[Coma	100%[*]]
[Paralysis	100%[*]]

[* Payable only once per lifetime, minimum benefit \$250]

[Health Screening Benefit

Amount per Screening	\$[25] [50] [100]
Number of Screenings per [Calendar] Year	1]

Minimum Participation Requirement

[5] [Employees] [and] [Dependents]]

Rates and Premiums**Mode of Premium Payment**

[Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual] [Annual]

Premium Due Dates

[Policy Effective Date and the first day of each month thereafter]

[Policy Effective Date and the first day of each calendar quarter thereafter]

Policy Effective Date and the first day [July] [and] [January] thereafter]

Contributions

The [entire] cost of this insurance is paid by [the] [[Policyholder]] [and] [Covered Persons].

Rates

Premium payable [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual] [Annual]

Issue Age	[Non-Tobacco Rate]	[Tobacco Rate]	[Uni-Smoker Rate]
18-24	[*]	[*]	[*]
25-29	[*]	[*]	[*]
30-34	[*]	[*]	[*]
35-39	[*]	[*]	[*]
40-44	[*]	[*]	[*]
45-49	[*]	[*]	[*]
50-54	[*]	[*]	[*]
55-59	[*]	[*]	[*]
60-64	[*]	[*]	[*]

65-69 [*] [*] [*]]

Composite Rate [*]

DEFINITIONS

Please note that certain words used in this Policy have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Policy have the meanings set forth below.

Active Service means that the [Employee] [or] [Dependent] is either:

1. at work on one of the [Employees] scheduled work days and is performing his regular duties on a [scheduled] basis, either at one of the [Employer's] usual places of business or at some other location to which the [Employer]'s business requires him to travel;
2. on a scheduled holiday[,] [or] vacation day [or period of [Employer]-approved paid leave of absence][, only if the [Employee] was in Active Service on the preceding scheduled workday].

A Covered Person is considered in Active Service if he is not one of the following:

1. an in-patient in a Hospital, skilled nursing facility, rehabilitation hospital, convalescent / personal care facility or receiving out-patient care and/or therapy that affects a Covered Person's ability to perform his regular duties on a scheduled basis;
2. confined at home under the care of a Physician or Doctor for a treatment of an injury or sickness; or
3. totally disabled.

Affiliate or Affiliated means a company, location, division, or organization while subsidiary to, affiliated with or controlled by the [Policyholder].

Cancer has the following meanings:

Invasive Cancer means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);
3. Skin Cancer, melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm), basal cell carcinoma and squamous cell carcinoma of the skin; and
4. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer.

Carcinoma in Situ means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Skin Cancer means melanoma that is diagnosed as Clark's level III, IV or Level V, or Breslow greater than .77 mm. Excluded are melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm), basal cell carcinoma and squamous cell carcinoma of the skin.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Cancer, and/or Carcinoma in Situ and/or Skin Cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. Clinical Diagnosis - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
 - a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
 - b. there is medical evidence to support the diagnosis; and
 - c. a doctor is treating a Covered Person for Cancer, Carcinoma in Situ and/or Skin Cancer.

Certificate means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

Coma means a profound state of unconsciousness that lasts for a period of 30 consecutive days and from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician. The Diagnosis of Coma must indicate that permanent neurological deficit is present.

Company or **we, us, our**, means HM Life Insurance Company, domiciled in Pennsylvania.

Coronary Artery Bypass means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, stents or other non-surgical procedures.

The diagnosis of the condition that necessitates the need for a Coronary Artery Bypass must be made by a cardiologist and based on angiographic evidence of the underlying disease.

Covered Person means an [Employee][,] [or] [Dependent] [Domestic Partner] , for whom an enrollment form has been accepted by us[, the required premium has been paid when due] and for whom coverage under this Policy remains in force. If [employee] is shown in the *Schedule of Benefits* we insure the [Employee]. Dependents are insured if either [Dependent spouse][,] [or] [Domestic Partner] or Dependent children is shown in the *Schedule of Benefits*.

Date of Diagnosis. The date of diagnosis is:

For cancer, carcinoma in situ and/or skin cancer: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.

For heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Myocardial Infarction (Heart Attack) definition.

For stroke: The date a stroke occurred must be determined by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

For end stage renal disease: The date that a physician recommends that a Covered Person qualifies for Medicare coverage for end stage renal disease.

For major organ transplant surgery: The date the surgery occurs for a transplant.

For coronary artery bypass open heart surgery: The date the surgery occurs for coronary artery bypass surgery.

For all other conditions: The date a Physician in the applicable field of medicine determines a Covered Critical Illness.

Dependent means the [Employee]'s:

1. Spouse, unless such spouse is eligible as a Covered [Employee] under this Policy; [and] [or]
- [2.] [Domestic Partner, unless such person is eligible as a Covered [Employee] under this Policy; and]
- [3.] Unmarried natural or step child, unless such child is eligible for medical coverage as a Covered [Employee] under this Policy and who:
 - [a.] is less than [19] [23] [25] [30] years old[; or
 - [b.] is unmarried, under [23] [25] [30] years of age and attends an accredited educational institution as a full-time student; or]
 - [c.] becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. This insurance will continue for as long as the Covered [Employee's] insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19.

This term includes a child who:

- [1.] [is living with the Covered [Employee] in a parent child relationship; or]
- [2.] is adopted by or placed for adoption with, or is party in a suit for adoption by, the Covered [Employee]; or
- [3.] is required to be provided coverage by the Covered Person or his [spouse] [Domestic Partner] under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]).

[Domestic Partner means a person of [the same] [or] [the opposite] sex who:

- [1.] [is not married or legally separated][;]
- [2.] [has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage][;]
- [3.] [Is not currently registered in a Domestic Partnership with a different domestic partner and has not been in such a relationship for at least six months][;]
- [4.] [occupies the same residence as the [Employee]][;]
- [5.] [has not entered into a Domestic Partnership relationship that is temporary, social, political, commercial or economic in nature][;] [and]
- [6.] [has entered into a Domestic Partnership Arrangement with the [Employee]].]

[Domestic Partnership Arrangement means the [Employee] and another person of [the same] [or] [the opposite] sex has any three of the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

1. joint lease, mortgage or deed;
2. joint ownership of a vehicle;
3. joint ownership of a checking account or credit account;
4. designation of the Domestic Partner as a beneficiary for the employee's life insurance or retirement benefits;

5. designation of the Domestic Partner as a beneficiary of the employee's will;
6. designation of the Domestic Partner as holding power of attorney for health care; or
7. shared household expenses].]

Eligibility Waiting Period means the period of time that must lapse before an [Employee][,] [Dependent] [or Domestic Partner] is eligible for insurance under the Policy. It will be extended by the number of days the [Employee][,] [Dependent] [or Domestic Partner] is not in Active Service. We will not pay benefits for a Specified Critical Illness that begins during the Eligibility Waiting Period or a Health Screening performed during such period.

[Provide **Evidence of Insurability** means a[n] [Employee][,] [and] [Dependent] [Domestic Partner] [Covered Person] must [upon request and at their expense]:

- [1.] complete and sign our [enrollment] [health and medical history] form[;]
- [2. sign our form authorizing us to obtain information about his health and other insurance coverage;
- [3.] provide any additional reasonable information about his insurability that we request; and
- [4.] undergo a physical examination and testing at our request].]

[Employee] means a [full-time] [employee] of the [Policyholder] [who works an average of [10] [15] [20] hours per week [or equivalent hours per month] [and who meets all of the requirements for one of the Covered Classes shown below].

- [[Class 1] [All [employee]s] of the [Policyholder] who are officers]
- [Class 2] [All [employee]s] of the [Policyholder] who are managers or supervisors]
- [Class 3] [All [employee]s] of the [Policyholder]] at [location]]
- [Class 4] All other [employee]s] of the [Policyholder]]]

End Stage Renal Disease (Kidney Failure) means end stage renal disease presenting as chronic, irreversible failure of one or both of kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or result in kidney transplantation. End stage renal disease is covered, provided it is not caused by a traumatic event, including surgical traumas.

The diagnosis of end stage renal disease must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.

[Guarantee Issue Benefit Amount means the maximum Benefit Amount available to a Covered Person without providing Evidence of Insurability].

He, him or his means an individual, male or female.

Hospital means an institution that meets all of the following:

1. it is licensed pursuant to applicable law; it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
2. it is managed under the supervision of a staff of legally licensed physicians;
3. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
4. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;

5. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent or custodial care; or
2. the aged.

Illness means a bodily disorder or disease that:

1. is first manifested while the Covered Person is insured under the Policy, and after any applicable Eligibility Waiting Period;
2. is not subject to the Pre-Existing Condition Limitation; and
3. is not otherwise excluded under the terms of this Policy.

Loss of Sight, Speech, or Hearing means the irreversible loss of sight in both eyes, the irreversible loss of the ability to speak, or the irreversible loss of hearing for all sounds in both ears.

The diagnosis of:

1. Loss of Sight, Speech, or Hearing must be made by a licensed professional or specialist in the applicable field of medicine.
2. Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 200 degrees in both eyes.
3. Loss of Speech must include documented evidence of the illness for the continuous 12- month period prior to the Diagnosis.
4. Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

This term does not include animal to human transplants; transplants of human to human organs other than a human heart, lung, liver, kidney, or pancreas; tissue transplants (corneas, skin, heart valves, bone, tendons, ligaments, cartilage and bone marrow), or a human to human transplant of a uterus, face or hand.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. The diagnosis must include at least three of the following criteria:

1. new and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction.
2. elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. chest pain.

Open Enrollment Period means a period of time agreed upon by the [Policyholder] and the Company, during which an [Employee] may apply for insurance.

Paralysis means complete and permanent loss of function of two or more limbs. Paralysis as a result of stroke is excluded. The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis. As used herein "limb" means an arm or leg.

Pathologist means a Physician, other than a Covered Person or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Physician or Doctor means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the [Policyholder]; or
2. living in the Covered Person's household; or
3. a parent, sibling, spouse[,] [Domestic Partner] or child of the Covered Person.

[Plan] Year or annual or annually means a period of twelve consecutive months beginning on the Policy Effective Date and subsequent Anniversary Dates.

[Policyholder] means the entity shown on the cover page of this Policy.

[Participating Organization] means the entity shown on the cover page of this Policy.]

Specified Critical Illness means such illness shown in the *Schedule of Benefits* and as defined in the Policy.

Stroke means a cerebrovascular incident caused by: infarction of brain tissue; cerebral hemorrhage; thrombosis, or embolization from an extra-cranial source lasting more than [24] hours that produces measurable evidence of permanent neurological deficit.

The following are not considered Strokes:

1. Transient Ischemic Attacks (TIAs)
2. Vertebro-Basilar Insufficiency
3. Incidental Findings on imaging studies
4. Head injury
5. Chronic cerebrovascular insufficiency
6. Reversible ischemic neurological deficits

“Transient Isechemic Attack (TIA)” means a neurological condition or event with the signs and symptoms of a stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.

ELIGIBILITY, EFFECTIVE DATE, TERMINATION AND CONTINUATION PROVISIONS

Policy Effective Date

We agree to provide Critical Illness Insurance Benefits described in this Policy in consideration of the [Policyholder]'s payment the premium when due. Insurance coverage begins on the Policy Effective Date shown on this Policy's first page as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied.

[Effective Date for Newly-Acquired Affiliates

Insurance becomes effective for any newly-acquired affiliate of the [Policyholder] on first of the month following the date it is acquired if we have been notified in writing within the time period specified in the *Schedule of Affiliates*, have agreed to provide insurance, and have received any additional premium due. If we are not so notified, insurance for the Affiliate will become effective on

the first of the month following the date we agree in writing to insure it and receive any additional premium due. Individuals who are [Employee]'s of an Affiliate on its effective date of insurance under this Policy will be eligible for insurance on that date.]

Eligibility

An [Employee][,][Dependent] [or][Domestic Partner] is eligible provided:

1. they meet the applicable definition shown in *Definitions*; and
2. they have completed the Eligibility Waiting Period, if any; and
- [3. in the case of an [Employee][,][Dependent spouse] [or] [Domestic Partner] they are under age 70 [on the Effective Date of the Certificate] [date they complete the Eligibility Waiting Period]; and]
- [4.] they meet the definition of Active Service in *Definitions*.

No person is eligible for insurance under this Policy as both an [Employee][,] [Dependent] [or Domestic Partner] at the same time.

Effective Date

The Effective Date of the Policy and Certificate is shown on the applicable cover page.

An eligible [Employee]'s insurance becomes effective on the [day] [first of the month] following the date he[:]

[1.] submits a complete enrollment form, if any [and we approve that form]; and]

[2.] has paid the required first contribution, if any].

An eligible Dependent's [or Domestic Partner]'s insurance becomes effective on the [day] [first of the month] following the date the [Employee] first becomes insured[, or the [day] [first of the month] following the date the person becomes eligible, if later][, provided[:]

[1.] [a completed enrollment form, if any, is submitted for the Dependent [and we approve that form];:] [and]

[2.] [the [Employee] has paid the required first contribution, if any, for the Dependent's coverage.

If either the [spouse] [or Domestic Partner] is eligible as an [Employee] the dependent children may be covered under only one [Employee].

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have no dependent children;

1. both will be insured as Covered Persons when a Covered Person is not required to contribute to the cost of his insurance; and
2. both may be insured as Covered Persons or one may elect to insure the other as a Dependent when a Covered Person is required to contribute to the cost of his insurance.

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have dependent children;

1. both will be insured as Covered Persons and dependent coverage will be provided via only the parent whose birthday occurs first during a Plan] Year, when an [Employee] is not required to contribute to the cost of his Dependents' insurance; and

2. both may be insured as an [Employee] but only one may elect dependent coverage to insure dependent children, when an [Employee] is required to contribute to the cost of his dependents' insurance.

A [spouse] [or Domestic Partner] that does not meet the definition of [Employee], or a dependent child may be insured as a Dependent provided one [spouse] [or Domestic Partner] meets the definition of [Employee] shown in *Definitions*.

[Newborn children of an [Employee] or spouse are automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. [Foster children [and other children living with the [Employee] or spouse in a parent child relationship] are eligible for coverage on the same basis upon placement in the home.]

[A child adopted by, or placed for adoption with, or who are a party in a suit for adoption by an [Employee] or spouse is covered automatically from birth provided we receive notification within 31 days after the birth of the newborn.]

Deferred Effective Date

The effective date of insurance will be deferred for any [Employee] who is not in Active Service on the [day] [first of the month] following the date he would otherwise have become eligible. Coverage will become effective on the later of the [day] [first of the month] following the date he returns to Active Service and the [day] [first of the month] following the date coverage would otherwise have become effective.

Late Enrollee

A person will be considered a late enrollee if he does not apply for insurance under this Policy within 31 days of the [day] [first of the month] following the date he is first eligible.

[Coverage for any late enrollee will become effective on the [day] [first of the month] following the date he [enrolls] [completes a [30] [60] [90] [120] [180] day late enrollee waiting period] [and submits the required premium].]

[If a person does not apply for insurance under this Policy within 31 days of the date he is first eligible, he must provide satisfactory Evidence of Insurability to become insured. Coverage for any late enrollee will become effective on the [first] day [of the month coinciding with or next] following the date we approve such person's Evidence of Insurability.]

[If a person does not apply for insurance under this Policy within 31 days of the date he is first eligible, he must wait until the [Policyholder]'s next Open Enrollment Period. Coverage for any late enrollee will become effective on the date specified by the [Policyholder].]

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from a change in benefits provided by this Policy or a change in the [Employee]'s Covered Class will take effect on the [day] [first of the month] following the date of such change. Increases will take effect subject to any Active Service and Evidence of Insurability requirement.

Termination of Insurance

Please read the *Continuation of Coverage* section of this Policy for information on continuation after eligibility for coverage would otherwise end.

The insurance on a Covered Person will end on the earliest date below:

1. first of the month following the date this Policy or insurance for a Covered Class is terminated;
2. the [day] [next premium due date after first of the month] following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;

[3.] [the [day] [next premium due date after first of the month] following the date the Covered Person attains age 70;]

[4.] the last day of the last period for which premium is paid;

[5.] the end of any period of continuation, as provided in the *Continuation of Coverage*; and

[6.] with respect to an Eligible Dependent, the [day] [first of the month] following the date of the death of the Covered [Employee] or the [day] [first of the month] following the date of divorce from the Covered [Employee][, or termination of a Domestic Partnership Arrangement].

Termination will not affect a Specified Critical Illness Diagnosed or Health Screening incurred after the Eligibility Waiting Period while coverage was in effect.

Continuation of Coverage

If a Covered Person's insurance terminates for any reason other than non-payment of any required premium when due or termination of the Policy, such person may elect to continue coverage under the Policy provided he has not attained age 70. To elect continued coverage, the Covered Person must[:

[1.] [have been continuously insured for at least [6] [12] [24] months under this Policy and/or any plan it replaced just before the date their insurance terminates; and]

[2.] make the election within 31 days of termination and pay all required premiums for the continued coverage.

Continued coverage is subject to all of the provisions and limitations of the Policy. The premium rate charged for the continued coverage will be 105% of the rate charged under the Policy based on the Covered Person's age at the time he elects to continue coverage.

Premiums for continued coverage will be collected from the terminated individual on a quarterly, semi-annual or annual basis, as elected by the Covered Person.

Coverage continued under this provision will end when [the Policy terminates][,] [the date such person attains age 70] or the last period for which premium is paid[, whichever occurs first].

Specified Critical Illness Benefit

We will pay this benefit if a Covered Person is diagnosed with one of the Specified Critical Illnesses shown in the *Schedule of Benefits* provided:

1. The first occurrence and the Date of Diagnosis is after the Eligibility Waiting Period; and
2. The Date of Diagnosis is while the Policy or the Certificate is in force; and
3. It is not excluded by name or specific description in the Policy.

[If the Date of Diagnosis of a Specified Critical Illness occurs during the Eligibility Waiting Period, the Certificate may be returned for a full refund of premium.]

The Benefit Amount is shown in the *Schedule of Benefits*. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.] Specified Critical Illness Benefits will be based on the Benefit Amount in effect when the loss begins. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

We will figure the benefits for each Specified Critical Illness by multiplying A times B minus C, where:

- A = The Benefit Amount in effect for the Covered Person's attained age when the loss begins.
- B = The Percentage Payable shown in the *Schedule of Benefits* for the applicable Specified Critical Illness and Covered Person's attained age.
- C = Any partial benefits paid for that Specified Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first Specified Critical Illness has been diagnosed unless the Date of Diagnosis is separated from the prior Specified Critical Illness by at least [30] [60] [90] [180] days [or in the case of Invasive Cancer, Carcinoma in Situ or Skin Cancer 12 months free of treatment].
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the Dates of Diagnosis are separated by at least [6] [9] [12] months.

[Health Screening Benefit

Subject to the terms and conditions of this Policy we will pay the benefit shown in the *Schedule of Benefits* for Health Screening Benefits incurred by a Covered Person. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.]

We will pay this benefit for the following Health Screening Tests performed after the Eligibility Waiting Period and while the Policy is in force. The amount we will pay per screening and number of screenings we will pay per Plan Year is shown in the *Schedule of Benefits*. Payment of this benefit will not reduce the Benefit Amount.

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill or the use of medication,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,

14. Mammography,
15. Pap test,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography,
19. Skin review by a dermatologist.

There is no limit to the number of years a Covered Person can receive benefits for Health Screening Tests, as long as the Policy or Certificate is in force.

We will pay this benefit regardless of a supporting Diagnosis or the results of the test.

No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.]

LIMITATIONS AND EXCLUSIONS

Limitations

1. Eligibility Waiting Period - No benefits are payable for any [Employee][,] [or] [Dependent] [or] [Domestic Partner] until the Eligibility Waiting Period shown in the *Schedule of Benefits* has been completed. If first diagnosed during the Eligibility Waiting Period, the Pre-Existing Condition Limitation will apply to any loss from that diagnosis. [At the [Policyholder]'s option, you may elect to void any coverage applied for and receive a full refund of premium. Any such request must be in writing and made prior to the end of the Eligibility Waiting Period.]
2. Pre-Existing Conditions - We will not pay benefits for any condition or illness starting within [3] [6] [12] months of the [Effective Date of the Certificate] [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] which is caused by, contributed to, or resulting from a Pre-Existing Condition. A claim for benefits for loss starting after 12 months from the Effective Date of the Certificate [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition.

A condition will no longer be considered Pre-Existing at the end of 12 consecutive months starting and ending after the Effective Date of the Policy [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance].

"Pre-Existing Condition" means a sickness or physical condition which, within the [3] [6] [12] month period prior to the Effective Date of the Policy [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] resulted in an insured receiving medical advice or treatment.

"Treatment" means consultation; care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

- [3. Reduction Schedule - The Benefit Amount [and Guarantee Issue Benefit Amount] payable for a Specified Critical Illness will be reduced by 50% if an Covered Person is age 70 or older on the date the benefit becomes payable. "Age" means the age of the Covered Person on such person's most recent birthday, regardless of the actual time of birth.]

Exclusions

We will not pay for:

1. Loss due to an accident, or any benefit for a diagnosis caused or contributed to by an accident. This includes any treatment received or expenses incurred for an accidental injury
2. Any benefit for a diagnosis the results in an experimental procedure, service or treatment, or a loss due to an experimental procedure, service or treatment;

3. Loss due to suicide or any attempt or threat to commit suicide, while sane or insane, or any intentionally self-inflicted injury or sickness;
4. Loss due to participation in a riot, civil commotion, civil disobedience, insurrection or unlawful assembly, unless a loss that occurs while a Covered Person is acting in a lawful manner within the scope of authority;
5. Loss due to committing, attempting to commit, or taking part in a felony or assault;
6. Loss due to the Covered Person being legally intoxicated as determined according to the laws of the United States of America;
7. Any benefit for a diagnosis of an illness resulting from the use of a controlled substance, or misuse of legal or illegal drugs, by a Covered Person that is not rendered by or at the direction of a Physician or Doctor;
8. Loss due to an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes an accidental injury or sickness contracted while in the service of any military, naval or air force of any country engaged in war (the Company will refund the pro rata unearned premium for any such period the Covered Person is not covered);
9. Loss due to an accident or sickness arising out of and in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made;
10. Any benefit for a diagnosis rendered by or at the direction of a Physician or Doctor during a period of time that insurance for a Covered Person is not in force;
11. Any benefit for a diagnosis rendered by or at the direction of a Physician or Doctor after this Policy has terminated;
12. Any diagnosis not rendered by or at the direction of a Physician or Doctor, or that is inconsistent with standards of medical practice for the applicable condition;
13. Benefits for a diagnosis rendered by or at the direction of a Physician or Doctor outside the United States or Canada;
14. Transportation; or
15. Benefits for a diagnosis rendered by any person who is:
 - a. employed or retained by the [Policyholder];
 - b. living in the Covered Person's household;
 - c. a parent, sibling, spouse[,] [Domestic Partner] or child of a Covered [Employee] or of His spouse; or
 - d. a Covered Person diagnosing himself.

CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Specified Critical Illness is Diagnosed or a Health Screening is performed or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent. Notice should include the [Policyholder]'s name, and the Covered Person's name, address, and Policy Number.

Claim Forms

We will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not sent within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

[Notice of Decision

We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;
2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours.]

Time of Payment of Claims

We will pay benefits due under this Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate.

If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

Claimant Cooperation Provision

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Claim Administration

For plans subject to the Employee Retirement Income Security Act (ERISA), the plan administrator of the employer's employee welfare benefit plan (the plan) has selected us as the plan fiduciary under federal law for the review of claims for benefits provided by this Policy and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact.

All decisions made by us in this capacity shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

We will have no fiduciary responsibility with respect to the administration of the plan except as described above. It is understood that our sole liability to the plan and to participants and beneficiaries under the plan shall be for the payment of benefits provided under this Policy.

We may contract with another entity to perform this function on our behalf.

Payment of Claims to Foreign [Employees]

The [Policyholder] may, in a fiduciary capacity, receive and hold any benefits payable to Covered [Employee]s whose place of employment is other than:

1. the United States and its possessions; or
2. the Dominion of Canada.

We will not be responsible for the application or disposition by the [Policyholder] of any such benefits paid. Our payments to the [Policyholder] will constitute a full discharge of our liability for those payments under this Policy.

Physical Examination and Autopsy

We, at our own expense, have the right and opportunity to examine the Covered Person when and as often as we may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

[Additional Coverage with the Company

We will only pay benefits for covered Illness, Condition or Procedure under one Specified Illness, Condition or Surgical Procedure Policy or Certificate if a Covered Person is covered by more than one of our Specified Illness, Condition or Surgical Procedure Policies or Certificates. A Covered Person may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Specified Illness, Condition or Surgical Procedure Policies or Certificates during the period there was more than one Policy or Certificate in force.]

Unpaid Premium - When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

ADMINISTRATIVE PROVISIONS

Cancellation

We or the [Policyholder] may cancel this Policy, after the first year as of any Premium Due Date, by giving the other party [31] [45] [60] [90] [120] [180] days advance written notice.

If a premium is not paid when due, we will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits*. The [Policyholder] has the sole responsibility to notify Covered Person's of such termination.

Grace Period

A Policy Grace Period of [30] [31] [60] [90] days will be granted for payment of required premiums due after the first premium, unless:

1. we do not intend to renew the coverage provided by the Certificate beyond the period for which premium has been accepted; and

2. written notice of our intention not to renew is delivered to the [Policyholder] at least [30] [45] [60] [90] [120] [180] days before the premium is due.

This Policy will be in force during the Policy Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last day of the Grace Period. The [Policyholder] is liable to us for any unpaid premium for the time this Policy was in force.

An individual Grace Period of 31 days, applicable when a Covered Person remains eligible under this Policy under *Continuation of Coverage*, will be granted for payment of required premiums. A Covered Person's insurance under this Policy will remain in force during the Grace Period.

We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates, as set forth in the *Schedule of Benefits* or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits*. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the [Policyholder].

Premium Payment

The total premium for this Policy is the sum of premiums paid:

1. by the [Policyholder] for all Covered Persons other than those described in (2) below, including any amounts contributed toward the cost of this coverage by Covered Persons; and
2. by Covered Persons who remain eligible for coverage under one of the *Continuation of Coverage* of this Policy.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

Changes in Premium Rates

We may change the premium rates from time to time with at least 60 days advance written notice to the [Policyholder]. No change in rates will be made until 12 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Policy change;
2. the number of [Employee]s eligible for coverage increases or decreases by more than 10% since the latter of the Policy Effective Date and the date of the last renewal of this Policy;
3. coverage is reinstated following failure to pay premium during the Grace Period;
4. acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible individuals;
5. a change in the number of eligible individuals which would, on a manual rate basis, require a change of 10% or more in the premium rate;
6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects our benefit obligations under this Policy; or
7. the [Policyholder] fails to provide sufficient information, as required by us, to confirm

adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

We will have the right to audit books and records of the [Policyholder] at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including [application (if any)][,] [individual enrollment forms (if any)][,] endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Misstatement of Age

If an age has been misstated on the enrollment form the Benefits will be those the premium paid would have purchased at the correct age.

Certificates

Where required by law, we will provide a Certificate of Insurance for delivery to the Covered Person. Each Certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

Assignment

The rights and benefits under this Policy may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his insurance should see the [Policyholder] for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's insurance (including an assignment on a form furnished by us or by the [Policyholder]).

Incontestability

1. Of This Policy

All statements made by the [Policyholder] to obtain this Policy are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the [Policyholder]. After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

2. Of A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from a Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud.

Reporting Requirements

The [Policyholder] or its authorized agent must report all of the following to us by the premium due date:

1. the number of persons insured on the Policy Effective Date;
2. the number of persons who are insured after the Policy Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by us.

Clerical Error

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, we will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that applies to this Policy are automatically changed to satisfy the minimum requirements of such laws.

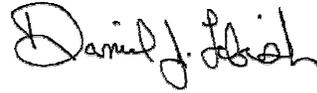
Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.

HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

HM Life Insurance Company certifies that you will be insured under the Policy Number issued to the Policyholder named below during the time, in the manner, and for the amounts provided in the Group Policy.



President

POLICYHOLDER:	[*]
POLICY NUMBER:	[*]
[PARTICIPATING ORGANIZATION:]	[*]
CERTIFICATE EFFECTIVE DATE:	[*]
STATE OF ISSUE:	[*]

Your coverage under the Policy **HM Life Insurance Company** issued to the Policyholder is shown in this Certificate. If your coverage is changed by an amendment to the Policy, we will provide the [Policyholder] with a revised Certificate or other notice to be given to you.

PLEASE READ THIS CERTIFICATE CAREFULLY

This Certificate of Insurance has a Table of Contents to help you find specific provisions. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Certificate Effective Date shown above, at the [Policyholder]'s address. The laws of the State of Issue shown above govern this Certificate.

"You" and "your" refer to the Covered Person. The "Company", we", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

• GROUP SPECIFIED CRITICAL ILLNESS • NON-PARTICIPATING

THE POLICY PROVIDES LIMITED BENEFITS

NO RECOVERY FOR PRE-EXISTING CONDITIONS - READ CAREFULLY.

No benefits will be provided for the first twelve months a person is covered under the Policy for conditions for which medical advice or treatment was received or recommended during the [three] [six] [twelve] month period prior to the effective date of such person's coverage under the Policy.

Questions or Comments

We want to hear from you. If you have any questions about this Certificate, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Certificate. Thank you for your loyal patronage.

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[SCHEDULE OF AFFILIATES

The following Affiliates are covered under this Certificate on the effective dates listed below. A newly-acquired Affiliate may be covered under this Certificate on the first of the month following the date it is acquired as long as the [Policyholder] notifies us within [30] [45] [60] [90] [180] days of its acquisition and pays the required premium. If we are not notified within the required time period, the Affiliate will be covered on the date we agree in writing to provide coverage and receive the required premium. Individuals who are [employed by] [members of] [associated with] the Affiliate on its effective date of coverage are eligible for coverage on that date.

[Affiliate Name	Location	Effective Date
[*]	[*]	[*]]

SCHEDULE OF BENEFITS

This Certificate is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the provisions of this Certificate carefully.

Specified Critical Illness Benefits will be based on the Benefit Amount in effect when the loss begins. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

Eligibility Waiting Period

[For [employee]s hired [30] [31] [60] days [or more] before the Certificate Effective Date:] **[None]** **[30]** **[31]** **[45]** **[60]** **[90]** [days] [The period determined by the [Policyholder’s] personnel practices]]

[For [employee]s hired after the Certificate Effective Date:] **[None]** **[30]** **[31]** **[45]** **[60]** **[90]** [days] [the [Policyholder]’s next Open Enrollment Period] [The period determined by the [Policyholder’s] personnel practices]]

Benefit Amount

[Employee]	[\$2,000 to \$500,000 in \$500 increments from \$2,000 to \$10,000; \$5000 increments from \$10,000 to \$100,000; \$10,000 increments from \$100,000 to \$200,000; and \$50,000 increments from \$200,000 to \$500,000]
[Spouse][Domestic Partner]	[Lesser of \$200,000 or] [50%] [75%] [100%] of [Employee] Amount]
[Child]	[Lesser of \$20,000 or] [10%] [25%] of [Employee] Amount]

[Guarantee Issue Benefit Amount

[Employee]	[\$2,000 to \$30,000 in \$500 increments]
[Dependent Spouse] [Domestic Partner]	[50%] [75%] [100%] of [Employee] Amount]
[Dependent Child]	[10%] [25%] of [Employee] Amount]]

You must provide satisfactory Evidence of Insurability to become insured for a Benefit Amount above the Guarantee Issue Amount. Thereafter, new Evidence of Insurability will be required for any further increase in your Benefit Amount. Coverage for any amount over the Guarantee Issue Amount will become effective on the later of the [day] [first of the month] following the date we approve the Covered Person’s Evidence of Insurability.]

[Reduction Schedule

Rate	50%
Attained Age	70]

Specified Critical Illness Benefits**Percentage Payable**

[Cancer	
Invasive Cancer	100%
Carcinoma in situ	25%[*]
Skin Cancer	10%[*]]
[End Stage Renal Disease (Kidney Failure)	100%]
[Stroke	100%]
[Major Organ Transplant	100%]
[Coronary Artery Bypass	25%[*]]
[Myocardial Infarction (Heart Attack)	100%]
[Loss of Sight, Speech, Hearing	100%[*]]
[Coma	100%[*]]
[Paralysis	100%[*]]

[* Payable only once per lifetime, minimum benefit \$250]

[Health Screening Benefit

Amount per Screening	\$[25] [50] [100]
Number of Screenings per [Calendar] Year	1]

Minimum Participation Requirement

[5] [Employees] [and] [Dependents]]

[Rates and Premiums]

[Mode of Premium Payment	[Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual] [Annual]]
---------------------------------	---

Premium Due Dates [Certificate Effective Date and the first day of each month thereafter]

[Certificate Effective Date and the first day of each calendar quarter thereafter]

Certificate Effective Date and the first day [July] [and] [January] thereafter]

Contributions

The [entire] cost of this insurance is paid by [the] [[Policyholder]] [and] [Covered Persons].

[Rates

Premium payable [Weekly] [Bi-weekly][Monthly] [Quarterly] [Semi-annual] [Annual]

Issue Age	[Non-Tobacco Rate]	[Tobacco Rate]	[Uni-Smoker Rate]
18-24	[*]	[*]	[*]
25-29	[*]	[*]	[*]
30-34	[*]	[*]	[*]
35-39	[*]	[*]	[*]
40-44	[*]	[*]	[*]
45-49	[*]	[*]	[*]
50-54	[*]	[*]	[*]

55-59	[*]	[*]	[*]
60-64	[*]	[*]	[*]
65-69	[*]	[*]	[*]
Composite Rate	[*]]	

DEFINITIONS

Please note that certain words used in this Certificate have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Active Service means that the [Employee] [or] [Dependent] is either:

1. at work on one of the [Employees] scheduled work days and is performing his regular duties on a [scheduled] basis, either at one of the [Employer's] usual places of business or at some other location to which the [Employer]'s business requires him to travel;
2. on a scheduled holiday[,] [or] vacation day [or period of [Employer]-approved paid leave of absence][, only if the [Employee] was in Active Service on the preceding scheduled workday].

A Covered Person is considered in Active Service if he is not one of the following:

1. an in-patient in a Hospital, skilled nursing facility, rehabilitation hospital, convalescent / personal care facility or receiving out-patient care and/or therapy that affects a Covered Person's ability to perform his regular duties on a scheduled basis;
2. confined at home under the care of a Physician or Doctor for a treatment of an injury or sickness; or
3. totally disabled.

Affiliate or Affiliated means a company, location, division, or organization while subsidiary to, affiliated with or controlled by the [Policyholder].

Cancer has the following meanings:

Invasive Cancer means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);
3. Skin Cancer, melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm), basal cell carcinoma and squamous cell carcinoma of the skin; and
4. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer.

Carcinoma in Situ means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Skin Cancer means melanoma that is diagnosed as Clark's level III, IV or Level V, or Breslow greater than .77 mm. Excluded are melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm), basal cell carcinoma and squamous cell carcinoma of the skin.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Cancer, and/or Carcinoma in Situ and/or Skin Cancer must be diagnosed in one of two ways:

1. Pathological Diagnosis - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. Clinical Diagnosis - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
 - a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
 - b. there is medical evidence to support the diagnosis; and
 - c. a doctor is treating a Covered Person for Cancer, Carcinoma in Situ and/or Skin Cancer.

Certificate means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

Coma means a profound state of unconsciousness that lasts for a period of 30 consecutive days and from which the Covered Person cannot be aroused to consciousness, even by powerful stimulation, as determined by a Physician. The Diagnosis of Coma must indicate that permanent neurological deficit is present.

Company or **we, us, our**, means HM Life Insurance Company, domiciled in Pennsylvania.

Coronary Artery Bypass means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, stents or other non-surgical procedures.

The diagnosis of the condition that necessitates the need for a Coronary Artery Bypass must be made by a cardiologist and based on angiographic evidence of the underlying disease.

[Employee] means a [full-time] [employee] of the [Policyholder] [who works an average of [10] [15] [20] hours per week [or equivalent hours per month] [and who meets all of the requirements for one of the Covered Classes shown below].

- [[Class 1] [All [employee]s] of the [Policyholder] who are officers]
- [Class 2] [All [employee]s] of the [Policyholder] who are managers or supervisors]
- [Class 3] [All [employee]s] of the [Policyholder]] at [location]]
- [Class 4] All other [employee]s] of the [Policyholder]]]

Covered Person means an [Employee][,] [or] [Dependent] [Domestic Partner] , for whom an enrollment form has been accepted by us[, the required premium has been paid when due] and for whom coverage under this Policy remains in force. If [employee] is shown in the *Schedule of Benefits* we insure the [Employee]. Dependents are insured if either [Dependent spouse][,] [or] [Domestic Partner] or Dependent children is shown in the *Schedule of Benefits*.

Date of Diagnosis- The date of diagnosis is:

For cancer, carcinoma in situ and/or skin cancer: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.

For heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Myocardial Infarction (Heart Attack) definition.

For stroke: The date a stroke occurred must be determined by a licensed neurologist and based on documented neurological deficits and confirmatory neuroimaging studies.

For end stage renal disease: The date that a physician recommends that a Covered Person qualifies for Medicare coverage for end stage renal disease.

For major organ transplant surgery: The date the surgery occurs for a transplant.

For coronary artery bypass open heart surgery: The date the surgery occurs for coronary artery bypass surgery.

For all other conditions: The date a Physician in the applicable field of medicine determines a Covered Critical Illness.

Dependent means the [Employee]'s:

1. Spouse, unless such spouse is eligible as a Covered [Employee] under this Certificate; [and] [or]
- [2.] [Domestic Partner, unless such person is eligible as a Covered [Employee] under this Certificate; and]
- [3.] Unmarried natural or step child, unless such child is eligible for medical coverage as a Covered [Employee] under this Certificate and who:
 - [a.] is less than [19] [23] [25] [30] years old[; or
 - [b. is unmarried, under [23] [25] [30] years of age and attends an accredited educational institution as a full-time student; or]
 - [c.] becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. This insurance will continue for as long as the Covered [Employee's] insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age 19.

This term includes a child who:

- [1.] [is living with the Covered [Employee] in a parent child relationship; or]
- [2.] is adopted by or placed for adoption with, or is party in a suit for adoption by, the Covered [Employee]; or
- [3.] is required to be provided coverage by the Covered Person or his [spouse] [Domestic Partner] under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609[a]).

[Domestic Partner means a person of [the same] [or] [the opposite] sex who:

- [1.] [is not married or legally separated][;]
- [2.] [has not been party to an action or proceeding for divorce or annulment within the last six months, or has been a party to such an action or proceeding and at least six months have elapsed since the date of the judgment terminating the marriage][;]
- [3.] [Is not currently registered in a Domestic Partnership with a different Domestic Partner and has not been in such a relationship for at least six months][;]
- [4.] [occupies the same residence as the [Employee]][;]
- [5.] [has not entered into a Domestic Partnership relationship that is temporary, social, political, commercial or economic in nature][;] [and]
- [6.] [has entered into a Domestic Partnership Arrangement with the [Employee]].]

[Domestic Partnership Arrangement] means the [Employee] and another person of [the same] [or] [the opposite] sex has any three of the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

1. joint lease, mortgage or deed;
2. joint ownership of a vehicle;
3. joint ownership of a checking account or credit account;
4. designation of the Domestic Partner as a beneficiary for the employee's life insurance or retirement benefits;
5. designation of the Domestic Partner as a beneficiary of the employee's will;
6. designation of the Domestic Partner as holding power of attorney for health care; or
7. shared household expenses].]

Eligibility Waiting Period means the period of time that must lapse before an [Employee][,] [Dependent] [or Domestic Partner] is eligible for insurance under this Certificate. It will be extended by the number of days the [Employee][,] [Dependent] [or Domestic Partner] is not in Active Service. We will not pay benefits for a Specified Critical Illness that begins during the Eligibility Waiting Period or a Health Screening performed during such period.

[Provide **Evidence of Insurability** means a[n] [Employee][,] [and] [Dependent] [Domestic Partner] [Covered Person] must [upon request and at their expense]:

- [1.] complete and sign our [enrollment] [health and medical history] form[;]
- [2. sign our form authorizing us to obtain information about his health and other insurance coverage;
 1. provide any additional reasonable information about his insurability that we request; and
 2. undergo a physical examination and testing at our request].]

End Stage Renal Disease (Kidney Failure) means end stage renal disease presenting as chronic, irreversible failure of one or both of kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemodialysis or peritoneal dialysis (at least weekly); or result in kidney transplantation. End stage renal disease is covered, provided it is not caused by a traumatic event, including surgical traumas.

The diagnosis of end stage renal disease must be based on chronic irreversible failure of the function of at least one kidney requiring regular hemodialysis or necessitating a kidney transplant.

[Guarantee Issue Benefit Amount] means the maximum Benefit Amount available to a Covered Person without providing Evidence of Insurability].

He, him or his means an individual, male or female.

Hospital means an institution that meets all of the following:

1. it is licensed pursuant to applicable law; it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
2. it is managed under the supervision of a staff of legally licensed physicians;
3. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);

4. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
5. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent or custodial care;
2. the aged.

Illness means a bodily disorder or disease that:

1. is first manifested while the Covered Person is insured under this Certificate, and after any applicable Eligibility Waiting Period;
2. is not subject to the Pre-Existing Condition Limitation; and
3. is not otherwise excluded under the terms of this Certificate.

Loss of Sight, Speech, or Hearing means the irreversible loss of sight in both eyes, the irreversible loss of the ability to speak, or the irreversible loss of hearing for all sounds in both ears.

The diagnosis of:

1. Loss of Sight, Speech, or Hearing must be made by a licensed professional or specialist in the applicable field of medicine.
2. Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 200 degrees in both eyes.
3. Loss of Speech must include documented evidence of the illness for the continuous 12- month period prior to the Diagnosis.
4. Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

This term does not include animal to human transplants; transplants of human to human organs other than a human heart, lung, liver, kidney, or pancreas; tissue transplants (corneas, skin, heart valves, bone, tendons, ligaments, cartilage and bone marrow), or a human to human transplant of a uterus, face or hand.

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. The diagnosis must include at least three of the following criteria:

1. new and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction.
2. elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. chest pain.

Open Enrollment Period means a period of time agreed upon by the [Policyholder] and the Company, during which an [Employee] may apply for insurance.

Paralysis means complete and permanent loss of function of two or more limbs. Paralysis as a result of stroke is excluded. The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis. As used herein “limb” means an arm or leg.

Pathologist means a Physician, other than a Covered Person or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Physician or Doctor means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. employed or retained by the [Policyholder]; or
2. living in the Covered Person’s household; or
3. a parent, sibling, spouse[,] [Domestic Partner] or child of the Covered Person.

[Plan] Year or annual or annually means a period of twelve consecutive months beginning on the Certificate Effective Date and subsequent Anniversary Dates.

[Policyholder] means the entity shown on the cover page of this Certificate.

Specified Critical Illness means such illness shown in the *Schedule of Benefits* and as defined in this Certificate.

Stroke means a cerebrovascular incident caused by: infarction of brain tissue; cerebral hemorrhage; thrombosis, or embolization from an extra-cranial source lasting more than [24] hours that produces measurable evidence of permanent neurological deficit.

The following are not considered Strokes:

1. Transient Ischemic Attacks (TIAs)
2. Vertebro-Basilar Insufficiency
3. Incidental Findings on imaging studies
4. Head injury
5. Chronic cerebrovascular insufficiency
6. Reversible ischemic neurological deficits

“Transient Isechemic Attack (TIA)” means a neurological condition or event with the signs and symptoms of a stroke, but which disappear within a short period of time with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.

ELIGIBILITY, EFFECTIVE DATE, TERMINATION AND CONTINUATION PROVISIONS

Certificate Effective Date

We agree to provide Critical Illness Insurance Benefits described in this Certificate in consideration of the [Policyholder]'s payment the premium when due. Insurance coverage begins on the Certificate Effective Date shown on this Certificate's first page as long as the Minimum Participation requirement shown in the *Schedule of Benefits* has been satisfied.

[Effective Date for Newly-Acquired Affiliates

Insurance becomes effective for any newly-acquired affiliate of the [Policyholder] on first of the month following the date it is acquired if we have been notified in writing within the time period specified in the *Schedule of Affiliates*, have agreed to provide insurance, and have received any additional premium due. If we are not so notified, insurance for the Affiliate will become effective on the first of the month following the date we agree in writing to insure it and receive any additional premium due. Individuals who are [Employee]'s of an Affiliate on its effective date of insurance under this Certificate will be eligible for insurance on that date.]

Eligibility

An [Employee][,][Dependent] [or][Domestic Partner] is eligible provided:

1. they meet the applicable definition shown in *Definitions*; and
2. they have completed the Eligibility Waiting Period, if any; and
- [3. in the case of an [Employee][,][Dependent spouse] [or] [Domestic Partner] they are under age 70 [on the Effective Date of the Certificate] [date they complete the Eligibility Waiting Period]; and]
- [4.] they meet the definition of Active Service in *Definitions*.

No person is eligible for insurance under this Certificate as both an [Employee][,] [Dependent] [or Domestic Partner] at the same time.

Effective Date

The Effective Date of the Certificate is shown on the applicable cover page.

An eligible [Employee]'s insurance becomes effective on the [day] [first of the month] following the date he[:]

- [1.] submits a complete enrollment form, if any [and we approve that form]; and]
- [2.] has paid the required first contribution, if any].

An eligible Dependent's [or Domestic Partner]'s insurance becomes effective on the [day] [first of the month] following the date the [Employee] first becomes insured[, or the [day] [first of the month] following the date the person becomes eligible, if later][, provided[:]

- [1.] [a completed enrollment form, if any, is submitted for the Dependent [and we approve that form][;] [and]
- [2.] [the [Employee] has paid the required first contribution, if any, for the Dependent's coverage.

If either the [spouse] [or Domestic Partner] is eligible as an [Employee] the dependent children may be covered under only one [Employee].

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have no dependent children;

1. both will be insured as Covered Persons when a Covered Person is not required to contribute to the cost of his insurance; and
2. both may be insured as Covered Persons or one may elect to insure the other as a Dependent when a Covered Person is required to contribute to the cost of his insurance.

If both of the [spouses] [or Domestic Partners] are eligible as an [Employee] and have dependent children;

1. both will be insured as Covered Persons and dependent coverage will be provided via only the parent whose birthday occurs first during a Plan] Year, when an [Employee] is not required to contribute to the cost of his Dependents' insurance; and
2. both may be insured as an [Employee] but only one may elect dependent coverage to insure dependent children, when an [Employee] is required to contribute to the cost of his dependents' insurance.

A [spouse] [or Domestic Partner] that does not meet the definition of [Employee], or a dependent child may be insured as a Dependent provided one [spouse] [or Domestic Partner] meets the definition of [Employee] shown in *Definitions*.

[Newborn children of an [Employee] or spouse are automatically covered from birth provided we receive notification within 31 days after the birth of the newborn. [Foster children [and other children living with the [Employee] or spouse in a parent child relationship] are eligible for coverage on the same basis upon placement in the home.]

[A child adopted by, or placed for adoption with, or who are a party in a suit for adoption by an [Employee] or spouse is covered automatically from birth provided we receive notification within 31 days after the birth of the newborn.]

Deferred Effective Date

The effective date of insurance will be deferred for any [Employee] who is not in Active Service on the [day] [first of the month] following the date he would otherwise have become eligible.

Coverage will become effective on the later of the [day] [first of the month] following the date he returns to Active Service and the [day] [first of the month] following the date coverage would otherwise have become effective.

Late Enrollee

A person will be considered a late enrollee if he does not apply for insurance within 31 days of the [day] [first of the month] following the date he is first eligible.

[Coverage for any late enrollee will become effective on the [day] [first of the month] following the date he [enrolls] [completes a [30] [60] [90] [120] [180] day late enrollee waiting period] [and submits the required premium].]

[If a person does not apply for insurance within 31 days of the date he is first eligible, he must provide satisfactory Evidence of Insurability to become insured. Coverage for any late enrollee will become effective on the [first] day [of the month coinciding with or next] following the date we approve such person's Evidence of Insurability.]

[If a person does not apply for insurance within 31 days of the date he is first eligible, he must wait until the [Policyholder]'s next Open Enrollment Period. Coverage for any late enrollee will become effective on the date specified by the [Policyholder].]

Effective Date of Changes

Any increase or decrease in the amount of insurance for the Covered Person resulting from a change in benefits provided by this Certificate or a change in the [Employee]'s Covered Class will take effect on the [day] [first of the month] following the date of such change. Increases will take effect subject to any Active Service and Evidence of Insurability requirement.

Termination of Insurance

Please read the *Continuation of Coverage* section of this Certificate for information on continuation after eligibility for coverage would otherwise end.

The insurance on a Covered Person will end on the earliest date below:

1. first of the month following the date this Certificate or insurance for a Covered Class is terminated;
2. the [day] [next premium due date after first of the month] following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Certificate;
- [3.] [the [day] [next premium due date after first of the month] following the date the Covered Person attains age 70;]
- [4.] the last day of the last period for which premium is paid;
- [5.] the end of any period of continuation, as provided in the *Continuation of Coverage*; and
- [6.] with respect to an Eligible Dependent, the [day] [first of the month] following the date of the death of the Covered [Employee] or the [day] [first of the month] following the date of divorce from the Covered [Employee][, or termination of a Domestic Partnership Arrangement].

Termination will not affect a Specified Critical Illness Diagnosed or Health Screening incurred after the Eligibility Waiting Period while coverage was in effect.

Continuation of Coverage

If a Covered Person's insurance terminates for any reason other than non-payment of any required premium when due or termination of this Certificate, such person may elect to continue coverage under this Certificate provided he has not attained age 70. To elect continued coverage, the Covered Person must[:

- [1.] [have been continuously insured for at least [6] [12] [24] months under this Certificate and/or any plan it replaced just before the date their insurance terminates; and]
- [2.] make the election within 31 days of termination and pay all required premiums for the continued coverage.

Continued coverage is subject to all of the provisions and limitations of this Certificate. The premium rate charged for the continued coverage will be 105% of the rate charged to the [Policyholder] for the coverage under this Certificate based on the Covered Person's age at the time he elects to continue coverage.

Premiums for continued coverage will be collected from the terminated individual on a quarterly, semi-annual or annual basis, as elected by the Covered Person.

Coverage continued under this provision will end when [the Certificate terminates][,] [the date such person attains age 70] or the last period for which premium is paid[, whichever occurs first].

Specified Critical Illness Benefit

We will pay this benefit if a Covered Person is diagnosed with one of the Specified Critical Illnesses shown in the *Schedule of Benefits* provided:

1. The first occurrence and the Date of Diagnosis are after the Eligibility Waiting Period; and
2. The Date of Diagnosis is while the Certificate is in force; and
3. It is not excluded by name or specific description in this Certificate.

[If the Date of Diagnosis of a Specified Critical Illness occurs during the Eligibility Waiting Period, the Certificate may be returned for a full refund of premium.]

The Benefit Amount is shown in the *Schedule of Benefits*. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.] Specified Critical Illness Benefits will be based on the Benefit Amount in effect when the loss begins. No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.

We will figure the benefits for each Specified Critical Illness by multiplying A times B minus C, where:

- A = The Benefit Amount in effect for the Covered Person's attained age when the loss begins.
- B = The Percentage Payable shown in the *Schedule of Benefits* for the applicable Specified Critical Illness and Covered Person's attained age.
- C = Any partial benefits paid for that Specified Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first Specified Critical Illness has been diagnosed unless the Date of Diagnosis is separated from the prior Specified Critical Illness by at least [30] [60] [90] [180] days [or in the case of Invasive Cancer, Carcinoma in Situ or Skin Cancer 12 months free of treatment].
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the Dates of Diagnosis are separated by at least [6] [9] [12] months.

[Health Screening Benefit

Subject to the terms and conditions of this Certificate we will pay the benefit shown in the *Schedule of Benefits* for Health Screening Benefits incurred by a Covered Person. [If the *Schedule of Benefits* shows a Reduction Schedule any benefit payable after the attained age will be reduced by the rate shown in Reduction Schedule.]

We will pay this benefit for the following Health Screening Tests performed after the Eligibility Waiting Period and while this Certificate is in force. The amount we will pay per screening and number of screenings we will pay per Plan Year is shown in the *Schedule of Benefits*. Payment of this benefit will not reduce the Benefit Amount.

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill or the use of medication,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),

9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,
14. Mammography,
15. Pap test,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography,
19. Skin review by a dermatologist.

There is no limit to the number of years a Covered Person can receive benefits for Health Screening Tests, as long as this Certificate is in force.

We will pay this benefit regardless of a supporting Diagnosis or the results of the test.

No benefits are payable for any Covered Person until the Eligibility Waiting Period has been completed.]

LIMITATIONS AND EXCLUSIONS

Limitations

1. Eligibility Waiting Period - No benefits are payable for any [Employee][,] [or] [Dependent] [or] [Domestic Partner] until the Eligibility Waiting Period shown in the *Schedule of Benefits* has been completed. If first diagnosed during the Eligibility Waiting Period, the Pre-Existing Condition Limitation will apply to any loss from that diagnosis. [At the [Policyholder]'s option, you may elect to void any coverage applied for and receive a full refund of premium. Any such request must be in writing and made prior to the end of the Eligibility Waiting Period.]
2. Pre-Existing Conditions - We will not pay benefits for any condition or illness starting within [3] [6] [12] months of the [Effective Date of the Certificate] [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] which is caused by, contributed to, or resulting from a Pre-Existing Condition. A claim for benefits for loss starting after 12 months from the Effective Date of the Certificate [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] will not be reduced or denied on the grounds that it is caused by a Pre-Existing Condition.

A condition will no longer be considered Pre-Existing at the end of 12 consecutive months starting and ending after the Effective Date of the Certificate [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance].

"Pre-Existing Condition" means a sickness or physical condition which, within the [3] [6] [12] month period prior to the Effective Date of the Certificate [effective date of an [Employee's][,] [or] [Dependent's] [or] [Domestic Partner's] insurance] resulted in an insured receiving medical advice or treatment.

"Treatment" means consultation; care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

[3. Reduction Schedule - The Benefit Amount [and Guarantee Issue Benefit Amount] payable for a Specified Critical Illness will be reduced by 50% if an Covered Person is age 70 or older on the date the benefit becomes payable. "Age" means the age of the Covered Person on such person's most recent birthday, regardless of the actual time of birth.]

Exclusions

We will not pay for:

1. Loss due to an accident, or any benefit for a diagnosis caused or contributed to by an accident. This includes any treatment received or expenses incurred for an accidental injury
2. Any benefit for a diagnosis the results in an experimental procedure, service or treatment, or a loss due to an experimental procedure, service or treatment;
3. Loss due to suicide or any attempt or threat to commit suicide, while sane or insane, or any intentionally self-inflicted injury or sickness;
4. Loss due to participation in a riot, civil commotion, civil disobedience, insurrection or unlawful assembly, unless a loss that occurs while a Covered Person is acting in a lawful manner within the scope of authority;
5. Loss due to committing, attempting to commit, or taking part in a felony or assault;
6. Loss due to the Covered Person being legally intoxicated as determined according to the laws of the United States of America;
7. Any benefit for a diagnosis of an illness resulting from the use of a controlled substance, or misuse of legal or illegal drugs, by a Covered Person that is not rendered by or at the direction of a Physician or Doctor;
8. Loss due to an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes an accidental injury or sickness contracted while in the service of any military, naval or air force of any country engaged in war (the Company will refund the pro rata unearned premium for any such period the Covered Person is not covered);
9. Loss due to an accident or sickness arising out of and in the course of any occupation for compensation, wage or profit or expenses which are payable under Workers' Compensation, Occupational Disease or similar law, whether or not application for such benefits has been made;
10. Any benefit for a diagnosis rendered by or at the direction of a Physician or Doctor during a period of time that insurance for a Covered Person is not in force;
11. Any benefit for a diagnosis rendered by or at the direction of a Physician or Doctor after this Certificate has terminated;
12. Any diagnosis not rendered by or at the direction of a Physician or Doctor, or that is inconsistent with standards of medical practice for the applicable condition;
13. Benefits for a diagnosis rendered by or at the direction of a Physician or Doctor outside the United States or Canada;
14. Transportation; or
15. Benefits for a diagnosis rendered by any person who is:
 - a. employed or retained by the [Policyholder];
 - b. living in the Covered Person's household;
 - c. a parent, sibling, spouse[,] [Domestic Partner] or child of a Covered [Employee] or of His spouse;
or

- d. a Covered Person diagnosing himself.

CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic/telephonic notice of claim must be given to us within 31 days after a Specified Critical Illness is Diagnosed or a Health Screening is performed or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent. Notice should include the [Policyholder]'s name, and the Covered Person's name, address, and [Policy] [Certificate] Number.

Claim Forms

We will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not sent within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Certificate for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Proof of Loss

Written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized agent within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable.

If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

[Notice of Decision

We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific certificate provisions, rules or guidelines on which the denial was based;

3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;
2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific certificate provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours.]

Time of Payment of Claims

We will pay benefits due under this Certificate for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under this Certificate, unless otherwise stated, will be payable to the Covered Person or to his estate.

If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to \$1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

Claimant Cooperation Provision

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Claim Administration

For plans subject to the Employee Retirement Income Security Act (ERISA), the plan administrator of the employer's employee welfare benefit plan (the plan) has selected us as the plan fiduciary under federal law for the review of claims for benefits provided by this Certificate and for deciding appeals of denied claims. In this role we shall have the authority, in our discretion, to interpret the terms of plan documents, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact.

All decisions made by us in this capacity shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

We will have no fiduciary responsibility with respect to the administration of the plan except as described above. It is understood that our sole liability to the plan and to participants and beneficiaries under the plan shall be for the payment of benefits provided under this Certificate.

We may contract with another entity to perform this function on our behalf.

Payment of Claims to Foreign [Employees]

The [Policyholder] may, in a fiduciary capacity, receive and hold any benefits payable to Covered [Employee]s whose place of employment is other than:

1. the United States and its possessions; or
2. the Dominion of Canada.

We will not be responsible for the application or disposition by the [Policyholder] of any such benefits paid. Our payments to the [Policyholder] will constitute a full discharge of our liability for those payments under this Certificate.

Physical Examination and Autopsy

We, at our own expense, have the right and opportunity to examine the Covered Person when and as often as we may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions

No action at law or in equity may be brought to recover under the Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Certificate. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Certificate.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

[Additional Coverage with the Company]

We will only pay benefits for covered Illness, Condition or Procedure under one Specified Illness, Condition or Surgical Procedure Policy or Certificate if a Covered Person is covered by more than one of our Specified Illness, Condition or Surgical Procedure Policies or Certificates. A Covered Person may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Specified Illness, Condition or Surgical Procedure Policies or Certificates during the period there was more than one Policy or Certificate in force.]

Unpaid Premium - When a claim is paid, any premium due and unpaid by the [Policyholder] may be deducted from the claim payment.

ADMINISTRATIVE PROVISIONS

Cancellation

We or the [Policyholder] may cancel the coverage provided by this Certificate, after the first year as of any Premium Due Date, by giving the other party [31] [45] [60] [90] [120] [180] days advance written notice.

If a premium is not paid by the [Policyholder] when due, we will cancel this Certificate at the end of the last period for which premium was paid, subject to the Grace Period provision. The [Policyholder] has the sole responsibility to notify Covered Person's of such termination.

Grace Period

The [Policyholder] will be granted a Grace Period of [30] [31] [60] [90] days for payment of required premiums due after the first premium, unless:

1. we do not intend to renew the coverage provided by this Certificate beyond the period for which premium has been accepted; and
2. written notice of our intention not to renew is delivered to the [Policyholder] at least [30] [45] [60] [90] [120] [180] days before the premium is due.

This Certificate will be in force during the Grace Period. If the required premiums are not paid by the [Policyholder] during the Grace Period, insurance will end on the last day of the Grace Period. The [Policyholder] is liable to us for any unpaid premium for the time this Certificate was in force.

If a Covered Person's insurance under this Certificate is being continued under Continuation of Coverage, such person will be granted an individual Grace Period of 31 days for payment of required premiums due.

If the required premiums are not paid by the Covered Person during the individual Grace Period, such person's insurance will end on the last day of the individual Grace Period. A Covered Person's insurance under this Certificate will remain in force during the individual Grace Period. The Covered Person is liable to us for any unpaid premium for the time their coverage under this Certificate is being continued under Continuation of Coverage.

We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Certificate will be based on the rates, agreed to by the [Policyholder] or subsequently changed, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected by the [Policyholder]. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the [Policyholder].

Premium Payment

The total premium for the insurance provided by this Certificate is the sum of premiums paid:

1. by the [Policyholder] for all Covered Persons other than those described in (2) below, including any amounts contributed toward the cost of this coverage by Covered Persons; and
2. by Covered Persons who remain eligible for coverage under the *Continuation of Coverage* provision of this Certificate.

If any premium is not paid when due, this Certificate will be cancelled as of the Premium Due Date of the unpaid premiums, except as provided in the Grace Period provision.

Changes in Premium Rates

We may change the premium rates from time to time with at least 60 days advance written notice to the [Policyholder]. No change in rates will be made until 12 months after the initial effective date of the coverage provided by this Certificate. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

1. the terms of this Certificate change;
2. the number of [Employee]s eligible for coverage increases or decreases by more than 10% since the latter of the initial effective date and the date of the last renewal of the coverage provided by this Certificate;
3. coverage is reinstated following failure to pay premium during the Grace Period;
4. acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of eligible individuals;
5. a change in the number of eligible individuals which would, on a manual rate basis, require a change of 10% or more in the premium rate;
6. a change in any federal or state law or regulation is enacted, adopted or amended to the extent that it affects our benefit obligations under this Certificate; or
7. the [Policyholder] fails to provide sufficient information, as required by us, to confirm adequacy of premiums and rates currently being paid.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro-rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit

We will have the right to audit books and records of the [Policyholder] at its place of business and during regularly-scheduled business hours, in order to determine the accuracy of premium paid.

GENERAL PROVISIONS

Entire Contract; Changes

The Policy [and this Certificate], including [application (if any)][,] [individual enrollment forms (if any)][,] endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in the Policy [or this Certificate] will be valid until approved by one of our executive officers and endorsed on or attached to the Policy or this Certificate. No agent has authority to change the Policy [or this Certificate], or to waive any of the Policy's [or Certificate's] provisions.

Misstatement of Age

If an age has been misstated on the enrollment form the Benefits will be those the premium paid would have purchased at the correct age.

Certificates

Where required by law, we will provide a Certificate of Insurance for delivery to the Covered Person. Each Certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment

The rights and benefits under this Certificate may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his insurance should see the [Policyholder] for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's insurance (including an assignment on a form furnished by us or by the [Policyholder]).

Incontestability

1. [Policyholder]

All statements made by the [Policyholder] to obtain the coverage provided by this Certificate are considered representations and not warranties.

No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of the coverage provided by this Certificate unless a copy of the instrument containing the statement is, or has been, furnished to the [Policyholder]. After two years from the initial effective date of the coverage provided by this Certificate, no such statement will cause the coverage provided by this Certificate to be contested except for fraud.

2. Covered Person

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from a Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud.

Reporting Requirements

The [Policyholder] or its authorized agent must report all of the following to us by the premium due date:

1. the number of persons insured on the Certificate Effective Date;
2. the number of persons who are insured after the Certificate Effective Date;
3. the number of persons whose insurance has terminated;
4. any additional information required by us.

Clerical Error

A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Certificate. If such error or delay is found, we will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that applies to this Certificate are automatically changed to satisfy the minimum requirements of such laws.

Compensation Insurance

This Certificate is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.