

SERFF Tracking Number: MGCC-125600858 State: Arkansas  
Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 38681  
IC  
Company Tracking Number: 25915-IP AR  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other  
Product Name: 2008 Ancillary Enhancements  
Project Name/Number: /

## Filing at a Glance

Company: The Mega Life and Health Insurance Company - IC

Product Name: 2008 Ancillary Enhancements SERFF Tr Num: MGCC-125600858 State: ArkansasLH

TOI: H111 Individual Health - Disability Income SERFF Status: Closed State Tr Num: 38681

Sub-TOI: H111.004 Other Co Tr Num: 25915-IP AR State Status: Approved-Closed

Filing Type: Form/Rate

Co Status:

Reviewer(s): Rosalind Minor

Authors: Courtney Andre, Kathleen Disposition Date: 04/21/2008

Allen

Date Submitted: 04/09/2008

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/21/2008

State Status Changed: 04/21/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The above referenced forms are being submitted for review and approval. These forms are new and not intended to replace any forms currently approved by your Department.

This is a Disability Income plan that will pay a specified benefit amount for disabilities resulting from injury or sickness. There will be an Elimination period, however the Elimination period may be waived following a hospital confinement

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meeting certain requirements listed in the policy.

Form number 25917-IR is a rider that will provide a waiver of premium benefit.

The bracketed items allow for the insured to customize benefits, or gives us flexibility to provide less administrative restrictions. The information enclosed in brackets is our standard for your state. At no time will this bracketed information be arranged in such a way as to violate the laws of your state.

To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

The Actuarial Memorandum and rates along with the appropriate certifications for this submission have been attached.

## Company and Contact

### Filing Contact Information

Kathleen Allen, Compliance Analyst III kathleen.allen@healthmarkets.com  
 9151 Boulevard 26 (817) 255-3590 [Phone]  
 North Richland Hills, TX 76180 (817) 255-8153[FAX]

### Filing Company Information

The Mega Life and Health Insurance Company CoCode: 97055 State of Domicile: Oklahoma  
 - IC  
 9151 Boulevard 26 Group Code: 264 Company Type: Health  
 North Richland Hills, TX 76180 Group Name: State ID Number:  
 (817) 255-3100 ext. [Phone] FEIN Number: 59-2213662  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: 1 rate filing=\$50.00

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1 policy form filing=\$50.00  
\$50.00 rate filing+\$50.00 policy form filing=\$100.00  
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Mega Life and Health Insurance Company - IC	\$100.00	04/09/2008	19388971

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/21/2008	04/21/2008

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## Disposition

Disposition Date: 04/21/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Disability Income Insurance Policy	Approved-Closed	Yes
<b>Form</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form</b>	Waiver of Premium Benefit Rider	Approved-Closed	Yes

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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	25915-IP AR	Policy/Cont	Disability Income ract/Fratern Insurance Policy al Certificate	Initial			25915-IP AR.pdf
Approved-Closed	25915-IP OC AR	Outline of Coverage	Outline of Coverage	Initial			25915-IP OC AR.pdf
Approved-Closed	25917-IR	Policy/Cont	Waiver of Premium ract/Fratern Benefit Rider al Certificate: Amendment, Insert Page, Endorsement or Rider	Initial			25917-IR.pdf

**PREMIUM RATES MAY BE CHANGED ON A CLASS BASIS  
GUARANTEED RENEWABLE TO AGE 65, SUBJECT TO THE TERMINATION OF  
COVERAGE PROVISION**

**THE MEGA LIFE AND HEALTH INSURANCE COMPANY**

A Stock Company  
(Hereinafter called: the Company, We, Our or Us)  
Home Office: Oklahoma City, Oklahoma  
Administrative Office: P.O. Box 982010  
North Richland Hills, Texas 76182-8010  
Customer Service: 1-800-527-5504

**DISABILITY INCOME INSURANCE POLICY**

We agree to pay benefits according to the provision of this Policy, subject to the definitions, conditions, exclusions and limitations of this Policy. This Policy is issued in consideration of the attached application and payment of the Initial Premium.

**IMPORTANT NOTICE**

The attached application is a part of this Policy. Please read it and check it carefully. This Policy is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect application may cause Your coverage to be voided, or a claim to be reduced or denied.

**10 DAY RIGHT TO EXAMINE THIS POLICY**

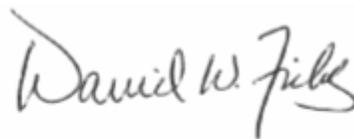
It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your Policy as of the Issue Date, refund all premiums paid and treat this Policy as if it were never issued.

**RENEWABILITY**

This Policy is guaranteed renewable to age 65, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of this Policy. The Company reserves the right, subject to 31 days prior written notice to the Policyholder, to change the applicable table of premium rates on a Class Basis. Any change in rates will be effective on the next following Premium Due Date. Rates are scheduled according to Attained Age. Please read the Premium Changes provision of this Policy carefully. The premium for this Policy may change in amount by reason of an increase in Your Attained Age or occupation.



SECRETARY



PRESIDENT

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**POLICY SCHEDULE**

POLICYHOLDER:

POLICY NUMBER:

ISSUE DATE:

INITIAL PREMIUM:

MODE OF PAYMENT:

**SCHEDULE OF BENEFITS**

**MONTHLY TOTAL DISABILITY BENEFITS**

Elimination Period [21 days]  
(waived for Hospital Confinement of [5][7] days)

Monthly Indemnity Benefit [\$500] / [\$1,000] / [\$1,500] / [\$2,000]

Maximum Period Payable for each  
Period of Total Disability [36 months]

**RIDERS**

**WAIVER OF PREMIUM RIDER**

## DEFINITIONS

**Actively at Work** means You are:

1. working on a permanent basis at least 25 hours per week; and
2. performing the material and substantial duties of Your regular job or any other job for which You are qualified by reason of education, training or experience.

**Attained Age** means Your age on the most recent Policy anniversary.

**Beneficiary** means the person(s) or legal entity You name in the application to receive the Survivor Benefit shown in this Policy.

**Class Basis** means the classification by which Your rates are determined. We will not and cannot change the rates on this Policy unless rates are changed on all Policies issued on the same Class Basis.

**Confined/Confinement** means Your Medically Necessary admission to and subsequent continued stay in a Hospital as an overnight bed patient and a charge for room and board is made.

**Elimination Period** means the consecutive period of time beginning from the date in which You are considered Totally Disabled before the Monthly Indemnity Benefit is payable. The Elimination Period is shown in the POLICY SCHEDULE.

**Hospital** means an institution operated pursuant to its license for the care and treatment of sick and injured persons for which a charge is made that the Insured Person is legally obligated to pay. The institution must:

1. maintain on its premises or in facilities available to the Hospital on a prearranged basis, organized facilities for medical, diagnostic and surgical care for sick and injured persons on an inpatient basis;
2. maintain a staff of one or more duly licensed Physicians;
3. provide 24 hour nursing care by or under the supervision of a registered graduate professional nurse (R.N.); and
4. is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

The term "Hospital" does not include a convalescent, nursing, rest or rehabilitative facility; a home for the aged; a facility for the care and treatment of drug addicts and alcoholics; or a special ward, floor or other accommodation for convalescent, nursing, rehabilitation, ambulatory or extended care purposes; or hotel units, residential annexes or nurse administered units in or associated with a hospital.

**Immediate Family** means Your spouse, parent, son, daughter, brother or sister.

**Injury** means bodily harm caused by an accident resulting in unforeseen trauma requiring immediate medical attention and is not contributed to, directly or indirectly, by disease. The Injury must occur after the Issue Date and while this Policy is in force.

**Issue Date** means the date this Policy becomes effective.

**Maximum Period Payable for each Period of Total Disability** means the maximum number of months for which benefits are payable under this Policy and its Riders, if any, for any one Period of Total Disability. The Maximum Period Payable for each Period of Total Disability is shown in the POLICY SCHEDULE.

**Medically Necessary or Medical Necessity** means that a service or supply is necessary and appropriate for the diagnosis or treatment of an Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

1. it is provided only as a convenience to the You or Your provider;
2. it is not appropriate treatment for Your diagnosis or symptoms;
3. it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. it is Experimental or Investigational Medicine.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

**Mental or Nervous Disorder** means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder, including but not limited to neurosis, psychoneurosis, psychopathy, psychosis, bipolar Affective Disorder or Autism. Mental or Nervous Disorder does not include Alzheimer's disease or similar forms of dementia resulting from degenerative diseases, stroke, head trauma or viral infection.

**Monthly Indemnity Benefit** means the amount that We will pay for any full month of Total Disability. The Monthly Indemnity Benefit will be the lesser of:

1. the Monthly Indemnity Benefit shown in the POLICY SCHEDULE; or
2. Your Prior Monthly Income.

**Period of Total Disability** means the period of time during which You are Totally Disabled.

**Physician** means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license. (A member of Your Immediate Family will not be considered a Physician.)

**Policyholder** means You, the person to which this Policy is issued.

**Pre-Existing Condition** means a medical condition, Sickness or Injury not excluded by name or specific description for which:

1. medical advice, Consultation, or treatment was recommended by or received from a Physician within the two year period before the Issue Date; or
2. symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the two year period before the Issue Date.

**Prior Monthly Income** means Your average monthly income over the last 12 months or the last calendar year, whichever is greater.

**Sickness** means an illness or disease which first manifests itself after the Issue Date and while this Policy is in force.

**Total Disability or Totally Disabled** means that due to Sickness or Injury, You are:

1. under a Physician's care; and
2. unable to engage in any employment or occupation for which You are qualified by reason of education, training or experience and are not in fact Actively at Work, as certified by a Physician upon Our request.

**We, Us and Our** means The MEGA Life and Health Insurance Company.

**You, Your, Yours** means the Policyholder named in the Policy Schedule whose coverage under this Policy has become effective and has not terminated.

## **EFFECTIVE DATE OF COVERAGE**

### **Beginning of Coverage**

We require evidence of insurability before coverage is provided. Once We have approved Your application based upon the information You provided therein, the effective date of Policy will be the Issue Date shown in the POLICY SCHEDULE.

### **PREMIUMS**

#### **Premium Due Date**

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, semi-annually or annually, as indicated in the POLICY SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period provision. Any indebtedness of the Policyholder to Us arising out of prior claims may be deducted in any settlement under this Policy.

#### **Grace Period**

There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31 day grace period, We may cancel this Policy without further notice. During the grace period, this Policy will remain in force; however, We are not obligated to pay any claims incurred by You during the grace period until the premium due is received. The grace period and any coverage under this Policy will not apply if We receive written notice from You that this Policy is to be terminated or if this Policy otherwise terminated due to events other than failure to pay premiums as provided in the TERMINATION OF COVERAGE provision.

#### **Premium Changes**

We reserve the right to change the table of premiums, on a Class Basis, becoming due under this Policy at any time and from time to time; provided, We have given the Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for this Policy may change in amount by reason of an increase in Your Attained Age or occupation.

#### **Unearned Premiums Refund**

Upon the death of an Insured Person, the proceeds payable to the Insured Person or his/her estate shall include premiums paid for insurance coverage for the period beyond the end of the month in which the death occurred. Unearned Premiums shall be paid in a lump sum payment no later than thirty (30) days after the proof of the Insured Person's death has been furnished to Us.

## **TERMINATION OF COVERAGE**

### **You**

Your coverage will terminate and no benefits will be payable under this Policy and the attached Riders, if any:

1. At the end of the period for which premium has been paid subject to the Grace Period;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage;
6. On the date We elect to discontinue all coverage in Your state;
7. On the date You are no longer a permanent resident of the United States; or
8. Upon Your attainment of age 65.

Termination of coverage will be without prejudice to any claim arising prior to the date of termination. If We accept any premium for coverage extending beyond the date for termination, coverage will continue during the period for which a premium has been accepted, except as provided in the Age or Occupation Misstatement provision.

### **Reinstatement**

As stated above, this Policy terminates at the end of the period for which premium has been paid, subject to the Grace Period. If We require an application for reinstatement. The reinstatement will not become effective unless We approved such application; or, lacking such approval, on the 45<sup>th</sup> day after the date of such application unless We previously notify You, in writing, of Our disapproval of the application. We will advise You of the effective date of reinstatement by giving You written notice of the date, by issuing You an amended Policy or by issuing You a new Policy. In any case, the reinstated coverage provides benefits only for a Total Disability due to an Injury occurring after the effective date of reinstatement or due to a Sickness commencing more than 10 days after such date; subject to the Elimination Period.

### **BENEFITS**

Unless otherwise stated herein, all Monthly Total Disability benefits are subject to:

1. The Elimination Period shown in the POLICY SCHEDULE, except as shown below in the Waiver of Elimination Period provision;
2. The Schedule of Benefits shown in the POLICY SCHEDULE;
3. The EXCLUSIONS AND LIMITATIONS; and
4. All other provisions of this Policy.

### **MONTHLY TOTAL DISABILITY BENEFIT**

Monthly Total Disability benefits are payable under this Policy if You become Totally Disabled while You are insured under this Policy and are Actively at Work. Your Monthly Indemnity Benefit will begin on the first day following the Elimination Period shown in the POLICY SCHEDULE. Total Disability must commence within 30 days of the Sickness or Injury, which caused Your Total Disability.

The amount that We will pay for any full month of Total Disability will be the lesser of:

1. the Monthly Indemnity Benefit shown in the POLICY SCHEDULE; or
2. Your Prior Monthly Income.

We will pay 1/30 of the Monthly Indemnity Benefit otherwise payable for each day of a Period of Total Disability that is less than a full month.

### **WAIVER OF ELIMINATION PERIOD**

We will waive the Elimination Period shown in the POLICY SCHEDULE for a Total Disability in which You are Hospital Confined for the period of time shown in the POLICY SCHEDULE.

### **RECURRENT DISABILITY**

After a Period of Total Disability for which We paid benefits ends, if You become Totally Disabled again within 6 months from the same or related cause, We will consider it a continuation of the prior Period of Total Disability. If You have been Actively at Work for more than 6 consecutive months between those two Periods of Total Disability, then We will consider it a new Period of Total Disability.

### **CONCURRENT DISABILITY**

If Total Disability is caused by more than one Sickness or Injury, or from both, We will pay benefits as if the Total Disability was caused by only one Sickness or Injury.

## **SURVIVOR BENEFIT**

Upon Your death, We will pay a survivor benefit to Your designated Beneficiary, if:

1. Monthly Total Disability benefits were being paid at the time of Your death; and
2. the Maximum Amount payable for each Period of Total Disability has not been exhausted.

The survivor benefit will be a lump-sum amount equal to three times the Monthly Indemnity Benefit payable under this Policy at the time of Your death. In the event no Beneficiary is named or living, the survivor benefit will be paid:

1. to Your surviving spouse; if none, then
2. equally to Your surviving natural and adopted children; if none; then
3. equally to Your surviving parent(s); if none, then
4. to Your estate.

## **RIGHT OF INSPECTION**

We may require information regarding pre-tax personal income, allowable business expenses, and other plans, including income tax returns, for periods before and after the start of a Period of Total Disability. Failure to provide such information may result in disqualification for benefit payment under this Policy.

## **COORDINATION WITH OTHER COMPENSATION**

The Monthly Indemnity Benefit will be reduced by any of the following You receive during any period of Total Disability for which a Monthly Indemnity Benefit is being paid:

1. Disability benefits paid under any employee benefit plan or arrangement;
2. Income received from any employer paid sick pay plan, retirement plan or pension plan; and
3. Benefits to which You are entitled from Workers' Compensation or any other retirement program, including retirement benefits under the Federal Social Security program.

## **EXCLUSIONS AND LIMITATIONS**

**We will not provide any benefits for any loss caused by or resulting from:**

1. any act of war, declared or undeclared;
2. pregnancy or childbirth;
3. suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
4. Mental or Nervous Disorders;
5. drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a Physician;
6. an overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, unless taken as prescribed by a Physician;
7. engaging in an illegal occupation or illegal activity or Your being incarcerated;
8. travel in or descent from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip; or
9. any condition excluded from coverage by name or specific description.

### **Pre-Existing Condition**

We will not provide benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Issue Date.

## GENERAL PROVISIONS

### Entire Contract

The Entire Contract consists of:

1. this Policy;
2. the application of the Policyholder, which will be attached to this Policy; and
3. any endorsements, amendments or riders attached.

All statements made by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend this Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of this Policy. Any change in this Policy will be made by amendment and signed by Us. Such amendment will not require Your consent.

**Term of Coverage** – The initial term of this Policy begins on the Issue Date as shown in the POLICY SCHEDULE at 12:00 noon, Standard Time of the place where You then reside and ends at 12:00 noon, Standard Time, on the date specified in the Termination of Coverage provision.

### Notice of Claim

Written notice of claim must be given to Us within 20 days, or as soon as reasonably possible. Written notice of claim given by You or on Your behalf to Us with information sufficient to identify You will be considered notice to Us.

### Claim Forms

When We receive the notice of claim, We will send You forms for filing proof of loss. If these forms are not furnished within 15 days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

### Proof of Loss

Written proof of loss must be furnished to Us at Our administrative office in North Richland Hills, Texas, within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

### Claim Payments

We will pay all benefits due under this Policy promptly upon receipt of due proof of loss.

All indemnities will be payable to You. Any accrued indemnities unpaid at Your death may, at Our option, be paid to any beneficiary or to Your estate.

### Physical Examination

We will, at Our own expense, have the right and opportunity to examine You when Your Total Disability is the basis of a claim when and as often as We may reasonably require during the pendency of a claim and to make an autopsy in case of death, unless prohibited by law.

### Legal Action

No action at law or in equity will be brought to recover on this Policy prior to the expiration of 60 days after proof of loss has been filed as required by this Policy; nor will any action be brought after expiration of 3 years after the time written proof of loss is required to be furnished.

### **Age or Occupation Misstatement**

If Your age or occupation has been misstated, Our records will be changed to show the correct age or occupation. The benefits provided will not be affected if You continue to be eligible for coverage at the correct age or occupation. However, premium adjustments, including collection of any premium due Us because of past underpayments, will be made so that We receive the premiums due at the correct age or for the correct occupation payable on the premium due date following Our notification of an age or occupation correction.

### **Incontestability**

After 2 years from the Issue Date, no misstatements, except fraudulent misstatements, made in the application will be used to void the coverage, or deny a claim unless the loss was incurred during the first 2 years following the Issue Date.

No claim for a loss incurred one year after the Issue Date will be reduced or denied as a Pre-Existing Condition.

### **Change of Occupation**

If You become Totally Disabled after changing Your occupation to one classified by Us as more hazardous than that stated in Your application or while doing for compensation anything pertaining to Your classified occupation, all benefits payable are those which the premium paid would have purchased for the more hazardous occupation. If You change Your occupation to one classified by Us as less hazardous than that stated in Your application, We will reduce the premium rate accordingly, upon receipt of proof of change of occupation, and will return the excess pro-rate unearned premium from the date of change of occupation or from the premium due date immediately preceding receipt of proof, whichever is more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been implemented by Us prior to the occurrence of the loss for which We are liable or prior to the date of proof of change in occupation with the state official having supervision of insurance in the state where You resided at the time this Policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by Us in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

### **Conformity**

Any provision of this Policy which, on the Issue Date, is in conflict with the statutes of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

# THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company  
(Hereinafter called: the Company, We, Our or Us)  
Home Office: Oklahoma City, Oklahoma  
Administrative Office: P.O. Box 982010  
North Richland Hills, Texas 76182-8010  
Customer Service: 1-800-527-5504

## DISABILITY INCOME INSURANCE POLICY – Form: 25915-IP AR REQUIRED OUTLINE OF COVERAGE

- A. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- B.** Disability Income coverage is designed to provide You with coverage for disabilities resulting from a covered accident or sickness or combination thereof. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the LIMITATIONS and EXCLUSIONS section.
- C. BENEFITS**

### SCHEDULE OF BENEFITS

#### MONTHLY TOTAL DISABILITY BENEFITS

Elimination Period (waived for Hospital Confinement of [5] [7] days)	[21 days]
Monthly Indemnity Benefit	[\$500] / [\$1,000] / [\$1,500] / [\$2,000]
Maximum Period Payable for each Period of Total Disability	[36 months]

#### MONTHLY TOTAL DISABILITY BENEFIT

Monthly Total Disability benefits are payable under the Policy if You become Totally Disabled while You are insured under the Policy and are Actively at Work. Your Monthly Indemnity Benefit will begin on the first day following the Elimination Period shown in the SCHEDULE OF BENEFITS. Total Disability must commence within 30 days of the Sickness or Injury, which caused Your Total Disability.

The amount that We will pay for any full month of Total Disability will be the lesser of:

1. the Monthly Indemnity Benefit shown in the SCHEDULE OF BENEFITS; or
2. Your Prior Monthly Income.

We will pay 1/30 of the Monthly Indemnity Benefit otherwise payable for each day of a Period of Total Disability that is less than a full month.

#### WAIVER OF ELIMINATION PERIOD

We will waive the Elimination Period shown above for a Total Disability in which You are Hospital Confined for the period of time shown in the SCHEDULE OF BENEFITS.

**RECURRENT DISABILITY**

After a Period of Total Disability for which We paid benefits ends, if You become Totally Disabled again within 6 months from the same or related cause, We will consider it a continuation of the prior Period of Total Disability. If You have been Actively at Work for more than 6 consecutive months between those two Periods of Total Disability, then We will consider it a new Period of Total Disability.

**CONCURRENT DISABILITY**

If Total Disability is caused by more than one Sickness or Injury, or from both, We will pay benefits as if the Total Disability was caused by only one Sickness or Injury.

**SURVIVOR BENEFIT**

Upon Your death, We will pay a survivor benefit to Your designated Beneficiary, if:

- 1. Monthly Total Disability benefits were being paid at the time of Your death; and
- 2. the Maximum Amount payable for each Period of Total Disability has not been exhausted.

The survivor benefit will be a lump-sum amount equal to three times the Monthly Indemnity Benefit payable under this Policy at the time of Your death. In the event no Beneficiary is named or living, the survivor benefit will be paid:

- 1. to Your surviving spouse; if none, then
- 2. equally to Your surviving natural and adopted children; if none; then
- 3. equally to Your surviving parent(s); if none, then
- 4. to Your estate.

**D. EXCLUSIONS AND LIMITATIONS**

**We will not provide any benefits for any loss caused by or resulting from:**

- 1. any act of war, declared or undeclared;
- 2. pregnancy or childbirth;
- 3. suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
- 4. Mental or Nervous Disorders;
- 5. drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a Physician;
- 6. an overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, unless taken as prescribed by a Physician;
- 7. engaging in an illegal occupation or illegal activity or Your being incarcerated;
- 8. travel in or descent from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip; or
- 9. any condition excluded from coverage by name or specific description.

**Pre-Existing Condition**

We will not provide benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Issue Date.

**COORDINATION WITH OTHER COMPENSATION**

The Monthly Indemnity Benefit will be reduced by any of the following You receive during any period of Total Disability for which a Monthly Indemnity Benefit is being paid:

- 1. Disability benefits paid under any employee benefit plan or arrangement;
- 2. Income received from any employer paid sick pay plan, retirement plan or pension plan; and
- 3. Benefits to which You are entitled from Workers' Compensation or any other retirement program, including retirement benefits under the Federal Social Security program.

**E. RENEWABILITY – The Policy is Guaranteed Renewable to Age 65, subject to the Termination of Coverage provision of the Policy, provided the required premium is paid on or before the date it is due subject to a 31 day grace period.**

**F. RIDER BENEFIT**

**Waiver of Premium Benefit Rider** – After You have been continuously Totally Disabled for [90] days, or the Elimination Period, if greater, We will waive premiums on a monthly basis; but only during the period that Total Disability benefits are payable. Your coverage and its benefits will continue during the waiver of premium period.

**G. PREMIUMS -**

We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Insured Person written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

**Premiums** - based on the mode of payment, checked below, the initial premiums are as follows:

- Monthly (Bank Draft)     
  Quarterly     
  Semiannually     
  Annually

Policy 25915-IP AR - described above	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
<b>TOTAL</b>	\$

**THE MEGA LIFE AND HEALTH INSURANCE COMPANY**

A Stock Company  
(Hereinafter called: the Company, We, Our or Us)  
Home Office: Oklahoma City, Oklahoma  
Administrative Office: P.O. Box 982010  
North Richland Hills, Texas 76182-8010  
Customer Service: 1-800-733-1110

**WAIVER OF PREMIUM BENEFIT RIDER**

This Rider is made a part of the Policy to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and any other rider.

**WAIVER OF PREMIUM**

After You have been continuously Totally Disabled for a period of [90 days], or the Elimination Period, if greater, We will waive premiums on a monthly basis; but only during the period that Total Disability benefits are payable. Your coverage and its benefits will continue during the waiver of premium period.

When You are no longer eligible for the waiver of premium, You can continue Your coverage in force by resuming premium payments within 31 days of the date You became ineligible for the waiver of premium.

[We will provide this benefit in consideration of the payment of the required premium for this Rider.]

[Rider effective date, if different from Policy Issue Date: \_\_\_\_\_]

**THE MEGA LIFE AND HEALTH INSURANCE COMPANY**



SECRETARY



PRESIDENT

SERFF Tracking Number: MGCC-125600858 State: Arkansas  
Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 38681  
IC  
Company Tracking Number: 25915-IP AR  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other  
Product Name: 2008 Ancillary Enhancements  
Project Name/Number: /

## Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MGCC-125600858 State: Arkansas  
Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 38681  
IC  
Company Tracking Number: 25915-IP AR  
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.004 Other  
Product Name: 2008 Ancillary Enhancements  
Project Name/Number: /

## Supporting Document Schedules

<b>Satisfied -Name:</b> Certification/Notice	<b>Review Status:</b> Approved-Closed	04/21/2008
<b>Comments:</b> Please refer to attached.		
<b>Attachments:</b> ARGA 0104.pdf Cert Compl Rule-Reg19 -AR.pdf Cert Compliance AR-Readability.pdf		
<b>Satisfied -Name:</b> Application	<b>Review Status:</b> Approved-Closed	04/21/2008
<b>Comments:</b> Form number: 25098-APP (2/08) Approval date: 12/18/07		
<b>Satisfied -Name:</b> Health - Actuarial Justification	<b>Review Status:</b> Approved-Closed	04/21/2008
<b>Comments:</b> Please refer to attached.		
<b>Attachment:</b> 25915-IP AR (20080408).pdf		
<b>Satisfied -Name:</b> Outline of Coverage	<b>Review Status:</b> Approved-Closed	04/21/2008
<b>Comments:</b> I have also attached the outline of coverage under the Form Schedule Tab.		
<b>Attachment:</b> 25915-IP OC AR.pdf		

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

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

### DISCLAIMER

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

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

**Insurance companies or their agents are required by law to provide you with this notice.**

**The Arkansas Life and Health Insurance Guaranty Association  
C/O The Liquidation Division  
1023 West Capitol, Suite 2  
Little Rock, Arkansas 72201**

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

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

### COVERAGE

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

### EXCLUSIONS FROM COVERAGE

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

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to suture assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

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

#### **LIMITS ON AMOUNT OF COVERAGE**

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

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: The MEGA Life and Health Insurance Company

Form Number(s):

25915-IP AR

25917-IR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



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Signature of Company Officer

Kay Phillips

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Name

Vice President and Chief Compliance Officer

---

Title

April 9, 2008

---

Date

## Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Name:            Disability Income Insurance Policy

Form Number:        25915-IP AR; 25917-IR

Flesch Reading Ease Score: 50.1



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Kay Phillips, Vice President and Chief Compliance Officer

April 9, 2008

---

Date



# THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company  
(Hereinafter called: the Company, We, Our or Us)  
Home Office: Oklahoma City, Oklahoma  
Administrative Office: P.O. Box 982010  
North Richland Hills, Texas 76182-8010  
Customer Service: 1-800-527-5504

## DISABILITY INCOME INSURANCE POLICY – Form: 25915-IP AR REQUIRED OUTLINE OF COVERAGE

- A. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**
- B.** Disability Income coverage is designed to provide You with coverage for disabilities resulting from a covered accident or sickness or combination thereof. Coverage is provided for the benefits described in the BENEFITS section below. The benefits described may be limited as outlined in the LIMITATIONS and EXCLUSIONS section.
- C. BENEFITS**

### SCHEDULE OF BENEFITS

#### MONTHLY TOTAL DISABILITY BENEFITS

Elimination Period (waived for Hospital Confinement of [5] [7] days)	[21 days]
Monthly Indemnity Benefit	[\$500] / [\$1,000] / [\$1,500] / [\$2,000]
Maximum Period Payable for each Period of Total Disability	[36 months]

#### MONTHLY TOTAL DISABILITY BENEFIT

Monthly Total Disability benefits are payable under the Policy if You become Totally Disabled while You are insured under the Policy and are Actively at Work. Your Monthly Indemnity Benefit will begin on the first day following the Elimination Period shown in the SCHEDULE OF BENEFITS. Total Disability must commence within 30 days of the Sickness or Injury, which caused Your Total Disability.

The amount that We will pay for any full month of Total Disability will be the lesser of:

1. the Monthly Indemnity Benefit shown in the SCHEDULE OF BENEFITS; or
2. Your Prior Monthly Income.

We will pay 1/30 of the Monthly Indemnity Benefit otherwise payable for each day of a Period of Total Disability that is less than a full month.

#### WAIVER OF ELIMINATION PERIOD

We will waive the Elimination Period shown above for a Total Disability in which You are Hospital Confined for the period of time shown in the SCHEDULE OF BENEFITS.

**RECURRENT DISABILITY**

After a Period of Total Disability for which We paid benefits ends, if You become Totally Disabled again within 6 months from the same or related cause, We will consider it a continuation of the prior Period of Total Disability. If You have been Actively at Work for more than 6 consecutive months between those two Periods of Total Disability, then We will consider it a new Period of Total Disability.

**CONCURRENT DISABILITY**

If Total Disability is caused by more than one Sickness or Injury, or from both, We will pay benefits as if the Total Disability was caused by only one Sickness or Injury.

**SURVIVOR BENEFIT**

Upon Your death, We will pay a survivor benefit to Your designated Beneficiary, if:

- 1. Monthly Total Disability benefits were being paid at the time of Your death; and
- 2. the Maximum Amount payable for each Period of Total Disability has not been exhausted.

The survivor benefit will be a lump-sum amount equal to three times the Monthly Indemnity Benefit payable under this Policy at the time of Your death. In the event no Beneficiary is named or living, the survivor benefit will be paid:

- 1. to Your surviving spouse; if none, then
- 2. equally to Your surviving natural and adopted children; if none; then
- 3. equally to Your surviving parent(s); if none, then
- 4. to Your estate.

**D. EXCLUSIONS AND LIMITATIONS**

**We will not provide any benefits for any loss caused by or resulting from:**

- 1. any act of war, declared or undeclared;
- 2. pregnancy or childbirth;
- 3. suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
- 4. Mental or Nervous Disorders;
- 5. drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, unless taken as prescribed by a Physician;
- 6. an overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, unless taken as prescribed by a Physician;
- 7. engaging in an illegal occupation or illegal activity or Your being incarcerated;
- 8. travel in or descent from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip; or
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**Pre-Existing Condition**

We will not provide benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Issue Date.

**COORDINATION WITH OTHER COMPENSATION**

The Monthly Indemnity Benefit will be reduced by any of the following You receive during any period of Total Disability for which a Monthly Indemnity Benefit is being paid:

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- 2. Income received from any employer paid sick pay plan, retirement plan or pension plan; and
- 3. Benefits to which You are entitled from Workers' Compensation or any other retirement program, including retirement benefits under the Federal Social Security program.

**E. RENEWABILITY – The Policy is Guaranteed Renewable to Age 65, subject to the Termination of Coverage provision of the Policy, provided the required premium is paid on or before the date it is due subject to a 31 day grace period.**

**F. RIDER BENEFIT**

**Waiver of Premium Benefit Rider** – After You have been continuously Totally Disabled for [90] days, or the Elimination Period, if greater, We will waive premiums on a monthly basis; but only during the period that Total Disability benefits are payable. Your coverage and its benefits will continue during the waiver of premium period.

**G. PREMIUMS -**

We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Insured Person written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

**Premiums** - based on the mode of payment, checked below, the initial premiums are as follows:

- Monthly (Bank Draft)     
  Quarterly     
  Semiannually     
  Annually

Policy 25915-IP AR - described above	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
_____	\$
<b>TOTAL</b>	\$