

SERFF Tracking Number: KANX-125799313 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number: 40130
Company Tracking Number: GDSAR0007410F01
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Group Disability Income
Project Name/Number: 8014 Group Disability Income/GDSAR0007410F01

Filing at a Glance

Company: Kanawha Insurance Company

Product Name: Group Disability Income

TOI: H11G Group Health - Disability Income

Sub-TOI: H11G.002 Short Term

Filing Type: Form

SERFF Tr Num: KANX-125799313 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 40130

Co Tr Num: GDSAR0007410F01

State Status: Approved-Closed

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI

Disposition Date: 09/05/2008

KanawhaInsuranceCompany

Date Submitted: 09/02/2008

Disposition Status: Approved-Closed

Implementation Date Requested: 10/03/2008

Implementation Date:

State Filing Description:

General Information

Project Name: 8014 Group Disability Income

Project Number: GDSAR0007410F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/05/2008

State Status Changed: 09/05/2008

Corresponding Filing Tracking Number:

Filing Description:

Kanawha Insurance Company is submitting the above captioned forms for review and approval. These forms are new and not intended to replace any other forms currently in use.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Deemer Date:

The enclosed forms are designed to provide group disability income coverage. The policy form will be issued in your state on a direct issue basis to groups traditionally recognized as eligible groups for group insurance in accordance with insurance laws, rules and regulations. The Company will use previously approved Group Policy Schedule Amendment

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form 1032 78-78, approved by your Department effective as of 07/29/05, with the forms.

With regard to marketing information, this policy will be offered on a contributory or non-contributory basis, where the insured may be required to contribute none, all, or a portion of the premium. Coverage will be marketed through agent/broker solicitation. This policy is being filed for concurrent approval in the domiciliary state, South Carolina.

All bracketed numbers are variable to the extent allowable by your state's laws. All bracketed text is variable to the extent allowed by law. In addition, the bracketed text may or may not be included in the policy when printed. In no event will numbers or text be changed to impact compliance with your law.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. In addition, the Master Application and Enrollment Form may be reproduced electronically which could result in formatting changes. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval. The Company will provide you a highlighted copy of any corrections it makes for your records.

The Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission

Company and Contact

Filing Contact Information

Margaret Dyches, Compliance
210 South White Street
Lancaster, SC 29720

margaret.dyches@kmgamerica.com
(803) 283-5300 [Phone]
(803) 313-5253[FAX]

Filing Company Information

Kanawha Insurance Company
210 South White Street
Lancaster, SC 29720
(803) 283-5300 ext. [Phone]

CoCode: 65110 State of Domicile: South Carolina
Group Code: Company Type:
Group Name: State ID Number:
FEIN Number: 570380426

Filing Fees

SERFF Tracking Number: KANX-125799313 State: Arkansas
Filing Company: Kanawha Insurance Company State Tracking Number: 40130
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Fee Required? Yes
Fee Amount: \$130.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kanawha Insurance Company	\$130.00	09/02/2008	22236635

SERFF Tracking Number: KANX-125799313 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/05/2008	09/05/2008

SERFF Tracking Number: *KANX-125799313* *State:* *Arkansas*
Filing Company: *Kanawha Insurance Company* *State Tracking Number:* *40130*
Company Tracking Number: *GDSAR0007410F01*
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.002 Short Term*
Product Name: *Group Disability Income*
Project Name/Number: *8014 Group Disability Income/GDSAR0007410F01*

Disposition

Disposition Date: 09/05/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: KANX-125799313 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number: 40130
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 Product Name: Group Disability Income
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Certification Rule 19	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOC	Approved-Closed	Yes
Supporting Document	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Evidence of Insurability	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	1380 11/08 AR	Application/Enrollment Form	Application/Master Application	Initial		45	1380 11_08 AR.PDF
Approved-Closed	1661 AR	Application/Enrollment Form	Application/Enrollment Form	Initial		46	1661 AR.PDF
Approved-Closed	1661 E AR	Other	Evidence of Insurability	Initial		54	1661 E AR.PDF
Approved-Closed	8014	Policy/Contract/Certificate	Policy	Initial		50	8014.PDF
Approved-Closed	8114	Certificate	Certificate	Initial		50	8114.PDF



Employer's Master Application For Group Voluntary Products

*Insurance products are underwritten
by Kanawha Insurance Company*

HUMANA[®]
Specialty Benefits

A. Employer Information

Name ABC Company
Address 101 Downtown Street City Anywhere State SC ZIP 29730
Telephone Number 555-555-4545 Fax Number 555-555-4545
Email Address jdoe@abccomp.com
Contact Person John Doe Title Vice President
Nature of Business _____
Employer Identification Number (EIN) 0001212010
Collectively Bargained Plan? Yes No Year Business Formed _____
Name of Plan ABC Company Plan
Plan Number 004545 (Assigned by Employer for use in filing IRS Form 5500)
Is this group considered a government entity or a church? Yes No

B. Billing Information (if different from above)

Name _____
Address _____ City _____ State _____ ZIP _____
Telephone Number _____ Fax Number _____
Email Address _____
Contact Person _____ Title _____

C. Billing Details (Billing to other than Employer requires prior Home Office Approval)

Billing Frequency: Monthly Other (specify day of month) _____
Payroll Frequency: Monthly Semi-Monthly Bi-Weekly Weekly Other _____
Preferred Billing Type: Paper E-mail Tape
Payroll Cutoff Date(s) to Receive Changes (specify day of month) 29th Day
Must Receive First Billing/Deductions by (specify day of month) 28th Day

D. Due Date

Effective Date of Policy and Due Date of First Premium will be (month, day, year) _____

E. Eligibility

Eligible Employees: Salary Exempt and Non-Exempt
 Wage and Hour Non-Exempt
 Other _____

An Eligible employee is one who is actively at work on a full-time basis working at least 30 hours per week.

Total Eligible Employees 30

Employer Contribution 50% Employee Contribution 50%

New employees hired after Effective Date of Policy will be eligible for coverage after:

- 1st of month following employment
 1st of month after 30 days of employment
 Other _____

F. Existing Coverage Available to Employees

Disability Income Carrier None Individual Group Coverage Termination Date _____
Dental Carrier None Individual Group Coverage Termination Date _____
CI/Cancer Carrier None Individual Group Coverage Termination Date _____

G. Products

DISABILITY

Plan Design:

- Benefits are provided in conjunction with an HSA Plan
 Benefits will be offered in conjunction with an IRS qualified pre-tax plan
- Benefit Period 90 Days 6 Months 1 Year 2 Years 3 Years
Elimination Period 0/7 7/7 0/14 14/14 30/30 60/60
 90/90 180/180 365/365

Optional Benefits – Employer Selectable

- Sickness Elimination Period Waiver - Available only if 7 or 14 day Elimination Period is selected for Sickness.
 Loss of Work Mental, Nervous, Alcohol and Drug Abuse
 24 hour Takeover (Prior carrier's policy and bill are required.)
 Portability

Optional Benefits – Employee Selectable

- COBRA Benefit Physical Therapy Benefit ICU/CCU Benefit

ACCIDENT INSURANCE

Base Plan:

- Level X Level 2 Level 3 Level 4

Optional Benefits

- Hospital Intensive Care Unit Benefit \$150 \$300 \$450 \$600
 Fracture and Dislocation Benefit \$750 \$1,500
 Accident Total Disability
Benefit (*Elimination Period*) 1 Day 7 Days 14 Days 30 Days
 On-the-Job Coverage Benefit

CRITICAL ILLNESS

Plan Design:

- Benefits are provided in conjunction with a HSA Plan
 Benefits will be offered in conjunction with an IRS qualified pre-tax plan

Coverage choices

- Vascular Cancer
 Other Critical Illnesses: 50% 100% (select one)

Optional Benefits – Employer Selectable

- Benefit Recurrence Loss of Work
 Takeover Benefit

Optional Benefits – Employee Selectable

- Health Screening Benefit \$50 \$100 \$150 (select one)
 Automatic Benefit Increase

TERM LIFE

Plan Design:

- 10 Year 20 Year

Optional Benefits – Employer Selectable

- Waiver of Premium Loss of Work
 Accidental Death and Loss of Sight Dismemberment
 Additional Benefit Increase
 Accelerated Living Benefit - Critical illness: 25% 50% 100% (select one)
 Takeover Benefit

H. State of Delivery

For the purpose of the Group Policy, the State of Situs will be Arkansas

Employer's Authorization/Agreement

Kanawha Insurance Company, a Humana Company, (hereafter referred to as Kanawha) is authorized to contact the employees of the Employer, named herein, concerning insurance to be provided by Kanawha.

Authorization is given to send billings to the location named herein. The responsibility of remitting premiums in a timely manner to Kanawha on behalf of their employees, whether collected via payroll deduction or employer-paid, is that of the Employer or Plan Sponsor.

Any employee may voluntarily stop his or her payroll deduction by notifying the Employer or Plan Sponsor. The Employer or Plan Sponsor will forward written notice of an employee's request to stop deductions to Kanawha's home office. It is also the Employer's or Plan Sponsor's responsibility to notify Kanawha of an employee's termination. The Employer or Plan Sponsor does not assume any responsibility of coverage after cancellation of the deductions or termination of employment of any employee.

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

Dated at Anywhere, AR this 22nd day of February, 20 08.
City State Month

Signature of Officer or Person Approving Agreement

Signature of Licensed Insurance Producer

Title

Printed Name of Licensed Insurance Producer

Printed Name of Officer or Person Approving Agreement

License Identification Number of Insurance Producer

**GOVERNMENT ENTITIES AND CHURCHES ARE CONSIDERED NON-ERISA CASES.
EMPLOYER GROUPS ELECTING OPTIONAL BENEFITS COVERAGE MAY BE SUBJECT
TO THE TERMS AND CONDITIONS OF ERISA.**

HUMANA
Specialty Benefits

210 South White Street
Post Office Box 7777
Lancaster, South Carolina 29721-7777
1 (877) 378-1505

Kanawha Insurance Company is a member of the Humana family of companies.

Enrollment Form for Voluntary Group Disability Income Benefits

Kanawha Insurance Company



PLEASE INDICATE: ENROLLMENT FOR NEW COVERAGE CHANGE TO EXISTING COVERAGE

Section A: Always complete this Section with Proposed Insured's information for all coverages.

Proposed Insured (Please Print)

Proposed Insured for Coverage (First Name, MI, Last Name) Suffix

J O H N C D O E

Birthdate (MM/DD/YYYY) Social Security Number Gender

0 8 / 2 9 / 1 9 5 0 1 2 3 - 4 5 - 6 7 8 9 Male Female

Address (Street or R.R.)

1 2 3 M A I N S T R E E T

City State ZIP Code Telephone Number

L A N C A S T E R S C 2 9 7 2 0 (8 0 3) 2 8 5 - 1 2 3 2

Employer Name or Group Number Date of Employment (MM/DD/YYYY)

K M G A M E R I C A 0 1 / 1 1 / 1 9 9 0

Benefit Group (If applicable) 1 2 3 4 5

DISABILITY INCOME COVERING ACCIDENT AND SICKNESS

Benefit Period

90 Days 6 Months 1 Year 2 Years 3 Years

Elimination Period

0/7 7/7 0/14 14/14
 30/30 60/60 90/90 180/180
 365/365

DISABILITY INCOME COVERING ACCIDENT AND SICKNESS WITH WAIVER OF ELIMINATION PERIOD

Benefit Period

90 Days 6 Months 1 Year 2 Years 3 Years

Elimination Period

0/7 7/7 0/14 14/14

OPTIONAL DISABILITY INCOME BENEFITS

ICU/CCU Benefit (\$200 per unit) 1 2 3 4

Takeover Physical Therapy Benefit COBRA Rider COBRA Rider Benefit Amount \$, 5 0 0

Earnings

\$, 5 0 0 . 0 0

Per Hour Month Week Year

Monthly Benefit

\$, 5 0 0

Modal Premium

\$, 5 0 0 . 0 0

Section B: Always complete this Section.

- 1. Are you currently actively at work?.....
- 2. How many hours per week do you work?.....
- 3. Do you have any other disability income coverage in force or an Application/Enrollment Form for disability insurance pending with this or any other company?.....
- 4. Have you used any form of tobacco in the past 12 months?.....

Proposed Insured

Yes No

40

Yes No

Yes No

Section C: Complete this Section and Questions 1-4 if applying for Contingent Guarantee Issue

- 5. Have you missed 5 or more consecutive days of work in the past 12 months for any injury or illness other than cold, flu or maternity?.....
- 6. Have you ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?.....
- 7. In the past 12 months, have you received medical advice, sought treatment, taken medication or been hospitalized for cancer (except basal cell skin cancer), insulin dependent diabetes or cirrhosis?.....

Proposed Insured

Yes No

Yes No

Yes No

Section D: Complete this Section and Questions 1-7 if applying for Simplified Issue

- 8. In the past 5 years have you received medical advice, sought treatment or taken medication for any of the following: heart attack, heart surgery, heart disease, high blood pressure reading of 140/90 or above, stroke, transient ischemic attack (TIA), cancer (except basal cell skin cancer), end stage renal/kidney disease, muscle, back, joint disorders, diabetes, emphysema, lung disease, liver disease, hepatitis, cirrhosis, neurological disorder, multiple sclerosis, chronic fatigue syndrome, fibromyalgia, digestive/intestinal disease, alcohol or drug usage?.....
- 9. Height (Ft-In) Weight

Proposed Insured

Yes No

5 - 02 165

PROPOSED INSURED'S REPRESENTATION AND AGREEMENT

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

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that the above statements are representations and not warranties.

Signed At LANCASTER SC
City State

08 / 28 / 2008
Date (MM/DD/YYYY)

JOHN C DOE
Signature of Proposed Insured

INSURANCE PRODUCER'S USE ONLY

I certify any information recorded by me on this Enrollment Form is true and accurate to the best of my knowledge and belief.

Date (MM/DD/YYYY)

Signature of Licensed Insurance Producer S/B LILLY KANAWHA
(Not required)

0 8 / 2 8 / 2 0 0 8

Insurance Producer Number

1 2 3 4 5 6 7 8 9

% Credit

1 0 0

Insurance Producer Number

% Credit

Section A: Always complete this Section with Proposed Insured's information for all coverages.

Proposed Insured (Please Print)	Proposed Insured for Coverage (First Name, MI, Last Name)										Suffix																			
	J	O	H	N					C	D	O	E																		
	Birthdate (MM/DD/YYYY)				Social Security Number				Gender																					
	0	8	/	2	8	/	1	9	5	0	1	2	3	-	4	5	-	6	7	8	9	<input checked="" type="radio"/> Male	<input type="radio"/> Female							
	Employer Name or Group Number										Date of Employment (MM/DD/YYYY)																			
K	M	G		A	M	E	R	I	C	A											0	1	/	0	1	/	1	9	9	0
Benefit Group (If applicable) <input checked="" type="radio"/> 1												<input type="radio"/> 2		<input type="radio"/> 3		<input type="radio"/> 4		<input type="radio"/> 5												

Section B: Always complete this Section.

<p>1. A) Are you currently pregnant?.....</p> <p>B) If "Yes", what was your pre-pregnancy weight.....</p> <p>2. Has the Proposed Insured had any surgery or been advised to have surgery in the past 6 months?.....</p> <p>3. Has the Proposed Insured been declined for any life or disability insurance coverage in the past 6 months?.....</p> <p>4. Has the Proposed Insured had any symptoms, injury, birth defect, disease or disorder not mentioned above?.....</p> <p>If "Yes" to questions 2-4, provide details.</p> <p>_____</p> <p>_____</p>	<p>Proposed Insured</p> <p><input type="radio"/> Yes <input checked="" type="radio"/> No</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

PROPOSED INSURED'S REPRESENTATION AND AGREEMENT

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

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that the above statements are representations and not warranties.

Signed At LANCASTER S C 0 8 / 2 8 / 2 0 0 8

City State Date (MM/DD/YYYY)

JOHN C DOE
 Signature of Proposed Insured

KANAWHA INSURANCE COMPANY

[210 SOUTH WHITE STREET, POST OFFICE BOX 610
LANCASTER, SC 29721-0610]
TELEPHONE [1-877-378-1505]

GROUP DISABILITY INCOME INSURANCE POLICY

POLICY NUMBER: [#####]

ISSUED TO POLICYHOLDER: [XYZ, INC.]

INITIAL EFFECTIVE DATE: [MM/DD/YYYY]

PREMIUMS PAYABLE: [MONTHLY]

SITUS STATE: [ANY STATE]

This Policy is a legal contract between Kanawha Insurance Company ("Company") and the Policyholder. All the provisions on this page and the following are part of this Policy.

The insurance offered by the Company is shown on the Application for this Policy. Insurance selected by the Policyholder and issued by the Company is shown on the Schedule. Insurance on Covered Persons is shown in their Certificates.

This Policy may be renewed on each Policy Renewal Date by agreement between the Company and the Policyholder. Any change in the terms will be shown on an amendment or amended Schedule.

This Policy is non-participating. This means that it will not share in the Company's profits or surplus earnings and the Company will pay no dividends on it.

This Policy is issued in and governed by the laws of the Situs State.

The Policy application may have been captured electronically or on paper. Please carefully review answers to questions on the Application to make sure they are answered correctly. If an error exists, please notify Us immediately.

Signed for the Company

[]

[President]

GROUP DISABILITY INCOME INSURANCE POLICY
Non-Participating

TABLE OF CONTENTS

Schedule 3
Eligibility 4
Eligibility to Enroll 4
Effective Date of Insurance 5
Benefits 5
Disability Income Benefits 5
Optional Benefits 7
Limitations and Exclusions 10
Claim Provisions 10
Premium Provisions 12
Policy Termination..... 12
Termination Of The [Employee/Member] Insurance..... 12
General Provisions 13
Definitions 15

SCHEDULE

[DISABILITY INCOME BENEFITS]

[Employee/Member]s:	[Exempt Employee/Member]'s] [Other Named Class] [Other Named Class]
Minimum Total Disability Monthly Benefit Amount:	\$300
Minimum Partial Disability Monthly Benefit Amount:	\$150
Maximum Total Disability Monthly Benefit Amount:	[70% or up to \$5,000]
Maximum Partial Disability Monthly Benefit Amount:	[70% or up to \$2,500]

Benefit Groups

[Accident/Sickness:

Elimination Periods: 0/7, 7/7, 0/14, 14/14,
30/30, 60/60, 90/90, 180/180 and 365/365

Benefit Periods: 90 days, 6 months, 1 year, 2
years and 3 years]

Note: Not all Elimination Periods may be
available with all Benefit Periods

[Accident/Sickness with Waiver of Elimination
Period:

Elimination Periods: 0/7, 7/7, 0/14, 14/14

Benefit Periods: 90 days, 6 months, 1 year, 2
years and 3 years]

[Waiver of Premium Benefit

Waives Certificate Premiums when Covered
[Employee/Member] is Totally Disabled for more
than 90 days or the Elimination Period, if longer]

[OPTIONAL BENEFITS]

Employer Selected

[24 Hour Coverage	[Included or Not Included]]
[Loss of Work Benefit	[Included or Not Included]]
[Mental Illness and Substance Abuse	[Included or Not Included]]

[Employee/Member Selected, if Employer Authorized]

[COBRA	[Included or Not Included]
	Min [\$200]
	Max [\$2000]
[Intensive Care Benefit]	[Included or Not Included]
	[\$200 per unit; max [four (4)] units]

SCHEDULE

[Physical Therapy Benefit

[Included or Not Included]]

[Evidence of Insurability may be required if an Amount applied for [exceeds Our normal limits] [or] [is [\$xxx,xxx] or higher].]

[[ELIGIBILITY

[Classes of Eligible [Employee/Member]s:]

[Exempt Employee/Members]

[Other Named Class]

[Other Named Class]

[[ELIGIBILITY REQUIREMENTS FOR THE ELIGIBLE [EMPLOYEE/MEMBER]S]

[In order to Enroll, the Eligible [Employee/Member] must be [Actively at Work (Active Employment)]:

[for the [Exempt Employee/Member]s Actively At Work means [20] hours per [week]]

[for [Other Named Class] Actively At Work means [20] hours per [week]]

[for [Other Named Class] Actively At Work means [20] hours per [week]]]

[[[Waiting Periods for Eligible [Employee/Member]s are as follows:]

[[Exempt Employee/Member]s are Eligible to Enroll on Date of Employment]

[[Other Named Class] are Eligible to Enroll after Active Employment for [30 days]]

[[Other Named Class] are Eligible to Enroll after Active Employment for [90 days]]]

However, if an Eligible [Employee/Member] is not Actively At Work at the end of the Waiting Period, the Waiting Period will be extended until the Eligible [Employee/Member] resumes work in a pattern that will establish Active Employment.]

[Eligible [Employee/Member]s must be Age [18] but not more than Age [99].] The Maximum Renewal Age is to Age [70]. [However, the [Employee/Member] who remains Actively At Work after Age [70] will remain an Eligible [Employee/Member].]

[EFFECTIVE DATES FOR CHANGES IN AMOUNTS OF INSURANCE]

[Increases in the amount of insurance based on Policy provisions will occur [on the first day of the [Calendar Month] following the change].]

[If Evidence of Insurability is not required, increases requested by the Insured will occur [on the first day of the [Calendar Month] following the change request].]

[If Evidence of Insurability is required, increases requested by the Insured will occur [on the first day of the [Calendar Month] after We approve the Evidence of Insurability].]

[Decreases requested by the Insured will occur on [the first day of the [Calendar Month]] following receipt of the written request by the Policyholder.]

ELIGIBILITY TO ENROLL

A person is Eligible to Enroll when He:

- is a member of a Class of Eligible [Employee/Member]s listed on the Schedule; and
- meets the Eligibility Requirements shown on the Schedule.

EFFECTIVE DATE OF INSURANCE

Subject to payment of Premium, insurance starts when a person:

- joins a Class of Eligible [Employee/Member]s;
- meets the Eligibility Requirements shown on the Schedule; and
- completes an Enrollment Form, if required.

However, if the Eligible [Employee/Member] does not Enroll, insurance will not become effective until the [first day] of the [Calendar Month] following a later Enrollment.

We may require Evidence of Insurability if Enrollment takes place more than [30] days after the [Employee/Member] first becomes Eligible.

[The Benefit Amount available without Evidence of Insurability is shown on the Schedule.]

EFFECTIVE DATE FOR POLICY PROVISION CHANGES

Changes will occur on the Policy Anniversary Date.

BENEFITS

Benefit Amounts selected by the Policyholder and approved by the Company are shown on the Schedule of this Policy.

Benefits shown on the Certificate are available:

- to persons Eligible;
- who have Enrolled for the Benefits;
- are covered under the terms and conditions of this Policy; and
- for whom premiums are paid.

The Monthly Benefit Amount of insurance based on Age, Class or other factors agreed to by the Company and the Policyholder are shown on the Schedule.

All Benefits of this Policy are subject to the Benefit Conditions, Limitations and Exclusions provision.

DISABILITY INCOME BENEFITS

TOTAL DISABILITY INCOME BENEFIT

We will pay the [Employee/Member] the Total Disability Income Benefit when He submits Proof of Loss after the Elimination Period ends.

We will pay the applicable benefit if the [Employee/Member] becomes Totally Disabled while insured under this Policy.

The Monthly Benefit Amount for Total Disability will begin to accrue with the first day after the applicable Elimination Period expires.

Partial months of Total Disability will be prorated based on a 30-day month. The [Employee/Member] will receive benefits as long as He remains Totally Disabled, up to the applicable Maximum Benefit Period for any one Total Disability.

The Monthly Benefit Amount and Elimination Period are shown on the Schedule of Benefits in each [Employee/Member]'s Certificate.

[WAIVER OF PREMIUM BENEFIT

We will waive premiums from the first date of Total Disability if the Disability of the [Employee/Member] continues:

- for more than 90 days; or
- the Elimination Period, if greater.

Premiums will be waived using the payment mode in effect on the day before Total Disability started.

Waiver of Premium will continue while the [Employee/Member] is receiving a Total Disability Income Benefit of this Policy.

When the [Employee/Member] is no longer eligible for Waiver of Premiums, He must resume payment of premiums to keep his Policy in force.]

PARTIAL DISABILITY BENEFIT

We will pay the [Employee/Member] the Partial Disability Monthly Benefit Amount when He:

- becomes Partially Disabled while insured under this Policy;
- satisfies the Elimination Period;
- has received a Total Disability Income Benefit for at least one day; and
- submits Proof of Loss.

This Benefit amount will be the lesser of:

- the Partial Disability Monthly Benefit Amount shown on the Schedule; or
- Occupational Income minus Compensation payable for the same period.

If the optional 24-Hour Coverage Disability Benefit is in force on the date of loss, this Benefit will be the lesser of:

- the Partial Disability Monthly Benefit Amount shown on the Schedule; or
- Occupational Income minus the sum of Compensation and Other Income payable for the same period.

We will never pay less than the Minimum Partial Disability Monthly Benefit Amount shown on the Schedule.

RECURRENT DISABILITY BENEFIT

No new Elimination Period will be required for a Recurrent Disability for which Benefits are payable.

We will pay the [Employee/Member] benefits for the remaining Benefit Period.

CONCURRENT TOTAL DISABILITIES

If Total Disability results from more than one Accident and/or Sickness at the same time, it will be considered the same Total Disability and the [Employee/Member] will be entitled to a Monthly Benefit Amount for only one Total Disability. We will pay only up to the Maximum Benefit Period shown on the Schedule for concurrent or partially concurrent periods of Total Disability resulting from two or more causes.

The existence of Concurrent Total Disabilities will not extend the Maximum Benefit Period shown on the Schedule or increase the Monthly Benefit Amount for Total Disability.

CONTINUOUS OR SUCCESSIVE TOTAL DISABILITIES

We will pay only up to the Maximum Benefit Period shown on the Schedule for continuous or successive periods of Total Disability due to different and/or unrelated causes. To be continuous or successive such periods must be separated by a return to work at the [Employee/Member]'s Regular Occupation for at least [30] consecutive regularly scheduled working days.

[OPTIONAL BENEFITS]

[24 HOUR COVERAGE

We will pay to the [Employee/Member] benefits for losses contributed to or caused by:

- His employment; or
- Sickness or Injury for which Benefits are paid or payable under any Workers' Compensation or occupational disease law.

Other Income paid or payable will reduce monthly Benefits payable for Total and Partial Disability under the Policy.

If Other Income is paid to the [Employee/Member] in a lump sum, We will:

- prorate the lump sum over the period that it covers; or
- if the lump sum covers no stated period, We will prorate it over His expected lifetime.

If Other Income is prorated over His expected lifetime, the amount will be:

- calculated by an actuary; and
- based on a mortality table with interest.

If the 24-Hour Coverage Disability Benefit is in force on the date of loss, We will pay the lesser of:

- the Total Disability Income Benefit amount shown on the Schedule; or
- Occupational Income minus Other Income payable for the same period.

We will never pay less than the Minimum Total Disability Monthly Benefit shown on the Schedule.]

[LOSS OF WORK BENEFIT

We will provide this Benefit if the [Employee/Member] suffers a Loss of Work that:

- starts more than 30 days after the Effective Date of Insurance; and
- continues for 30 or more consecutive days.

[The 30-day period after the Effective Date of Insurance will be reduced by one day for each day that a Replaced Policy with a Loss of Work Benefit was in force.]

We will waive premiums of the [Employee/Member]'s Certificate. Premiums will be waived as they fall due beginning on the 31st day of the Loss of Work.

We will waive premiums for a maximum of [six (6) months] during a continuous Loss of Work. Losses of Work separated by less than six (6) months are considered continuous.

We will waive premiums for not more than [12] months for all Losses of Work occurring while this Benefit is in force.

We will refund any Premium paid but not due.]

[MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFIT

We will pay 50% of the Benefits for Total or Partial Disability shown on the Schedule when disability is contributed to or caused by Mental or Emotional Disease or Disorder, Alcoholism or Drug Addiction.

Benefits for Mental or Emotional Disease or Disorder are payable when the [Employee/Member] submits Proof of Loss after the Elimination Period. He must be under the care of:

- a registered psychiatrist;
- a Physician treating Him as advised by a registered psychiatrist; or
- a Physician, if, in Our opinion, such treatment is appropriate for His condition.

Benefits for Alcoholism or Drug Addiction are payable when the [Employee/Member] submits Proof of Loss after the Elimination Period. He must be in a treatment program licensed or certified by an appropriate government authority in the United States that provides substance abuse treatment.

During any disabilities due to Mental or Emotional Disease or Disorder, Alcoholism or Drug Addiction, the Maximum Benefit Period is six (6) months, or the Maximum Benefit Period shown on the Schedule, if less. We will pay no more than 12 months, during the entire time that the Policy is in force for any disabilities contributed to or caused by Mental or Emotional Disease or Disorder, Alcoholism or Drug Addiction.]

[ELIMINATION PERIOD WAIVER BENEFIT

The Monthly Benefit Amount for Total Disability will be paid from the first day of inpatient confinement to a licensed acute care Hospital until:

- the end of the Elimination Period; or
- the end of Total Disability, if earlier.

This benefit does not apply to this Policy's Maximum Benefit Period.]

[PORTABILITY

PORTABILITY BENEFIT

If employment is terminated and the Employee is no longer in Active Employment with the Employer, the Employee may continue coverage under the Policy subject to the Benefit Conditions, Limitations and Exclusions and by:

- providing Us with satisfactory Evidence of Insurability, if required, within 31 days after coverage is terminated; and
- paying premiums when due.

The Policy must be in force on the date that the Employee ports coverage. If the Policy terminates, the ported Certificate terminates.

The Loss of Work Benefit does not apply to ported coverage.

Subject to the Benefit Conditions, Limitations and Exclusions provision, the Employee may port Benefits when He:

- has been continuously covered by the Policy for at least [six (6)] months;
- is less than Age [70];
- is not Totally Disabled; and
- is no longer Actively At Work as the Employee.

If the Employee is no longer eligible for coverage for any other reason stated in the Termination of Employee/Member Insurance provision, the Employee may not continue coverage under the Certificate.]

[COBRA BENEFIT

We will pay an additional Benefit equal to the monthly expense the [Employee/Member] incurs for medical COBRA Premiums of a medical coverage plan but not to exceed the amount shown on the Policy Schedule. The medical COBRA Premium amount eligible is the amount He would have paid for His coverage on the date He first became eligible for COBRA. The Benefit will be paid in addition to the Total Disability Income Benefit of the Policy when:

- He is Totally Disabled by a condition covered by the Total Disability Income Benefit of the Policy;
- He has satisfied the Elimination Period of the Policy;
- His employment terminates while We are paying the Total Disability Income Benefit of the Policy;
- He was covered under a medical coverage plan eligible for COBRA continuation when employment terminated;
- He elected to continue medical coverage under COBRA in accordance with the terms of the Medical Coverage Plan of his employer and paid the medical COBRA Premiums; and
- He submits proof of payment that the medical COBRA Premiums were paid.

We will continue payment of the Benefit until the earliest of the following:

- the date Total Disability ends;
- the date the Total Disability Income Benefit Period of the Policy ends;
- the date He discontinues paying medical COBRA Premiums; or
- the date on which He is no longer eligible for COBRA coverage.

The COBRA benefit is not available for [Employee/Member]s who selected the 90 day Benefit Period.]

[PHYSICAL THERAPY BENEFIT

For each new Total Disability We will pay [\$100] per visit up to five [5] visits for treatments provided by a Licensed Physical Therapist when:

- such treatment is due to a covered Total Disability;
- the [Employee/Member] has satisfied the Elimination Period for that Total Disability; and
- visits are within 180 days after the end of the Benefit Period.

[This benefit is not payable for treatments related to the [Employee/Member]'s employment or for treatments which are related to a Sickness or Injury covered under Workers Compensation or any other occupational disease law.]]

[INTENSIVE CARE/CARDIAC CARE UNIT BENEFIT

When the [Employee/Member] is confined to a Hospital Intensive Care/Cardiac Care Unit as a result of Injury or Sickness, We will pay [\$200] per day per unit for each confinement. This benefit is limited to a maximum of [four (4)] units and total of [30] days per calendar year.

This benefit is subject to base policy exclusions and limitations except:

- the [Employee/Member]'s employment; and
- Sickness or Injury for which Benefits are paid or payable under any Workers' Compensation or occupational disease law.]

LIMITATIONS AND EXCLUSIONS

Benefits are not payable for losses contributed to or caused by:

- [the [Employee/Member]'s employment;]
- [Sickness or Injury for which Benefits are paid or payable under any Workers' Compensation or occupational disease law;]
- Pre-Existing Conditions causing a loss within [12] months after the Date of Certificate;
- suicide, attempted suicide or intentionally self-inflicted Injury, whether sane or insane;
- voluntary inhalation of or asphyxiation by gas or fumes;
- voluntary ingestion or injection of any drug, narcotic, sedative or poison, unless prescribed by and taken in accordance with the directions of the prescribing Physician;
- [Mental or Emotional Disease or Disorder;]
- [Alcoholism or Drug Addiction;]
- being intoxicated as intoxication is defined by the laws of the state in which the incident occurred;
- participating in a riot or civil insurrection;
- war or act of war (whether declared or undeclared);
- travel or flight in or descent from any aircraft other than as a fare-paying passenger on a regularly scheduled airline;
- Injury sustained or Sickness contracted as a result of full-time active duty (other than for 30 days or less training) in any branch of the military forces;
- engaging in an illegal occupation; or
- committing or attempting to commit a felony or an assault.

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given to Us within [30] days after the date of a loss. If that is not possible, We must be notified as soon as it is reasonably possible to do so.

When We receive written notice of claim, We will send claim forms. If the claim forms are not received within [15] days after the notice is sent, written proof of claim can be sent to Us without waiting for the forms.

PROOF OF LOSS

Proof of Loss must be given to Us within [90] days after a loss occurs or starts.

If it is not possible to give proof within this time limit, it must be given as soon as reasonably possible. Proof of Loss may not be given later than one year after the time such proof is otherwise required, except if the individual is legally unable to provide it.

Proof of Loss includes a claim form or other documents satisfactory to Us.

Proof of Loss may also include statements completed by the [Employee/Member] and/or the claimant, [the Employer] and the attending Physician documenting:

- the nature of the loss;
- the date, or inclusive dates, of loss; and
- the cause of loss.

[For the Waiver of Premium Benefit, We may require Proof of Loss on a monthly basis. We will not require such Proof of Loss on a monthly basis when it is no longer reasonably necessary to do so.]

[For the Loss of Work Benefit, Proof of Loss includes documentation from the [Employee/Member]'s Employer and/or union that He is Laid Off, Locked Out, or On Strike.]

On request, We will tell the [Employee/Member] or other claimant what forms or documents are required.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

We will give the [Employee/Member] or the claimant a claim form upon request. He is responsible for any costs to complete the claim form.

We may ask for other Proof of Loss from Hospitals and Physicians. We will pay the reasonable cost of obtaining these records.

PAYMENT OF CLAIMS

Benefits will be paid to the [Employee/Member]. If He does not live to receive payment, any Benefit will be paid to His:

- beneficiary, if one is named; or
- estate.

If Benefits are payable to the [Employee/Member]'s estate or to a beneficiary who cannot give Us a valid release, We can pay up to [\$1,000] to someone related to him, by blood or marriage, whom We find is justly entitled to payment. Such a payment made in good faith will discharge Us to the extent of the amount paid.

TIME PAYMENT OF CLAIMS

Payment will be issued upon receipt of Proof of Loss acceptable to Us but not later than [30] days after receipt of Proof of Loss.

EXAMINATION

We, at Our own expense, will have the right and opportunity to have a claimant examined by a healthcare professional of Our choice. This right may be exercised as often as reasonably required.

[PRE-EXISTING CONDITIONS LIMITATION

[Total Disability caused by Pre-existing Conditions is not covered for [12] months after the Date of Certificate of the [Employee/Member.]] [However, Benefits may be paid for a loss due to a Pre-existing Condition of a Covered Person who was covered:

- by a Replaced Policy; and
- by this Policy on its Initial Effective Date.

We will determine payment of claim using the following:

1. We will review the claim. If this Policy's Pre-Existing Condition Exclusion does not apply, We will pay the Benefits of this Policy.
2. If the Covered Person does not satisfy this Policy's Pre-Existing Condition Exclusion, but can satisfy the Replaced Policy's Pre-Existing Condition Exclusion giving credit for all time insured under both policies; then We will pay the lesser of:
 - (a) this Policy's Benefit without applying the Pre-Existing Condition Exclusion; or
 - (b) the Benefit of the Replaced Policy.

Any payment under "(a)" or "(b)" above will be in accord with all terms of the relevant policy.

3. If the Covered Person does not satisfy the Pre-Existing Condition Exclusion of this Policy or that of the Replaced Policy, no Benefit will be paid.
4. If the replaced certificate provided a benefit that this policy does not provide, no benefit will be paid.]]

PREMIUM PROVISIONS

PREMIUMS

Premiums are payable to the Company.

The first Premium is due on the Initial Effective Date. Later premiums are due according to the mode of Premium payment shown on the face page of this Policy.

We actuarially determine the premiums. We reserve the right to change the premiums as stated in the Change in Premium provision.

CHANGE IN PREMIUM

We may change the Premium rates:

- [when the number of [Employee/Members] covered changes by [20%] or more after the Initial Effective Date, or the Anniversary Date, if later;]
- [when Policy terms or conditions are modified;]
- [when there is a material change in the risk insured];
- [when the Policyholder is sold or merges with another entity];
- [when the Policyholder purchases, acquires or establishes a new affiliate or subsidiary]; or
- [on any Premium Due Date.]

[However, if the Company has given a Rate Guarantee, We will not change premiums prior to the end of such Rate Guarantee period. We will provide the Policyholder with at least [45] days advance notice of any Premium rate change.]

POLICY TERMINATION

The Policyholder has the right to cancel this Policy on any Premium due date. Written notice must be given to Us at least [45] days before the date this Policy is to end.

We have the right to cancel this Policy on any Premium due date. [However, if We have given a Rate Guarantee, We will not cancel this Policy prior to the end of such Rate Guarantee period.] We will give the Policyholder at least [45] days notice before this Policy is to end.

This Policy and its insurance shall end if the Policyholder fails to pay the Premium before the end of the Grace Period.

Termination is without prejudice to any Claim that takes place or starts prior to the date of termination.

TERMINATION OF THE [EMPLOYEE/MEMBER] INSURANCE

The [Employee/Member] will cease to be insured under this Policy on the earliest of the following dates:

- the date on which the [Employee/Member] requests termination, if this Policy provides contributory insurance;
- the date on which this Policy is terminated;
- the date on which the [Employee/Member] is no longer in an eligible class;
- the date on which the [Employee/Member]'s class is no longer included for insurance;

- the end of the period for which the last required contribution for the [Employee/Member]'s insurance has been paid; or
- the date on which Active Employment ends, or the [Employee/Member]'s Retirement Date.

Termination of the [Employee/Member]'s insurance is without prejudice to any claim that occurred or commenced prior to the date of such termination.

GENERAL PROVISIONS

AGREEMENTS AND POLICY CHANGES

No change in this Policy shall be valid unless made by endorsement or amendment. Such a change is valid only if signed by Our Chairman, Chief Executive Officer, President, a Vice President or the Secretary.

No other person can waive any Policy terms or make any agreements about this policy that are binding on Us.

CERTIFICATES

We will give a Certificate to the Policyholder for delivery to each [Employee/Member] stating:

- [the insurance protection provided[.]] [;] [and]
- [to whom the insurance Benefits are payable[.]] [;] [and]
- [the Portability rights provided by this Policy.]

CLERICAL ERROR

No Clerical Error by the Policyholder will:

- delay the Effective Date of the [Employee/Member]'s insurance;
- end insurance otherwise validly in force;
- continue insurance otherwise validly terminated; or
- provide coverage for an ineligible [Employee/Member].

CONFORMITY WITH STATE STATUTES

Any Policy wording that, on the Initial Effective Date, is in conflict with the statutes of the Situs State is hereby amended to meet the minimum requirements of such statutes.

DATA REQUIRED

The Policyholder will give Us all data and proof that We may reasonably need to administer this Policy.

DATE OF BIRTH OR TOBACCO USE

If the [Employee/Member]'s date of birth or tobacco use is misstated, We will adjust the Benefits payable. The Benefits will be those which We would have issued based on the correct information and based on the premiums that were paid.

ENTIRE CONTRACT

This Policy, the Application, Enrollment forms and Evidence of Insurability as well as any endorsements and amendments shall make up the entire contract.

Statements made by the Policyholder or the [Employee/Member] shall be deemed representations and not warranties.

EVIDENCE OF INSURABILITY

We may require evidence that a person meets our underwriting standards for this insurance.

GRACE PERIOD

This Policy has a Grace Period of [31] days for the payment of any Premium due except the first.

During the Grace Period, this Policy is in force, unless the Policyholder gives Us written notice to cancel it before the end of the Grace Period. The Policyholder shall be liable to Us for the payment of a pro-rata premium for the time this Policy was in force during the Grace Period.

INCONTESTABILITY

The validity of this Policy will not be contested except for nonpayment of premiums after it has been in force for [two (2)] years from its Initial Effective Date.

No statement made by the [Employee/Member] shall be used in any contest unless a copy of the statement is or has been furnished to:

- the [Employee/Member]; or,
- in the event of death or incapacity of the [Employee/Member], to His beneficiary or personal representative.

Except for claims incurred within [two (2)] year[s] after the [Employee/Member]'s Effective Date of Insurance, no statement made by any [Employee/Member] when applying for insurance will be used to contest the validity of that insurance after:

- the insurance has been continuously in force for [two (2)] years during the lifetime of the covered person; and
- unless it is contained in a written form signed by the [Employee/Member].

The [two (2)] year period will be extended by any period for which the [Employee/Member] is Totally and/or Partially Disabled.

This provision shall not preclude the assertion at any time of defenses based upon Policy provisions that relate to eligibility for coverage.

LEGAL ACTIONS

Legal action cannot be taken against Us:

- sooner than 60 days after due Proof of Loss has been filed; or
- more than [three (3)] years after the time written Proof of Loss is required to be filed according to the terms of the Policy.

NON-PARTICIPATING

This Policy is a non-participating policy. We will not pay dividends on this Policy.

DEFINITIONS

Accident means a sudden, unexpected, violent and external event that causes bodily injury to the [Employee/Member].

Actively at Work (Active Employment) means that the [Employee/Member] is performing the normal duties of His Regular Occupation or Any Occupation:

- on a full-time basis;
- at the Employer's usual place of business; and
- Is not Partially Disabled.

The [Employee/Member] is deemed to be Actively at Work on each day of regular paid vacation or legal holiday if He:

- is not Totally Disabled or Partially Disabled; and
- was Actively at Work on the last working day before such vacation or legal holiday.

Age means the Age of the [Employee/Member] on His last birthday as of the Certificate Effective Date and any subsequent Certificate anniversary date.

Alcoholism means a combination of symptoms including tolerance of, physical dependence on and pathological organ changes caused by alcohol consumption.

Any Occupation means a job, profession or activity for wages or profit that the [Employee/Member] is or becomes fitted to perform based on His education, training and experience.

Benefit Period means the period of time for which Monthly Income Benefits are payable for disability due to the same cause. It starts on the day after the Elimination Period ends. It continues until the earliest of the following:

- the date the [Employee/Member] is no longer Totally Disabled;
- the end of the Benefit Period shown on the Schedule; or
- the date of His death.

Certificate Effective Date means the date that coverage begins under the Certificate once premiums are paid.

Class means a group of [Employee/Member]s categorized together for rating purposes under this Policy form.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985.

Compensation means the [Employee/Member]'s monthly salary, wages and/or commissions received from an Employer.

Date of Policy means the date shown on the Schedule or in an Endorsement to this Policy.

Drug Addiction means the use of a drug for a reason other than which it was intended or in a manner or in quantities other than directed by the prescribing Physician.

Effective Date means the date that coverage begins under the Policy.

Elimination Period means the number of days that the [Employee/Member] must be Totally Disabled before Benefits for Total or Partial Disability are payable.

Days of Total Disability will count toward the Elimination Period if continuous or:

- due to the same or related cause(s), and

- separated from the prior period of Total Disability by less than eight days.
Days of Partial Disability do not count toward the Elimination Period.

Benefits subject to the Elimination Period are shown on the Schedule.

[Employee means a person who:

- is in Active Employment of the Policyholder; and
- meets the Enrollment Eligibility and Waiting Period provisions shown on the Certificate Schedule.]

[Employer means an entity that employs a workforce of persons in Active Employment. Employer includes any division, subsidiary or affiliated.] [For the purpose of this definition, Employer also includes employers of union members.]

Enroll means application by the [Employee/Member] for Policy coverage. By agreement between the Company and the Policyholder, Enrollment may:

- require completion of an Enrollment Form by the [Employee/Member]; or
- be automatic, in which case it is not necessary for the [Employee/Member] to complete an Enrollment Form; and
- require Evidence of Insurability.

Hospital means an accredited institution where people receive medical, surgical, or psychiatric treatment and nursing care.

Initial Effective Date means the first date that coverage begins for any class under the Policy.

Injury means bodily harm caused by an Accident that the [Employee/Member] sustains which:

- is independent of all other causes, and
- occurs after the Effective Date and while this Policy is in force.

Insured means the [Employee/Member] who is covered by the Policy.

[Laid Off means that the [Employee/Member]'s job has been ended or suspended by His employer due to:

- a decrease in output by the Employer;
- a decrease in staff due to economic conditions;
- a reorganization that eliminates the Insured's job; or
- a reorganization that eliminates the Employer's need for the Insured's job skills.

Laid Off does not include termination for cause or because the [Employee/Member] is no longer physically able to perform the job.]

[Licensed Physical Therapist means a person who:

- is trained and certified by a state or accrediting body;
- provides treatment of physical dysfunction or injury by the use of therapeutic exercise; and
- applies therapeutic modalities, intended to restore or facilitate normal function or development.]

[Locked Out means that the [Employee/Member]'s place of employment has been shut down by His employer during a labor dispute. The Lockout must be lawful.]

[Loss of Work means that the [Employee/Member] is Laid Off, Locked Out or On Strike, or any combination of the three.]

Maximum Benefit Period means the period of time for which a Benefit is payable. Maximum Benefit Periods are shown on the Schedule.

After a Benefit is paid for its Maximum Benefit Period, that Benefit is not payable except as may be allowed by the Continuous or Successive Disabilities provision.

[Member means a person who is in a Class shown on the Schedule [and in good standing as defined by the [Association's] requirements and bylaws.]]

Mental or Emotional Disease or Disorder means a condition so classified in the [Diagnostic and Statistical Manual of Mental Disorders (DSM)]. We will use the [DSM] most current as of the date of loss. If the [DSM] is discontinued or replaced, We will use published data that, in Our opinion, provides the most comparable information.

Mental or Emotional Disease or Disorder does not include any condition excluded from the coverage of this Policy by name or specific description.

Mental or Emotional Disease or Disorder does not include dementia, if caused by:

- stroke;
- trauma;
- infection; or
- Alzheimer's disease.

[Occupational Income means the Eligible Persons' monthly rate of earnings from His Employer as of the day before the start of Total Disability. Occupational Income does not include:

- overtime pay;
- bonuses; or
- extra compensation other than commissions.

Occupational Income will include commissions averaged over:

- the 12 calendar months ending the month before Total Disability began; or
- the number of full calendar months that the [Employee/Member] was employed before Total Disability began, if less than 12 months.]

[On Strike (Strike) means that the [Employee/Member]s acting together:

- have ceased work, or
- are refusing to work or to continue to work for the [Employee/Member]'s Employer.

The Strike must be authorized under the rules of a union or unions representing the [Employee/Member] and other striking Employees.

The union or unions authorizing the strike must be recognized by the [Employee/Member]'s Employer for collective bargaining purposes.

The Strike must be lawful and must not take place while a labor contract is still in effect.]

[Other Income means periodic or lump-sum Benefits of the following when payable because the [Employee/Member] is disabled or retired:

- Workers' Compensation;
- occupational disease law;
- State Disability Insurance;
- Social Security;
- any pension plan of an Employer;
- Railroad Retirement;

- any group disability benefit plan or policy of an Employer; or
- any individual disability benefit insurance policy, if the premiums are paid by or through an Employer.

Other Income does not include increases in the above that occur after the start of the [Employee/Member]'s Elimination Period.]

Partial Disability (Partially Disabled) means that, because of a covered Sickness or Injury, the [Employee/Member] is:

- working more than 20% but not more than 80% of His normal pre-disability schedule; and
- under the regular care of a Physician.

His normal pre-disability schedule is as defined by the [Employee/Member]'s Employer but does not include overtime.

Physician means a medical doctor or other person recognized as a physician by law or regulation in the state where services are provided. The person must be licensed and practicing in the United States.

Physician does not include:

- the [Employee/Member];
- a person related to the [Employee/Member] by blood or marriage; or
- a medical doctor or other person practicing outside of the United States.

Policy Anniversary Date means the day the policy is initially issued and is yearly renewed.

Pre-Existing Condition means an Injury or Sickness which a Physician has treated or for which a Physician has advised treatment within 12 months prior to the Certificate Date. It is also one which would cause a person to seek diagnosis or care within the same 12-month period.

A normal pregnancy beginning prior to the Effective Date is considered to be a Pre-Existing Condition, whether or not it was disclosed on the Enrollment Form.

Recurrent Disability means Total and/or Partial Disability that:

- is due to the same or related causes as a prior period of disability;
- follows a prior period for which a Monthly Benefit was paid; and
- occurs within 180 days after the end of a prior period for which a Monthly Benefit was paid.

Regular Occupation means the [Employee/Member]'s usual job, profession or activity for wages, compensation or profit at the start of a Total Disability covered by this Policy.

[Replaced Policy] means a policy or certificate for which the premiums are paid by or through the Policyholder. It must:

- have a paid-to date within [60] days of the Policy's Date of Application;
- be replaced by this Policy; and
- end upon issue of this Policy.

At Our request, the Policyholder must give Us Proof about the [Employee/Member]'s Replaced Policy or Certificate.]

Sickness means an illness, disease or complication of pregnancy that first makes itself known after the Effective Date and while this Policy is in force.

Benefits for a normal pregnancy are provided on the same basis as for any other Sickness.

[State Disability Insurance means the temporary disability insurance programs sponsored by:

- California;
- Hawaii;
- New Jersey;
- New York;
- Rhode Island;
- Puerto Rico; or
- a political subdivision of the United States.]

Successive Disability means a Total and/or Partial Disability that is:

- not due to the same or related causes as a prior period of disability; and
- separated from any prior period for which Monthly Benefits were paid by [30] consecutive days during which the [Employee/Member] is Actively at Work and not Partially Disabled.

Totally Disabled (Total Disability) means, for the first [24] months of a disability that the [Employee/Member] is:

- unable to perform the substantial and material duties of His Regular Occupation;
- not working in any other occupation; and
- under the care of a Physician for the disability.

After [24] months of Total Disability, Totally Disabled means that the [Employee/Member] is:

- unable to perform the duties of Any Occupation; and
- under the care of a Physician for the disability.

We will not require care of a Physician when it is no longer needed for the sound medical care of the condition causing Total Disability.

United States means the United States of America, including its states, territories and possessions.

We, Us, Our and Company all mean Kanawha Insurance Company.

You and Your mean the [Employee/Member].

Any reference to "He," "Him" or "His" will also refer to "She" or "Her," "They," "Them" or "Their."

KANAWHA INSURANCE COMPANY

[210 SOUTH WHITE STREET, POST OFFICE BOX 610
LANCASTER, SC 29721-0610]
TELEPHONE [1-877-378-1505]

**GROUP DISABILITY INCOME INSURANCE CERTIFICATE
NON-PARTICIPATING**

[POLICYHOLDER LOGO (OPTIONAL)]

CERTIFICATE OF GROUP DISABILITY INCOME INSURANCE FOR:
[EXEMPT EMPLOYEES OF XYZABC, INC.]
[OTHER NAMED CLASS]

TABLE OF CONTENTS

Insuring Information..... 3
Schedule 4
Eligibility 5
Effective Date of Insurance 5
Benefits 5
Disability Income Benefits 5
Optional Benefits 7
Limitations and Exclusions 9
Claim Provisions 10
Termination Of Your Insurance 11
General Provisions 11
Definitions 13

INSURING INFORMATION

Kanawha Insurance Company has issued Group Disability Income Insurance Policy [#####] (“the Policy”) to the Policyholder:

[XYZABC, Inc.]
[1234 Any Street]
[Any City, Any State 99999]

The Policy’s Initial Effective Date was [January 1, 2008].

Your Certificate Effective Date is [January 1, 2008].

This is a Certificate issued under the terms of the Policy. It is a summary of the Policy.

If the Policy and this Certificate differ, the Policy will govern. On request, the Policyholder will provide You with the Policy or a copy of it for review.

SCHEDULE

[DISABILITY INCOME BENEFITS]

[Employee/Member]s:	[Exempt Employees] [Other Named Class]
Minimum Total Disability Monthly Benefit Amount:	\$300
Minimum Partial Disability Monthly Benefit Amount:	\$150
Your Total Disability Monthly Benefit Amount:	[\$5,000]
Your Partial Disability Monthly Benefit Amount:	[\$2,500]

Benefit Groups

[Accident/Sickness:	
Elimination Period:	[0/7, 7/7, 0/14, 14/14, 30/30, 60/60, 90/90, 180/180 or 365/365]
Benefit Period:	[90 days, 6 months, 1 year, 2 years or 3 years]]
[Accident/Sickness with Waiver of Elimination Period:	
Elimination Period:	[0/7, 7/7, 0/14, or 14/14]
Benefit Period:	[90 days, 6 months, 1 year, 2 years or 3 years]]
[Waiver of Premium Benefit	Waives Certificate Premium when You are Totally Disabled for more than 90 days or the Elimination Period, if longer]]

[OPTIONAL BENEFITS]

[Employer Selected]

[24 Hour Coverage	[Included or Not Included]]
[Loss of Work Benefit	[Included or Not Included]]
[Mental Illness and Substance Abuse	[Included or Not Included]]

[Your Selection, if Employer Authorized]

[COBRA	[Included or Not Included] Benefit Amount: [\$2000]]
[Intensive Care Benefit	[Included or Not Included] Benefit Amount: [\$200][\$400][\$600] or [\$800]]
[Physical Therapy Benefit	[Included or Not Included]]

[Evidence of Insurability may be required if an Amount applied for [exceeds Our normal limits].

[[ELIGIBILITY

[Your Class:]

[Exempt [Employee/Member]s]
[Other Named Class]

[You must be Age [18] but not more than Age [99] to participate in this plan.] The Maximum Renewal Age is to Age [70]. [However, an [Employee] who remains Actively At Work after Age [70] will remain an Eligible [Employee/Member].]

[CHANGES IN AMOUNTS OF INSURANCE

Changes in amounts of Your insurance will occur under the terms of the Policy.]

EFFECTIVE DATE OF INSURANCE

Subject to payment of Premium, insurance starts when You:

- join a Class of Eligible [Employee/Member]s;
- meet the Eligibility Requirements stated in the Policy; and
- complete an Enrollment Form, if required.

However, if You do not Enroll, insurance will not become effective until the [first day] of the [Calendar Month] following a later Enrollment.

We may require You to provide Us with Evidence of Insurability if Enrollment takes place more than [30] days after You first become Eligible.

BENEFITS

Benefit Amounts selected by the Policyholder and approved by the Company are shown on the Schedule of the Policy.

Benefits shown on this Certificate are available to You if:

- enrolled for the Benefits;
- covered under the terms and conditions of the Policy; and
- premiums are paid.

All Benefits of the Policy are subject to the Benefit Conditions, Limitations and Exclusions provision.

DISABILITY INCOME BENEFITS

TOTAL DISABILITY INCOME BENEFIT

We will pay You the Total Disability Income Benefit when You submit Proof of Loss after the Elimination Period ends.

We will pay the applicable benefit if You become Totally Disabled while insured under the Policy.

The Monthly Benefit Amount for Total Disability will begin to accrue with the first day after the applicable Elimination Period expires.

Partial months of Total Disability will be prorated based on a 30-day month. You will receive benefits as long as You remain Totally Disabled, up to the applicable Maximum Benefit Period for any one Total Disability.

The Monthly Benefit Amount and Elimination Period are shown on the Schedule of Benefits.

[WAIVER OF PREMIUM BENEFIT

We will waive premiums from the first date of Total Disability if Your Total Disability continues:

- for more than 90 days; or
- the Elimination Period, if greater.

Premiums will be waived using the payment mode in effect on the day before Total Disability started.

Waiver of Premium will continue while You are receiving a Total Disability Income Benefit.

When You are no longer eligible for Waiver of Premiums, You must resume payment of premiums to keep Your Certificate in force.]

PARTIAL DISABILITY BENEFIT

We will pay You the Partial Disability Monthly Benefit Amount when You:

- become Partially Disabled while insured under the Policy;
- satisfy the Elimination Period;
- have received a Total Disability Income Benefit for at least one day; and
- submit Proof of Loss.

This Benefit amount will be the lesser of:

- the Partial Disability Monthly Benefit Amount shown on the Schedule, or
- Occupational Income minus Compensation payable for the same period.

If the optional 24-Hour Coverage Disability Benefit is in force on the date of loss, this Benefit will be the lesser of:

- the Partial Disability Monthly Benefit Amount shown on the Schedule, or
- Occupational Income minus the sum of Compensation and Other Income payable for the same period.

We will never pay less than the Minimum Partial Disability Monthly Benefit Amount shown on the Schedule.

RECURRENT DISABILITY BENEFIT

No new Elimination Period will be required for a Recurrent Disability for which Benefits are payable.

We will pay You benefits for the remaining Benefit Period.

CONCURRENT TOTAL DISABILITIES

If Total Disability results from more than one Accident and/or Sickness at the same time, it will be considered the same Total Disability and You will be entitled to a Monthly Benefit Amount for only one Total Disability. We will pay only up to the Maximum Benefit Period shown on the Schedule for concurrent or partially concurrent periods of Total Disability resulting from two or more causes.

The existence of Concurrent Total Disabilities will not extend the Maximum Benefit Period shown on the Schedule or increase the Monthly Benefit Amount for Total Disability.

CONTINUOUS OR SUCCESSIVE TOTAL DISABILITIES

We will pay only up to the Maximum Benefit Period shown on the Schedule for continuous or successive periods of Total Disability due to different and/or unrelated causes. To be continuous or successive such

periods must be separated by a return to work at Your Regular Occupation of at least [30] consecutive regularly scheduled working days.

[OPTIONAL BENEFITS]

[24 Hour Coverage]

We will pay to You benefits for losses contributed to or caused by:

- Your employment; or
- Sickness or Injury for which Benefits are paid or payable under any Workers' Compensation or occupational disease law.

Other Income paid or payable will reduce monthly Benefits payable for Total and Partial Disability under the Policy.

If Other Income is paid to You in a lump sum, We will:

- prorate the lump sum over the period that it covers, or
- if the lump sum covers no stated period, We will prorate it over Your expected lifetime.

If Other Income is prorated over Your expected lifetime, the amount will be:

- calculated by an actuary, and
- based on a mortality table with interest.

If the 24-Hour Coverage Disability Benefit is in force on the date of loss, We will pay the lesser of:

- the Total Disability Benefit amount shown on the Schedule; or
- Occupational Income minus Other Income payable for the same period.

We will never pay less than the Minimum Total Disability Monthly Benefit shown on the Schedule.]

[LOSS OF WORK BENEFIT]

We will provide this Benefit if You suffer a Loss of Work that:

- starts more than 30 days after the Effective Date of Insurance; and
- continues for 30 or more consecutive days.

[The 30-day period after the Effective Date of Insurance will be reduced by one day for each day that a Replaced Policy with a Loss of Work benefit was in force.]

We will waive premiums of this Certificate. Premiums will be waived as they fall due beginning on the 31st day of the Loss of Work.

We will waive premiums for a maximum of [six (6) months] during a continuous Loss of Work. Losses of Work separated by less than six (6) months are considered continuous.

We will waive premiums for not more than [12] months for all Losses of Work occurring while this Benefit is in force.

We will refund any Premium paid but not due.]

[MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFIT]

We will pay 50% of the Benefits for Total or Partial Disability shown on the Schedule when disability is contributed to or caused by Mental or Emotional Disease or Disorder, Alcoholism or Drug Addiction.

Benefits for Mental or Emotional Disease or Disorder are payable when You submit Proof of Loss after the Elimination Period. You must be under the care of:

- a registered psychiatrist;
- a Physician treating You as advised by a registered psychiatrist; or
- a Physician, if, in Our opinion, such treatment is appropriate for Your condition.

Benefits for Alcoholism or Drug Addiction are payable when You submit Proof of Loss after the Elimination Period. You must be in a treatment program licensed or certified by an appropriate government authority in the United States that provides substance abuse treatment.

During any disabilities due to Mental or Emotional Disease or Disorder, Alcoholism or Drug Addiction, the Maximum Benefit Period is six (6) months, or the Maximum Benefit Period shown on the Schedule, if less. We will pay no more than 12 months, during the entire time that the Policy is in force for any disabilities contributed to or caused by Mental or Emotional Disease or Disorder, Alcoholism or Drug Addiction.]

[Elimination Period Waiver Benefit

The Monthly Benefit Amount for Total Disability will be paid from the first day of inpatient confinement to a licensed acute care Hospital unit until:

- the end of the Elimination Period; or
- the end of Total Disability, if earlier.

This benefit does not apply to this Certificate's Maximum Benefit Period.]

[PORTABILITY

Portability Benefit

If employment is terminated and You are no longer in Active Employment with Your Employer, You may continue Your Certificate coverage under the Policy subject to the Benefit Conditions, Limitations and Exclusions and by:

- providing Us with satisfactory Evidence of Insurability, if required, within 31 days after coverage is terminated; and
- paying premiums when due.

The Policy must be in force on the date that You port coverage. If the Policy terminates the ported Certificate terminates.

The Loss of Work Benefit does not apply to ported coverage.

Subject to the Benefit Conditions, Limitations and Exclusions provision, You may port Benefits when You:

- have been continuously covered by the Policy for at least [six (6)] months;
- are less than Age [70];
- are not Totally Disabled; and
- are no longer Actively At Work as the Employee.

If You are no longer eligible for coverage for any other reason stated in the Termination of Your Insurance provision, You may not continue coverage under this Certificate.]

[COBRA BENEFIT

We will pay an additional Benefit equal to the monthly expense You incur for medical COBRA premiums of a medical coverage plan but not to exceed the amount shown on the Certificate Schedule. The medical COBRA Premium amount eligible is the amount You would have paid for Your initial COBRA coverage on the date You first became eligible for COBRA. The Benefit will be paid in addition to the Total Disability Income Benefit of the Policy when:

- You are Totally Disabled by a condition covered by the Total Disability Income Benefit;
- You have satisfied the Elimination Period;
- Your employment terminates while We are paying the Total Disability Income Benefit;
- You were covered under a medical coverage plan eligible for COBRA continuation when employment terminated;
- You have elected to continue medical coverage under COBRA in accordance with the terms of the medical coverage plan of Your employer and paid the medical COBRA premiums; and
- You have submitted proof of payment that the Medical COBRA premiums were paid.

We will continue payment of the Benefit until the earliest of the following:

- the date Total Disability ends;
- the date the Total Disability Income Benefit Period ends;
- the date You discontinue paying medical COBRA premiums; or
- the date on which You are no longer eligible for COBRA coverage.

The COBRA benefit is not available if you have selected the 90 day Benefit Period.]

[PHYSICAL THERAPY BENEFIT

For each new Total Disability, We will pay [\$100] per visit up to [five (5)] visits for treatments provided by a Licensed Physical Therapist when:

- such treatment is due to a covered Total Disability;
- You have satisfied the Elimination Period for that Total Disability; and
- visits are within 180 days after the end of the Benefit Period.

This benefit is not payable for treatments related to Your employment or for treatments which are related to a Sickness or Injury covered under Workers Compensation or any other occupational disease law.]

[INTENSIVE CARE/CARDIAC CARE UNIT BENEFIT

When You are confined to a Hospital Intensive Care/Cardiac Care Unit as a result of Injury or Sickness, We will pay [\$200] per day per unit for each confinement. This benefit is limited to a maximum of [four (4)] units and a total of [30] days per calendar year.

This benefit is subject to base policy exclusions and limitations except:

- Your employment; and
- Sickness or Injury for which Benefits are paid or payable under any Workers' Compensation or occupational disease law.]

LIMITATIONS AND EXCLUSIONS

Benefits are not payable for losses contributed to or caused by:

- [Your employment;]
- [Sickness or Injury for which Benefits are paid or payable under any Workers' Compensation or occupational disease law;]
- Pre-Existing Conditions causing a loss within [12] months after the Date of Certificate;
- suicide, attempted suicide or intentionally self-inflicted Injury, whether sane or insane;
- voluntary inhalation of or asphyxiation by gas or fumes;
- voluntary ingestion or injection of any drug, narcotic, sedative or poison, unless prescribed by and taken in accordance with the directions of the prescribing Physician;
- [Mental or Emotional Disease or Disorder;]
- [Alcoholism or Drug Addiction;]
- being intoxicated as intoxication is defined by the laws of the state in which the incident occurred;
- participating in a riot or civil insurrection;
- war or act of war (whether declared or undeclared);

- travel or flight in or descent from any aircraft other than as a fare-paying passenger on a regularly scheduled airline;
- Injury sustained or Sickness contracted as a result of full-time active duty (other than for 30 days or less training) in any branch of the military forces;
- engaging in an illegal occupation; or
- committing or attempting to commit a felony or an assault.

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given to Us within [30] days after the date of a loss. If that is not possible, We must be notified as soon as it is reasonably possible to do so.

When We receive written notice of claim, We will send claim forms. If the claim forms are not received within [15] days after the notice is sent, written proof of claim can be sent to Us without waiting for the forms.

PROOF OF LOSS

Proof of Loss must be given to Us within [90] days after a loss occurs or starts.

If it is not possible to give proof within this time limit, it must be given as soon as reasonably possible. Proof of Loss may not be given later than one year after the time such proof is otherwise required, except if the individual is legally unable to provide it.

Proof of Loss includes a claim form or other documents satisfactory to Us.

Proof of Loss may also include statements completed by You and/or the claimant, [the Employer] and the attending Physician documenting:

- the nature of the loss;
- the date, or inclusive dates, of loss; and
- the cause of loss.

PAYMENT OF CLAIMS

Benefits will be paid to You. If You do not live to receive payment, any Benefit will be paid to Your:

- beneficiary, if one is named; or
- estate.

If Benefits are payable to Your estate or to a beneficiary who cannot give Us a valid release, We can pay up to [\$1,000] to someone related to You, by blood or marriage, whom We find is justly entitled to payment. Such a payment made in good faith will discharge Us to the extent of the amount paid.

TIME PAYMENT OF CLAIMS

Payment will be issued upon receipt of Proof of Loss acceptable to Us but not later than [30] days after receipt of Proof of Loss.

EXAMINATION

We, at Our own expense, will have the right and opportunity to have You examined by a healthcare professional of Our choice. This right may be exercised as often as reasonably required.

[PRE-EXISTING CONDITIONS LIMITATION

[Total Disability caused by Pre-Existing Conditions is not covered for [12] months after Your Date of Certificate.] [However, Benefits may be paid for a loss due to a Pre-Existing Condition if you were covered:

- by a Replaced Policy; and
- by the Policy on its Initial Effective Date.

We will determine payment of claim using the following:

1. We will review the claim. If this Certificate's Pre-Existing Condition Exclusion does not apply, We will pay the Benefits of the Policy.
2. If the Covered Person does not satisfy the Policy's Pre-Existing Condition Exclusion, but can satisfy the Replaced Policy's Pre-Existing Condition Exclusion giving credit for all time insured under both policies; then We will pay the lesser of:
 - (a) the Policy's Benefit without applying the Pre-Existing Condition Exclusion; or
 - (b) the Benefit of the Replaced Policy.Any payment under "(a)" or "(b)" above will be in accord with all terms of the relevant policy.
3. If You do not satisfy the Pre-Existing Condition Exclusion of the Policy or that of the Replaced Policy, no Benefit will be paid.
4. If the replaced policy provided a benefit that the Policy does not provide, no benefit will be paid.]]

TERMINATION OF YOUR INSURANCE

You will cease to be insured under the Policy on the earliest of the following dates:

- the date on which You request termination, if the Policy provides contributory insurance;
- the date on which the Policy is terminated;
- the date on which You are no longer in an eligible class;
- the date on which Your class is no longer included for insurance;
- the end of the period for which the last required contribution for Your insurance has been paid; or
- the date on which Active Employment ends or Your Retirement Date.

Termination of Your insurance is without prejudice to any claim that occurred or commenced prior to the date of such termination.

GENERAL PROVISIONS

AGREEMENTS AND POLICY CHANGES

No change in the Policy shall be valid unless made by endorsement or amendment. Such a change is valid only if signed by Our Chairman, Chief Executive Officer, President, a Vice President or the Secretary.

No other person can waive any Policy terms or make any agreements about the policy that are binding on Us.

CLERICAL ERROR

No Clerical Error by the Policyholder will:

- delay the Effective Date of Your insurance;
- end insurance otherwise validly in force;
- continue insurance otherwise validly terminated; or
- provide coverage for an ineligible [Employee/Member].

CONFORMITY WITH STATE STATUTES

Any Policy wording that, on the Initial Effective Date, is in conflict with the statutes of the Situs State is hereby amended to meet the minimum requirements of such statutes.

DATE OF BIRTH OR TOBACCO USE

If Your date of birth or tobacco use is misstated, We will adjust the Benefits payable. The Benefits will be those which We would have issued based on the correct information and based on the premiums that were paid.

ENTIRE CONTRACT

This Certificate, the Policy, the Application, Enrollment forms and Evidence of Insurability as well as any endorsements and amendments shall make up the entire contract.

Statements made by the Policyholder or You shall be deemed representations and not warranties.

EVIDENCE OF INSURABILITY

We may require evidence that You meet our underwriting standards for this insurance.

GRACE PERIOD

The Policy has a Grace Period of [31] days for the payment of any Premium due except the first.

During the Grace Period, the Policy is in force, unless the Policyholder gives Us written notice to cancel it before the end of the Grace Period. The Policyholder shall be liable to Us for the payment of a pro-rata premium for the time the Policy was in force during the Grace Period.

INCONTESTABILITY

The validity of the Policy will not be contested except for nonpayment of premiums after it has been in force for [two (2)] years from its Initial Effective Date.

No statement made by You shall be used in any contest unless a copy of the statement is or has been furnished to:

- You; or,
- in the event of Your death or incapacity, to Your beneficiary or personal representative.

Except for claims incurred within [two (2)] year[s] after Your Certificate Effective Date of Insurance, no statement made by You when applying for insurance will be used to contest the validity of that insurance after:

- the insurance has been continuously in force for [two (2)] years during Your lifetime; and
- unless it is contained in a written form signed by You.

The [two (2)] year period will be extended by any period for which You are Totally and/or Partially Disabled.

This provision shall not preclude the assertion at any time of defenses based upon Policy provisions that relate to eligibility for coverage.

LEGAL ACTIONS

Legal action cannot be taken against Us:

- sooner than 60 days after due Proof of Loss has been filed; or
- More than [three (3)] years after the time written Proof of Loss is required to be filed according to the terms of the Policy.

DEFINITIONS

Accident means a sudden, unexpected, violent and external event that causes You bodily Injury.

Actively at Work (Active Employment) means that You perform the normal duties of Your Regular Occupation or Any Occupation:

- on a full-time basis;
- at the Employer's usual place of business; and
- are not Partially Disabled.

You are deemed to be Actively at Work on each day of regular paid vacation or legal holiday if You:

- are not Totally Disabled or Partially Disabled, and
- were Actively at Work on the last working day before such vacation or legal holiday.

Age means Your Age on Your last birthday as of the Certificate Effective Date and any subsequent Certificate anniversary date.

Alcoholism means a combination of symptoms including tolerance of, physical dependence on and pathological organ changes caused by alcohol consumption.

Any Occupation means a job, profession or activity for wages or profit that You are or become fitted to perform based on Your education, training and experience.

Benefit Period means the period of time for which Monthly Income Benefits are payable for disability due to the same cause. It starts on the day after the Elimination Period ends. It continues until the earliest of the following:

- the date You are no longer Totally Disabled;
- the end of the Benefit Period shown on the Schedule; or
- the date of Your death.

Certificate Effective Date means the date that coverage begins under this Certificate once premium is paid.

Class means a group of Eligible [Employee/Member]s categorized together for rating purposes under the Policy form.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985.

Compensation means Your monthly salary, wages and/or commissions received from an Employer.

Drug Addiction means the use of a drug for a reason other than which it was intended or in a manner or in quantities other than directed by the prescribing Physician.

Effective Date means the date that coverage begins under the Policy.

Elimination Period means the number of days that You must be Totally Disabled before Benefits for Total or Partial Disability are payable.

Days of Total Disability will count toward the Elimination Period if continuous or:

- due to the same or related cause(s), and
- separated from the prior period of Total Disability by less than eight days.

Days of Partial Disability do not count toward the Elimination Period.

Benefits subject to the Elimination Period are shown on the Schedule.

[Employee means a person who:

- is in Active Employment of the Policyholder; and
- meets the Enrollment Eligibility and Waiting Period provisions shown on the Policy Schedule .]

[Employer means an entity that employs a workforce of persons in Active Employment. Employer includes any division, subsidiary or affiliated company.] [For the purpose of this definition, Employer also includes employers of union members.]

Enroll means application by You for Policy coverage, if required. By agreement between the Company and the Policyholder, Enrollment may:

- require completion of an Enrollment Form by You; or
- be automatic, in which case it is not necessary for You to complete an Enrollment Form; and
- require Evidence of Insurability.

Hospital means an accredited institution where people receive medical, surgical, or psychiatric treatment and nursing care.

Initial Effective Date means the first date that coverage begins for any class under the Policy.

Injury means bodily harm caused by an Accident that You sustain which:

- is independent of all other causes, and
- occurs after the Effective Date and while the Policy is in force.

[Laid Off means that Your job has been ended or suspended by Your employer due to:

- a decrease in output by the employer;
- a decrease in staff due to economic conditions;
- a reorganization that eliminates Your job; or
- a reorganization that eliminates the employer's need for Your job skills.

Laid Off does not include termination for cause or because You are no longer physically able to perform the job.]

[Licensed Physical Therapist means a person who:

- is trained and certified by a state or accrediting body;
- provides treatment of physical dysfunction or injury by the use of therapeutic exercise; and
- applies therapeutic modalities, intended to restore or facilitate normal function or development.]

[Locked Out means that Your place of employment has been shut down by Your employer during a labor dispute. The Lockout must be lawful.]

[Loss of Work means that You are Laid Off, Locked Out, On Strike, or any combination of the three.]

Maximum Benefit Period means the period of time for which a Benefit is payable. Maximum Benefit Periods are shown on the Schedule.

After a Benefit is paid for its Maximum Benefit Period, that Benefit is not payable except as may be allowed by the Continuous or Successive Disabilities provision.

[Member means a person who is in a Class shown on the Schedule [and in good standing as defined by the [Association's] requirements and bylaws.]]

Mental or Emotional Disease or Disorder means a condition so classified in the [Diagnostic and Statistical Manual of Mental Disorders (DSM)]. We will use the [DSM] most current as of the date of loss.

If the [DSM] is discontinued or replaced, We will use published data that, in Our opinion, provides the most comparable information.

Mental or Emotional Disease or Disorder does not include any condition excluded from the coverage of this Policy by name or specific description.

Mental or Emotional Disease or Disorder does not include dementia, if caused by:

- stroke;
- trauma;
- infection; or
- Alzheimer's disease.

[Occupational Income means Your monthly rate of earnings from Your Employer as of the day before the start of Total Disability. Occupational Income does not include:

- overtime pay;
- bonuses; or
- extra compensation other than commissions.

Occupational Income will include commissions averaged over:

- the 12 calendar months ending the month before Total Disability began; or
- the number of full calendar months that You were employed, before Total Disability began, if less than 12 months.

If You were self-employed when Total Disability began, Occupational Income means Your business income, as shown on Your federal tax return, divided by the lesser of 12 or the number of months of self-employment.]

[On Strike (Strike) means that You and other [Employee/Member]s acting together:

- have ceased work, or
- are refusing to work or to continue to work for Your employer.

The Strike must be authorized under the rules of a union or unions representing You and other striking Employees.

The union or unions authorizing the strike must be recognized by Your employer for collective bargaining purposes.

The Strike must be lawful and must not take place while a labor contract is still in effect.]

[Other Income means periodic or lump-sum Benefits of the following when payable because You are disabled or retired:

- Workers' Compensation;
- occupational disease law;
- State Disability Insurance;
- Social Security;
- any pension plan of an Employer;
- Railroad Retirement;
- any group disability benefit plan or policy of an Employer; or
- any individual disability benefit insurance policy, if the premiums are paid by or through an Employer.

Other Income does not include increases in the above that occur after the start of Your Elimination Period.]

Partial Disability (Partially Disabled) means that, because of a covered Sickness or Injury, You are:

- working more than 20% but not more than 80% of Your normal pre-disability schedule, and

- under the regular care of a Physician.

Your normal pre-disability schedule is as defined by Your Employer but does not include overtime.

Physician means a medical doctor or other person recognized as a physician by law or regulation in the state where services are provided. The person must be licensed and practicing in the United States.

Physician does not include:

- You;
- a person related to You by blood or marriage; or
- a medical doctor or other person practicing outside of the United States.

Pre-Existing Condition means an Injury or Sickness which a Physician has treated or for which a Physician has advised treatment within 12 months prior to the Certificate Date. It is also one which would cause a person to seek diagnosis or care within the same 12-month period.

A normal pregnancy beginning prior to the Effective Date is considered to be a Pre-Existing Condition, whether or not it was disclosed on the Enrollment Form.

Recurrent Disability means Total and/or Partial Disability that:

- is due to the same or related causes as a prior period of disability;
- follows a prior period for which a Monthly Benefit was paid; and
- occurs within 180 days after the end of a prior period for which a Monthly Benefit was paid.

Regular Occupation means Your usual job, profession or activity for wages, compensation or profit at the start of a Total Disability covered by the Policy.

[Replaced Policy means a policy or certificate for which, the premiums are paid by or through the Policyholder. It must:

- have a paid-to date within [60] days of the Policy's Date of Application;
- be replaced by the Policy; and
- end upon issue of the Policy.

At Our request, the Policyholder must give Us Proof about the Replaced Policy.]

Sickness means an illness, disease or complication of pregnancy that first makes itself known after the Effective Date and while the Policy is in force.

Benefits for a normal pregnancy are provided on the same basis as for any other Sickness.

[State Disability Insurance means the temporary disability insurance programs sponsored by:

- California;
- Hawaii;
- New Jersey;
- New York;
- Rhode Island;
- Puerto Rico; or
- a political subdivision of the United States.]

Successive Disability means a Total and/or Partial Disability that is:

- not due to the same or related causes as a prior period of disability; and
- separated from any prior period for which Monthly Benefits were paid by at least [30] consecutive days during which You are Actively at Work and not Partially Disabled.

Totally Disabled (Total Disability) means, for the first [24] months of a disability that You are:

- unable to perform the substantial and material duties of Your Regular Occupation;
- not working in any other occupation; and
- under the care of a Physician for Your disability.

After [24] months of Total Disability, Totally Disabled means that You are:

- unable to perform the duties of Any Occupation; and
- under the care of a Physician for Your disability.

We will not require care of a Physician when it is no longer needed for the sound medical care of the condition causing Total Disability.

United States means the United States of America, including its states, territories and possessions.

We, Us, Our and Company all mean Kanawha Insurance Company.

You and Your mean the Eligible [Employee/Member].

Any reference to "He," "Him" or "His" will also refer to "She" or "Her," "They," "Them" or "Their."

SERFF Tracking Number: *KANX-125799313* *State:* *Arkansas*
Filing Company: *Kanawha Insurance Company* *State Tracking Number:* *40130*
Company Tracking Number: *GDSAR0007410F01*
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.002 Short Term*
Product Name: *Group Disability Income*
Project Name/Number: *8014 Group Disability Income/GDSAR0007410F01*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: KANX-125799313 State: Arkansas
 Filing Company: Kanawha Insurance Company State Tracking Number: 40130
 Company Tracking Number: GDSAR0007410F01
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Group Disability Income
 Project Name/Number: 8014 Group Disability Income/GDSAR0007410F01

Supporting Document Schedules

Bypassed -Name: Application **Review Status:** Approved-Closed 09/05/2008
Bypass Reason: Included with forms.
Comments:

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 09/05/2008
Comments:
Attachment:
 Certificate of Readability.PDF

Satisfied -Name: Certification Rule 19 **Review Status:** Approved-Closed 09/05/2008
Comments:
 Certification Rule 19
Attachment:
 Certification Rule 19.PDF

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 09/05/2008
Comments:
Attachment:
 Cover Letter.PDF

Satisfied -Name: AR - NAIC TRANSMITTAL DOC **Review Status:** Approved-Closed 09/05/2008
Comments:
Attachment:
 AR - NAIC TRANSMITTAL DOC.PDF

Satisfied -Name: AR - NAIC FORM FILING **Review Status:** Approved-Closed 09/05/2008

SERFF Tracking Number: *KANX-125799313* *State:* *Arkansas*
Filing Company: *Kanawha Insurance Company* *State Tracking Number:* *40130*
Company Tracking Number: *GDSAR0007410F01*
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.002 Short Term*
Product Name: *Group Disability Income*
Project Name/Number: *8014 Group Disability Income/GDSAR0007410F01*
ATTACHMENT

Comments:

Attachment:

AR - NAIC FORM FILING ATTACHMENT.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME:

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
8014	50.0
8114	50.3
1380 11/08 AR	44.9
1661 AR	45.6
1661 E AR	53.7

Signed: 
Name: R. Dale Vaughan
Title: President, Kanawha Insurance Company
Date: August 28, 2008

STATE OF ARKANSAS

KANAWHA INSURANCE COMPANY

210 South White St., Lancaster, SC 29720

CERTIFICATION OF COMPLIANCE
REGULATION 19

Form: 8014, 8114, 1380 11/08 AR, 1661 AR, and 1661 E AR

We hereby certify that Kanawha Insurance Company has reviewed Regulation 19 regarding unfair sex discrimination in the sale of insurance and is in compliance with this Regulation.

A handwritten signature in black ink that reads "R. Dale Vaughan". The signature is written in a cursive style with a large, prominent initial "R".

R. Dale Vaughan
President, Kanawha Insurance Company



210 South White Street
P.O. Box 610
Lancaster, SC 29721-0610



Phone: 800-635-4252

NAIC COMPANY CODE 65110
FEDERAL TAX ID # 57-0380426
NAIC GROUP CODE 000

August 28, 2008

Commissioner Julie Benafield Bowman
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Kanawha Insurance Company
Group Disability Income Policy Form 8014, et al

Dear Commissioner,

Kanawha Insurance Company is submitting the above captioned forms for review and approval. These forms are new and not intended to replace any other forms currently in use.

The enclosed forms are designed to provide group disability income coverage. The policy form will be issued in your state on a direct issue basis to groups traditionally recognized as eligible groups for group insurance in accordance with insurance laws, rules and regulations. The Company will use previously approved Group Policy Schedule Amendment form 1032 78-78, approved by your Department effective as of 07/29/05, with the forms.

With regard to marketing information, this policy will be offered on a contributory or non-contributory basis, where the insured may be required to contribute none, all, or a portion of the premium. Coverage will be marketed through agent/broker solicitation. This policy is being filed for concurrent approval in the domiciliary state, South Carolina.

All bracketed numbers are variable to the extent allowable by your state's laws. All bracketed text is variable to the extent allowed by law. In addition, the bracketed text may or may not be included in the policy when printed. In no event will numbers or text be changed to impact compliance with your law.

The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. In addition, the Master Application and Enrollment Form may be reproduced electronically which could result in formatting changes. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval. The Company will provide you a highlighted copy of any corrections it makes for your records. The Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission.

Thank you for your attention to this filing. If you should have any questions, please contact me at 1-800-635-4252 Ext 5442. My email address is mdyches4@humana.com.

Sincerely,

Margaret Dyches
Compliance

Life, Accident & Health, Annuity, Credit Transmittal Document

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 #	State #
Kanawha Insurance Company 210 South White Street Lancaster SC 29720	SC	Life, Accident & Health	000	65110	57038042 6	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Margaret Dyches 210 South White Street Lancaster SC 29720	800-635-4252 Ext. 5442	803-313-5253	margaret.dyches@kmgameric a.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	GDSAR0007410F01
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7. X New Submission	<input type="checkbox"/> Resubmission	Previous file # _____
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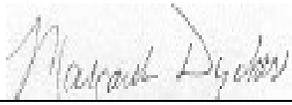
8. Market	<input type="checkbox"/> Individual	<input type="checkbox"/> Franchise
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9. Type of Insurance	H11G Group Health - Disability Income
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10. Product Coding Matrix Filing Code	H11G.002 Short Term
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11. Submitted Documents	<p>X FORMS</p> <p> <input checked="" type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input checked="" type="checkbox"/> Other: <u>Evidence of Insurability</u> </p> <p><input type="checkbox"/> RATES</p> <p> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate </p> <p><input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____</p> <p>SUPPORTING DOCUMENTATION</p> <p> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____ </p>
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12.	Filing Submission Date	September 2, 2008
13.	Filing Fee (If required)	Amount <u>\$130.00</u> Check Date _____ Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u>EFT</u>
14.	Date of Domiciliary Approval	Pending
15.	Filing Description:	
	<p>Kanawha Insurance Company is submitting the above captioned forms for review and approval. These forms are new and not intended to replace any other forms currently in use.</p> <p>The enclosed forms are designed to provide group disability income coverage. The policy form will be issued in your state on a direct issue basis to groups traditionally recognized as eligible groups for group insurance in accordance with insurance laws, rules and regulations. The Company will use previously approved Group Policy Schedule Amendment form 1032 78-78, approved by your Department effective as of 07/29/05, with the forms.</p> <p>With regard to marketing information, this policy will be offered on a contributory or non-contributory basis, where the insured may be required to contribute none, all, or a portion of the premium. Coverage will be marketed through agent/broker solicitation. This policy is being filed for concurrent approval in the domiciliary state, South Carolina.</p> <p>All bracketed numbers are variable to the extent allowable by your state's laws. All bracketed text is variable to the extent allowed by law. In addition, the bracketed text may or may not be included in the policy when printed. In no event will numbers or text be changed to impact compliance with your law.</p> <p>The forms are in final print, subject to minor variations in formatting, duplexing, shading and fonts. In addition, the Master Application and Enrollment Form may be reproduced electronically which could result in formatting changes. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval. The Company will provide you a highlighted copy of any corrections it makes for your records.</p> <p>The Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission</p>	

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> <p>Print Name <u>Margaret Dyches</u> Title <u>Compliance</u></p> <p>Signature  Date <u>09/02/08</u></p>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		GDSAR0007410F01
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Master Application	1380 11/08 AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Enrollment Form	1661 AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Evidence of Insurability	1661 E AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	Policy	8014	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05	Certificate	8114	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input 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 _____	
11			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	