

SERFF Tracking Number: UNUM-125350597 State: Arkansas
Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 37360
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: R-UL-LTC
Project Name/Number: LONG-TERM CARE/R-UL-LTC

Filing at a Glance

Company: Colonial Life & Accident Insurance Company

Product Name: R-UL-LTC

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Filing Type: Form/Rate

SERFF Tr Num: UNUM-125350597 State: ArkansasLH

SERFF Status: Closed

Co Tr Num:

Co Status:

State Tr Num: 37360

State Status: Approved-Closed

Reviewer(s): Marie Bennett, Harris Shearer

Authors: Cathy Brooks, Donna Mazloom, Angela Mctier, Lauren Sease, Annette Smith, Melissa Allen

Disposition Date: 05/09/2008

Date Submitted: 11/08/2007

Disposition Status: Approved

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: LONG-TERM CARE

Project Number: R-UL-LTC

Requested Filing Mode:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: The filing has been submitted for our domicile state, South Carolina, but it is not yet approved

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/09/2008

State Status Changed: 05/09/2008

Corresponding Filing Tracking Number:

Filing Description:

Long-Term Care Rider

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

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Company and Contact

Filing Contact Information

Melissa Allen, Contract Analyst mford3@unum.com
 1200 Colonial Life Boulevard (803) 213-4117 [Phone]
 Columbia, SC 29202

Filing Company Information

Colonial Life & Accident Insurance Company CoCode: 62049 State of Domicile: South Carolina
 1200 Colonial Life Boulevard Group Code: 565 Company Type:
 Post Office Box 1365
 Columbia, SC 29202 Group Name: State ID Number:
 (803) 798-7000 ext. [Phone] FEIN Number: 57-0144607

Filing Fees

Fee Required? Yes
 Fee Amount: \$140.00
 Retaliatory? No
 Fee Explanation: 7 Forms times \$20.00= \$140.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Colonial Life & Accident Insurance Company	\$140.00	11/08/2007	16550178

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	05/09/2008	05/09/2008

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	Harris Shearer	04/25/2008	04/25/2008	Angela Mctier	04/25/2008	04/25/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Supplemental Form Application for Long-Term Care Replacement Form		Angela Mctier	02/08/2008	02/08/2008
Submission Letter	Supporting Document	Angela Mctier	11/09/2007	11/09/2007

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Status Request	Note To Reviewer	Angela Mctier	03/24/2008	03/24/2008
Status Request	Note To Reviewer	Angela Mctier	01/24/2008	01/24/2008

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Status Request Note To Reviewer Angela Mctier 12/20/2007 12/20/2007

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Disposition

Disposition Date: 05/09/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Supporting Document	NAIC Transmittal		Yes
Supporting Document (revised)	Submission Letter		Yes
Supporting Document	Submission Letter		No
Form	Long-Term Care Benefit Rider		Yes
Form	Long-Term Care Benefit Outline		Yes
Form	Restoration of Benefits Rider		Yes
Form	Restoration of Benefits Outline		Yes
Form (revised)	Supplemental Application for Long-Term Care		Yes
Form	Supplemental Application for Long-Term Care		No
Form (revised)	Replacement Form		Yes
Form	Replacement Form		No
Form (revised)	Third Party Notice		Yes
Form	Third Party Notice		No

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 04/25/2008
Submitted Date 04/25/2008
Respond By Date 05/23/2008

Dear Melissa Allen,

This will acknowledge receipt of the captioned filing.

Objection 1

- Third Party Notice (Form)

Comment: THE REQUEST FOR SOCIAL SECURITY NUMBER AND BIRTHDAY OF THE THIRD PARTY DESIGNEE WILL NOT BE ALLOWED. REQUIRING THIS INFORMATION COULD PLACE AN UNDUE BURDEN ON THE COVERED INSURED TO GET THE INFORMATION. PLEASE REVISE.

Please feel free to contact me if you have questions.

Sincerely,
Harris Shearer

Response Letter

Response Letter Status Submitted to State
Response Letter Date 04/25/2008
Submitted Date 04/25/2008

Dear Marie Bennett,

Comments:

Response 1

Comments: We removed the social security number and birthday of the third party designee from the TPN form.

Related Objection 1

Applies To:

- Third Party Notice (Form)

Comment:

THE REQUEST FOR SOCIAL SECURITY NUMBER AND BIRTHDAY OF THE THIRD PARTY DESIGNEE WILL NOT BE ALLOWED. REQUIRING THIS INFORMATION COULD PLACE AN UNDUE BURDEN ON THE

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COVERED INSURED TO GET THE INFORMATION. PLEASE REVISE.

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
Third Party Notice	TPN-AR		Other	Revised		50	TPN-AR.pdf
Previous Version							
Third Party Notice	TPN		Other	Initial		50	TPN Regular 68587.pdf

No Rate/Rule Schedule items changed.

Sincerely,
 Angela Mctier, Annette Smith, Cathy Brooks, Donna Mazloom, Lauren Sease, Melissa Allen

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Note To Reviewer

Created By:

Angela Mctier on 03/24/2008 10:08 AM

Subject:

Status Request

Comments:

Please provide the status for review of this submission.

Thanks,
Angela McTier

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Amendment Letter

Amendment Date:
 Submitted Date: 02/08/2008

Comments:

We added a "Signature of Applicant" line to the LTCSUPP 08 and LTC Replace forms.

Please review the updated LTCSUPP 08 and LTC Replace forms.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LTC Supp 08-AR	Application/ESupplemental Form	Application for Long-Term Care	Revised			LTC Supp 08-AR	50	LTCSUPP 08 - AR 68541 John Doe revised[1].pdf

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LTC Replace	Other	Replacement Form	Revised			LTC Replace	50	LTC Relace - regular 68588 revised[1].pdf

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Note To Reviewer

Created By:

Angela Mctier on 01/24/2008 02:28 PM

Subject:

Status Request

Comments:

Please advise the status of this submission.

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Note To Reviewer

Created By:

Angela Mctier on 12/20/2007 10:14 AM

Subject:

Status Request

Comments:

Please advise the status of this submission.

Thanks,
Angela McTier

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Amendment Letter

Amendment Date:

Submitted Date: 11/09/2007

Comments:

Revised submission letter.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Submission Letter

Comment:

LTC Submission Letter-Outline-ARrev.pdf

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Form Schedule

Lead Form Number: R-UL-LTC

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	R-UL-LTC	Policy/Cont	Long-Term Care ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51	R-UL-LTC.pdf
	R-UL-LTC-O	Outline of	Long-Term Care Coverage Benefit Outline	Initial		50	R-UL-LTC-O.pdf
	R-UL-RB	Policy/Cont	Restoration of ract/Fratern Benefits Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		50	R-UL-RB.pdf
	R-UL-RB-O	Outline of	Restoration of Coverage Benefits Outline	Initial		50	R-UL-RB-O.pdf
	LTC Supp 08-AR	Application/ Enrollment Form	Supplemental Application for Long- Term Care	Revised	Replaced Form #: LTC Supp 08-AR Previous Filing #:	50	LTCSUPP 08 - AR 68541 John Doe revised[1].pdf
	LTC Replace	Other	Replacement Form	Revised	Replaced Form #: LTC Replace Previous Filing #:	50	LTC Relace - regular 68588 revised[1].pdf
	TPN-AR	Other	Third Party Notice	Revised	Replaced Form #: Previous Filing #:	50	TPN-AR.pdf



COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

Long-Term Care Benefit Rider Schedule

Insured: [John Doe]

Policy Number: [1234567890]
[E99999999999]

This Rider Provides the Coverage Shown on the Schedule below.

Long-Term Care Benefit Rider

Age At Issue: [35]
Premium Class: [Nontobacco]
Rider Effective Date: [November 1, 2007]
Monthly Rider Premium: [\$ 1.00]

SECTION II RIDER GUIDE

SECTION I	RIDER SCHEDULE
SECTION II	RIDER GUIDE
SECTION III	RIDER INFORMATION
SECTION IV	DEFINITIONS
SECTION V	MONTHLY PREMIUM INFORMATION
SECTION VI	ELIGIBILITY FOR THE PAYMENT OF BENEFITS
SECTION VII	LIMITATIONS AND EXCLUSIONS
SECTION VIII	CLAIM INFORMATION
SECTION IX	GENERAL PROVISIONS



COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
1-800-325-4368 www.coloniallife.com
A Stock Company

LONG-TERM CARE BENEFIT RIDER

THIS RIDER IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM INSURANCE CONTRACT UNDER SECTION 7702B(b) and (e)(1) OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED.

NOTICE TO BUYER: This rider may not cover all the expenses associated with your long-term care needs. You are advised to review carefully all rider limitations. The benefit amount paid may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE; IT IS NOT DESIGNED TO FILL THE GAPS OF MEDICARE. If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company. Neither Colonial Life & Accident Insurance Company nor its agents represent Medicare, the federal government or any state government.

Caution: The issuance of this Long-Term Care Benefit rider is based upon your responses to the questions on your application. A copy of your application is attached. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your policy. The best time to clear up any question is now, before a claim arises! If for any reason, any of your answers are incorrect, contact us at this address: Colonial Life & Accident Insurance Company, P.O. Box 1365, Columbia, South Carolina 29202.

Your Right to Return This Rider

If, for any reason, you are not satisfied with this rider, you can return it to us at our home office within 31 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this rider as if it never existed. Any Premium paid will be refunded.

About This Rider

This rider provides benefits for Long-Term Care Confinement, Assisted Living Confinement, Home Health Care and Adult Day Care services for the Insured. We have issued this rider as a part of the policy to which it is attached. It is issued in consideration of the application and the payment of the additional premium shown on the Rider Schedule. All terms of the policy apply to this rider except as provided herein.

Renewability

Coverage under this rider is guaranteed renewable. We may not cancel or reduce coverage under this rider. We reserve the right to change Premiums for this rider. The Premium can be changed only if we change it on all riders of this kind in force in the state where the rider was issued. Premiums cannot be increased because of a change in the age or health of the Insured. We will send you written notice of any change in Premiums at least 60 days in advance. Only you can request that we terminate this rider. Unless you request termination, it will remain in force as long as the policy remains in force and required Premiums for this rider are paid when due.

Pre-existing Conditions Limitation

No benefits will be paid for any Benefit Period that results from a Pre-existing Condition and that starts during the first six months after the effective date of this rider. A Pre-existing Condition means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within the six months preceding the effective date of this rider.

Rider Effective Date

The effective date of this rider is the same as that of the policy to which it is attached unless otherwise indicated on the Rider Schedule.

SECTION IV DEFINITIONS

Activities of Daily Living (ADLs) means the following activities:

- *Bathing* means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- *Continence* means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- *Dressing* means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- *Eating* means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- *Toileting* means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- *Transferring* means the ability to move in or out of a chair, bed or wheelchair.

The Insured will not be considered unable to perform the ADL if he can perform the ADL using equipment or adaptive devices and does not require Substantial Assistance in order to do so.

Adult Day Care means a program for six or more individuals of social and health related services provided during the day in a group setting. Its purpose is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home in an Adult Day Care Facility.

Adult Day Care Facility means a facility that provides Adult Day Care and meets all of the following requirements:

- operates under state licensing laws and any other laws that apply;
- operates at least five days per week for at least six hours per day and is not an overnight facility;
- maintains a written record for each client which includes a Plan of Care and a record of services provided;
- has a staff that includes a full-time director and at least one registered nurse (RN) who is there during operating hours for at least four hours per day;
- maintains a full-time staff to client ratio of at least one to eight respectively;
- has established procedures for obtaining appropriate aid in the event of a medical emergency; and
- provides a range of physical and social support services to adults including formal arrangements to provide the services of a Physician, dietician, licensed physical therapist, licensed speech therapist, and licensed occupational therapist.

Assisted Living Facility means a facility that is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support the needs of the Insured resulting from a Chronic Illness.

An Assisted Living Facility must also:

- provide care 24 hours per day;
- provide Qualified Long-Term Care Services for a charge, including room and board; and
- have formal arrangements for services of a Physician or nurse in the event of a medical emergency.

Assisted Living Confinement means the Insured's confinement in an Assisted Living Facility due to Chronic Illness.

Benefit Period means continuous or successive periods of Long-Term Care Confinement, Assisted Living Confinement, Home Health Care, and Adult Day Care services that:

- are due to the same or related condition;
- are not separated by more than six months; and
- occur while this rider is in force.

A Benefit Period may include, in any sequence, any or all of the following: Long-Term Care Confinement, Assisted Living Confinement, Home Health Care, and Adult Day Care. If separated by more than six months, a new Benefit Period begins, subject to a new Elimination Period.



Benefit Period Maximum: means the maximum amount of benefits that may be paid during a Benefit Period. This amount equals 100% of the Death Benefit of the policy, less any indebtedness, at the end of the Elimination Period of each Benefit Period. No benefits will be paid under this rider once the Benefit Period Maximum has been reached.

A payment or advance of any part of the Death Benefit under any provision of the policy, or any rider other than this rider, will reduce the amount payable under this rider by the requested amount of such payment or advance. The Benefit Period Maximum will be reduced by any Policy Loan made after benefits have begun. In no event will the benefits paid under any provision of the policy, or any rider attached thereto providing a payment or advance of any part of the Death Benefit, ever exceed the Death Benefit, except as otherwise explicitly stated.

Chronic Illness or Chronically Ill means the Insured has been certified within the last 12 months by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

Doctor or Physician means a person, other than the named Insured or a Family Member, who:

- is licensed by the state to practice a healing art; and
- performs services for an Insured which are allowed by his license and the services are appropriate to the care of the Insured's Chronic Illness.

Elimination Period means the first 90 days of the Benefit Period. No benefits are payable for care or service received during this time.

Family Member means you, your spouse, the Insured or Insured's spouse; and any persons related to the aforementioned, including children, parents, grandparents, grandchildren, brothers, sisters, in-law and step relatives and their respective spouses.

Home Health Care means Qualified Long-Term Care Services provided to the Insured for at least one hour or more per day by/through a Licensed Home Health Care Agency or by a Licensed Home Health Care Professional.

Home Health Care Agency means:

- An organization that is either:
 - a) licensed or certified by the appropriate licensing agency of the state where Qualified Long-Term Care Services will be provided; or
 - b) certified as a Home Health Care organization as defined under Medicare; or
- Any organization that meets all of the following tests:
 - a) primarily provides nursing care and other therapeutic services;
 - b) has standards, policies and rules established by a professional group which is associated with the organization;
 - c) includes at least one Physician or one registered nurse on staff; and
 - d) requires a Plan of Care and a written record of care or services provided to be maintained for each person served by the organization.

Insured means the person named as the Insured on the Policy Schedule. It does not include other persons who may be covered by riders under the policy.

Licensed Health Care Practitioner means a Physician, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury. We will consider a person to be a Licensed Health Care Practitioner only when that person is performing tasks that are within the limits of their license, and such tasks are appropriate to the care of the Insured's Chronic Illness. We will not recognize a Family Member as a Licensed Health Care Practitioner under this rider.

Licensed Health Care Practitioner's Certification means a written certification provided by a licensed Health Care Practitioner that the Insured:

- is unable to perform (without Substantial Assistance) at least two ADLs for a period of at least 90 days; or
- requires Substantial Supervision due to Severe Cognitive Impairment.

Licensed Home Health Care Professional means a licensed therapist, practical nurse or vocational nurse or a registered nurse, or a certified hospice caregiver operating within the scope of their license and/or certification. A Licensed Home Health Care Professional must provide services pursuant to a Plan of Care and maintain patient records. We will not recognize a Family Member as a Licensed Home Health Care Professional under this rider.

Long-Term Care (LTC) Facility means a facility (including nursing, hospice, rehabilitation, Alzheimer's or residential care facilities) that is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support the needs of the Insured resulting from a Chronic Illness.

A LTC Facility must also:

- provide care 24 hours per day;
- provide three meals per day, including special dietary requirements;
- have at least one employee on duty at all times who is awake, trained and ready to provide care;
- have formal arrangements for services of a Physician or nurse in the event of a medical emergency;
- be authorized to administer medication to patients on the order of a Physician;
- have accommodations for at least three inpatients in one location; or be a facility that provides a formal program of care for terminally ill patients whose life expectancy is less than six months, provided on an inpatient basis and directed by a Physician, such as a hospice facility; and
- be Medicare certified, or be a similar facility approved by us.

NOTE: If a facility has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a LTC facility only if it:

- meets all the above criteria;
- is authorized by its license, to the extent that licensing is required by law to provide such care to inpatients; and
- is primarily engaged in providing not only room and board, but also care and services, which meet all of the above criteria.

A Long-Term Care Facility is not:

- a hospital or clinic;
- a sub-acute hospital or unit;
- a place which operates primarily for the treatment of alcoholism or drug addiction;
- the Insured's primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or
- a substantially similar establishment.

Long-Term Care Confinement means the Insured's confinement in a LTC Facility due to Chronic Illness.

Medicaid means the reimbursement system under Title XIX of the Federal Social Security Act, as amended.

Medicare means the reimbursement system under Title XVIII of the Federal Social Security Act, as amended.

Plan of Care means a written plan prescribed by a Licensed Health Care Practitioner, based upon an evaluation of the Insured's level of functional capacity. The Plan of Care must describe the necessary services to be performed, the frequency, the type of care, and the most appropriate providers for such care. The care described must be in accordance with acceptable medical and nursing standards of practice and must be appropriate for the Chronic Illness of the Insured.

Preexisting Condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within the six months preceding the effective date of this rider.



Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a Chronically Ill individual, and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Qualified Long-Term Care Services do not include any of the following: durable medical equipment; hospital and laboratory charges; medical supplies; Physician charges; prescription or non-prescription medication; transportation and items or services furnished for the beautification, comfort, convenience, or entertainment of the Insured.

Severe Cognitive Impairment means severe deterioration or loss in:

- short or long-term memory;
- orientation as to person, place, or time; or
- deductive or abstract reasoning or judgment as it relates to safety awareness.

Specified Amount means the Specified Amount shown on the Policy Schedule.

Substantial Assistance means stand-by or hands-on assistance without which the Insured would not be able to safely and completely perform the ADLs. Stand-by assistance means the presence of another person within arm's reach of the Insured while the ADLs are performed. Hands-on assistance means physical assistance from another person (minimal, moderate, or maximal) without which the Insured would not be able to perform the ADL.

Substantial Supervision means constant direction and management (which may include cueing by verbal prompting, gestures or other demonstrations) by another person for the purpose of protecting the Insured from threats to his health or safety.

SECTION V MONTHLY PREMIUM INFORMATION

Monthly Rider Premium

The Monthly Rider Premium for this rider is on the Rider Schedule. We reserve the right to change Premiums for this rider. The Premium can be changed only if we change it on all riders of this kind in force in the state where the rider was issued. Premiums cannot be increased because of a change in the age or health of the Insured. We will send you written notice of any change in Premiums at least 60 days in advance.

Waiver of Monthly Deduction

If benefits are payable under this rider and if the monthly deductions are not being waived under another waiver benefit under the policy, we will waive any monthly deduction made on the policy. If benefits are no longer payable under this rider and you have not exhausted the Death Benefit, monthly deductions must resume.

Refund of Premium Due to Termination

If this rider is terminated, we will refund the Premium paid for any period beyond the date of termination. The refund will be made within 30 days of the effective date of such termination. Such payments will be made to you, unless you specify otherwise.

SECTION VI ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Long-Term Care Facility Benefit

We will pay the monthly Long-Term Care Facility Benefit if:

- we receive a Licensed Health Care Practitioner Certification dated within the last 12 months;
- the Insured has satisfied the Elimination Period; and
- the Insured receives Long-Term Care Confinement.

The Monthly Long-Term Care Facility Benefit amount is 6% of the Death Benefit in effect under the policy on the date the Elimination Period ends less any outstanding Policy Loans.

Assisted Living Facility Benefit

We will pay the monthly Assisted Living Facility Benefit if:

- we receive a Licensed Health Care Practitioner Certification dated within the last 12 months;
- the Insured has satisfied the Elimination Period; and
- the Insured receives Assisted Living Confinement.

The monthly Assisted Living Facility Benefit amount is 6% of the Death Benefit in effect under the policy on the date the Elimination Period ends less any outstanding Policy Loans.

Home Health Care Benefit

We will pay the monthly Home Health Care Benefit if:

- we receive a Licensed Health Care Practitioner Certification dated within the last 12 months;
- the Insured has satisfied the Elimination Period; and
- the Insured receives Home Health Care.

The monthly Home Health Care Benefit amount is 4% of the Death Benefit in effect under the policy on the date the Elimination Period ends less any outstanding Policy Loans.

Adult Day Care Benefit

We will pay the monthly Adult Day Care Benefit if:

- we receive a Licensed Health Care Practitioner Certification dated within the last 12 months;
- the Insured has satisfied the Elimination Period; and
- the Insured receives Adult Day Care.

The monthly Adult Day Care Benefit amount is 4% of the Death Benefit in effect under the policy on the date the Elimination Period ends less any outstanding Policy Loans.

Payment of Monthly Benefit Amounts

For a partial month of Qualified Long-Term Care Services, benefits are payable on a prorated basis. 1/30th of the monthly benefit amount will be paid for each 24-hour day of Qualified Long-Term Care Services. We will also prorate for any change during the month from a LTC Facility Benefit Amount (6%) or an Assisted Living Facility Benefit Amount (6%), to the Home Health Care Benefit Amount (4%), or the Adult Day Care Benefit Amount (4%), as well as if the situation were reversed.

If a new term of Qualified Long-Term Care Services occurs within the same Benefit Period as a previous term, benefits are resumed at the appropriate monthly benefit amount. Such benefits are subject to the Benefit Period Maximum.

If more than one Chronic Illness contributes to the long-term care, the monthly benefit amount payable remains the same as for a single cause.

Prior Rider Benefits Paid

In determining the monthly benefit amount payable, the Death Benefit at the end of the Elimination Period is reduced by the total amount of Qualified Long-Term Care Services benefits paid during all previous Benefit Periods.

Change in Benefit Amount

During a Benefit Period the monthly benefit amount will be unaffected by changes in the Death Benefit, except that if a Cash Withdrawal, a decrease in Specified Amount, or a Policy Loan occurs during a Benefit Period at your request, the monthly benefit amount will be re-determined. The revised benefit, and future payments in this Benefit Period, will be based on the Death Benefit as it exists immediately following the Cash Withdrawal, decrease in Specified Amount or Policy Loan. The monthly benefit payable during a Benefit Period will not change on account of any increase in the Death Benefit of the policy.

Extension of Benefits

Termination of this rider will not affect payment of any benefits payable for Long-Term Care Confinement or Assisted Living Facility Confinement if such confinement began while the rider was in force and continues without interruption after



termination. Such Extension of Benefits beyond the period the rider was in force is subject to the Benefit Period Maximum and may be subject to any Elimination Period, and all other applicable provisions of the rider.

Effects of Long-Term Care Benefit Payments on the Policy

Each monthly or partial payment under this rider will reduce the following items under the policy, as applicable:

- Specified Amount;
- Death Benefit;
- Fund Value;
- Any indebtedness;
- Amount available for Policy Loans and Cash Withdrawals;
- Surrender Charges; and
- Amount available for advance of any part of the Death Benefit under any provision of the policy or any rider other than this rider.

Each monthly benefit payment will reduce each of the items listed above by a proportional amount. This proportion will equal the monthly benefit payment divided by the Death Benefit at that time. A pro-rata reduction will be made for a partial month of payment.

During the Benefit Period you may not exercise increases, Death Benefit Option changes or rider additions under the policy.

SECTION VII LIMITATIONS AND EXCLUSIONS

Preexisting Condition Limitations

No benefits will be paid for any Benefit Period that results from a Pre-existing Condition and that starts during the first six months after the effective date of this rider.

Other Limitations or Conditions on Eligibility for Benefits

We will not pay benefits for confinement or services:

- resulting from mental or nervous disorder; however, Alzheimer’s Disease and related degenerative and dementing illnesses are covered;
- resulting from alcoholism, alcohol abuse, drug addiction or drug abuse;
- for which there is no charge in the absence of insurance;
- provided by a Family Member;
- received while residing or confined outside the United States and Canada; and
- due to Chronic Illnesses resulting from:
 - war or any act of war, whether declared or undeclared, or service in any armed forces or auxiliary units thereto;
 - intentionally self-inflicted injuries or suicide;
 - participation in a felony, riot or insurrections; and
 - aviation (if a non-fare paying passenger).

Non-Duplication of Benefits

Qualified Long-Term Care Services do not include services for which charges are covered under any of the following:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amounts);
- any other government program or facility (except Medicaid); and
- any state or federal worker’s compensation, employer’s liability or occupational disease law, or under any motor vehicle no-fault law.

SECTION VIII CLAIM INFORMATION

Notice of Claim

Notice of claim must be given to us at our home office within 30 days of the date the Insured first receives Qualified Long-Term Care services or as soon as reasonably possible. The Notice should include the Insured’s name and policy number as shown on the Policy Schedule.

Claim Forms

When we receive your Notice of Claim, we will send you claim forms within 15 days. If you do not receive claim forms, a written statement along with Proof of Loss will be used to process your claim.

Proof of Loss

You must give us written Proof of Loss within 90 days after the date the Insured first receives Qualified Long-Term Care Services. Written Proof of Loss, provided at your expense and in English or Spanish, must include:

- the date the Chronic Illness began;
- the cause and extent of the Chronic Illness, including restrictions and limitations preventing the Insured from performing the ADLs or causing Severe Cognitive Impairment;
- a Licensed Health Care Practitioner's Certification;
- a copy of the Insured's Plan of Care;
- a Physician's statement and/or copies of relevant medical records from any Physician or health care provider involved in the Insured's care;
- the name and address of any hospital or institution where the Insured received treatment, and/or the name and address of any health care provider who treated the Insured, including all attending Physicians; and
- proof of Qualified Long-Term Care Services provided.

If you are not able to give us written Proof of Loss within 90 days, it will not have a bearing on your claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

In addition, we may require at our expense that the Insured or his caregiver provide or participate in one or more of the following as Proof of Loss:

- a personal interview with the Insured and/or a review of his records by our representative at such time and with such frequency as we reasonably require;
- an independent medical examination or functional capacity evaluation. This may include related tests that are reasonably necessary to the performance of the examination or evaluation by a Physician or specialist appropriate for the condition and at such time and such frequency as we reasonably require. We reserve the right to select the examiner. We will pay for the examination if it cannot be conducted locally; and/or
- such other proof as we deem necessary.

We reserve the right to request additional information necessary to our claim determination from you, the Insured, the Insured's Physician, or other health care providers. You must promptly sign and return any forms we require in order to process your claim.

We will request proof of continued Chronic Illness or an updated written Plan of Care at intervals determined by us.

You must respond within 30 days of the request for an updated Plan of Care, proof of continued Chronic Illness or additional information for us to continue to evaluate and process your claim. We reserve the right to deny your claim or stop sending payment if the appropriate information is not submitted.

You must notify us immediately when the Insured is no longer Chronically Ill or is no longer receiving Qualified Long-Term Care Services.

Time of Payment of Claim

After we receive written Proof of Loss and process the Insured's claim, we will immediately pay any monthly benefits due for Qualified Long-Term Care Services that have been rendered.

Payment of Claim

Benefits will be paid to you unless we receive a written authorization to pay them elsewhere. This is called *assignment*. Any accrued benefits unpaid at the Insured's death will be paid according to the Your Right to Name a Beneficiary provision in the policy.



Questions Concerning Your Claim

If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

Claim Overpayment

If, for any reason, benefits have been paid for a period for which benefits were not due, repayment of the overpayment must be made to us within 45 days of notice to you. We may recover any amounts not repaid by offsetting them against any amount otherwise payable to you under this rider or by other reasonable means.

Right of Appeal

We will notify you in writing if we do not approve your claim or any part of a claim, and provide you with a written explanation of the reasons for the denial.

If you are not satisfied with the reason for the denial, you have the right to appeal any claim decision and may ask to have the claim reviewed by us. Your appeal must be in writing and must be sent to us within 90 days of your denial notice. You should include all supporting materials or information that will help us to review the claim. We will review your appeal and all new information submitted and notify you of our decision within 60 days of receiving your appeal. If special circumstances require an extension of time for our processing, you will be notified of the reasons for the extension and the date by which we expect to make a decision.

A decision shall be made no later than 120 days following receipt of the initial request for review. We can extend the time period if we have not received needed information from you. In some cases, we may request that you provide additional information to assist in the review. With proper authorization, you may request copies of the pertinent relevant documents we used to review your claim.

Legal Action

We cannot be sued for benefits under this rider:

- until 60 days after we are sent written proof of loss; or
- more than five years after the time has passed in which we require written Proof of Loss.

SECTION IX GENERAL PROVISIONS

Incontestability Period

If this rider has been in force for less than six months, we may rescind it or deny a Long-Term Care insurance claim upon a showing of misrepresentation that is material to the acceptance of the application.

If this rider has been in force for at least six months but less than two years, we may rescind a long-term care claim upon a showing of misrepresentation that is *both* material to the acceptance for coverage and which pertains to the Chronic Illness condition for which benefits are sought.

If this rider has been in force for two years or more, it may be contested only upon a showing you knowingly and intentionally misrepresented relevant facts relating to the Insured's health.

If we have paid benefits under this Long-Term Care Benefit rider, the benefit payments may not be recovered by us in the event that the rider is rescinded.

Conformity With Federal Statutes

We designed this rider to be Qualified Long-Term Care insurance under Sections 7702B(b) and (e)(1) of the Internal Revenue Code of 1986, as amended. If in the future changes are needed to maintain the tax status of this rider, we will make every reasonable effort to amend this rider to maintain its tax status. You will be given the opportunity to amend this rider in order to preserve its favorable income tax treatment. If the required changes are not made, this rider may lose its status as tax-Qualified Long-Term Care insurance.

Third Party Notice

You have the right to designate in writing at least one person, in addition to yourself, who is to receive notice of lapse or termination of this rider for nonpayment of premium, unless you have dated and signed a written waiver electing not to designate additional persons to receive notice. You have the right to designate at least one person who is to receive the notice of termination, in addition to the Insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the Insured. You have the right to periodically update your authorized designee.

Benefits Termination

Benefit payments under this rider will end upon the earliest of the following;

- the date the Insured is no longer Chronically Ill;
- the date the Insured's Licensed Health Care Practitioner's Certification expires;
- the date the Insured is no longer receiving Qualified Long-Term Care Services; or
- the date the Benefit Period Maximum is reached.

Rider Termination

This rider will terminate on the first date that any of the following occurs:

- the date the Benefit Period Maximum is reached;
- the date the policy to which this rider is attached terminates; or
- the date we receive your written request to terminate this rider.

Grace Period

The Grace Period provision of the policy also applies to this rider.

Reinstatement

If the policy to which this rider is attached is put back in force, you may have the right to put this rider back in force, if you meet certain requirements:

- you must furnish us with proof that the Insured is insurable. We may require a physical examination; and
- you must pay enough Premium to keep the policy and this rider in force for two months that follow the reinstatement date, plus the Minimum Monthly Premium for the two months of coverage provided in the Grace Period provision in the policy.

When these conditions are met, we will reinstate this rider as of the policy's reinstatement date. The reinstated rider will only cover Qualified Long-Term Care Services for injuries which occur after the reinstatement date, or sicknesses which begin more than 10 days after the reinstatement date.

In the event of lapse we will reinstate the coverage, if we are provided proof that the Insured was Severely Cognitively Impaired or had a loss of functional capacity before the Grace Period contained in the policy expired. This option will be available to you if reinstatement is requested within five months after termination and will allow for the collection of past due Premium, where appropriate.

A new contestable period will begin from the date of reinstatement. Contestability will be limited to statements made on the application reinstating the rider.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

[



Secretary]



COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
1-800-325-4368 www.coloniallife.com
A Stock Company

LONG-TERM CARE BENEFIT RIDER

OUTLINE OF COVERAGE

(Applicable to Rider form, R- UL-LTC, including state abbreviations where used.)

Caution: The issuance of the Long-Term Care Benefit Rider is based upon your responses to the questions on your application. A copy of your application is enclosed. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your policy. The best time to clear up any question is now, before a claim arises! If for any reason, any of your answers are incorrect, contact us at this address: Colonial Life & Accident Insurance Company, P.O. Box 1365, Columbia, South Carolina 29202.

NOTICE TO BUYER: The rider may not cover all the expenses associated with your Qualified Long-Term Care Services needs. You are advised to carefully review all rider limitations.

STATEMENT OF INSURANCE: The rider is attached to an individual policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the rider. You should compare this outline of coverage to outlines of coverage for other riders available to you. This is not an insurance contract, but only a summary of coverage. Only the individual rider contains governing contractual provisions. This means that the rider sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR RIDER CAREFULLY!**

FEDERAL TAX CONSEQUENCES

THE RIDER IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM INSURANCE CONTRACT UNDER SECTION 7702B(b) and (e)(1) OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED.

The benefit amount paid may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THE RIDER IS GUARANTEED RENEWABLE This means you have the right, subject to the terms of your rider, to continue The rider as long as you pay your Premiums on time.

TERMS UNDER WHICH COMPANY MAY CHANGE PREMIUMS

We reserve the right to change Premiums for the rider. The Premium can be changed only if we change it on all riders of this kind in force in the state where the rider was issued. Premiums cannot be increased because of a change in the age or health of the Insured.

TERMS UNDER WHICH THE RIDER MAY BE RETURNED AND PREMIUM REFUNDED

Your Right to Return The Rider

If, for any reason, you are not satisfied with the rider, you can return it to us at our home office within 31 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider the rider as if it never existed. Any Premium paid will be refunded.

Refund of Premium Due to Termination

If the rider is terminated, we will refund the Premium paid for any period beyond the date of termination. The refund will be made within 30 days of the effective date of such termination. Such payments will be made to you, unless you specify otherwise.

The rider does not contain provisions providing for a refund or partial refund of Premium upon the death of an Insured.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE; IT IS NOT DESIGNED TO FILL THE GAPS OF MEDICARE. If you are eligible for Medicare, review the [Guide To Health Insurance for People with Medicare](#) available from the company. Neither Colonial Life & Accident Insurance Company nor its agents represent Medicare, the federal government or any state government.

LONG-TERM CARE COVERAGE. Riders of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. The rider may not cover all the expenses associated with your Long-Term Care needs.

The rider provides coverage in the form of a fixed dollar indemnity benefit for covered Long-Term Care expenses, subject to policy limitations.

BENEFITS PROVIDED BY THE RIDER. When we receive satisfactory proof that the Insured receives care, services or confinement while the rider and the policy to which it is attached are in force, we will pay to the Insured the benefits according to the terms and conditions of the rider.

The rider provides benefits for Long-Term Care Confinement, Assisted Living Confinement, Home Health Care and Adult Day Care services for the Insured. We have issued the rider as a part of the policy to which it is attached. It is issued in consideration of the application and the payment of the additional Premium shown on the Rider Schedule. All terms of the policy apply to the rider except as provided herein.

BENEFITS

Long-Term Care Facility Benefit

We will pay the monthly Long-Term Care Facility Benefit if:

- we receive a Licensed Health Care Practitioner Certification dated within the last 12 months;
- the Insured has satisfied the Elimination Period; and
- the Insured receives Long-Term Care Confinement.

The Monthly Long-Term Care Facility Benefit amount is 6% of the Death Benefit in effect under the policy on the date the Elimination Period ends less any outstanding Policy Loans.

Assisted Living Facility Benefit

We will pay the monthly Assisted Living Facility Benefit if:

- we receive a Licensed Health Care Practitioner Certification dated within the last 12 months;
- the Insured has satisfied the Elimination Period; and
- the Insured receives Assisted Living Confinement.

The monthly Assisted Living Facility Benefit amount is 6% of the Death Benefit in effect under the policy on the date the Elimination Period ends less any outstanding Policy Loans.

Home Health Care Benefit

We will pay the monthly Home Health Care Benefit if:

- we receive a licensed Health Care Practitioner Certification dated within the last 12 months;
- the Insured has satisfied the Elimination Period; and
- the Insured receives Home Health Care.

The monthly Home Health Care Benefit amount is 4% of the Death Benefit in effect under the policy on the date the Elimination Period ends less any outstanding Policy Loans.

Adult Day Care Benefit

We will pay the monthly Adult Day Care Benefit if:

- we receive a Licensed Health Care Practitioner Certification dated within the last 12 months;
- the Insured has satisfied the Elimination Period; and
- the Insured receives Adult Day Care.



The monthly Adult Day Care Benefit amount is 4% of the Death Benefit in effect under the policy on the date the Elimination Period ends less any outstanding Policy Loans.

Payment of Monthly Benefit Amounts

For a partial month of Qualified Long-Term Care Services, benefits are payable on a prorated basis. 1/30th of the monthly benefit amount will be paid for each 24-hour day of Qualified Long-Term Care Services. We will also prorate for any change during the month from a LTC Facility Benefit Amount (6%) or an Assisted Living Facility Benefit Amount (6%), to the Home Health Care Benefit Amount (4%), or the Adult Day Care Benefit Amount (4%), as well as if the situation were reversed.

If a new term of Qualified Long-Term Care Services occurs within the same Benefit Period as a previous term, benefits are resumed at the appropriate monthly benefit amount. Such benefits are subject to the Benefit Period Maximum.

If more than one Chronic Illness contributes to the Long-Term Care, the monthly benefit amount payable remains the same as for a single cause.

Prior Rider Benefits Paid

In determining the monthly benefit amount payable, the Death Benefit at the end of the Elimination Period is reduced by the total amount of Qualified Long-Term Care Services benefits paid during all previous Benefit Periods.

Change in Benefit Amount

During a Benefit Period the monthly benefit amount will be unaffected by changes in the Death Benefit, except that if a Cash Withdrawal, a decrease in Specified Amount, or a Policy Loan occurs during a Benefit Period at your request, the monthly benefit amount will be re-determined. The revised benefit, and future payments in this Benefit Period, will be based on the Death Benefit as it exists immediately following the Cash Withdrawal, decrease in Specified Amount or Policy Loan. The monthly benefit payable during a Benefit Period will not change on account of any increase in the Death Benefit of the policy.

Extension of Benefits

Termination of the rider will not affect payment of any benefits payable for Long-Term Care Confinement or Assisted Living Facility Confinement if such confinement began while the rider was in force and continues without interruption after termination. Such extension of benefits beyond the period the rider was in force is subject to the Benefit Period Maximum and may be subject to any Elimination Period, and all other applicable provisions of the rider.

Effects of Long-Term Care Benefit Payments on the Policy

Each monthly or partial payment under the rider will reduce the following items under the policy, as applicable:

- Specified Amount;
- Death Benefit;
- Fund Value;
- Any indebtedness;
- Amount available for Policy Loans and Cash Withdrawals;
- Surrender Charges; and
- Amount available for advance of any part of the Death Benefit under any provision of the policy or any rider other than the rider.

Each monthly benefit payment will reduce each of the items listed above by a proportional amount. This proportion will equal the monthly benefit payment divided by the Death Benefit at that time. A prorata reduction will be made for a partial month of payment.

During the Benefit Period you may not exercise increases, Death Benefit Option changes or rider additions under the policy.

Definitions

Activities of Daily Living (ADLs) means the following activities:

- *Bathing* means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- *Continence* means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- *Dressing* means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

- *Eating* means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- *Toileting* means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- *Transferring* means the ability to move in or out of a chair, bed or wheelchair.

The Insured will not be considered unable to perform the ADL if he can perform the ADL using equipment or adaptive devices and does not require substantial assistance in order to do so.

Adult Day Care means a program for six or more individuals of social and health related services provided during the day in a group setting. Its purpose is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home in an Adult Day Care Facility.

Adult Day Care Facility means a facility that provides Adult Day Care and meets all of the following requirements:

- operates under state licensing laws and any other laws that apply;
- operates at least five days per week for at least six hours per day and is not an overnight facility;
- maintains a written record for each client which includes a Plan of Care and a record of services provided;
- has a staff that includes a full-time director and at least one registered nurse (RN) who is there during operating hours for at least four hours per day;
- maintains a full-time staff to client ratio of at least one to eight respectively;
- has established procedures for obtaining appropriate aid in the event of a medical emergency; and
- provides a range of physical and social support services to adults including formal arrangements to provide the services of a physician, dietician, licensed physical therapist, licensed speech therapist, and licensed occupational therapist.

Assisted Living Facility means a facility that is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support the needs of the Insured resulting from a Chronic Illness.

An Assisted Living Facility must also:

- provide care 24 hours per day;
- provide Qualified Long-Term Care Services for a charge, including room and board; and
- have formal arrangements for services of a physician or nurse in the event of a medical emergency.

Assisted Living Confinement means the Insured's confinement in an Assisted Living Facility due to Chronic Illness.

Benefit Period means continuous or successive periods of Long-Term Care Confinement, Assisted Living Confinement, Home Health Care, and Adult Day Care services that:

- are due to the same or related condition;
- are not separated by more than six months; and
- occur while the rider is in force.

A benefit period may include, in any sequence, any or all of the following: Long-Term Care Confinement, Assisted Living Confinement, Home Health Care, and Adult Day Care. If separated by more than six months, a new Benefit Period begins, subject to a new Elimination Period.

Benefit Period Maximum means the maximum amount of benefits that may be paid during a Benefit Period. This amount equals 100% of the Death Benefit of the policy, less any indebtedness, at the end of the Elimination Period of each Benefit Period. No benefits will be paid under the rider once the Benefit Period Maximum has been reached.

A payment or advance of any part of the Death Benefit under any provision of the policy, or any rider other than the rider, will reduce the amount payable under the rider by the requested amount of such payment or advance. The Benefit Period Maximum will be reduced by any Policy Loan made after benefits have begun. In no event will the benefits paid under any provision of the policy, or any rider attached thereto providing a payment or advance of any part of the Death Benefit, ever exceed the Death Benefit, except as otherwise explicitly stated.



Chronic Illness or Chronically Ill means the Insured has been certified within the last 12 months by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another individual, at least two Activities Of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
- requiring Substantial Supervision to protect the individual from threats to health and safety due to Severe Cognitive Impairment.

Doctor or Physician means a person, other than the named Insured or a family member, who:

- is licensed by the state to practice a healing art; and
- performs services for an Insured which are allowed by his license and the services are appropriate to the care of the Insured's Chronic Illness.

Elimination Period means the first 90 days of the Benefit Period. No benefits are payable for care or service received during this time.

Family Member means you, your spouse, the Insured or Insured's spouse; and any persons related to the aforementioned, including children, parents, grandparents, grandchildren, brothers, sisters, in-law and step relatives and their respective spouses.

Home Health Care means Qualified Long-Term Care Services provided to the Insured for at least one hour or more per day by/through a Licensed Home Health Care Agency or by a Licensed Home Health Care Professional.

Home Health Care Agency means:

- An organization that is either:
 - a) licensed or certified by the appropriate licensing agency of the state where Qualified Long-Term Care Services will be provided; or
 - b) certified as a Home Health Care organization as defined under Medicare; or
- Any organization that meets all of the following tests:
 - a) primarily provides nursing care and other therapeutic services;
 - b) has standards, policies and rules established by a professional group which is associated with the organization;
 - c) includes at least one physician or one registered nurse on staff; and
 - d) requires a Plan Of Care and a written record of care or services provided to be maintained for each person served by the organization.

Insured means the person named as the Insured on the Policy Schedule. It does not include other persons who may be covered by riders under the policy.

Licensed Health Care Practitioner means a Physician, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury. We will consider a person to be a Licensed Health Care Practitioner only when that person is performing tasks that are within the limits of their license, and such tasks are appropriate to the care of the Insured's Chronic Illness. We will not recognize a Family member as a Licensed Health Care Practitioner under the rider.

Licensed Health Care Practitioner's Certification means a written certification provided by a licensed Health Care Practitioner that the Insured:

- is unable to perform (without Substantial Assistance) at least two ADLs for a period of at least 90 days; or
- requires Substantial Supervision due to Severe Cognitive Impairment.

Licensed Home Health Care Professional means a licensed therapist, practical nurse or vocational nurse or a registered nurse, or a certified hospice caregiver operating within the scope of their license and/or certification. A Licensed Home Health Care Professional must provide services pursuant to a Plan of Care and maintain patient records. We will not recognize a Family member as a Licensed Home Health Care Professional under the rider.

Long-Term Care (LTC) Facility means a facility (including nursing, hospice, rehabilitation, Alzheimer's or residential care facilities) that is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support the needs of the Insured resulting from a Chronic Illness.

A LTC Facility must also:

- provide care 24 hours per day;
- provide three meals per day, including special dietary requirements;
- have at least one employee on duty at all times who is awake, trained and ready to provide care;
- have formal arrangements for services of a Physician or nurse in the event of a medical emergency;
- be authorized to administer medication to patients on the order of a Physician;
- have accommodations for at least three inpatients in one location; or be a facility that provides a formal program of care for terminally ill patients whose life expectancy is less than six months, provided on an inpatient basis and directed by a Physician, such as a hospice facility; and
- be Medicare certified, or be a similar facility approved by us.

NOTE: If a facility has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a LTC facility only if it:

- meets all the above criteria;
- is authorized by its license, to the extent that licensing is required by law to provide such care to inpatients; and
- is primarily engaged in providing not only room and board, but also care and services, which meet all of the above criteria.

A Long-Term Care Facility is not:

- a hospital or clinic;
- a sub-acute hospital or unit;
- a place which operates primarily for the treatment of alcoholism or drug addiction;
- the Insured's primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or
- a substantially similar establishment.

Long-Term Care Confinement means the Insured's confinement in a LTC Facility due to Chronic Illness.

Medicaid means the reimbursement system under Title XIX of the Federal Social Security Act, as amended.

Medicare means the reimbursement system under Title XVIII of the Federal Social Security Act, as amended.

Plan of Care means a written plan prescribed by a Licensed Health Care Practitioner, based upon an evaluation of the Insured's level of functional capacity. The Plan of Care must describe the necessary services to be performed, the frequency, the type of care, and the most appropriate providers for such care. The care described must be in accordance with acceptable medical and nursing standards of practice and must be appropriate for the Chronic Illness of the Insured.

Preexisting Condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within the six months preceding the effective date of the rider.

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a Chronically Ill individual, and are provided pursuant to a Plan Of Care prescribed by a Licensed Health Care Practitioner.

Qualified Long-Term Care Services do not include any of the following: durable medical equipment; hospital and laboratory charges; medical supplies; Physician charges; prescription or non-prescription medication; transportation and items or services furnished for the beautification, comfort, convenience, or entertainment of the Insured.

Severe Cognitive Impairment means severe deterioration or loss in:

- short or long-term memory;
- orientation as to person, place, or time; or
- deductive or abstract reasoning or judgment as it relates to safety awareness.

Specified Amount means the Specified Amount shown on the Policy Schedule.

Substantial Assistance means stand-by or hands-on assistance without which the Insured would not be able to safely and completely perform the ADLs. Stand-by assistance means the presence of another person within arm's reach of the Insured while the ADLs are



performed. Hands-on assistance means physical assistance from another person (minimal, moderate, or maximal) without which the Insured would not be able to perform the ADL.

Substantial Supervision means constant direction and management (which may include cueing by verbal prompting, gestures or other demonstrations) by another person for the purpose of protecting the Insured from threats to his health or safety.

LIMITATIONS AND EXCLUSIONS

Pre-existing Condition Limitations

No benefits will be paid for any benefit period that results from a Pre-Existing Condition and that starts during the first six months after the effective date of the rider.

Other Limitations or Conditions on Eligibility for Benefits

We will not pay benefits for confinement or services:

- resulting from mental or nervous disorder; however, Alzheimer's Disease and related degenerative and dementing illnesses are covered;
- resulting from alcoholism, alcohol abuse, drug addiction or drug abuse;
- for which there is no charge in the absence of insurance;
- provided by a Family Member;
- received while residing or confined outside the United States and Canada; and
- due to Chronic Illnesses resulting from:
 - war or any act of war, whether declared or undeclared, or service in any armed forces or auxiliary units thereto;
 - intentionally self-inflicted injuries or suicide;
 - participation in a felony, riot or insurrections; and
 - aviation (if a non-fare paying passenger).

Non-Duplication of Benefits

Qualified Long-Term Care Services do not include services for which charges are covered under any of the following:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amounts);
- any other government program or facility (except Medicaid); and
- any state or federal worker's compensation, employer's liability or occupational disease law, or under any motor vehicle no-fault law.

THE RIDER MAY NOT COVER ALL OF THE EXPENSES ASSOCIATED WITH YOUR QUALIFIED LONG-TERM CARE SERVICES NEEDS.

RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the cost of Long-Term Care Facility, Assisted Living Facility, Home Health Care and Adult Day Care services will likely increase over time, you should consider whether and how the benefits of the plan may be adjusted.

The level of benefits under the rider is directly related to the Death Benefit under the policy, excluding any term rider. Under policy Death Benefit Option A, the Death Benefit is generally related to the Specified Amount of the policy and, therefore, would remain level. Whereas, under policy Death Benefit Option B, the Death Benefit normally increases over time as it includes the Fund Value. The level of benefit may be increased by increasing the Death Benefit of the policy to which the rider is attached, but only before benefits begin. Any increase in the policy Death Benefit is subject to the terms of the policy. The cost for any additional benefit added as described above will be calculated on the same basis as the level of benefits prior to the increase.

ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Loss due to Alzheimer's disease and related degenerative and dementing illnesses will be covered by the rider.

PREMIUM

The monthly Premium for the rider is on the Rider Schedule.

ADDITIONAL FEATURES

Issue of the rider is subject to the Insured furnishing evidence of insurability satisfactory to us.

CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE RIDER.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

Restoration of Benefits Rider Schedule

Insured: [John Doe]

Policy Number: [1234567890]
[E99999999999]

This Rider Provides the Coverage Shown on the Schedule below.

Long-Term Care Benefit Rider

Age At Issue:	[35]
Premium Class:	[Nontobacco]
Rider Effective Date:	[November 1, 2007]
Monthly Rider Premium:	[\$ 3.50]

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COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
1-800-325-4368 www.coloniallife.com
A Stock Company

RESTORATION OF BENEFITS RIDER

Your Right to Return This Rider

If, for any reason, you are not satisfied with this rider, you can return it to us at our home office within 31 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this rider as if it never existed. Any Premium paid will be refunded.

About This Rider

This rider restores the policy values on a monthly basis as benefits are paid under the Long-Term Care Benefit Rider. We have issued this rider as a part of the policy to which it is attached. It is issued in consideration of the application and the payment of the additional Premium shown on the Rider Schedule. All terms of the policy apply to this rider except as provided herein.

Coverage Provided by This Rider

The following values in the policy to which this rider is attached will be restored 100% under this rider:

- Specified Amount;
- Fund Value; and
- Death Benefit.

In addition, any applicable policy Surrender Charges will be restored. The terms, conditions, exclusions and limitations of the Long-Term Care Benefit Rider govern the payment of restored benefits under this rider.

Restoration Benefits begin with the first full month for which benefits are paid under the Long-Term Care Benefit Rider. Subsequent restorations shall be made on a monthly basis coinciding with the payment of benefits under the Long-Term Care Benefit Rider.

Benefits continue until the first of the following occurs:

- the restored policy values equal 100% of the amount of the policy values which were reduced when the benefits were paid under the Long-Term Care Benefit rider;
- the Insured no longer meets the conditions for payment of benefits under the Long-Term Care Benefit Rider; or
- the sum of all Restoration Benefits equals 100% of the Specified Amount.

Rider Effective Date

The effective date of this rider is the same as that of the policy to which it is attached unless otherwise indicated on the Rider Schedule.

Incontestability

The coverage provided by this rider may only be Contested on the same basis as the Long-Term Care Benefit Rider.

Monthly Rider Premium

The Monthly Rider Premium for this rider is shown on the Rider Schedule. We reserve the right to change Premiums for this rider. The Premium can be changed only if we change it on all policies of this kind in force in the state where the rider was issued. Premiums cannot be increased because of a change in the age or health of the Insured. We will send you written notice of any change in Premiums at least 60 days in advance.

Termination

This rider will terminate on the first date that any of the following occurs:

- the date the Long-Term Care Rider terminates;
- the date all benefits in this rider are exhausted;
- the date the policy to which this rider is attached terminates; or
- the date we receive your written request to terminate this rider.

Grace Period

The Grace Period provision of the policy also applies to this rider.

Reinstatement

If the policy and the Long-Term Care Benefit Rider are put back in force, you may have the right to put this rider back in force, if you meet certain requirements:

- you must furnish us with proof that the Insured is insurable. We may require a physical examination; and
- you must pay enough Premiums to keep the policy and this rider in force for two months, plus the Minimum Monthly Premium for the two months of coverage provided in the Grace Period provision in the policy.

When these conditions are met, we will reinstate this rider as of the policy's reinstatement date.

In the event of lapse we will reinstate the coverage, if we are provided proof that the Insured was Severely Cognitively Impaired or had a loss of functional capacity before the Grace Period contained in the policy expired. This option will be available to you if reinstatement is requested within five months after termination and will allow for the collection of past due Premium, where appropriate.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

[



Secretary]



COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
1-800-325-4368 www.coloniallife.com
A Stock Company

RESTORATION OF BENEFITS RIDER

OUTLINE OF COVERAGE

(Applicable to Rider form, R- UL-RB, including state abbreviations where used.)

Your Right to Return The Rider

If, for any reason, you are not satisfied with the rider, you can return it to us at our home office within 31 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider the rider as if it never existed. Any Premium paid will be refunded.

About The Rider

The rider restores the policy values on a monthly basis as benefits are paid under the Long-Term Care Benefit Rider. We have issued the rider as a part of the policy to which it is attached. It is issued in consideration of the application and the payment of the additional Premium shown on the Rider Schedule. All terms of the policy apply to the rider except as provided herein.

Coverage Provided by The Rider

The following values in the policy to which the rider is attached will be restored 100% under the rider:

- Specified Amount;
- Fund Value; and
- Death Benefit.

In addition, any applicable policy Surrender Charges will be restored. The terms, conditions, exclusions and limitations of the Long-Term Care Benefit Rider govern the payment of restored benefits under the rider.

Restoration Benefits begin with the first full month for which benefits are paid under the Long-Term Care Benefit Rider. Subsequent restorations shall be made on a monthly basis coinciding with the payment of benefits under the Long-Term Care Benefit Rider.

Benefits continue until the first of the following occurs:

- the restored policy values equal 100% of the amount of the policy values which were reduced when the benefits were paid under the Long-Term Care Benefit rider;
- the Insured no longer meets the conditions for payment of benefits under the Long-Term Care Benefit Rider; or
- the sum of all Restoration Benefits equals 100% of the Specified Amount.

Rider Effective Date

The effective date of the rider is the same as that of the policy to which it is attached unless otherwise indicated on the Rider Schedule.

Incontestability

The coverage provided by the rider may only be Contested on the same basis as the Long-Term Care Benefit Rider.

Monthly Rider Premium

The Monthly Rider Premium for the rider is shown on the Rider Schedule. We reserve the right to change Premiums for the rider. The Premium can be changed only if we change it on all policies of the kind in force in the state where the rider was issued. Premiums cannot be increased because of a change in the age or health of the Insured. We will send you written notice of any change in Premiums at least 60 days in advance.

Termination

The rider will terminate on the first date that any of the following occurs:

- the date the Long-Term Care Rider terminates;
- the date all benefits in the rider are exhausted;
- the date the policy to which the rider is attached terminates; or
- the date we receive your written request to terminate the rider.

Grace Period

The Grace Period provision of the policy also applies to the rider.

Reinstatement

If the policy and the Long-Term Care Benefit Rider are put back in force, you may have the right to put the rider back in force, if you meet certain requirements:

- you must furnish us with proof that the Insured is insurable. We may require a physical examination; and
- you must pay enough Premiums to keep the policy and the rider in force for two months, plus the Minimum Monthly Premium for the two months of coverage provided in the Grace Period provision in the policy.

When these conditions are met, we will reinstate the rider as of the policy's reinstatement date.

In the event of lapse we will reinstate the coverage, if we are provided proof that the Insured was Severely Cognitively Impaired or had a loss of functional capacity before the Grace Period contained in the policy expired. This option will be available to you if reinstatement is requested within five months after termination and will allow for the collection of past due Premium, where appropriate.

**Supplemental Application for Long-Term Care Insurance to:
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY PO Box 1365 Columbia, SC 29202**

Proposed Insured Section	
Proposed Insured's Name (First, MI, Last) John K Doe	Social Security Number 111-11-1111
Payroll Deduction Employer Name ABC Company	

Eligibility Section			Proposed Insured
1. Are you covered by Medicaid? If yes, you are not eligible for coverage.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
2. Do you need assistance, supervision, or use equipment or adaptive devices to perform any of the following activities: eating, dressing, toileting, transferring from bed to chair, continence, walking, or bathing?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. Have you ever received medical advice or sought treatment from a member of the medical profession (including medication) for: osteoporosis, rheumatoid arthritis, chronic fatigue syndrome, Parkinson's disease, Alzheimer's disease, or dementia?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
4. Do you have another long-term care insurance policy, certificate or rider in force (including health care service contract, health maintenance organization contract)? If yes, list details below.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
5. Did you have another long-term care insurance policy, certificate or rider in force during the last twelve (12) months? If yes, list details below.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
6. Do you intend to replace any of your medical or health insurance coverage with this long-term care insurance? If yes, list details below check appropriate box of coverage being replaced and complete replacement form if applicable in your state			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Insured Name	Insurance Company	Is coverage lapsed? If yes, when?	Check yes if replacement
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Agreement Section	
<p>Any person who knowingly presents a false or fraudulent claim for payment for 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. The answers and statements above are true and complete to the best of my knowledge and belief. I agree that they shall form a part of my application and any policy issued there under. If there is any conflict between the above statements and answers and those given in the application, the statements and answers contained on this supplemental application will control. This supplemental application is not complete without the application for life insurance.</p> <p>Caution: If your answers on this application are incorrect or untrue, Colonial has the right to deny benefits or rescind your rider.</p>	
<u><i>John K Doe</i></u> Signature of Proposed Insured	<u>10/1/2007</u> Date (mm/dd/yyyy)
_____ Signature of Applicant	

Agent Section	
<p>Listed below are any other health insurance policies I have sold to the Proposed Insured. Included are policies still in force and policies sold in the past 5 years which are no longer in force (provide dates of coverage). If none, check here: <input checked="" type="checkbox"/> None</p> <p>_____</p> <p>_____</p>	
<p>I hereby certify that I have truthfully and accurately recorded on this supplemental application the information supplied by the Proposed Insured. I further certify that I am a licensed agent in the state where this supplemental application is being taken. I understand that this supplemental application is not complete without the application for life insurance.</p>	
<u><i>Tom R Agent</i></u> Signature of Agent	<u>10/1/2007</u> Date (mm/dd/yyyy)

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

Colonial Life & Accident Insurance Company

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance rider to be issued by Colonial Life & Accident Insurance Company. Your new rider provides thirty (30) days within which you may decide without cost, whether you desire to keep the rider. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new rider

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new rider. This could result in denial or delay in payment of benefits under the new rider, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy, rider or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting condition or probationary periods in the new rider (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your rider had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Date _____ Agent's Name (If Present) _____
mm/dd/yyyy Please Print

(x) _____
Signature of Licensed Agent

The above "Notice to Applicant" was delivered to me on:

(x) _____ Date _____
Signature of Proposed Insured mm/d/yyyy

(x) _____
Signature of Applicant

THIRD PARTY NOTICE REQUEST

Colonial Life & Accident Insurance Company P.O. Box 1365, Columbia SC 29210

Proposed Insured Name: _____

Proposed Insured Social Security Number: _____

Name of Payroll Deduction Account: _____

Prior to our issuing a policy, certificate or rider, you have the right to provide your insurer with a written designation of at least one person who is to receive the notice of cancellation of the policy, certificate or rider for nonpayment of premium in addition to you, OR sign a waiver electing not to designate a person. If you elect to name a third party and your premium is not paid before the expiration of the grace period, the secondary addressee named below will be notified at least 30 days before your policy, certificate or rider is cancelled.

I hereby designate the following person to receive additional notification of Colonial Life & Accident Insurance Company's intent to cancel due to nonpayment of premium.

Name of Designated Person (First, MI, Last)			
Home Address – Street	City	State	Zip Code

OR

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination for nonpayment of premium. I understand that notice will not be given until after the expiration of the grace period. I elect not to designate any person to receive such notice.

Date _____
mm/dd/yyyy

(x) _____
Signature of Proposed Insured or Owner if Other than Proposed Insured

SERFF Tracking Number: UNUM-125350597 *State:* Arkansas
Filing Company: Colonial Life & Accident Insurance Company *State Tracking Number:* 37360
Company Tracking Number:
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: R-UL-LTC
Project Name/Number: LONG-TERM CARE/R-UL-LTC

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: UNUM-125350597 State: Arkansas
Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 37360
Company Tracking Number:
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: R-UL-LTC
Project Name/Number: LONG-TERM CARE/R-UL-LTC

Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 11/07/2007
Comments:
Attachments:
COMPLIANCE CERTIFICATION.pdf
READABILITY COMPLIANCE CERTIFICATION.pdf

Review Status:
Satisfied -Name: Application 11/07/2007
Comments:
Application is attached to the Form Schedule Tab.

Review Status:
Satisfied -Name: Outline of Coverage 11/07/2007
Comments:
The Outline of Coverages are attached to the Form Schedule Tab.

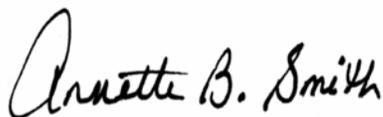
Review Status:
Satisfied -Name: NAIC Transmittal 11/07/2007
Comments:
Attachment:
AR NAIC Transmittal.pdf

Review Status:
Satisfied -Name: Submission Letter 11/09/2007
Comments:
Attachment:
LTC Submission Letter-Outline-ARrev.pdf

COMPLIANCE CERTIFICATION

FORM: R-UL-LTC
R-UL-LTC-O
R-UL-RB
R-UL-RB-O
LTC Supp 08-AR
LTC Replace
TPN

I certify that this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements.



November 7, 2007
Date

Annette Smith
Contract Analyst

READABILITY COMPLIANCE CERTIFICATION

<u>Form No.</u>	<u>Flesch Score</u>
R-UL-LTC	50.6
R-UL-LTC-O	50.2
R-UL-RB	50.5
R-UL-RB-O	50.0
LTC Supp 08-AR	50.0
LTC Replace	50.0
TPN	50.0

This is to certify that the attached Forms (listed above) have achieved the above Flesch Reading Ease Score and comply with the requirements of Arkansas Stat. Ann. § §66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



November 7, 2007

Annette Smith
Contract Analyst

Date

Life, Accident & Health, Annuity, Credit Transmittal Document (Revised 1/1/06)

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #
	Colonial Life & Accident Insurance Company PO BOX 1365 Columbia SC 29202	SC		0565	62049	57-0144607

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Annette B. Smith PO BOX 1365 Columbia SC 29202	800 845-7330 ext 6676	803 750-7341	absmith@coloniallife.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	R-UL-LTC, et al
-----------	--------------------------------	-----------------

7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise Group: <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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9.	Type of Insurance	LT03I Long Term Care
-----------	--------------------------	----------------------

10.	Product Coding Matrix Filing Code	LTC03I.001 Qualified
------------	--	----------------------

11.	Submitted Documents	<input type="checkbox"/> FORMS <input type="checkbox"/> Policy X Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment X Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other Rates <input checked="" type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input checked="" type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	November 7, 2007	
13	Filing Fee (If required)	Amount <u>\$140.00 (EFT)</u>	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval	Pending	
15.	Filing Description:		

16.	Certification (If required)		
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>			
Print Name <u>Wendy Smith</u>		Title <u>Assistant Secretary</u>	
Signature 		Date: <u>November 7, 2007</u>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		R-UL-LTC
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Long-Term Care Benefit Rider	R-UL-LTC	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Long-Term Care Benefit Rider Outline	R-UL-LTC-O	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Restoration of Benefits Rider	R-UL-RB	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	Restoration of Benefits Rider Outline	R-UL-RB-O	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05	Supplemental Application for Long-Term Care	LTC SUPP 08-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06	Replacement Form	LTC Replace	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07	Third Party Notice	TPN	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1



for what happens next

November 9, 2007

Julie Benafield Bowman
Commissioner of Insurance
Arkansas Insurance Department
Life & Health Division
1200 W 3rd St
Little Rock AR 72201-1904

RE: NAIC#/Group#: 62049 / 0565
Insurer: Colonial Life & Accident Insurance Company
Filing Type: Form
Line of Business: Health
Form(s): R-UL-LTC, et al

Dear Commissioner Bowman:

Enclosed for your consideration and approval are the following new individual Long-Term Care Benefit rider forms:

<u>Form Number</u>	<u>Description</u>	<u>Flesch Score</u>	<u>Issue Ages</u>
R-UL-LTC	Long-Term Care Benefit Rider	50.6	16-79 yrs
R-UL-LTC-O	Long-Term Care Benefit Rider Outline	50.2	
R-UL-RB	Restoration of Benefits Rider	50.5	16-79 yrs
R-UL-RB-O	Restoration of Benefits Rider Outline	50.0	
LTC Supp 08-AR	Supplemental Application for Long-Term Care	50.0	
LTC Replace	Replacement Form	50.0	
TPN	Third Party Notice Request Form	50.0	

Application form, LTC Supp 08-AR will be used to apply for the Long-Term Care Benefit Rider and Restoration of Benefits Rider forms. When scored with the rider, the LTC Supp 08-AR, LTC Replace and TPN forms achieve a score of 50 on the readability test.

The Long-Term Care Benefit Rider is intended to be a Qualified Long-Term Insurance contract under section 7702B(b) and (e)(1) of the Internal Revenue Code of 1986, as amended.

The rider forms will be used with our new individual Flexible Premium Adjustable (Universal) Life Insurance forms currently pending approval with your office.

The bar codes at the top right corner of the forms may appear differently in the submission packets. However, it will appear as a bar code on the policy forms that are issued to the policyholders by our mainframe system.

Colonial Supplemental Insurance

1200 Colonial Life Boulevard, Columbia, South Carolina 29210 • 803.798.7000 • www.coloniallife.com
Colonial Supplemental Insurance is the marketing brand of Colonial Life & Accident Insurance Company.

The Long-Term Care Benefit Rider provides benefits for Long-Term Care Confinement, Assisted Living Confinement, Home Health Care and Adult Day Care services for the Insured. Each monthly or partial payment under this rider will reduce the following items under the individual Flexible Premium Adjustable (Universal) Life Insurance policy, as applicable:

- Specified Amount;
- Death Benefit;
- Fund Value;
- Any indebtedness;
- Amount available for Policy Loans and Cash Withdrawals;
- Surrender Charges; and
- Amount available for advance of any part of the Death Benefit under any provision of the policy or any rider other than this rider.

Each monthly benefit payment will reduce each of the items listed above by a proportional amount.

Based on Long-Term Care Insurance Model Regulation 641, the following requirements do not apply because this rider will be attached to a life policy:

- Requirement to offer Inflation Protection;
- Suitability;
- Availability of new services or providers;
- Right to reduce coverage and lower premiums;
- Nonforfeiture Benefit; and
- Requirement to deliver Shopper's Guide; however, we will submit required information in the Policy Summary as outlined in the Long-Term Care Act Model 640.

The Restoration of Benefits Rider restores the policy values on a monthly basis as benefits are paid under the Long-Term Care Benefit Rider.

Enrollment methods include agent-assisted (in person or via call centers) and electronic application processes.

This plan will primarily be marketed to employees at the worksite. However, we may have some individual sales as well.

These forms were submitted to our domicile state, South Carolina, on October 31, 2007; however, they are not yet approved.

We are enclosing an Actuarial Memorandum and have submitted \$140.00 to cover the filing fees through Electronic Funds Transfer (EFT).

All required advertising will be submitted for consideration after approval of the rider forms.

If acceptable, we shall appreciate your notifying us via SERFF. If you have any questions, please contact me at (800) 845-7330, extension 6676. My email address is absmith@coloniallife.com. The fax number is (803) 750-7341.

Sincerely,



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Contract Analyst

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SERFF Tracking Number: UNUM-125350597 *State:* Arkansas
Filing Company: Colonial Life & Accident Insurance Company *State Tracking Number:* 37360
Company Tracking Number:
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: R-UL-LTC
Project Name/Number: LONG-TERM CARE/R-UL-LTC

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Third Party Notice	11/07/2007	TPN Regular 68587.pdf
No original date	Form	Supplemental Application for Long-Term Care	11/07/2007	LTC Supp 08-AR 68541 John Doe.pdf
No original date	Form	Replacement Form	11/07/2007	LTC Relace - Regular 68588.pdf
No original date	Supporting Document	Submission Letter	11/08/2007	LTC Submission Letter-Outline-AR.pdf

THIRD PARTY NOTICE REQUEST

Colonial Life & Accident Insurance Company P.O. Box 1365, Columbia SC 29210

Proposed Insured Name: _____

Proposed Insured Social Security Number: _____

Name of Payroll Deduction Account: _____

Prior to our issuing a policy, certificate or rider, you have the right to provide your insurer with a written designation of at least one person who is to receive the notice of cancellation of the policy, certificate or rider for nonpayment of premium in addition to you, OR sign a waiver electing not to designate a person. If you elect to name a third party and your premium is not paid before the expiration of the grace period, the secondary addressee named below will be notified at least 30 days before your policy, certificate or rider is cancelled.

I hereby designate the following person to receive additional notification of Colonial Life & Accident Insurance Company's intent to cancel due to nonpayment of premium.

Name of Designated Person (First, MI, Last)	Social Security Number	Date of Birth (mm/dd/yyyy)	
Home Address – Street	City	State	Zip Code

OR

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination for nonpayment of premium. I understand that notice will not be given until after the expiration of the grace period. I elect not to designate any person to receive such notice.

Date _____
mm/dd/yyyy

(x) _____
Signature of Proposed Insured or Owner if Other than Proposed Insured

**Supplemental Application for Long-Term Care Insurance to:
 COLONIAL LIFE & ACCIDENT INSURANCE COMPANY PO Box 1365 Columbia, SC 29202**

Proposed Insured Section	
Proposed Insured's Name (First, MI, Last) John K Doe	Social Security Number 111-11-1111
Payroll Deduction Employer Name ABC Company	

Eligibility Section			Proposed Insured
1. Are you covered by Medicaid? If yes, you are not eligible for coverage.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
2. Do you need assistance, supervision, or use equipment or adaptive devices to perform any of the following activities: eating, dressing, toileting, transferring from bed to chair, continence, walking, or bathing?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. Have you ever received medical advice or sought treatment from a member of the medical profession (including medication) for: osteoporosis, rheumatoid arthritis, chronic fatigue syndrome, Parkinson's disease, Alzheimer's disease, or dementia?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
4. Do you have another long-term care insurance policy, certificate or rider in force (including health care service contract, health maintenance organization contract)? If yes, list details below.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
5. Did you have another long-term care insurance policy, certificate or rider in force during the last twelve (12) months? If yes, list details below.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
6. Do you intend to replace any of your medical or health insurance coverage with this long-term care insurance? If yes, list details below check appropriate box of coverage being replaced and complete replacement form if applicable in your state			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Insured Name	Insurance Company	Is coverage lapsed? If yes, when?	Check yes if replacement
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Agreement Section	
<p>Any person who knowingly presents a false or fraudulent claim for payment for 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. The answers and statements above are true and complete to the best of my knowledge and belief. I agree that they shall form a part of my application and any policy issued there under. If there is any conflict between the above statements and answers and those given in the application, the statements and answers contained on this supplemental application will control. This supplemental application is not complete without the application for life insurance.</p> <p>Caution: If your answers on this application are incorrect or untrue, Colonial has the right to deny benefits or rescind your rider.</p>	
<u><i>John K Doe</i></u> Signature of Proposed Insured	<u>10/1/2007</u> Date (mm/dd/yyyy)

Agent Section	
Listed below are any other health insurance policies I have sold to the Proposed Insured. Included are policies still in force and policies sold in the past 5 years which are no longer in force (provide dates of coverage). If none, check here: <input checked="" type="checkbox"/> None _____ _____ _____	
I hereby certify that I have truthfully and accurately recorded on this supplemental application the information supplied by the Proposed Insured. I further certify that I am a licensed agent in the state where this supplemental application is being taken. I understand that this supplemental application is not complete without the application for life insurance.	
<u><i>Tom R Agent</i></u> Signature of Agent	<u>10/1/2007</u> Date (mm/dd/yyyy)

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

Colonial Life & Accident Insurance Company

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance rider to be issued by Colonial Life & Accident Insurance Company. Your new rider provides thirty (30) days within which you may decide without cost, whether you desire to keep the rider. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new rider

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new rider. This could result in denial or delay in payment of benefits under the new rider, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy, rider or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting condition or probationary periods in the new rider (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your rider had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Date _____ Agent's Name (If Present) _____
mm/dd/yyyy Please Print

(x) _____
Signature of Licensed Agent

The above "Notice to Applicant" was delivered to me on:

(x) _____ Date _____
Signature of Proposed Insured mm/dd/yyyy



for what happens next

November 7, 2007

Julie Benafield Bowman
Commissioner of Insurance
Arkansas Insurance Department
Life & Health Division
1200 W 3rd St
Little Rock AR 72201-1904

RE: NAIC#/Group#: 62049 / 0565
Insurer: Colonial Life & Accident Insurance Company
Filing Type: Form
Line of Business: Health
Form(s): R-UL-LTC, et al

Dear Commissioner Bowman:

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Contract Analyst

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