

SERFF Tracking Number: AMLC-126375322 State: Arkansas  
Filing Company: Globe Life and Accident Insurance Company State Tracking Number: 44002  
Company Tracking Number: GCANLS-2  
TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only  
Product Name: Cancer Policy  
Project Name/Number: Cancer Policy/GCANLS-2

## Filing at a Glance

Company: Globe Life and Accident Insurance Company

Product Name: Cancer Policy

SERFF Tr Num: AMLC-126375322 State: Arkansas

TOI: H071 Individual Health - Specified Disease - Limited Benefit SERFF Status: Closed-Approved- Closed State Tr Num: 44002

- Limited Benefit

Closed

Sub-TOI: H071.002A Dread Disease - Cancer Only Co Tr Num: GCANLS-2 State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Author: Mary Johnson

Disposition Date: 11/16/2009

Date Submitted: 11/09/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Cancer Policy

Status of Filing in Domicile: Pending

Project Number: GCANLS-2

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/16/2009

Explanation for Other Group Market Type:

State Status Changed: 11/16/2009

Deemer Date:

Created By: Mary Johnson

Submitted By: Mary Johnson

Corresponding Filing Tracking Number:

Filing Description:

Individual Health - Specified Disease - Limited Benefit Policy

Attached for your review and approval is the captioned policy, and the outline of coverage for our Cancer product. Required forms and the actuarial memorandum with rates are also attached. We will be using application GCANLS-AP. The subject filing is new and is not intended to replace any previously approved filing.

Form GCANLS-2 has been mirrored from form LCANLS-2 which was filed in your state for our sister company Liberty

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National Life and Accident Insurance Company. This product will be marketed through our licensed agents to government employees.

The Benefit Amounts on the application are bracketed to allow us to offer varying amounts in the future to cater to market trends.

These forms do not contain any unusual or unorthodox provisions or wordings. The readability score is shown on the readability certification form enclosed.

I hereby certify that I have carefully reviewed this form and to the best of my knowledge and ability find:

1. The form conforms to all insurance statutes and department requirements of your jurisdiction.
2. The form contains no provisions previously disapproved by your department.
3. The forms have been filed in Nebraska, our state of domicile, and have been filed in all jurisdictions where the company operates.

## Company and Contact

### Filing Contact Information

Mary Johnson, Compliance Analyst mjohnson@torchmarkcorp.com  
3700 S. Stonebridge Drive 214-544-5335 [Phone]  
McKinney, TX 75070 972-569-3728 [FAX]

### Filing Company Information

Globe Life and Accident Insurance Company CoCode: 91472 State of Domicile: Nebraska  
204 North Robinson Avenue Group Code: 290 Company Type: Life and Health  
Oklahoma City, OK 73102 Group Name: Liberty National State ID Number:  
(405) 270-1400 ext. [Phone] FEIN Number: 63-0782739

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: \$50.00 x 1 filing submission = \$50.00  
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Globe Life and Accident Insurance Company	\$50.00	11/09/2009	31890555

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/16/2009	11/16/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/12/2009	11/12/2009	Mary Johnson	11/13/2009	11/13/2009
Pending Industry Response	Rosalind Minor	11/10/2009	11/10/2009	Mary Johnson	11/11/2009	11/11/2009



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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Form (revised)</b>	Cancer Policy	Approved-Closed	Yes
<b>Form</b>	Cancer Policy	Replaced	Yes
<b>Form</b>	Cancer Policy	Replaced	Yes
<b>Form</b>	Application	Approved-Closed	Yes
<b>Rate</b>	Rates	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 11/12/2009  
Submitted Date 11/12/2009

Respond By Date

Dear Mary Johnson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Cancer Policy, GCANLS-2 (Form)

Comment:

The new attachment still has a time period for furnishing notice. The language in the policy reads: You must furnish Us notice of the dependency status within 31 days of the termination date. The 31 days must be removed.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 11/13/2009  
Submitted Date 11/13/2009

Dear Rosalind Minor,

### Comments:

Thank you for your review of the above noted filing submission

### Response 1

Comments: We have removed all reference to the time frame as required by your regulation. See attached revised policy.

### Related Objection 1

Applies To:

SERFF Tracking Number: AMLC-126375322 State: Arkansas  
 Filing Company: Globe Life and Accident Insurance Company State Tracking Number: 44002  
 Company Tracking Number: GCANLS-2  
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only  
 Product Name: Cancer Policy  
 Project Name/Number: Cancer Policy/GCANLS-2  
 - Cancer Policy, GCANLS-2 (Form)  
 Comment:

The new attachment still has a time period for furnishing notice. The language in the policy reads: You must furnish Us notice of the dependency status within 31 days of the termination date. The 31 days must be removed.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Cancer Policy	GCANLS-2		Policy/Contract/Fraternal Certificate	Initial		57.800	GCANLS-2-AR.pdf
<b>Previous Version</b>							
Cancer Policy	GCANLS-2		Policy/Contract/Fraternal Certificate	Initial		57.800	GCANLS-2-AR.pdf
Cancer Policy	GCANLS-2		Policy/Contract/Fraternal Certificate	Initial		57.800	GCANLS-2-AR.pdf

No Rate/Rule Schedule items changed.

Thank you

Sincerely,  
Mary Johnson

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Product Name: Cancer Policy  
Project Name/Number: Cancer Policy/GCANLS-2

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 11/10/2009  
Submitted Date 11/10/2009

Respond By Date

Dear Mary Johnson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Cancer Policy, GCANLS-2 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 11/11/2009  
Submitted Date 11/11/2009

Dear Rosalind Minor,

### Comments:

Thank you for your review of the above noted filing submission. The attached revised document comes to address the objection outlined in correspondence received from your office dated 11/10/09

### Response 1

Comments: Pursuant to ACA 23-85-131(b) and Bulletin 14-81 the language has been revised to note that the company requires proper notice to continue coverage.

### Related Objection 1

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 Product Name: Cancer Policy  
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Applies To:  
 - Cancer Policy, GCANLS-2 (Form)  
 Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Cancer Policy	GCANLS-2		Policy/Contract/Fraternal Certificate	Initial		57.800	GCANLS-2-AR.pdf
<b>Previous Version</b>							
Cancer Policy	GCANLS-2		Policy/Contract/Fraternal Certificate	Initial		57.800	GCANLS-2-AR.pdf

No Rate/Rule Schedule items changed.

Thank ing you in advance for your assistance.

Sincerely,  
 Mary Johnson

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## Form Schedule

**Lead Form Number: GCANLS-2**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/16/2009	GCANLS-2	Policy/Contract/Certificate	Cancer Policy	Initial		57.800	GCANLS-2-AR.pdf
Approved-Closed 11/16/2009	GCANLS-AP(03)	Application/Enrollment Form	Application	Initial		47.490	GCANLS-AP(03).pdf

# CANCER POLICY

BENEFITS FOR FIRST DIAGNOSIS OF CANCER. THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE; THE COMPANY RESERVES THE RIGHT TO CHANGE PREMIUMS ON A CLASS BASIS BY STATE.

**GLOBE LIFE AND ACCIDENT INSURANCE COMPANY**  
**GLOBE LIFE CENTER \* OKLAHOMA CITY, OKLAHOMA 73184 (800) 478-3291**  
**A Legal Reserve Stock Company**

## CONSIDERATION

This policy is issued in consideration of statements made in Your application and the payment of premium shown in the Policy Schedule. Your application is attached and is a part of this policy. We will pay You the benefit amount for Cancer which is first diagnosed 30 days after the Effective Date of this policy.

## RIGHT TO EXAMINE POLICY

If You are not satisfied with this policy, You may return it for a full refund of premiums. You must return the policy within 30 days after You receive it. You may return the policy by delivering it or mailing it to the agent who took Your application or to Our Administrative Offices. Upon such return, We will void the policy as of the Effective Date, and We will refund the premium paid.

IMPORTANT NOTICE: This policy was issued based on the information in Your application, a copy of which is attached to this policy. Advise Us immediately if any of the information is incorrect. Incorrect information could result in the denial of a claim or the termination of this policy.

## THIS IS A LEGAL CONTRACT – READ YOUR POLICY CAREFULLY

### CAUTION: THIS IS A LIMITED POLICY

## RENEWAL PROVISION

You are guaranteed the right to renew this policy for Your lifetime by the payment of the premium in effect on the date it is due. The premium must be paid on or before the due date, or within the 31 days that follow.

We may change the premium on a class basis for all policies of this same form in Your state. Class is based on gender, issue age and year of issue.

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### POLICY SCHEDULE

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POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM	BENEFIT AMOUNT
[12345678	10/01/2009	11/01/2009	\$ 00.00]	
[INSURED:	John Doe			\$10,000]
[SPOUSE:	Jane Doe			\$10,000]
[CHILD 1:	One Doe			\$10,000]
[CHILD 2:	Two Doe			\$10,000]
[CHILD 3:	Three Doe			\$10,000]
[CHILD 4:	Four Doe			\$10,000]

## TABLE OF CONTENTS

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## DEFINITIONS

**CANCER:** Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, melanoma, leukemia, or Hodgkin's disease, or any form of malignant growth positively diagnosed as Cancer (malignant neoplasm) by a legally licensed doctor of medicine certified by the American Board of Pathology or a certified Osteopathic Pathologist. Cancer is further defined for the purposes of this policy to include cancer in situ, which is in the natural or normal place; confined to the site of origin without having invaded neighboring tissue. Pre-malignant conditions or conditions with malignant potential are not to be construed as Cancer in interpreting this policy.

Criteria for malignancy are those accepted by the American Board of Pathology or the Osteopathic Board of Pathology. This diagnosis must be based on a microscopic study of body tissue or fluid. The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis of Cancer will be accepted as evidence that cancer exists in a Covered Person when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of Cancer and the Covered Person received treatment of Cancer.

**COVERED FAMILY MEMBER:** The spouse of the Insured and all unmarried children of the Insured, under age 19, on the Effective Date. To be covered, each existing member must be named in the application. Any member who has had Cancer diagnosed is excluded from coverage. Stepchildren and legally adopted children can be included if listed in the application.

Any newborn or newly adopted children of the Primary Insured will automatically be a Covered Person from the moment of birth or adoption if such birth or adoption occurs after the Effective Date of the policy. This will also cover children You have filed a petition to adopt.

You may apply for coverage on other dependents acquired after the Effective Date of the policy, subject to Our approval. Coverage on Your children terminates when they marry. It also terminates on the policy anniversary date following their 25<sup>th</sup> birthday, unless they are still dependent on You due to a physical or mental handicap. You must furnish Us notice of the disability and dependency status prior to the termination date. If a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 25<sup>th</sup> birthday, then the child will continue to be a Covered Person for as long as such disability continues. Proof of such incapacity or disability must be furnished upon Our request, but not more often than annually.

**COVERED PERSON:** Refers to either You or a Covered Family Member.

**FIRST DIAGNOSIS:** "First Diagnosis" means the first time a Covered Person is diagnosed as having internal Cancer or malignant melanoma (this excludes all other Skin Cancer); provided the diagnosis is after the Waiting Period and while this policy is in force with respect to the Covered Person.

**PHYSICIAN:** A person who is a practitioner of the healing arts, other than Yourself or a member of Your immediate family or household, and who is duly licensed to practice, and is practicing, medicine in the United States to treat an injury or illness.

**SKIN CANCER:** Any form of malignant growth positively diagnosed as Cancer (malignant neoplasm) which is confined to the epidermis, dermis (corium) and/or subcutaneous tissue. Such diagnosis must be based on a microscopic study performed by a recognized pathologist. **Skin Cancer is not covered under this policy.**

**WAITING PERIOD:** No benefit is payable if Cancer first manifests itself before the policy has been in force for 30 days from the Effective Date shown in the Policy Schedule. Cancer is manifested when symptoms exist

**WE, US, OUR and COMPANY:** Globe Life And Accident Insurance Company.

**YOU, YOUR and INSURED:** The Covered Person whose name is shown in the Policy Schedule.

### BENEFITS

We will pay You the Cancer Benefit Amount as shown in the Policy Schedule when We receive due proof of a Covered Person's First Diagnosis of Cancer while this policy is in force. No benefit is payable if the Cancer first manifests itself before the end of the 30-day Waiting Period. In such case, You may void the policy from the beginning and receive a full refund of premium, provided You request the refund within 60 days after the end of the Waiting Period. **A Covered Person is limited to only one First Diagnosis benefit. Coverage for such person terminates upon payment of their benefit.**

### LIMITATIONS AND EXCLUSIONS

1. This policy pays a benefit only for First Diagnosis of Cancer while this policy is in force. Proof of First Diagnosis of Cancer must be provided. Pathologic or clinical diagnosis proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness, disability or incapacity.
2. This policy contains a 30-day Waiting Period. No benefit is payable to anyone who has Cancer manifested before the policy has been in force for 30 days from the Effective Date shown in the Policy Schedule.
3. This policy will not pay benefits if the First Diagnosis of Cancer is made outside the United States of America.

### GENERAL PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by Us. This approval must be noted on or attached to this policy.

No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the policy Effective Date only fraudulent misstatements in the application may be Used to void this policy or deny any claim resulting from First Diagnosis of a covered Cancer after the expiration of the 2-year period. No claim for loss incurred that starts after 2 years from the Effective Date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before that Effective Date of coverage.

**PREMIUM PAYMENTS:** This policy is issued based on the application and the payment of the first premium. A copy of the application is a part of this policy. This policy takes effect at 12 o'clock noon, Standard Time at the place where You reside, and remains in effect until the same hour on the date of which the initial term expires.

The Effective Date of this policy, the first premium and the date the initial term expires are shown in the Policy Schedule. All premiums, except the first premium, shall be due and payable at Our Administrative Offices.

**GRACE PERIOD:** The policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period this policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Us (or by Our agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If We or Our agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45<sup>th</sup> day after the date of the conditional receipt unless We have written You earlier of its disapproval.

The reinstated policy will cover only First Diagnosis of Cancer that is manifested more than 10 days after the date of reinstatement. In all other respects Your rights and Our rights will remain the same, subject to any provision endorsed on or attached to the reinstated policy.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after First Diagnosis of Cancer or as soon as reasonably possible. The notice can be given to Us at Our Administrative Offices or to one of Our agents. Notice should include Your name, the name of the Covered Person who suffered the loss, and the policy number.

**CLAIM FORMS:** When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of First Diagnosis requirements by giving Us a statement from the pathologist or Physician that describes the occurrence, nature and extent of the diagnosis within the time limit stated in the "Proof of First Diagnosis" provision.

**PROOF OF FIRST DIAGNOSIS:** Written proof of First Diagnosis must be given to Us within 90 days after the date of such First Diagnosis. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. However, the proof required must be given no later than one year from the time specified unless You were legally incapacitated.

**TIME OF PAYMENT CLAIMS:** Benefits provided by this policy will be paid as soon as We receive proper written proof of First Diagnosis.

**PAYMENT OF CLAIMS:** Benefits will be paid to You unless You assign them to the doctor or hospital. Any benefit unpaid at death will be paid to Your named beneficiary or, at Our option, to Your estate. If benefits are payable to Your estate, We can pay benefits up to \$3,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

**PHYSICAL EXAMINATION:** We have the right to have a Covered Person examined, at Our expense, as often as reasonably needed while a claim is pending

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of First Diagnosis has been given as required by this policy. No such action may be brought after 3 years from the time written proof of First Diagnosis is required to be given.

**MISSTATEMENT OF AGE:** If a Covered Person's age has been misstated, the benefit will be such as the premium paid would have purchased at the correct age. In the event coverage would not have become effective, or would have terminated, Our liability will be limited to a refund. Such refund must be requested by You and will be equal to the portion of the premiums paid for the period not covered by this policy.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

**ASSIGNMENT:** No assignment under this policy shall be binding upon Us unless the original (or a copy of it) is on file at Our Administrative Offices. We do not assume any responsibility for the validity of any assignment. We will pay the benefits of this policy to any state agency (such as Medicaid) when required by state law.

**REFUND OF UNEARNED PREMIUMS ON DEATH:** Upon the death of a Family Member insured under this policy, We will refund any premiums paid in behalf of the member, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

This policy is signed for Us by Our President and Secretary.

  
Secretary

  
President

Countersigned:

\_\_\_\_\_  
Licensed Resident Agent where required by law.

GLOBE LIFE CENTER \* OKLAHOMA CITY, OKLAHOMA 73184

Requested Effective Date (mm-dd-yyyy)

Requested Effective Date (mm-dd-yyyy) form with '20' in the year field.

Payment Mode

- Monthly (APP only)
Semi-Annual
Quarterly
Annually

Weekly Premium form with input fields for dollars and cents.

Payment Type

- Bank Draft
Direct
Allotment

Draft Day (01 to 28 only)

Draft Day form with input fields.

Payroll Center:

City, State, (Dept. Code):

Amounts

- Primary Insured
Spouse
Child 1
Child 2
Child 3

- \$10,000
\$20,000
\$30,000
\$40,000
\$50,000

Premium

Premium amount form with dollar sign and input fields.

Full Name(s) of Family Member(s) to be insured

Main family member information form including First Name, Last Name, Address, City, State, Zip Code, Age, Birth State, Date of Birth, SS#, Height, Weight, and Gender.

E-mail Address

E-mail Address form with input field.

I, the agent, have personally seen this person. Yes No

Primary Insured's Occupation

Primary Insured's Occupation form with input field.

Spouse

Spouse information form including First Name, Last Name, Age, Birth State, Date of Birth, SS#, Height, Weight, Gender, and Occupation.

I, the agent, have personally seen this person. Yes No

Child 1

Child 1 information form including First Name, Last Name, Age, Date of Birth, Height, Weight, Gender, and a personal sighting statement.

I, the agent, have personally seen this person. Yes No

Application Verification Information

A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:

- 8 AM - Noon
Noon - 6 PM
6 PM - 9 PM

- Home Phone No.
Work Phone No.

Home Phone No. form with input fields.

Work Phone No. form with input fields.



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## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved- Rates Closed 11/16/2009		GCANLS-2	New		GCANLS-2 Rate Page 50% 091029 - AR.pdf

**GLOBE LIFE AND ACCIDENT INSURANCE COMPANY**

**McKinney, Texas**

**POLICY FORM GCANLS-2**

**A CANCER POLICY**

**Proposed Annual Premium Rates  
Per \$10,000 Lump Sum Amount  
For Policies Issued with Issue Age Rates**

<b>Issue Age</b>	<b>Male</b>	<b>Female</b>
<b>Individuals</b>		
00 - 17	55.00	55.00
18 - 25	55.00	63.25
26 - 30	55.00	71.50
31 - 35	60.50	79.75
36 - 40	71.50	90.75
41 - 45	104.50	118.25
46 - 50	151.25	148.50
51 - 55	225.50	192.50
56 - 60	327.25	244.75
61 - 65	470.25	310.75
66 - 69	569.25	335.50
<b>Two Parent Families (Issue Age Based on Age of Older Spouse)</b>		
00 - 17	82.50	82.50
18 - 25	90.75	90.75
26 - 30	99.00	99.00
31 - 35	107.25	107.25
36 - 40	121.00	121.00
41 - 45	167.75	167.75
46 - 50	225.50	225.50
51 - 55	313.50	313.50
56 - 60	429.00	429.00
61 - 65	577.50	577.50
66 - 69	682.00	682.00
<b>Single Parent Families (Issue Age Based on Age of Parent)</b>		
00 - 17	66.00	66.00
18 - 25	66.00	74.25
26 - 30	66.00	82.50
31 - 35	71.50	90.75
36 - 40	82.50	101.75
41 - 45	115.50	129.25
46 - 50	162.25	159.50
51 - 55	236.50	203.50
56 - 60	338.25	255.75
61 - 65	481.25	321.75
66 - 69	580.25	346.50

**Modal Premium Factors:**

Semi-Annual	= Annual	* 0.520
Quarterly	= Annual	* 0.265
Monthly	= Annual	/ 11

For Company Use:

Plan Codes J65, J66, J67

SERFF Tracking Number: AMLC-126375322 State: Arkansas  
 Filing Company: Globe Life and Accident Insurance Company State Tracking Number: 44002  
 Company Tracking Number: GCANLS-2  
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only  
 Product Name: Cancer Policy  
 Project Name/Number: Cancer Policy/GCANLS-2

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> Readability Cert GCANLS-2 .pdf	Approved-Closed	11/16/2009

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> Application has also been added to the forms tab. <b>Attachment:</b> GCANLS-AP(03).pdf	Approved-Closed	11/16/2009

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage <b>Comments:</b> <b>Attachment:</b> DS-GCANLS-2_03.pdf	Approved-Closed	11/16/2009

# GLOBE LIFE AND ACCIDENT INSURANCE COMPANY

Oklahoma City, Oklahoma

## READABILITY CERTIFICATION

We hereby certify we have carefully reviewed the form(s) listed below and to the best of our knowledge and ability determine the Flesch scale analysis readability test score to be as shown:

<u>FORM</u>	<u>SCORE</u>	
Cancer Policy	GCANLS-2	57.8
Application	GCANLS-AP	47.49

November 9, 2009

Date



Michael J. Gaisbauer, Vice President

S-1351

GLOBE LIFE CENTER \* OKLAHOMA CITY, OKLAHOMA 73184

Requested Effective Date (mm-dd-yyyy)

Requested Effective Date (mm-dd-yyyy) form with '20' in the year field.

Payment Mode

- Monthly (APP only)
Semi-Annual
Quarterly
Annually

Weekly Premium form with input fields for dollars and cents.

Payment Type

- Bank Draft
Direct
Allotment

Draft Day (01 to 28 only)

Draft Day form with input fields.

Payroll Center:

City, State, (Dept. Code):

- Primary Insured
Spouse
Child 1
Child 2
Child 3

Amounts

- \$10,000
\$20,000
\$30,000
\$40,000
\$50,000

Premium

Premium form with dollar sign and input fields.

Full Name(s) of Family Member(s) to be insured

Form for family member details including First Name, Last Name, Address, City, State, Zip Code, Age, Birth State, Date of Birth, SS#, Height, Weight, and Gender.

E-mail Address

E-mail Address form with input field.

I, the agent, have personally seen this person. Yes No

Primary Insured's Occupation

Primary Insured's Occupation form with input field.

Spouse

Form for spouse details including First Name, Last Name, Age, Birth State, Date of Birth, SS#, Height, Weight, Gender, and Occupation.

I, the agent, have personally seen this person. Yes No

Child 1

Form for child 1 details including First Name, Last Name, Age, Date of Birth, Height, Weight, Gender, and a personal sighting statement.

I, the agent, have personally seen this person. Yes No

Application Verification Information

A recorded interview may be necessary as part of the underwriting of your application for insurance. The most convenient time and place for the interview is:

- 8 AM - Noon
Noon - 6 PM
6 PM - 9 PM

- Home Phone No.
Work Phone No.

Home Phone No. form with input fields.

Work Phone No. form with input fields.



<b>Child 2</b>	First Name <input type="text"/>	M.I. <input type="text"/>	<input type="radio"/> Male	Height (ft. in.) <input type="text"/>
	Last Name <input type="text"/>		<input type="radio"/> Female	Weight (lbs.) <input type="text"/>
	Age <input type="text"/>	Date of Birth (mm-dd-yyyy) <input type="text"/>	I, the agent, have personally seen this person. <input type="radio"/> Yes <input type="radio"/> No	
<b>Child 3</b>	First Name <input type="text"/>	M.I. <input type="text"/>	<input type="radio"/> Male	Height (ft. in.) <input type="text"/>
	Last Name <input type="text"/>		<input type="radio"/> Female	Weight (lbs.) <input type="text"/>
	Age <input type="text"/>	Date of Birth (mm-dd-yyyy) <input type="text"/>	I, the agent, have personally seen this person. <input type="radio"/> Yes <input type="radio"/> No	

**IF THE ANSWER TO ANY QUESTION IS "YES," THE PROPOSED INSURED IS NOT ELIGIBLE FOR COVERAGE.**

	PRIMARY INSURED	SPOUSE	CHILD 1	CHILD 2	CHILD 3
	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
1. Has this person ever been diagnosed or treated by a physician for internal or skin cancer, melanoma, malignant growth, leukemia, Hodgkins disease or premalignant lesions?	<input type="radio"/>				
2. Has this person ever been treated for, diagnosed, or tested positive as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or immune deficiency related disorders or ever tested positive for antibodies for the AIDS (HIV) virus?	<input type="radio"/>				
3. Within the past 2 years has this person been advised by a physician to have medical tests or examinations to diagnose a possible malignancy but not yet done so?	<input type="radio"/>				
4. Are you covered under a state Medicaid program?	<input type="radio"/>				

**AGREEMENT:** I hereby apply to Globe Life And Accident Insurance Company ("Company") for a policy to be issued in reliance on my written answers to all questions. The applicant(s) represent(s) to the Company that the agent asked each and every question that appears on the application and that all the answers are true, correct and complete. I agree the policy shall not be effective unless it has actually been issued by the Company. I acknowledge that no agent has the authority to make, alter, modify or discharge any policy or any of its provisions for or on behalf of the Company; nor is the Company bound by any statement or representation made to any agent unless the statement or representation is included in this application.

I authorize the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to Globe Life And Accident Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to the MIB, Inc., reinsuring companies or other persons or organization performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a copy of this authorization is to be acceptable. This authorization will remain in effect for a period of 24 months from the date signed. I understand that I may request a copy of this authorization. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.

**I understand that no benefits are payable for a diagnosis of cancer in the first 30 days after the effective date of this policy.**

-  -  at ,

Date Application Signed (mm-dd-yyyy) City State

The undersigned Agent certifies that the Applicant has read, or had read to him, the complete application and that the Applicant realizes that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

To the best of your knowledge as writing agent, is the insurance applied for intended to replace any existing insurance?  Yes  No

I certify I have given an outline of coverage for the policy applied for to the Applicant.

Agent's Last Name

Agent No.

**Applicant's Signature**

**SEND POLICY TO:**  
 Agent  Insured

Amount paid to Agent: \$  ,  .

for first  months premium.

**Agent's Signature**

Initials of Proposed Insured



**GLOBE LIFE AND ACCIDENT INSURANCE COMPANY**  
**GLOBE LIFE CENTER \* OKLAHOMA CITY, OKLAHOMA 73184 (800) 478-3291**  
**A Legal Reserve Stock Company**

**OUTLINE OF COVERAGE FOR LUMP SUM CANCER POLICY**

**Policy Form GCANLS-2**  
(Please Keep for Your Records)

**READ YOUR POLICY CAREFULLY**

This outline of coverage provides a very brief description of the important features of your policy. This outline of coverage is not the insurance contract and only the actual policy provisions will control your benefits. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Therefore, it is important that you **READ YOUR POLICY CAREFULLY**.

**CANCER BENEFIT**

Policies of this category are designed to provide a lump sum benefit to the covered person upon First Diagnosis of Cancer. Each covered person is limited to one First Diagnosis benefit under the terms of this policy. To any one covered person, the maximum benefit available shall be the amount set forth in the listed Benefit Amount in the Policy Schedule. Coverage for such person terminates upon payment of such benefit.

**LIMITATIONS AND EXCLUSIONS**

1. This policy pays a benefit only for First Diagnosis of Cancer while this policy is in force. Proof of First Diagnosis of Cancer must be provided. Pathologic or clinical diagnosis proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness, disability or incapacity.
2. This policy contains a 30-day waiting period. No benefit is payable to anyone who has Cancer manifested before the policy has been in force for 30 days from the effective date shown in the Policy Schedule.
3. This policy will not pay benefits if the First Diagnosis of Cancer is made outside the United States of America.

**FIRST DIAGNOSIS**

“First Diagnosis” means the first time a covered person is diagnosed as having internal Cancer or malignant melanoma (this excludes all other skin cancer); provided the diagnosis is after the waiting period and while this policy is in force with respect to the covered person.

**RENEWABLE**

This policy is guaranteed renewable for life. We have the right to change the renewal premium for this policy in accordance with our table of premium rates applicable to all policies of this form and class in your state. Class is based on gender, issue age and year of issue. This policy provides a 31-day grace period.

**This outline of coverage is only a brief summary and is not the contract of insurance. Please refer to the policy for further policy provisions.**

SERFF Tracking Number: AMLC-126375322 State: Arkansas  
 Filing Company: Globe Life and Accident Insurance Company State Tracking Number: 44002  
 Company Tracking Number: GCANLS-2  
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002A Dread Disease - Cancer Only  
 Product Name: Cancer Policy  
 Project Name/Number: Cancer Policy/GCANLS-2

## Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/11/2009	Form	Cancer Policy	11/13/2009	GCANLS-2-AR.pdf (Superseded)
11/09/2009	Form	Cancer Policy	11/11/2009	GCANLS-2-AR.pdf (Superseded)

# CANCER POLICY

BENEFITS FOR FIRST DIAGNOSIS OF CANCER. THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE; THE COMPANY RESERVES THE RIGHT TO CHANGE PREMIUMS ON A CLASS BASIS BY STATE.

**GLOBE LIFE AND ACCIDENT INSURANCE COMPANY**  
**GLOBE LIFE CENTER \* OKLAHOMA CITY, OKLAHOMA 73184 (800) 478-3291**  
**A Legal Reserve Stock Company**

## CONSIDERATION

This policy is issued in consideration of statements made in Your application and the payment of premium shown in the Policy Schedule. Your application is attached and is a part of this policy. We will pay You the benefit amount for Cancer which is first diagnosed 30 days after the Effective Date of this policy.

## RIGHT TO EXAMINE POLICY

If You are not satisfied with this policy, You may return it for a full refund of premiums. You must return the policy within 30 days after You receive it. You may return the policy by delivering it or mailing it to the agent who took Your application or to Our Administrative Offices. Upon such return, We will void the policy as of the Effective Date, and We will refund the premium paid.

IMPORTANT NOTICE: This policy was issued based on the information in Your application, a copy of which is attached to this policy. Advise Us immediately if any of the information is incorrect. Incorrect information could result in the denial of a claim or the termination of this policy.

## THIS IS A LEGAL CONTRACT – READ YOUR POLICY CAREFULLY

### CAUTION: THIS IS A LIMITED POLICY

## RENEWAL PROVISION

You are guaranteed the right to renew this policy for Your lifetime by the payment of the premium in effect on the date it is due. The premium must be paid on or before the due date, or within the 31 days that follow.

We may change the premium on a class basis for all policies of this same form in Your state. Class is based on gender, issue age and year of issue.

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### POLICY SCHEDULE

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POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM	BENEFIT AMOUNT
[12345678	10/01/2009	11/01/2009	\$ 00.00]	
[INSURED:	John Doe			\$10,000]
[SPOUSE:	Jane Doe			\$10,000]
[CHILD 1:	One Doe			\$10,000]
[CHILD 2:	Two Doe			\$10,000]
[CHILD 3:	Three Doe			\$10,000]
[CHILD 4:	Four Doe			\$10,000]

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## DEFINITIONS

**CANCER:** Cancer is defined as a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells, the invasion of tissue, melanoma, leukemia, or Hodgkin's disease, or any form of malignant growth positively diagnosed as Cancer (malignant neoplasm) by a legally licensed doctor of medicine certified by the American Board of Pathology or a certified Osteopathic Pathologist. Cancer is further defined for the purposes of this policy to include cancer in situ, which is in the natural or normal place; confined to the site of origin without having invaded neighboring tissue. Pre-malignant conditions or conditions with malignant potential are not to be construed as Cancer in interpreting this policy.

Criteria for malignancy are those accepted by the American Board of Pathology or the Osteopathic Board of Pathology. This diagnosis must be based on a microscopic study of body tissue or fluid. The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis of Cancer will be accepted as evidence that cancer exists in a Covered Person when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of Cancer and the Covered Person received treatment of Cancer.

**COVERED FAMILY MEMBER:** The spouse of the Insured and all unmarried children of the Insured, under age 19, on the Effective Date. To be covered, each existing member must be named in the application. Any member who has had Cancer diagnosed is excluded from coverage. Stepchildren and legally adopted children can be included if listed in the application.

Any newborn or newly adopted children of the Primary Insured will automatically be a Covered Person from the moment of birth or adoption if such birth or adoption occurs after the Effective Date of the policy. This will also cover children You have filed a petition to adopt.

You may apply for coverage on other dependents acquired after the Effective Date of the policy, subject to Our approval. Coverage on Your children terminates when they marry. It also terminates on the policy anniversary date following their 25<sup>th</sup> birthday, unless they are still dependent on You due to a physical or mental handicap. You must furnish Us notice of the dependency status within 31 days of the termination date. If a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 25<sup>th</sup> birthday, then the child will continue to be a Covered Person for as long as such disability continues. Proof of such incapacity or disability must be furnished upon Our request, but not more often than annually.

**COVERED PERSON:** Refers to either You or a Covered Family Member.

**FIRST DIAGNOSIS:** "First Diagnosis" means the first time a Covered Person is diagnosed as having internal Cancer or malignant melanoma (this excludes all other Skin Cancer); provided the diagnosis is after the Waiting Period and while this policy is in force with respect to the Covered Person.

**PHYSICIAN:** A person who is a practitioner of the healing arts, other than Yourself or a member of Your immediate family or household, and who is duly licensed to practice, and is practicing, medicine in the United States to treat an injury or illness.

**SKIN CANCER:** Any form of malignant growth positively diagnosed as Cancer (malignant neoplasm) which is confined to the epidermis, dermis (corium) and/or subcutaneous tissue. Such diagnosis must be based on a microscopic study performed by a recognized pathologist. **Skin Cancer is not covered under this policy.**

**WAITING PERIOD:** No benefit is payable if Cancer first manifests itself before the policy has been in force for 30 days from the Effective Date shown in the Policy Schedule. Cancer is manifested when symptoms exist

**WE, US, OUR and COMPANY:** Globe Life And Accident Insurance Company.

**YOU, YOUR and INSURED:** The Covered Person whose name is shown in the Policy Schedule.

## BENEFITS

We will pay You the Cancer Benefit Amount as shown in the Policy Schedule when We receive due proof of a Covered Person's First Diagnosis of Cancer while this policy is in force. No benefit is payable if the Cancer first manifests itself before the end of the 30-day Waiting Period. In such case, You may void the policy from the beginning and receive a full refund of premium, provided You request the refund within 60 days after the end of the Waiting Period. **A Covered Person is limited to only one First Diagnosis benefit. Coverage for such person terminates upon payment of their benefit.**

## LIMITATIONS AND EXCLUSIONS

1. This policy pays a benefit only for First Diagnosis of Cancer while this policy is in force. Proof of First Diagnosis of Cancer must be provided. Pathologic or clinical diagnosis proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness, disability or incapacity.
2. This policy contains a 30-day Waiting Period. No benefit is payable to anyone who has Cancer manifested before the policy has been in force for 30 days from the Effective Date shown in the Policy Schedule.
3. This policy will not pay benefits if the First Diagnosis of Cancer is made outside the United States of America.

## GENERAL PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by Us. This approval must be noted on or attached to this policy.

No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the policy Effective Date only fraudulent misstatements in the application may be Used to void this policy or deny any claim resulting from First Diagnosis of a covered Cancer after the expiration of the 2-year period. No claim for loss incurred that starts after 2 years from the Effective Date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before that Effective Date of coverage.

**PREMIUM PAYMENTS:** This policy is issued based on the application and the payment of the first premium. A copy of the application is a part of this policy. This policy takes effect at 12 o'clock noon, Standard Time at the place where You reside, and remains in effect until the same hour on the date of which the initial term expires.

The Effective Date of this policy, the first premium and the date the initial term expires are shown in the Policy Schedule. All premiums, except the first premium, shall be due and payable at Our Administrative Offices.

**GRACE PERIOD:** The policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period this policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Us (or by Our agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If We or Our agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45<sup>th</sup> day after the date of the conditional receipt unless We have written You earlier of its disapproval.

The reinstated policy will cover only First Diagnosis of Cancer that is manifested more than 10 days after the date of reinstatement. In all other respects Your rights and Our rights will remain the same, subject to any provision endorsed on or attached to the reinstated policy.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after First Diagnosis of Cancer or as soon as reasonably possible. The notice can be given to Us at Our Administrative Offices or to one of Our agents. Notice should include Your name, the name of the Covered Person who suffered the loss, and the policy number.

**CLAIM FORMS:** When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of First Diagnosis requirements by giving Us a statement from the pathologist or Physician that describes the occurrence, nature and extent of the diagnosis within the time limit stated in the "Proof of First Diagnosis" provision.

**PROOF OF FIRST DIAGNOSIS:** Written proof of First Diagnosis must be given to Us within 90 days after the date of such First Diagnosis. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. However, the proof required must be given no later than one year from the time specified unless You were legally incapacitated.

**TIME OF PAYMENT CLAIMS:** Benefits provided by this policy will be paid as soon as We receive proper written proof of First Diagnosis.

**PAYMENT OF CLAIMS:** Benefits will be paid to You unless You assign them to the doctor or hospital. Any benefit unpaid at death will be paid to Your named beneficiary or, at Our option, to Your estate. If benefits are payable to Your estate, We can pay benefits up to \$3,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

**PHYSICAL EXAMINATION:** We have the right to have a Covered Person examined, at Our expense, as often as reasonably needed while a claim is pending

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of First Diagnosis has been given as required by this policy. No such action may be brought after 3 years from the time written proof of First Diagnosis is required to be given.

**MISSTATEMENT OF AGE:** If a Covered Person's age has been misstated, the benefit will be such as the premium paid would have purchased at the correct age. In the event coverage would not have become effective, or would have terminated, Our liability will be limited to a refund. Such refund must be requested by You and will be equal to the portion of the premiums paid for the period not covered by this policy.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

**ASSIGNMENT:** No assignment under this policy shall be binding upon Us unless the original (or a copy of it) is on file at Our Administrative Offices. We do not assume any responsibility for the validity of any assignment. We will pay the benefits of this policy to any state agency (such as Medicaid) when required by state law.

**REFUND OF UNEARNED PREMIUMS ON DEATH:** Upon the death of a Family Member insured under this policy, We will refund any premiums paid in behalf of the member, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

This policy is signed for Us by Our President and Secretary.

  
Secretary

  
President

Countersigned:

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Licensed Resident Agent where required by law.

# CANCER POLICY

BENEFITS FOR FIRST DIAGNOSIS OF CANCER. THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE; THE COMPANY RESERVES THE RIGHT TO CHANGE PREMIUMS ON A CLASS BASIS BY STATE.

**GLOBE LIFE AND ACCIDENT INSURANCE COMPANY**  
**GLOBE LIFE CENTER \* OKLAHOMA CITY, OKLAHOMA 73184 (800) 478-3291**  
**A Legal Reserve Stock Company**

## CONSIDERATION

This policy is issued in consideration of statements made in Your application and the payment of premium shown in the Policy Schedule. Your application is attached and is a part of this policy. We will pay You the benefit amount for Cancer which is first diagnosed 30 days after the Effective Date of this policy.

## RIGHT TO EXAMINE POLICY

If You are not satisfied with this policy, You may return it for a full refund of premiums. You must return the policy within 30 days after You receive it. You may return the policy by delivering it or mailing it to the agent who took Your application or to Our Administrative Offices. Upon such return, We will void the policy as of the Effective Date, and We will refund the premium paid.

IMPORTANT NOTICE: This policy was issued based on the information in Your application, a copy of which is attached to this policy. Advise Us immediately if any of the information is incorrect. Incorrect information could result in the denial of a claim or the termination of this policy.

## THIS IS A LEGAL CONTRACT – READ YOUR POLICY CAREFULLY

### CAUTION: THIS IS A LIMITED POLICY

## RENEWAL PROVISION

You are guaranteed the right to renew this policy for Your lifetime by the payment of the premium in effect on the date it is due. The premium must be paid on or before the due date, or within the 31 days that follow.

We may change the premium on a class basis for all policies of this same form in YOUR state. Class is based on gender, issue age and year of issue.

---

### POLICY SCHEDULE

---

POLICY NUMBER	EFFECTIVE DATE	INITIAL TERM EXPIRES ON	INITIAL PREMIUM	BENEFIT AMOUNT
[12345678	10/01/2009	11/01/2009	\$ 00.00]	
[INSURED:	John Doe			\$10,000]
[SPOUSE:	Jane Doe			\$10,000]
[CHILD 1:	One Doe			\$10,000]
[CHILD 2:	Two Doe			\$10,000]
[CHILD 3:	Three Doe			\$10,000]
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## DEFINITIONS

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Criteria for malignancy are those accepted by the American Board of Pathology or the Osteopathic Board of Pathology. This diagnosis must be based on a microscopic study of body tissue or fluid. The pathologist establishing the diagnosis shall base his judgment solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis of Cancer will be accepted as evidence that cancer exists in a Covered Person when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of Cancer and the Covered Person received treatment of Cancer.

**COVERED FAMILY MEMBER:** The spouse of the Insured and all unmarried children of the Insured, under age 19, on the Effective Date. To be covered, each existing member must be named in the application. Any member who has had Cancer diagnosed is excluded from coverage. Stepchildren and legally adopted children can be included if listed in the application.

Any newborn or newly adopted children of the Primary Insured will automatically be a Covered Person from the moment of birth or adoption if such birth or adoption occurs after the Effective Date of the policy. This will also cover children You have filed a petition to adopt.

You may apply for coverage on other dependents acquired after the Effective Date of the policy, subject to Our approval. Coverage on Your children terminates when they marry. It also terminates on the policy anniversary date following their 25<sup>th</sup> birthday, unless they are still dependent on You due to a physical or mental handicap. You must furnish Us proof of the disability and dependency status within 31 days of the termination date. If a dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and if such disability occurred prior to the first policy anniversary following the child's 25<sup>th</sup> birthday, then the child will continue to be a Covered Person for as long as such disability continues. Proof of such incapacity or disability must be furnished upon Our request, but not more often than annually.

**COVERED PERSON:** Refers to either You or a Covered Family Member.

**FIRST DIAGNOSIS:** "First Diagnosis" means the first time a Covered Person is diagnosed as having internal Cancer or malignant melanoma (this excludes all other Skin Cancer); provided the diagnosis is after the Waiting Period and while this policy is in force with respect to the Covered Person.

**PHYSICIAN:** A person who is a practitioner of the healing arts, other than Yourself or a member of Your immediate family or household, and who is duly licensed to practice, and is practicing, medicine in the United States to treat an injury or illness.

**SKIN CANCER:** Any form of malignant growth positively diagnosed as Cancer (malignant neoplasm) which is confined to the epidermis, dermis (corium) and/or subcutaneous tissue. Such diagnosis must be based on a microscopic study performed by a recognized pathologist. **Skin Cancer is not covered under this policy.**

**WAITING PERIOD:** No benefit is payable if Cancer first manifests itself before the policy has been in force for 30 days from the Effective Date shown in the Policy Schedule. Cancer is manifested when symptoms exist

**WE, US, OUR and COMPANY:** Globe Life And Accident Insurance Company.

**YOU, YOUR and INSURED:** The Covered Person whose name is shown in the Policy Schedule.

### **BENEFITS**

We will pay You the Cancer Benefit Amount as shown in the Policy Schedule when We receive due proof of a Covered Person's First Diagnosis of Cancer while this policy is in force. No benefit is payable if the Cancer first manifests itself before the end of the 30-day Waiting Period. In such case, You may void the policy from the beginning and receive a full refund of premium, provided You request the refund within 60 days after the end of the Waiting Period. **A Covered Person is limited to only one First Diagnosis benefit. Coverage for such person terminates upon payment of their benefit.**

### **LIMITATIONS AND EXCLUSIONS**

1. This policy pays a benefit only for First Diagnosis of Cancer while this policy is in force. Proof of First Diagnosis of Cancer must be provided. Pathologic or clinical diagnosis proof thereof must be submitted. This policy does not provide benefits for any other disease, sickness, disability or incapacity.
2. This policy contains a 30-day Waiting Period. No benefit is payable to anyone who has Cancer manifested before the policy has been in force for 30 days from the Effective Date shown in the Policy Schedule.
3. This policy will not pay benefits if the First Diagnosis of Cancer is made outside the United States of America.

### **GENERAL PROVISIONS**

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between You and Us. No change in this policy will be effective until approved by Us. This approval must be noted on or attached to this policy.

No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** After 2 years from the policy Effective Date only fraudulent misstatements in the application may be Used to void this policy or deny any claim resulting from First Diagnosis of a covered Cancer after the expiration of the 2-year period. No claim for loss incurred that starts after 2 years from the Effective Date will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before that Effective Date of coverage.

**PREMIUM PAYMENTS:** This policy is issued based on the application and the payment of the first premium. A copy of the application is a part of this policy. This policy takes effect at 12 o'clock noon, Standard Time at the place where You reside, and remains in effect until the same hour on the date of which the initial term expires.

The Effective Date of this policy, the first premium and the date the initial term expires are shown in the Policy Schedule. All premiums, except the first premium, shall be due and payable at Our Administrative Offices.

**GRACE PERIOD:** The policy has a 31-day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period this policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Us (or by Our agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If We or Our agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45<sup>th</sup> day after the date of the conditional receipt unless We have written You earlier of its disapproval.

The reinstated policy will cover only First Diagnosis of Cancer that is manifested more than 10 days after the date of reinstatement. In all other respects Your rights and Our rights will remain the same, subject to any provision endorsed on or attached to the reinstated policy.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after First Diagnosis of Cancer or as soon as reasonably possible. The notice can be given to Us at Our Administrative Offices or to one of Our agents. Notice should include Your name, the name of the Covered Person who suffered the loss, and the policy number.

**CLAIM FORMS:** When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of First Diagnosis requirements by giving Us a statement from the pathologist or Physician that describes the occurrence, nature and extent of the diagnosis within the time limit stated in the "Proof of First Diagnosis" provision.

**PROOF OF FIRST DIAGNOSIS:** Written proof of First Diagnosis must be given to Us within 90 days after the date of such First Diagnosis. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. However, the proof required must be given no later than one year from the time specified unless You were legally incapacitated.

**TIME OF PAYMENT CLAIMS:** Benefits provided by this policy will be paid as soon as We receive proper written proof of First Diagnosis.

**PAYMENT OF CLAIMS:** Benefits will be paid to You unless You assign them to the doctor or hospital. Any benefit unpaid at death will be paid to Your named beneficiary or, at Our option, to Your estate. If benefits are payable to Your estate, We can pay benefits up to \$3,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

**PHYSICAL EXAMINATION:** We have the right to have a Covered Person examined, at Our expense, as often as reasonably needed while a claim is pending

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of First Diagnosis has been given as required by this policy. No such action may be brought after 3 years from the time written proof of First Diagnosis is required to be given.

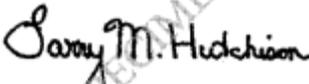
**MISSTATEMENT OF AGE:** If a Covered Person's age has been misstated, the benefit will be such as the premium paid would have purchased at the correct age. In the event coverage would not have become effective, or would have terminated, Our liability will be limited to a refund. Such refund must be requested by You and will be equal to the portion of the premiums paid for the period not covered by this policy.

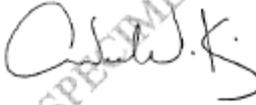
**CONFORMITY WITH STATE STATUTES:** Any provision of this policy that, on its Effective Date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

**ASSIGNMENT:** No assignment under this policy shall be binding upon Us unless the original (or a copy of it) is on file at Our Administrative Offices. We do not assume any responsibility for the validity of any assignment. We will pay the benefits of this policy to any state agency (such as Medicaid) when required by state law.

**REFUND OF UNEARNED PREMIUMS ON DEATH:** Upon the death of a Family Member insured under this policy, We will refund any premiums paid in behalf of the member, for any period beyond the ending of the policy month the death occurred, within 30 days after We receive proof of death.

This policy is signed for Us by Our President and Secretary.

  
Secretary

  
President

Countersigned:

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Licensed Resident Agent where required by law.