

SERFF Tracking Number: ALST-125969969 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
 Company Tracking Number: GVCP3AR  
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
 Product Name: Group Cancer and Specified Disease  
 Project Name/Number: GVCP3AR/

## Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Group Cancer and Specified Disease SERFF Tr Num: ALST-125969969 State: Arkansas

TOI: H07G Group Health - Specified Disease - Limited Benefit SERFF Status: Closed-Approved-Closed State Tr Num: 42305

Sub-TOI: H07G.002A Dread Disease - Cancer Only Co Tr Num: GVCP3AR State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Angie Redden, Jennifer Aiello, Lynn Bautista, Shayla Washington, Patti Hicks, Leslie Blandford, Juli Clausen

Disposition Date: 05/15/2009

Date Submitted: 05/06/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: GVCP3AR

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Association

Filing Status Changed: 05/15/2009

Explanation for Other Group Market Type:

State Status Changed: 05/15/2009

Deemer Date:

Created By: Angie Redden

Submitted By: Leslie Blandford

Corresponding Filing Tracking Number:

Filing Description:

RE: Group Cancer and Specified Disease Policy GVCP3AR, et al. as listed on the attached List of Forms

NAIC Number: 60534

FEIN Number: 59-0781901

SERFF Tracking Number: ALST-125969969 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
 Company Tracking Number: GVCP3AR  
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
 Product Name: Group Cancer and Specified Disease  
 Project Name/Number: GVCP3AR/

The above referenced forms are being submitted for your review and approval. These forms are new and do not replace any forms previously approved by your department. They will be solicited by agents licensed to do business within your state. Forms GVCP3AR; GVCC3AR; GVC3APPAR; G-AMD will be used to issue and enroll in Group Cancer and Specified Disease Insurance. ERAPPAR; AWD4502EAR; AWD4502PAR will be used with the Group Cancer and Specified Disease Insurance as well as some of our other products which have already been previously filed and approved in your state. AWD4515AR will be used with our existing Group Cancer and Specified Disease Insurance business until the group policies are replaced with this new Group Cancer and Specified Disease Insurance. The form numbers and approval dates for these existing products are:

Policy	Policy Number	Approval Date
Group Voluntary Accident Insurance	GVAP1AR	April 22, 2002
Group Voluntary Cancer Specified Disease Insurance	GVCP2	August 1, 2000
Group Voluntary Hospital Indemnity Insurance	GVSP1AR	October 18, 2004
Group Dental Insurance	G-DEN(AR)-P	April 5, 2001

Material may vary, but will always be in accordance with your state laws. The bracketing on this form will allow us the ability to customize the form for particular groups by removing products the employer has chosen to not offer to their employees. The language in the medical questions used on the forms will not be altered from their filed versions. They will simply be removed or left on as needed for a specific group. A Statement of Variability is enclosed, which outlines the variables for the submitted forms. Any logo, officer signature, or Home Office address and telephone number that appears on these forms is subject to change.

The enrollment may be taken through electronic enrollment procedures by our licensed agents using a pen-based signature pad, PIN numbers, and any other valid electronic signature method. You have our assurance that appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it.

If you have any questions regarding this filing, feel free to contact me at aredden@allstate.com , or (904) 992-3045.

## Company and Contact

### Filing Contact Information

Angie Redden, Compliance Analyst, Group Insurance      ARedden@allstate.com  
 ATTN: Legal/Compliance      800-521-3535 [Phone] 3045 [Ext]  
 1776 American Heritage Life Drive      904-992-2975 [FAX]  
 Jacksonville, FL 32224-9983

SERFF Tracking Number: ALST-125969969 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
 Company Tracking Number: GVCP3AR  
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
 Product Name: Group Cancer and Specified Disease  
 Project Name/Number: GVCP3AR/

**Filing Company Information**

American Heritage Life Insurance Company	CoCode: 60534	State of Domicile: Florida
ATTN: Legal/Compliance	Group Code: 8	Company Type: Life and Health
1776 American Heritage Life Drive	Group Name: Allstate	State ID Number:
Jacksonville, FL 32224-9983	FEIN Number: 59-0781901	
(904) 992-1776 ext. [Phone]		

-----

**Filing Fees**

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	05/06/2009	27679041

SERFF Tracking Number: ALST-125969969 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
 Company Tracking Number: GVCP3AR  
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
 Product Name: Group Cancer and Specified Disease  
 Project Name/Number: GVCP3AR/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/15/2009	05/15/2009

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Statement of Variability	Leslie Blandford	05/07/2009	05/07/2009

SERFF Tracking Number: ALST-125969969 State: Arkansas  
Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
Company Tracking Number: GVCP3AR  
TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
Product Name: Group Cancer and Specified Disease  
Project Name/Number: GVCP3AR/

## Disposition

Disposition Date: 05/15/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ALST-125969969 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
 Company Tracking Number: GVCP3AR  
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
 Product Name: Group Cancer and Specified Disease  
 Project Name/Number: GVCP3AR/

Schedule	Schedule Item	Schedule Item Status	Public Access
<b>Supporting Document (revised)</b>	Statement of Variability	Approved-Closed	Yes
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Forms Listing	Approved-Closed	Yes
<b>Supporting Document</b>	Readability Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Statement of Variability	Replaced	Yes
<b>Form</b>	Group Cancer and Specified Disease Policy	Approved-Closed	Yes
<b>Form</b>	Group Cancer and Specified Disease Certificate	Approved-Closed	Yes
<b>Form</b>	Employer Application	Approved-Closed	Yes
<b>Form</b>	Employer Application	Approved-Closed	Yes
<b>Form</b>	Amendment	Approved-Closed	Yes
<b>Form</b>	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes
<b>Form</b>	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes
<b>Form</b>	Evidence of Insurability and Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: ALST-125969969 State: Arkansas  
Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
Company Tracking Number: GVCP3AR  
TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
Product Name: Group Cancer and Specified Disease  
Project Name/Number: GVCP3AR/

**Amendment Letter**

Submitted Date: 05/07/2009

**Comments:**

We inadvertently submitted the incorrect the Statement of Variability with our filing of 5/06/09. Please replace it with the revised version attached. We apologize for any confusion this may cause. Thank you for your consideration.

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**User Added -Name: Statement of Variability**

Comment:

GVCP3 Statement of Variability.pdf

SERFF Tracking Number: ALST-125969969 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
 Company Tracking Number: GVCP3AR  
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
 Product Name: Group Cancer and Specified Disease  
 Project Name/Number: GVCP3AR/

## Form Schedule

### Lead Form Number: GVCP3AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/15/2009	GVCP3AR	Policy/Contractual Certificate	Group Cancer and Specified Disease Policy	Initial		50.700	GVCP3AR.pdf
Approved-Closed 05/15/2009	GVCC3AR	Certificate	Group Cancer and Specified Disease Certificate	Initial		50.100	GVCC3AR.pdf
Approved-Closed 05/15/2009	GVC3APP AR	Application/Enrollment Form	Employer Application	Initial		54.000	GVC3APPAR.pdf
Approved-Closed 05/15/2009	ERAPPAR	Application/Enrollment Form	Employer Application	Initial		55.300	ERAPPAR.pdf
Approved-Closed 05/15/2009	G-AMD	Policy/Contractual Certificate: Amendment, Insert Page, Endorsement or Rider	Amendment	Initial		57.800	G-AMD blank amendment.pdf
Approved-Closed 05/15/2009	AWD450E AR	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Initial		53.700	AWD450EAR.pdf
Approved-Closed 05/15/2009	AWD450P AR	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Initial		53.700	AWD450PAR.pdf
Approved-Closed	AWD4515A R	Application/Enrollment Form	Evidence of Insurability and Enrollment Form	Initial		52.100	AWD4515AR GVC2

SERFF Tracking Number: ALST-125969969 State: Arkansas  
Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
Company Tracking Number: GVCP3AR  
TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
Product Name: Group Cancer and Specified Disease  
Project Name/Number: GVCP3AR/  
05/15/2009 Form Enrollment Form only.pdf

1



**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

HOME OFFICE:  
[1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687]  
(904) 992-1776

A Stock Company

**GROUP CANCER AND SPECIFIED DISEASE INSURANCE POLICY  
NON-PARTICIPATING**

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this policy carefully and contact us promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholder's signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

2

[ *Gay S. Steu* ]

Secretary

[ *David A. Beard* ]

President

**THIS IS LIMITED BENEFIT CANCER AND SPECIFIED DISEASE COVERAGE  
WHICH ONLY PROVIDES BENEFITS FOR CANCER  
AND SPECIFIED DISEASES AS DEFINED AND  
OTHER OPTIONAL BENEFITS  
DESCRIBED HEREIN**

# TABLE OF CONTENTS

POLICY SPECIFICATIONS.....	3
POLICYHOLDER PROVISIONS .....	4
GENERAL PROVISIONS.....	5-9
<span style="border: 1px solid black; padding: 0 2px;">3</span> [CONTINUATION OF INSURANCE (COBRA) .....	[10-11]
PORTABILITY PRIVILEGE .....	[12]
LIMITATIONS/EXCEPTIONS .....	[13]
BENEFIT INFORMATION.....	[14-20]
SCHEDULE OF SURGICAL PROCEDURES .....	[17-19]
CLAIM INFORMATION .....	[21-22]
GLOSSARY.....	[23-26]

## CANCER AND SPECIFIED DISEASE POLICY SPECIFICATIONS

4 POLICYHOLDER: [XYZ COMPANY, INC.]  
5 POLICY NUMBER: [GROUP 106]  
6 POLICY EFFECTIVE DATE: [January 1, 2009]  
7 POLICY ANNIVERSARY DATE: [January 1, 2010 and the first day of month each calendar year thereafter.]  
8 GOVERNING JURISDICTION: The state of [XXXXXXX] and subject to the laws of that jurisdiction.

9 **ELIGIBLE CLASS(ES):** [All full-time active employees or members working at least [30] hours per week excluding those who are insured under any other cancer or specified disease policy issued by American Heritage Life Insurance Company.]

10 **ELIGIBILITY WAITING PERIOD:** [None] [3 Months]

**BENEFITS:** See page 3A

11 **OPTIONAL BENEFIT(S):** [Cancer Initial Diagnosis: \$1,000.00]  
[Intensive Care:  
Hospital Intensive Care Unit Confinement: \$200.00/day  
Step-Down Hospital Intensive Care Unit Confinement: \$100.00/day  
Ambulance: Actual Charges]  
[Wellness: \$25.00/year]]

12 **INITIAL RATE:** [Monthly rate of \$XX.XX per employee or member for Individual Coverage; or \$XX.XX per employee or member for Individual and Spouse Coverage; or \$XX.XX per employee or member for Individual and Child(ren) Coverage; or \$XX.XX per employee or member for Family Coverage]

13 **RATE GUARANTEE DATE:** [01/01/2010]

14 **PREMIUM DUE:** [01/01/2009] and the [first day] of each [calendar month] thereafter. The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

Premium payments are required while the employee or member is receiving benefits except as provided in the Waiver of Premium benefit.

15 **COST OF COVERAGE:** [The policyholder pays the cost of the employee's or member's coverage.]  
[The employee or member pays the cost of the dependent's coverage.]  
[The employee or member and the policyholder share the cost of coverage.]  
[The employee or member pays the cost of coverage.]

16 **DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES**

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

**Name**

**Location (City And State)**

[None]

**CANCER AND SPECIFIED DISEASE POLICY – GVCP3AR**  
SEE BENEFITS SECTION OF POLICY FOR DETAILS OF BENEFITS

<u>BENEFITS</u>	<u>AMOUNT</u>
A. CONTINUOUS HOSPITAL CONFINEMENT	\$100.00/DAY
B. GOVERNMENT/CHARITY HOSPITAL	\$100.00/DAY
C. PRIVATE DUTY NURSING SERVICES	\$100.00/DAY
D. EXTENDED CARE FACILITY	\$100.00/DAY
E. AT HOME NURSING	\$100.00/DAY
F. HOSPICE CARE	
1. FREESTANDING HOSPICE CARE CENTER	\$100.00/DAY
2. HOSPICE CARE TEAM	\$100.00/VISIT
G. RADIATION/CHEMOTHERAPY FOR CANCER	UP TO \$2,500.00/12 MONTHS
H. BLOOD, PLASMA AND PLATELETS	UP TO \$2,500.00/12 MONTHS
I. HEMATOLOGICAL DRUGS	UP TO \$50.00/12 MONTHS
J. MEDICAL IMAGING	UP TO \$125.00/12 MONTHS
K. SURGERY	UP TO \$1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 1 UNIT OF COVERAGE
L. ANESTHESIA	25% OF SURGERY BENEFIT
M. BONE MARROW OR STEM CELL TRANSPLANT	
1. AUTOLOGOUS TRANSPLANT	\$500.00/12 MONTHS
2. NON-AUTOLOGOUS TRANSPLANT	\$1250.00/12 MONTHS
3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	\$2500.00/12 MONTHS
N. AMBULATORY SURGICAL CENTER	\$250.00/DAY
O. SECOND OPINION	\$200.00
P. INPATIENT DRUGS AND MEDICINE	\$25.00/DAY
Q. PHYSICIAN'S ATTENDANCE	\$50.00/DAY
R. AMBULANCE	\$100.00/CONFINEMENT
S. NON-LOCAL TRANSPORTATION	COACH FARE OR \$0.40/MILE
T. OUTPATIENT LODGING	\$50.00/DAY \$2,000.00/12 MONTHS
U. FAMILY MEMBER LODGING AND TRANSPORTATION	\$50.00/DAY COACH FARE OR \$0.40/MILE
V. PHYSICAL OR SPEECH THERAPY	\$50.00/DAY
W. NEW OR EXPERIMENTAL TREATMENT	UP TO \$5,000.00/12 MONTHS
X. PROSTHESIS	UP TO \$2,000.00/AMPUTATION
Y. HAIR PROSTHESIS	\$25.00/2 YEARS
Z. NONSURGICAL EXTERNAL BREAST PROSTHESIS	\$50.00/INITIAL PROSTHESIS
AA. ANTI-NAUSEA	\$200.00/YEAR
BB. WAIVER OF PREMIUM	AFTER 90 DAYS]

**POLICYHOLDER PROVISIONS****RATE GUARANTEE**

A change in premium rate will not take effect before the Rate Guarantee Date shown on page 3 except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insureds changes by [25%] or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than [25%] of those eligible for coverage are participating.

We will notify the policyholder in writing at least [30 days] before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

**PREMIUM INCREASES OR DECREASES**

Premium increases or decreases may take effect any time subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

**INFORMATION REQUIRED FROM THE POLICYHOLDER**

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
  - a. who are eligible to become insured; and
  - b. whose coverage changes; and
  - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

**CANCELING POLICY**

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least [31 days] written notice to the policyholder, if:

1. [less than [25%] of those eligible for coverage are participating; or]
2. this policy has been in effect more than [12] months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than [5] employees or members are insured; or
6. the policyholder fails to pay any premium within the [31] day grace period.

If the premium is not paid during the grace period, this policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must pay us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least [31] days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

## GENERAL PROVISIONS

### ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. the employee's or member's legal spouse [or domestic partner]; and
2. unmarried children of the employee or member including adopted children from the moment of placement in the residence, stepchildren, [children of a domestic partner] or legal ward who are [under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school]. The employee's or member's children must be dependent on the employee or member for support or reside with the employee or member over 50% of the time in a regular parent-child relationship and be named on the enrollment [or evidence of insurability] form.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to this policy if we are notified within 31 days after they become eligible.

If the insured employee or member has Individual Coverage [or Individual and Child(ren) Coverage], then marries and desires coverage for his or her spouse, we must be notified within 31 days of the marriage. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.]

[If the insured employee or member has Individual Coverage [or Individual and Child(ren) Coverage], then establishes a domestic partnership and desires coverage for his or her domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the date a domestic partnership was formed, then evidence of insurability will be required.]]

A child born to the insured employee or member or spouse [or domestic partner], while [Individual and Child(ren) Coverage or] Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other person covered under this policy.

If the insured employee or member has Individual Coverage [or Individual and Spouse Coverage,] newborn children are automatically covered from the moment of birth for a period of 31 days. If the insured employee or member desires uninterrupted coverage for a newborn child, the insured employee or member must notify us within 31 days of that child's birth. Upon notification, we will convert the insured employee's or member's Individual Coverage [to Individual and Child(ren) Coverage] [or Individual and Spouse Coverage] to Family Coverage and provide notification of additional premium due. If the insured employee or member does not notify us within 31 days of the birth of the child, the temporary automatic coverage ends.

An adopted child or child pending adoption will be covered as follows, as long as [Individual and Child(ren) Coverage or] Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured employee or member has been entered within 60 days after the date of birth.
2. If adoption proceedings have been instituted by the insured employee or member within 60 days after the date of birth and the insured employee or member has temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as the insured employee or member has custody of the child pursuant to decree of the court and required premiums are paid.

### ELIGIBILITY DATE

If the employee is working for the employer in an eligible class or if a person is a member of the policyholder's union or association, the date such or member is eligible for coverage is the later of:

1. this policy's effective date; or
2. the date such person becomes a member of the eligible class and completes any applicable eligibility waiting period.

## GENERAL PROVISIONS (Continued)

### 23 WHEN AN ELIGIBLE EMPLOYEE OR MEMBER CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. The employee or member may apply for coverage during:
  - a. his or her initial enrollment period; or
  - b. at any other time[, subject to evidence of insurability].
2. The employee or member may increase coverage [at any time] [at the next annual enrollment period] [, subject to evidence of insurability].
3. The employee or member may discontinue coverage at any time.

### 24 [WHEN EVIDENCE OF INSURABILITY IS REQUIRED

[Evidence of insurability is required at the time of enrollment.

Evidence of insurability is also required if:

1. the employee or member:
  - a. voluntarily canceled coverage and is reapplying; or
  - b. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period; or
2. an eligible dependent did not enroll within 31 days of eligibility.]

[Evidence of insurability is required if:

1. the employee or member:
  - a. voluntarily canceled coverage and is reapplying; or
  - b. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.]]

### EFFECTIVE DATE OF COVERAGE

Coverage for each eligible employee or member is effective at 12:01 a.m. on the effective date shown on the certificate of insurance issued to that person.

- 25 For any change in an insured employee's or member's coverage [that is subject to evidence of insurability], the change in coverage is effective on the date we approve such change.

[For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.]

### WHEN AN EMPLOYEE IS ABSENT FROM WORK OR A MEMBER IS NOT ENGAGED IN ACTIVE EMPLOYMENT ON THE EFFECTIVE DATE OF COVERAGE

If an employee or member is absent from work due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage for that person begins on the date they meet the definition of active employment. This applies to such person's initial coverage, as well as any increase or addition to coverage that occurs after such person's initial coverage is effective.

### CERTIFICATES OF INSURANCE

We will issue certificates of insurance for each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the benefits provided; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under this policy.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

## GENERAL PROVISIONS (Continued)

### TERMINATION OF COVERAGE

The insured employee's or member's coverage under the certificate ends on the earliest of:

1. the date this policy is canceled; or
2. the last day of the period for which such employee made any required premium payments; or
3. the last day such insured employee or member is in active employment or membership, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or
4. the date such insured employee or member is no longer in an eligible class; or
5. the date such insured employee's or member's class is no longer eligible.

We will provide coverage for a payable claim incurred while the insured employee or member is covered under this policy.

- 26** If the insured employee's or member's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or death of the insured employee or member.

[If the insured employee's or member's domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or death of the insured employee or member.]

- 27** Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible. This is the earlier of: a) when the child marries; or b) reaches age [22 (26 if a full-time student attending an educational institution of higher learning beyond high school)]; or c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon the insured employee or member for support and maintenance.

The child's coverage continues as long as the insured employee's or member's coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us, at our expense, when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if the insured employee or member has [Individual and Child(ren) Coverage or] Family Coverage and there are other eligible dependents covered under this policy.

### AGENCY

For purposes of this policy, this policyholder acts on its own behalf or as the employee's or member's agent. Under no circumstances will the policyholder be deemed our agent.

### TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If an insured employee or member ceases active employment or terminates membership because of a temporary layoff or leave of absence while coverage is in force, we will continue the insured employee's or member's coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved the leave in writing. Coverage will be continued for [3 months] following the date the insured employee or member ceases active employment or membership.

**28**

If the insured employee's or member's coverage ends while on a Family and Medical Leave of Absence, his or her coverage will be reinstated when he or she returns to active status.

**29**

We will not[;]

- [1.] apply a new pre-existing conditions limitation [; or
2. require evidence of insurability].

## GENERAL PROVISIONS (Continued)

### ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

### INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy. After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

### [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

30

The following applies only when the administration of this policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of this policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of this policy, such determinations shall be final and conclusive.]

### LEGAL ACTION

No legal action may be brought to obtain benefits under this policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

### CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

### UNPAID PREMIUM

Upon the payment of a claim under this policy, any unpaid premium may be deducted.

### [31] [EFFECT OF PRIOR COVERAGE ON LOSSES FOR PRE-EXISTING CONDITIONS

We may pay benefits if an insured employee's or member's claim results from a pre-existing condition if he or she was:

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior group policy when it terminated.

The coverage that was provided under the prior group policy must be substantially similar to this plan and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits the insured employee or member must satisfy the pre-existing condition provision under:

- a. the American Heritage Life plan; or
- b. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If item a. or b. above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item a. is satisfied, we will determine our payment according to our policy provisions.]

## GENERAL PROVISIONS (Continued)

### IF AN INSURED EMPLOYEE OR MEMBER HAS A LOSS DUE TO A PRE-EXISTING CONDITION AND CHANGES FROM INDIVIDUAL INSURANCE THROUGH AMERICAN HERITAGE LIFE TO GROUP INSURANCE THROUGH AMERICAN HERITAGE LIFE

We may pay benefits if an insured employee's or member's loss results from a pre-existing condition if the insured employee or member was:

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior individual insurance policy with American Heritage Life when it terminated.

The coverage that was provided under the prior individual policy must be substantially similar to this plan and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits, the insured employee or member must satisfy the pre-existing condition provision under:

- a. the American Heritage Life plan; or
- b. the prior individual insurance policy through American Heritage Life, if benefits would have been paid had the policy remained in force.

If item a. or b. above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item a. or b. is satisfied, we will determine our payments according to our policy provisions.

**(This space intentionally left blank.)**

**[CONTINUATION OF INSURANCE (COBRA)]**

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if a covered person's insurance would otherwise end due to one of the following events, called a qualifying event.

1. Termination of employment (other than by reason of gross misconduct), or of an insured employee's or member's eligibility due to reduction in his or her hours. Insurance may be continued for any covered person [, except for domestic partners and their covered dependents].
2. The death of an insured employee or member. Insurance may be continued for any covered person [, except for domestic partners and their covered dependents].
3. Divorce or legal separation. Insurance may be continued for a covered spouse whose insurance would otherwise end. [However, COBRA does not extend continuation of coverage to domestic partners and their dependents).
4. The insured employee or member becoming eligible for Medicare. Insurance may be continued for any covered dependents who are not entitled to Medicare [, except for domestic partners and their covered dependents].
5. A child ceasing to be an eligible dependent as defined in this policy. Insurance may be continued for that child.
6. The policyholder files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of insurance, a person must be insured under this policy on the day before the qualifying event. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

A person will not be denied continuation solely because he or she is covered under another group cancer and specified disease policy or eligible for Medicare on the date the qualifying event occurs.

**COVERAGE CONTINUED**

The insurance being continued is subject to all terms and provisions of this policy that do not conflict with this section. The insurance will be the same as that provided under this policy for other persons in the same insurance class in which such person would have been if the qualifying event had not occurred. The continued insurance will be subject to any changes to this policy affecting the benefits of such class following the qualifying event.

**NOTIFICATION AND PAYMENT REQUIREMENTS**

The insured employee or member or other qualifying dependents have the responsibility to inform the policyholder of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under this policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the plan administrator of: (a) an insured employee's or member's death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify the qualifying person of the right to continue within 14 days of the notice described above. The person will then have 60 days to elect to continue his or her insurance. Failure to elect to continue insurance within 60 days after a person is notified by the plan administrator will result in loss of the right to continue such insurance.

The qualifying person will be required to pay a premium for the continued insurance to the policyholder. He or she will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

**[CONTINUATION OF INSURANCE (COBRA) – (Continued)**

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

**TERMINATION**

Insurance being continued will terminate on the first of the following dates that apply:

1. The date this policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverage has been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date the person becomes covered under any other group cancer policy, whether as an insured or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date the person becomes entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees or members of policyholders under Chapter 11 Bankruptcy and his or her dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
  - a. If a person is totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, the covered person must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
    1. within 60 days of the Social Security determination of total disability; and
    2. within the initial 18 months of continuation coverage.
  - b. If an insured employee or member has a qualifying event (termination or reduction in hours worked) and he or she had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
    1. 36 months from the date the insured employee or member first became entitled to Medicare; or
    2. 18 months from the insured employee's or member's termination or reduction in hours.
  - c. For a qualifying event involving retired employees or members of policyholders under Chapter 11 Bankruptcy and his or her dependents, the maximum period of continuation coverage is:
    1. the lifetime of the retiree; or
    2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
    3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.

## PORTABILITY PRIVILEGE

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for a covered person, unless:

1. coverage under this policy terminates under the General Provision entitled "Termination of Coverage"; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. a request is made for that purpose.

No portability coverage will be provided for any person, if his or her insurance under this policy terminated due to his or her failure to make required premium payments.

### PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under this policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under this policy. Any change made to this policy after a person is insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under this policy terminates.

33

### PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate is the rate in effect under this policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least [31] days before the change is to take effect.

### GRACE PERIOD

The grace period, as defined in this policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

### TERMINATION OF INSURANCE

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. the date the person again becomes eligible for insurance under this policy; or
2. the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
  - a. the date the employee's or member's insurance terminates; or
  - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

### TERMINATION OF THE POLICY

If this policy terminates, insured employees or members and their covered dependents will be eligible to exercise the portability privilege on the termination date of this policy. Portability coverage may continue beyond the termination date of this policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

## **LIMITATIONS / EXCEPTIONS**

### **1. PRE-EXISTING CONDITION LIMITATION**

We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became a covered person.

### **2. OTHER LIMITATIONS AND EXCEPTIONS**

We do not pay for any loss except for losses due directly from cancer or a specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim.

**(This space intentionally left blank.)**

## BENEFIT INFORMATION

### PAYMENT OF BENEFITS

If cancer or a specified disease is diagnosed on or after the covered person's effective date, we pay according to the benefits provisions in this policy, subject to the Limitations/Exceptions provision and all other provisions contained in this policy.

If diagnosis is made while the covered person is hospital confined, benefits begin retroactively to the day of admission or 10 days prior to the date of diagnosis if this is more favorable.

If positive diagnosis is made within 12 months after a tentative diagnosis, benefits are paid from the date of tentative diagnosis if the tentative diagnosis is made on or after the effective date, subject to the Pre-existing Condition Limitation provision.

If a covered person dies while an inpatient in a hospital and cancer or a specified disease is not diagnosed until after the covered person's death, benefits will begin retroactively to the day of admission, up to a maximum of 30 days prior to death.

### SCHEDULE OF BENEFITS

We pay the following benefits for the necessary services and products for a covered cancer or a specified disease. Treatment must be received in the United States or its territories.

For those benefits for which we pay actual charges up to a specified maximum amount, benefits K., W. and X., if specific charges are not obtainable as proof of loss, we will pay 50% of the applicable maximum for the benefits payable.

No benefits are payable for the treatment of cancer or a specified disease except those expressly stated in this Schedule of Benefits.

**A. Continuous Hospital Confinement.** If a covered person is admitted to and confined as an inpatient in a hospital, we pay the amount shown on page 3A per day for each day.

**B. Government or Charity Hospital.** In lieu of all other benefits in this policy (except the Waiver of Premium Benefit), we pay the amount shown on page 3A per day for each day a covered person is confined to: (1) a hospital operated by or for the U.S. Government (including the Veteran's Administration); or (2) a hospital that does not charge for the services it provides (charity).

**C. Private Duty Nursing Services.** While a covered person is an inpatient receiving treatment, we pay the amount shown on page 3A per day if such covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by the attending physician and must be provided by a nurse.

**D. Extended Care Facility.** We pay the amount shown on page 3A per day for each day a covered person is confined in an extended care facility. Confinement in the extended care facility must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. This benefit is limited to the number of days of the previous continuous hospital confinement.

**E. At Home Nursing.** While a covered person is receiving treatment, we pay the amount shown on page 3A per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician. This benefit is limited to the number of days of the previous continuous hospital confinement.

**F. Hospice Care.** When a covered person is:

1. determined by a physician to be terminally ill; and
2. expected to live 6 months or less;

we pay one of the following two benefits for hospice care:

**a. Freestanding Hospice Care Center.** We pay the amount shown on page 3A per day for confinement in a licensed freestanding hospice care center. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the confinement. This benefit is payable only if a covered person is admitted to a freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

**b. Hospice Care Team.** We pay the amount shown on page 3A per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. This benefit is payable only if: (1) the covered person has been diagnosed as terminally ill; and (2) the attending physician has approved such services. We do not pay for: (a) food services or meals other than dietary counseling; or (b) services related to well-baby care; or (c) services provided by volunteers; or (d) support for the family after the death of the covered person.

## BENEFIT INFORMATION (Continued)

**G. Radiation/Chemotherapy for Cancer.** We pay the actual costs, up to the amount stated below for radiation therapy and chemotherapy received by a covered person.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

We only pay this benefit for cancer treatment consisting of:

1. cancericidal chemical substances for the purpose of modification or destruction of cancer or a specified disease; and
2. X-ray radiation; and
3. radium and cesium implants; and
4. cobalt.

This benefit does not pay for: (a) any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; or (b) treatment planning; or treatment consultation; or treatment management; or the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory tests; or X-ray or other imaging used for diagnosis or disease monitoring; or the diagnostic tests related to these treatments; or (c) any devices or supplies including intravenous solutions and needles related to these treatments.

**H. Blood, Plasma and Platelets.** We pay the actual costs, up to the limit stated below, when a covered person receives:

1. blood, plasma and platelets (including transfusions and administration charges); and
2. processing and procurement costs; and
3. cross-matching.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. We do not pay for blood replaced by donors. We also do not pay for immunoglobulins.

**I. Hematological Drugs.** We pay the actual costs up to the amount shown on page 3A for drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit (benefit G.) is paid.

**J. Medical Imaging.** We pay the actual costs once per calendar year, up to the amount shown on page 3A if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transrectal ultrasound; or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

**K. Surgery.** We pay the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure per unit of coverage shown on page 3A when surgery is performed on a covered person:

1. for the purpose of treating a diagnosed cancer or specified disease; or
2. for the purpose of diagnosing cancer or a specified disease and that surgery results in a diagnosis of cancer or a specified disease; or
3. that is the first surgery performed subsequent to a diagnosis of cancer or a specified disease that is performed for the purpose of verifying the complete removal of the cancer or specified disease.

If any surgical procedure other than those listed in the Schedule of Surgical Procedures is performed, we pay the actual charges, up to the unit value for the surgical procedure as set forth in the 1964 California Relative Value Schedule (C.R.V.S.) multiplied by \$10.00 per unit of coverage. If the surgical procedure has no unit value or is not shown in the 1964 C.R.V.S., we pay the actual charges, up to an amount we reasonably determine to be consistent (based upon relative difficulty) with the Schedule of Surgical Procedures per unit of coverage. Two or more procedures performed at the same time through one incision or entry point are considered one operation; we pay the amount for the procedure with the greatest benefit. Payment will never exceed the maximum per unit of coverage. Surgery performed on an outpatient basis is paid at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in this Schedule of Benefits.

**L. Anesthesia.** We pay 25% of the amount paid for the Surgery Benefit (benefit K.) for anesthesia received by an anesthetist.

## BENEFIT INFORMATION (Continued)

**M. Bone Marrow or Stem Cell Transplant.** We pay the amounts shown on page 3A for the following types of bone marrow or stem cell transplants performed on a covered person:

1. A transplant which is other than non-autologous.
2. A transplant which is non-autologous for the treatment of cancer or a specified disease, other than Leukemia.
3. A transplant which is non-autologous for the treatment of Leukemia.

This benefit is payable only once per covered person per calendar year.

A non-autologous transplant is an allogeneic or syngeneic graft from one human being to another.

**N. Ambulatory Surgical Center.** We pay the amount shown on page 3A for the use of an ambulatory surgical center for a surgical procedure covered under the Surgery Benefit (benefit K.) that is performed at an ambulatory surgical center.

**O. Second Opinion.** If surgery or treatment is recommended by a physician and the covered person chooses to obtain the opinion of a second physician, we pay the amount shown on page 3A. This second opinion must be: rendered prior to surgery or treatment being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

**P. Inpatient Drugs and Medicine.** We pay the amount shown on page 3A for charges per day, made by the hospital for drugs and medicine while hospital confined, for each day of continuous hospital confinement. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy benefit (benefit G.) or the Anti-Nausea benefit (benefit AA.).

**Q. Physician's Attendance.** We pay the amount shown on page 3A per day for a visit by a physician while a covered person is receiving treatment during hospital confinement. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician. Admission to the hospital as an inpatient is required.

**R. Ambulance.** We pay the amount shown on page 3A per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined.

**S. Non-Local Transportation.** We pay the following benefit for transportation to receive treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally: (1) actual cost of round trip coach fare on a common carrier; or (2) the amount shown on page 3A, up to 700 miles, for round trip personal vehicle transportation. Mileage is measured from the covered person's home to the nearest treatment facility as described above. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

**T. Outpatient Lodging.** We pay a daily lodging benefit when a covered person receives radiation or chemotherapy treatment (benefit G.) on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. The benefit is for a single room in a motel, hotel, or other accommodations acceptable to us, for the amount shown on page 3A per day during treatment. This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

**U. Family Member Lodging and Transportation.** We pay the following benefits for one adult member of the covered person's family to be near the covered person, when they are confined in a non-local hospital for specialized treatment:

1. **Lodging** - The actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to the amount shown on page 3A per day. This benefit is limited to 60 days for each period of continuous hospital confinement; and
2. **Transportation** - The actual cost of round trip coach fare on a common carrier or a personal vehicle allowance of the amount shown on page 3A per mile, up to 700 miles per continuous hospital confinement. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation benefit (benefit S.), when the family member lives in the same city or town as the covered person.

**V. Physical or Speech Therapy.** We pay the amount shown on page 3A per day, for physical or speech therapy for restoration of normal body function.

## BENEFITS INFORMATION (Continued)

**W. New or Experimental Treatment.** We pay the actual charges, up to the limit stated below, for new or experimental treatment for cancer or a specified disease when:

1. the treatment is judged necessary by the attending physician; and
2. no other generally accepted treatment produces superior results in the opinion of the attending physician.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in this Schedule of Benefits.

**X. Prosthesis.** We pay the actual charges, up to the amount shown on page 3A for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation. This benefit is limited to the amount shown on page 3A per covered person, per amputation.

**Y. Hair Prosthesis.** We pay the amount shown on page 3A every 2 years, for a wig or hairpiece if the covered person experiences hair loss.

**Z. Nonsurgical External Breast Prosthesis.** We pay the actual costs up to the amount shown on page 3A for the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under this policy.

**AA. Anti-Nausea Benefit.** We pay the actual costs up to the amount shown on page 3A per calendar year for anti-nausea medication prescribed for a covered person by a physician. We will not pay this benefit for medication administered while the covered person is an inpatient.

**BB. Waiver of Premium.** If, while this coverage is in force, the insured employee or member, as defined, becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, we pay premiums due after such 90 days for as long as the insured employee or member remains disabled. The term "disabled" means that the insured employee or member is:

1. unable to work at any job for which they are qualified by education, training or experience; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of cancer.

This benefit is only available to the insured employee or member, as defined. It does not apply to any other covered person.

(This space intentionally left blank.)

**[OPTIONAL BENEFIT(S)]**

**Cancer Initial Diagnosis.** We pay a one-time benefit when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. The benefit is the amount shown on page 3. The benefit is payable only once per covered person.

**(This space intentionally left blank.)**

**[OPTIONAL BENEFIT(S)]****Intensive Care.**

**A. Hospital Intensive Care Unit Confinement.** We pay the amount shown on page 3 for each day of continuous hospital intensive care unit confinement, as defined, for any illness or accident. This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid. We do not pay for intensive care if a covered person is admitted because of:

1. an attempted suicide; or
2. intentional self-inflicted injury; or
3. intoxication or being under the influence of drugs not prescribed or recommended by a physician; or
4. alcoholism or drug addiction.

We do not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step-down units and any other lesser care treatment units do not qualify as hospital intensive care units.

We do not pay this benefit for continuous hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

Children born within 10 months of the effective date are not covered for any continuous hospital intensive care unit confinement that occurs or begins during the first 30 days of such child's life.

**B. Step-Down Hospital Intensive Care Unit Confinement.** We pay the amount shown on page 3 for each day of step-down hospital intensive care unit confinement, as defined, for any illness or accident. This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms; post-anesthesia care units, progressive care units; intermediate care units; private monitored rooms; observation units located in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment; an emergency room; labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit.

We do not pay this benefit for continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

Children born within 10 months of the effective date are not covered for any step-down hospital intensive care unit confinement that occurs or begins during the first 30 days of such child's life.

**C. Ambulance.** We pay the actual charges, for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. We do not pay this benefit if an ambulance benefit is paid under the Ambulance Benefit (benefit R.) in the Schedule of Benefits.

**DEFINITIONS**

As used in this section, the terms listed below have the following meanings:

**Hospital Intensive Care Unit.** A hospital area of special care including cardiac or coronary care units, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full time basis; and
2. direction and/or supervision by a full time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

**Hospital Intensive Care Unit Confinement.** Means one continuous confinement or two or more step-down hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

**Step-Down Hospital Intensive Care Unit.** Means a specifically designated facility of the hospital that provides a level of medical care below the highest level of acute medical care provided in the hospital, but the level of medical care is above the level of care provided in a regular private or semi-private room or ward. The facility must be separate from other hospital areas, permanently equipped with telemetry equipment and under continual observation by nurses specially trained for that level of care.

**[OPTIONAL BENEFIT(S)]**

**Wellness.** We pay this benefit if a covered person has a wellness test performed. We pay the amount shown on page 3 per calendar year per covered person for any one of the wellness tests. Each covered person is covered for no more than the amount shown on page 3 per calendar year. We pay this benefit regardless of the result of the test. There is no limit as to the number of years we pay for wellness tests. The eligible wellness tests are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

**(This space intentionally left blank.)**

**SCHEDULE OF SURGICAL PROCEDURES  
PER UNIT OF SURGERY COVERAGE**

[SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S.	PER UNIT OF SURGERY COVERAGE
<b>BRAIN</b>		
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma .....	61510 .....	\$1,250.00
Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial.....	61512 .....	\$1,500.00
Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion .....	61575 .....	\$1,250.00
Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography .....	61751 .....	\$1,400.00
<b>BREAST</b>		
Biopsy of breast; needle core (separate procedure) .....	19100 .....	\$ 25.00
Biopsy of breast; incisional .....	19101 .....	\$ 150.00
Excision of malignant tumor (except 19140), male or female, one or more lesions .....	19120 .....	\$ 150.00
Mastectomy, partial.....	19160 .....	\$ 150.00
Mastectomy, simple, complete.....	19180 .....	\$ 300.00
Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle .....	19240 .....	\$ 600.00
<b>DIGESTIVE SYSTEM</b>		
Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with collection of specimen(s) by brushing or washing (separate procedure).....	43235 .....	\$ 150.00
Gastrectomy, total; with esophagoenterostomy.....	43620 .....	\$1,000.00
Colectomy, partial; with anastomosis.....	44140 .....	\$ 800.00
Proctectomy; complete, combined abdominoperineal, with colostomy, one or two stages .....	45110 .....	\$1,000.00
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) .....	45378 .....	\$ 280.00
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique .....	45385 .....	\$ 500.00
<b>EXTERNAL GENITALIA</b>		
<b>FEMALE</b>		
Vulvectomy, simple; partial .....	56620 .....	\$ 400.00
Vulvectomy, simple; complete .....	56625 .....	\$ 550.00
Vulvectomy, radical, partial .....	56630 .....	\$ 800.00
Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy .....	56640 .....	\$1,000.00]

**SCHEDULE OF SURGICAL PROCEDURES (Continued)  
PER UNIT OF SURGERY COVERAGE**

[SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S.	PER UNIT OF SURGERY COVERAGE
<b>EXTERNAL GENITALIA (CONT)</b>		
<b>MALE</b>		
Biopsy of testis, needle (separate procedure) .....	54500 .....	\$ 20.00
Orchiectomy, radical, for tumor; inguinal approach .....	54530 .....	\$ 400.00
<b>LIVER</b>		
Biopsy of liver; percutaneous needle .....	47000 .....	\$ 50.00
Biopsy of liver, wedge (separate procedure) .....	47100 .....	\$ 400.00
Hepatectomy, resection of liver; partial lobectomy .....	47120 .....	\$ 800.00
<b>LUNG</b>		
Bronchoscopy; with biopsy .....	31625 .....	\$ 200.00
Biopsy, lung or mediastinum, percutaneous needle .....	32405 .....	\$ 50.00
Removal of lung, total pneumonectomy.....	32440 .....	\$1,000.00
<b>MUSCULOSKELETAL</b>		
Biopsy, bone, trocar or needle; superficial (e.g., ilium, sternum, spinous process, ribs) .....	20220 .....	\$ 50.00
Excision of tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular .....	21556 .....	\$ 100.00
Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical.....	63275 .....	\$1,000.00
<b>PROSTATE</b>		
Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included).....	52601 .....	\$ 800.00
Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy) .....	55801 .....	\$ 800.00
Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphaden- ectomy, including external iliac, hypogastric and obturator nodes .....	55845 .....	\$1,300.00
<b>SKIN</b>		
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion (pathology report required) .....	11100 .....	\$ 30.00
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); each separate/additional lesion (pathology report required).....	11101 .....	\$ 15.00]



## CLAIM INFORMATION

### NOTICE OF CLAIM

38 We encourage the insured employee or member to notify us of claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this policy, or as soon as is reasonably possible. Notice given by, or on behalf of, the insured employee, the member or the beneficiary to us at [1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687], or to any authorized agent of ours, with the insured employee's or member's name and certificate number, is notice to us.

The claim form can be requested from us. If it is not received within 15 days of the request, written proof of the claim may be sent to us without waiting for the form.

### FILING A CLAIM

The insured employee or member and the employer must complete their own sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to us.

### PROOF OF CLAIM

If this policy provides for periodic payment of a continuing loss, written proof of loss must be given to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given to us within 90 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless the insured employee or member is legally incapacitated.

### COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

### PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

### PAYMENT OF CLAIMS

After receiving written proof of claim, we pay all benefits then due under this policy. Benefits for any other loss covered by this policy are paid as soon as we receive proper written proof.

We will make payments to the insured employee or member unless he or she assigns such payments. Any amounts unpaid at the insured employee's or member's death may, at our option, be paid either to the named beneficiary or to the insured employee's or member's estate.

If benefits are payable to the insured employee's or member's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to the insured employee or member or beneficiary 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.

### ASSIGNMENT

An assignment of the coverage under this policy is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

## **CLAIM INFORMATION (Continued)**

### **OVERPAID CLAIM**

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

The insured employee or member must reimburse us in full. We will work with such insured employee or member to develop a reasonable method of repayment if he or she is financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

### **CLAIM REVIEW**

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the insured employee's or member's right to ask for a review of his or her claim; and
4. the right to submit any additional information that might allow us to change our decision.

The insured employee or member may, upon written request, read any reports that are not confidential. For a fee, we will make copies of those reports.

### **APPEALS PROCEDURE**

Prior to filing any lawsuit and within 60 days after denial of a claim, the insured employee or member or his or her beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

**(This space intentionally left blank.)**

## GLOSSARY

**Active Employment.** Means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. The employee or member must be working at least the minimum number of hours as described under Eligible Class(es) in each plan. The employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

**Actual Charge.** Means the amount billed for a treatment or service before any insurance discounts, other insurance payment, reductions or discounts of any kind.

**Actual Cost.** Means the amount actually paid by or on behalf of the covered person and accepted by the provider as full payment for the particular goods or services provided.

**Ambulatory Surgical Center.** Means a licensed surgical center consisting of: an operating room; facilities for the administration of general anesthesia; and a post surgery recovery room that the patient is admitted to and discharged from within the same working day. This includes an ambulatory surgical center that is a part of a hospital.

**Autologous Bone Marrow Transplant.** Means a procedure in which bone marrow is removed from a patient, stored, and then given back to the patient following intensive treatment.

**Bone Marrow Transplant.** Means a procedure to replace bone marrow destroyed by treatment with high doses of anticancer drugs or radiation. A transplant may be autologous (the person's own marrow saved before treatment), allogeneic (marrow donated by someone else), or syngeneic (marrow donated by an identical twin).

**Calendar Year.** Means a consecutive 12 month period beginning on January 1<sup>st</sup> of each year and ending on December 31<sup>st</sup> of the same year.

**Cancer.** Means a disease manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes: Hodgkin's Disease; leukemia; lymphoma; carcinoma; sarcoma; or malignant tumor. It does not include other conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions.

**Common Carrier.** Means only the following: commercial airlines; or passenger trains; or inter-city buslines. It does not include taxis; intra-city buslines; or private charter planes.

**Continuous Hospital Confinement.** Means one continuous confinement or two or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

**39 Covered Person.** Means any of the following:

1. any eligible family member (including the employee or member) named on the enrollment form [or evidence of insurability form] and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

**Date of Diagnosis.** Means the earliest of the date of: tentative diagnosis; or clinical diagnosis; or the day the tissue specimen, culture(s) and/or titer(s) are taken, upon which the positive or tentative diagnosis of cancer or specified disease is made.

## GLOSSARY (Continued)

40

**[Domestic Partner.** Means the employee's or member's same-sex or opposite-sex partner who is eligible for coverage providing that:

1. both the employee or member and the employee's or member's same-sex or opposite sex partner must be considered as domestic partners according to the law of employee's or member's state of residence; or
2. if the employee's or member's state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, the employee or member must satisfy the definition of domestic partner as defined by the policyholder; or
3. if the employee's or member's state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both the employee and member and the employee's or member's same-sex or opposite sex partner must:
  - a. have resided together in the same permanent residence; and
  - b. be at least 18 years of age; and
  - c. intend to remain each other's sole domestic partner indefinitely; and
  - d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon the employee or member for care and financial assistance; and
  - e. not be legally married to or the legal domestic partner of anyone else; and
  - f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.]

**Employee.** Means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

**Employer.** Means the individual, company or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

41

**[Evidence of Insurability.** Means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.]

**Extended Care Facility.** Means a licensed nursing facility under the direction of a physician which provides continuous skilled nursing service under the supervision of a graduate registered nurse (R.N.) and maintains daily medical records on each patient. It does not include any institution, or part thereof, used primarily as a place for the aged, drug addicts, alcoholics, or rest.

42

**Family Coverage.** Means coverage that includes the insured employee or member as defined, his or her spouse [or domestic partner] and eligible children.

**Freestanding Hospice Care Center.** Means a center which is not a hospital, a wing, or section of a hospital, providing 24 hours a day care for the terminally ill under the medical direction of a physician.

43

**Grace Period.** Means a period of [31] days following the premium due date during which premium payment may be made.

**Hospital.** Means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

## GLOSSARY (Continued)

44 **[Individual and Child(ren) Coverage.** Means coverage that includes only the insured employee or member, as defined and eligible children.]

45 **[Individual and Spouse Coverage.** Means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse[ or domestic partner].]

**Individual Coverage.** Means coverage that includes only the insured employee or member, as defined.

**Initial Enrollment Period.** Means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending [31] days after the date he or she is first eligible to apply for coverage.

46 **[Insured Employee or Member.** Means the employee or member accepted for coverage by us who has completed and signed the enrollment form [or evidence of insurability] and whose name appears on the certificate specification page.

**Intoxication.** Means a temporary state of being as determined by the laws of the state in which the loss occurred.

**Material and Substantial Duties.** Means duties that:

1. are normally required for the performance of the employee's or member's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the employee or member is required to work on average in excess of 40 hours per week, we will consider such person able to perform that requirement if he or she is working or has the capacity to work 40 hours per week.

47 **[Member.** Means a member in good standing in an labor union, association or other entity named as the policyholder and who is: a) a citizen or resident of the United States; and b) is [(1)] engaged in [, or (2) able to engage in and currently seeking,] active employment.

**Nurse.** Means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. a licensed practical nurse (L.P.N.); or
2. a licensed vocational nurse (L.V.N.); or
3. a graduate registered nurse (R.N.).

**Non-Autologous Bone Marrow Transplant.** Means an allogeneic or syngeneic graft of living bone marrow from one human being to another.

**Oncologist.** Means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified to practice in the field of Oncology.

**Pathologist.** Means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified by the American Board of Pathology to practice Pathological Anatomy.

**Payable Claim.** Means a claim for which we are liable under the terms of this policy.

**Physician.** Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

We will not recognize the insured employee or member, his or her spouse, children, parents, or siblings as a physician for a claim.

## GLOSSARY (Continued)

**Policyholder.** Means the legal entity to whom this policy is issued.

**Positive Diagnosis (of cancer).** Means a diagnosis by a licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on a microscopic examination of fixed tissue, or preparations from the hemic system (except for skin cancer). We accept clinical diagnosis of cancer as evidence that cancer existed in a covered person when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis and the covered person received definitive treatment for the cancer.

**Positive Diagnosis (of a specified disease).** Means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

**Pre-Existing Condition.** Means a disease or physical condition for which:

1. symptoms existed within the 12 month period prior to the effective date of coverage; or
2. medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage.

A pre-existing condition can exist even though a diagnosis has not yet been made.

**Radiologist.** Means a person who is licensed to administer X-ray therapy, radium therapy, or radio-active isotopes therapy and is certified by the American Board of Radiology.

**Re-Enrollment Period.** Means a period of time as set by the policyholder and us during which the employee or member may apply, in writing, for coverage under this policy, or change coverage under this policy if he or she is currently enrolled.

**Specified Disease.** Only any one of the following:

- |   |   |                                  |
|---|---|----------------------------------|
| 1. Addison's Disease  | 10. Legionnaire's Disease   | 19. Rabies                       |
| 2. Amyotrophic Lateral Sclerosis<br>(Lou Gehrig's Disease)              | (confirmation by culture or<br>sputum)                                | 20. Reye's Syndrome              |
| 3. Brucellosis  | 11. Lyme Disease  | 21. Rocky Mountain Spotted Fever |
| 4. Cerebrospinal Meningitis<br>(bacterial)                              | 12. Multiple Sclerosis  | 22. Scarlet Fever                |
| 5. Cystic Fibrosis  | 13. Muscular Dystrophy  | 23. Sickle Cell Anemia           |
| 6. Diphtheria   | 14. Myasthenia Gravis   | 24. Systemic Lupus Erythematosus |
| 7. Encephalitis   | 15. Osteomyelitis   | 25. Tetanus                      |
| 8. Hansen's Disease   | 16. Poliomyelitis   | 26. Thalassemia                  |
| 9. Hepatitis (Chronic B or Chronic<br>C with liver failure or hepatoma) | 17. Primary Biliary Cirrhosis   | 27. Tuberculosis                 |
|   | 18. Primary Sclerosing Cholangitis<br>(Walter Payton's Liver Disease) | 28. Tularemia                    |
|   |   | 29. Typhoid Fever                |

**Stem Cell Transplant.** Means a method of replacing immature blood and bone marrow cells that were destroyed by cancer treatment. The stem cells are given to the person after treatment to help the bone marrow recover and continue producing healthy blood cells.

**Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence.** Means the employee or member is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**Tentative Diagnosis.** Means a diagnosis based upon dated medical records which indicate a diagnosis of a probable or possible cancer or specified disease.

**We, Us, and Our.** Means American Heritage Life Insurance Company.



**Allstate**<sup>®</sup>

Workplace Division ]

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

HOME OFFICE:

[1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687]  
(904) 992-1776

A Stock Company

**THIS IS LIMITED BENEFIT CANCER AND SPECIFIED DISEASE COVERAGE  
WHICH ONLY PROVIDES BENEFITS FOR CANCER  
AND SPECIFIED DISEASES AS DEFINED AND  
OTHER OPTIONAL BENEFITS  
DESCRIBED HEREIN**



**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
HOME OFFICE:  
[1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687]  
(904) 992-1776  
A Stock Company

**GROUP CANCER AND SPECIFIED DISEASE INSURANCE CERTIFICATE  
NON-PARTICIPATING**

(called "we", "our" or "us")

**CERTIFICATE OF INSURANCE**

This certificate explains the policy of insurance underwritten by us. It is not the contract of insurance. The policy (called the "policy"), as issued to the policyholder by us, alone makes up the agreement under which insurance coverage is provided and benefits are determined. The policy is delivered in and is governed by the laws of the governing jurisdiction, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The policy may be inspected at the office of the policyholder during normal business hours.

**CONSIDERATION**

Your coverage under the policy is issued to you in consideration of your enrollment form or other form of application and the payment of the first premium. Your coverage under the policy is effective from 12:01 a.m. Standard Time on your effective date.

**INSURING CLAUSE**

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due. All such coverage is subject to the terms of the policy.

In this certificate the insured certificate holder will be referred to as "you", "your" or "yours".

This certificate supersedes and replaces any certificate previously issued to you under the policy.

Secretary

President

**THIS IS LIMITED BENEFIT CANCER AND SPECIFIED DISEASE COVERAGE  
WHICH ONLY PROVIDES BENEFITS FOR CANCER  
AND SPECIFIED DISEASES AS DEFINED AND  
OTHER OPTIONAL BENEFITS  
DESCRIBED HEREIN**

# TABLE OF CONTENTS

CERTIFICATE SPECIFICATIONS .....	3
GENERAL PROVISIONS.....	4-8
[CONTINUATION OF INSURANCE (COBRA) .....	9-10]
PORTABILITY PRIVILEGE .....	[11]
LIMITATIONS/EXCEPTIONS.....	[12]
BENEFIT INFORMATION.....	[13-16]
SCHEDULE OF SURGICAL PROCEDURES.....	[17-19]
CLAIM INFORMATION .....	[20-21]
GLOSSARY.....	[22-25]

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

1776 American Heritage Life Drive, Jacksonville, Florida 32224

---

**CERTIFICATE SPECIFICATIONS**

---

FORM NO.	DESCRIPTION OF BENEFITS	NUMBER OF YEARS PAYABLE	ANNUAL PREMIUM AMOUNT	
[GVCC3AR	CANCER AND SPECIFIED DISEASE COVERAGE	LIFE**	\$ 000.00	
	CANCER INITIAL DIAGNOSIS	\$ 1000.00	LIFE**	\$ 00.00
	INTENSIVE CARE UNIT	\$ 200.00/DAY	LIFE**	\$ 00.00
	WELLNESS	\$ 25.00/YEAR	LIFE**	\$ 00.00
		TOTAL	\$ 000.00	

FAMILY COVERAGE

\*\* SUBJECT TO TERMINATION OF COVERAGE PROVISION

---

The effective date and issue age of each benefit is the Effective Date unless otherwise specified.

**TOTAL PREMIUMS**

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
\$000.00	\$000.00	\$00.00	\$00.00	\$00.00

Premium Payment Method PAYROLL - MONTHLY

---

INSURED: JOHN DOE

ISSUE AGE: 35

EFFECTIVE DATE: MAY 01, 2009

CERTIFICATE NUMBER: GROUP106

GROUP POLICY NUMBER: 00001]

# CANCER AND SPECIFIED DISEASE CERTIFICATE – GVCC3AR

SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS

<u>BENEFITS</u>	<u>AMOUNT</u>
[A. CONTINUOUS HOSPITAL CONFINEMENT	\$100.00/DAY
B. GOVERNMENT/CHARITY HOSPITAL	\$100.00/DAY
C. PRIVATE DUTY NURSING SERVICES	\$100.00/DAY
D. EXTENDED CARE FACILITY	\$100.00/DAY
E. AT HOME NURSING	\$100.00/DAY
F. HOSPICE CARE	
1. FREESTANDING HOSPICE CARE CENTER	\$100.00/DAY
2. HOSPICE CARE TEAM	\$100.00/VISIT
G. RADIATION/CHEMOTHERAPY FOR CANCER	UP TO \$2,500.00/12 MONTHS
H. BLOOD, PLASMA AND PLATELETS	UP TO \$2,500.00/12 MONTHS
I. HEMATOLOGICAL DRUGS	UP TO \$50.00/12 MONTHS
J. MEDICAL IMAGING	UP TO \$125.00/12 MONTHS
K. SURGERY	UP TO \$1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 1 UNIT OF COVERAGE
L. ANESTHESIA	25% OF SURGERY BENEFIT
M. BONE MARROW OR STEM CELL TRANSPLANT	
1. AUTOLOGOUS TRANSPLANT	\$500.00/12 MONTHS
2. NON-AUTOLOGOUS TRANSPLANT	\$1,250.00/12 MONTHS
3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	\$2500.00/12 MONTHS
N. AMBULATORY SURGICAL CENTER	\$250.00/DAY
O. SECOND OPINION	\$200.00
P. INPATIENT DRUGS AND MEDICINE	\$25.00/DAY
Q. PHYSICIAN'S ATTENDANCE	\$50.00/DAY
R. AMBULANCE	\$100.00/CONFINEMENT
S. NON-LOCAL TRANSPORTATION	COACH FARE OR \$0.40/MILE
T. OUTPATIENT LODGING	UP TO \$50.00/DAY UP TO \$2,000.00/12 MONTHS
U. FAMILY MEMBER LODGING AND TRANSPORTATION	UP TO \$50.00/DAY COACH FARE OR \$0.40/MILE
V. PHYSICAL OR SPEECH THERAPY	\$50.00/DAY
W. NEW OR EXPERIMENTAL TREATMENT	UP TO \$5,000.00/12 MONTHS
X. PROSTHESIS UP TO \$2,000.00/AMPUTATION	
Y. HAIR PROSTHESIS	\$25.00/2 YEARS
Z. NONSURGICAL EXTERNAL BREAST PROSTHESIS	\$50.00/INITIAL PROSTHESIS
AA. ANTI-NAUSEA	\$200.00/YEAR
BB. WAIVER OF PREMIUM	AFTER 90 DAYS]

GVCC3AR

## GENERAL PROVISIONS

### COVERAGE SUBJECT TO POLICY

The coverage described in this certificate is subject in every way to the terms of the policy that is issued to the policyholder. It alone makes up the agreement by which the insurance is provided. The policy may at any time be amended or discontinued by agreement between us and the policyholder. Your consent is not required for this. Neither are we required to give you prior notice.

### ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. your legal spouse [or domestic partner]; and
2. your unmarried children including adopted children from the moment of placement in the residence, stepchildren, [children of a domestic partner] or legal ward who are [under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school]. Your children must be dependent on you for support or reside with you over 50% of the time in a regular parent-child relationship and be named on the enrollment [or evidence of insurability] form.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to the certificate if we are notified within 31 days after they become eligible.

If you have Individual Coverage [or Individual and Child(ren) Coverage], then marry and desire coverage for your spouse, we must be notified within 31 days of the marriage. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.]

[If you have Individual Coverage [or Individual and Child(ren) Coverage], then establish a domestic partnership and desire coverage for your domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of a date domestic partnership was formed, then evidence of insurability will be required.]]

A child born to you or your spouse [or domestic partner], while Individual Coverage [or Individual and Spouse Coverage] or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other person insured under the certificate. No additional premium will be required for newborns added if [Individual and Child(ren) Coverage or] Family Coverage is in force at the time the newborn is added.

An adopted child or child pending adoption will be covered as follows, as long as [Individual and Child(ren) Coverage or] Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 60 days after the date of birth.
2. If adoption proceedings have been instituted by you within 60 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

### WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
  - a. the initial enrollment period; or
  - b. at any other time[, subject to evidence of insurability].
2. You may increase coverage [at any time] [at the next annual enrollment period] [, subject to evidence of insurability].
3. You may discontinue coverage at any time.

## GENERAL PROVISIONS (Continued)

### **[WHEN EVIDENCE OF INSURABILITY IS REQUIRED**

[Evidence of insurability is required at the time of enrollment.

Evidence of insurability is also required if:

1. you:
  - a. voluntarily canceled coverage and are reapplying; or
  - b. are applying for the coverage, or an increase in the amount of coverage, at any time after your initial enrollment period; or
2. an eligible dependent did not enroll within 31 days of eligibility.]

### **EFFECTIVE DATE OF COVERAGE**

Your coverage will be effective at 12:01 a.m. on the effective date shown on the certificate of insurance issued to you.

For any change in coverage [that is subject to evidence of insurability], the change in coverage is effective on the date we approve such change.

[For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.]

### **WHEN YOU ARE ABSENT FROM WORK ON THE EFFECTIVE DATE OF COVERAGE**

If you are absent from work due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you meet the definition of active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

### **CERTIFICATE OF INSURANCE**

Once you have been approved for coverage, a certificate of insurance is issued describing the insurance provided by the policy stating:

1. the benefits provided; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under the policy.

If there is any discrepancy between the provisions of the certificate and the provisions of the policy, the provisions of the policy govern.

## GENERAL PROVISIONS (Continued)

### TERMINATION OF COVERAGE

Your coverage under the certificate ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which you made any required premium payments; or
3. the last day you are in active employment or membership, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible.

We will provide coverage for a payable claim incurred while you are covered under the policy.

If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death.

[If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death.]

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible. This is the earlier of when the child: (a) marries; or (b) reaches age [22 (26 if a full-time student attending an educational institution of higher learning beyond high school)]; or (c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as your coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us, at our expense, when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if you have [Individual and Child(ren) Coverage or] Family Coverage and there are other eligible dependents covered under the policy.

### AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

### TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease active employment or terminate membership because of a temporary layoff or leave of absence while coverage is in force, we will continue your coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved the leave in writing. Coverage will be continued for [3 months] following the date you cease active employment or membership.

If your coverage ends while on a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active status.

We will not:

1. apply a new pre-existing conditions limitation [; or
2. require evidence of insurability].

## GENERAL PROVISIONS (Continued)

### INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

### [DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.]

### LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

### CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

### UNPAID PREMIUM

Upon the payment of a claim under this policy, any unpaid premium may be deducted.

### EFFECT OF PRIOR COVERAGE ON LOSSES FOR PRE-EXISTING CONDITIONS

We may pay benefits if your claim results from a pre-existing condition if you were:

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior group policy when it terminated.

The coverage that was provided under the prior group policy must be substantially similar to this plan and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits you must satisfy the pre-existing condition provision under:

- a. the American Heritage Life plan; or
- b. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If item a. or b. above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item a. is satisfied, we will determine our payment according to our policy provisions.]

## **GENERAL PROVISIONS (Continued)**

### **IF YOU HAVE A LOSS DUE TO A PRE-EXISTING CONDITION AND CHANGE FROM INDIVIDUAL INSURANCE THROUGH AMERICAN HERITAGE LIFE TO GROUP INSURANCE THROUGH AMERICAN HERITAGE LIFE**

We may pay benefits if your loss results from a pre-existing condition if you were:

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior individual insurance policy with American Heritage Life when it terminated.

The coverage that was provided under the prior individual policy must be substantially similar to this plan and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits, you must satisfy the pre-existing condition provision under:

- a. the American Heritage Life plan; or
- b. the prior individual insurance policy through American Heritage Life, if benefits would have been paid had the policy remained in force.

If item a. or b. above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item a. or b. is satisfied, we will determine our payments according to our policy provisions.

**(This space intentionally left blank.)**

## **[CONTINUATION OF INSURANCE (COBRA)**

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if your insurance would otherwise end due to one of the following events, called a qualifying event.

1. Termination of employment (other than by reason of gross misconduct), or of your eligibility due to reduction in your hours. Insurance may be continued for any covered person [, except for domestic partners and their covered dependents].
2. The death of a covered person. Insurance may be continued for any covered person [, except for domestic partners and their covered dependents].
3. Divorce or legal separation. Insurance may be continued for a covered spouse whose insurance would otherwise end. [However, COBRA does not extend continuation of coverage to domestic partners and their dependents.]
4. The covered person becoming eligible for Medicare. Insurance may be continued for any covered dependents who are not entitled to Medicare [, except for domestic partners and their covered dependents].
5. A child ceasing to be an eligible dependent as defined in the policy. Insurance may be continued for that child.
6. The policyholder files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of insurance, you must be insured under the policy on the day before the qualifying event. In the case of bankruptcy, you must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

You will not be denied continuation solely because you are covered under another group cancer and specified disease policy or eligible for Medicare on the date the qualifying event occurs.

### **COVERAGE CONTINUED**

The insurance being continued is subject to all terms and provisions of the policy that do not conflict with this section. The insurance will be the same as that provided under the policy for other persons in the same insurance class in which such person would have been if the qualifying event had not occurred. The continued insurance will be subject to any changes to the policy affecting the benefits of such class following the qualifying event.

### **NOTIFICATION AND PAYMENT REQUIREMENTS**

You or other qualifying dependents have the responsibility to inform the policyholder of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the plan administrator of: (a) your death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify you of the right to continue within 14 days of the notice described above. You will then have 60 days to elect to continue your insurance. Failure to elect to continue insurance within 60 days after you are notified by the plan administrator will result in loss of the right to continue such insurance.

You will be required to pay a premium for the continued insurance to the policyholder. You will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

## [CONTINUATION OF INSURANCE (COBRA) – (Continued)]

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

### TERMINATION

Insurance being continued will terminate on the first of the following dates that apply:

1. The date the policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverage has been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date you become covered under any other group cancer policy, whether as the insured or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date you become entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees or members of policyholders under Chapter 11 Bankruptcy and their dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
  - a. If you are totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, you must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
    1. within 60 days of the Social Security determination of total disability; and
    2. within the initial 18 months of continuation coverage.
  - b. If you have a qualifying event (termination or reduction in hours worked) and you had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
    1. 36 months from the date you first became entitled to Medicare; or
    2. 18 months from your termination or reduction in hours.
  - c. For a qualifying event involving retired employees or members of policyholders under Chapter 11 Bankruptcy and their dependents, the maximum period of continuation coverage is:
    1. the lifetime of the retiree; or
    2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
    3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.

## **PORTABILITY PRIVILEGE**

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

1. coverage under the policy terminates under the General Provision entitled "Termination of Coverage"; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

### **PORTABILITY COVERAGE**

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after you are insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

### **PORTABILITY PREMIUMS**

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate is the rate in effect under the policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of covered persons on portability on any premium due date. Written notice will be given at least [31] days before the change is to take effect.

### **GRACE PERIOD**

The grace period, as defined in the policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

### **TERMINATION OF INSURANCE**

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. The date you again become eligible for insurance under the policy.
2. The last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
  - a. the date your insurance terminates; or
  - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

### **TERMINATION OF THE POLICY**

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

## **LIMITATIONS / EXCEPTIONS**

### **1. PRE-EXISTING CONDITION LIMITATION**

We do not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became a covered person.

### **2. OTHER LIMITATIONS AND EXCEPTIONS**

We do not pay for any loss except for losses due directly from cancer or a specified disease. We do not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim.

**(This space intentionally left blank.)**

## BENEFIT INFORMATION

### PAYMENT OF BENEFITS

If cancer or a specified disease is diagnosed on or after the covered person's effective date, we pay according to the benefits provisions in this certificate, subject to the Limitations/Exceptions provision and all other provisions contained in the certificate.

If cancer or a specified disease is diagnosed while the covered person is hospital confined, benefits begin retroactively to the day of admission or 10 days prior to the date of diagnosis if this is more favorable.

If positive diagnosis is made within 12 months after a tentative diagnosis, benefits are paid from the date of tentative diagnosis if the tentative diagnosis is made on or after the effective date, subject to the Pre-existing Condition Limitation provision.

If a covered person dies while an inpatient in a hospital and cancer or a specified disease is not diagnosed until after the covered person's death, benefits will begin retroactively to the day of admission, up to a maximum of 30 days prior to death.

### SCHEDULE OF BENEFITS

We pay the following benefits for the necessary services and products for a covered cancer or a specified disease. Treatment must be received in the United States or its territories.

For those benefits for which we pay actual charges up to a specified maximum amount, except benefits K., W and X., if specific charges are not obtainable as proof of loss, we will pay 50% of the applicable maximum for the benefits payable.

No benefits are payable for the treatment of cancer or a specified disease except those expressly stated in this Schedule of Benefits.

**A. Continuous Hospital Confinement.** If a covered person is admitted to and confined as an inpatient in a hospital, we pay the amount shown on page 3A per day for each day.

**B. Government or Charity Hospital.** In lieu of all other benefits in the policy (except the Waiver of Premium Benefit), we pay the amount shown on page 3A per day for each day a covered person is confined to: (1) a hospital operated by or for the U.S. Government (including the Veteran's Administration); or (2) a hospital that does not charge for the services it provides (charity).

**C. Private Duty Nursing Services.** While a covered person is an inpatient receiving treatment, we pay the amount shown on page 3A per day if such covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by the attending physician and must be provided by a nurse.

**D. Extended Care Facility.** We pay the amount shown on page 3A per day for each day a covered person is confined in an extended care facility. Confinement in the extended care facility must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. This benefit is limited to the number of days of the previous continuous hospital confinement.

**E. At Home Nursing.** While a covered person is receiving treatment, we pay the amount shown on page 3A per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician. This benefit is limited to the number of days of the previous continuous hospital confinement.

## BENEFIT INFORMATION (Continued)

**F. Hospice Care.** When a covered person is:

1. determined by a physician to be terminally ill; and
2. expected to live 6 months or less;

we pay one of the following two benefits for hospice care:

**a. Freestanding Hospice Care Center.** We pay the amount shown on page 3A per day for confinement in a licensed freestanding hospice care center. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the confinement. This benefit is payable only if a covered person is admitted to a freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

**b. Hospice Care Team.** We pay the amount shown on page 3A per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. This benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. We do not pay for: (a) food services or meals other than dietary counseling; or (b) services related to well-baby care; or (c) services provided by volunteers; or (d) support for the family after the death of the covered person.

**G. Radiation/Chemotherapy for Cancer.** We pay the actual cost, up to the amount stated below for radiation therapy and chemotherapy received by a covered person.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

We only pay this benefit for cancer treatment consisting of:

1. cancericidal chemical substances for the purpose of modification or destruction of cancer or a specified disease; and
2. X-ray radiation; and
3. radium and cesium implants; and
4. cobalt.

This benefit does not pay for: (a) any other chemical substance which may be administered with or in conjunction with radiation/chemotherapy; (b) treatment planning; or treatment consultation; or treatment management; or the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory tests; or X-ray or other imaging used for diagnosis or disease monitoring; or the diagnostic tests related to these treatments; or (c) any devices or supplies including intravenous solutions and needles related to these treatments.

**H. Blood, Plasma and Platelets.** We pay the actual cost, up to the limit stated below, when a covered person receives:

1. blood, plasma and platelets (including transfusions and administration charges); and
2. processing and procurement costs; and
3. cross-matching.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. We do not pay for blood replaced by donors. We also do not pay for immunoglobulins.

**I. Hematological Drugs.** We pay the actual cost up to the amount shown on page 3A per calendar year, per unit of coverage for drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy benefit (benefit G.) is paid.

**J. Medical Imaging.** We pay the actual cost once per calendar year, up to the amount shown on page 3A, if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transrectal ultrasound; or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

## BENEFIT INFORMATION (Continued)

**K. Surgery.** We pay the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure per unit of coverage shown on page 3A when surgery is performed on a covered person:

1. for the purpose of treating a diagnosed cancer or specified disease; or
2. for the purpose of diagnosing cancer or a specified disease and that surgery results in a diagnosis of cancer or a specified disease; or
3. that is the first surgery performed subsequent to a diagnosis of cancer or a specified disease that is performed for the purpose of verifying the complete removal of the cancer or specified disease.

If any surgical procedure, other than those listed in the Schedule of Surgical Procedures, is performed, we pay the actual charges, up to the unit value for the surgical procedure as set forth in the 1964 California Relative Value Schedule (C.R.V.S.) multiplied by \$10.00 per unit of coverage. If the surgical procedure has no unit value or is not shown in the 1964 C.R.V.S., we pay the actual charges, up to an amount we reasonably determine to be consistent (based upon relative difficulty) with the Schedule of Surgical Procedures per unit of coverage. Two or more procedures performed at the same time through one incision or entry point are considered one operation; we pay the amount for the procedure with the greatest benefit. Payment will never exceed the maximum per unit of coverage. Surgery performed on an outpatient basis is paid at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in this Schedule of Benefits.

**L. Anesthesia.** We pay 25% of the amount paid for the Surgery Benefit (benefit K.) for anesthesia received by an anesthetist.

**M. Bone Marrow or Stem Cell Transplant.** We pay the amounts shown on page 3A for the following types of bone marrow or stem cell transplants performed on a covered person.

1. A transplant which is other than non-autologous.
2. A transplant which is non-autologous for the treatment of cancer or a specified disease, other than Leukemia.
3. A transplant which is non-autologous for the treatment of Leukemia.

This benefit is payable only once per covered person per calendar year.

A non-autologous transplant is an allogeneic or syngeneic graft from one human being to another.

**N. Ambulatory Surgical Center.** We pay for the use of an ambulatory surgical center, up to the amount shown on page 3A for a surgical procedure covered under the Surgery benefit (benefit K.) that is performed at an ambulatory surgical center.

**O. Second Opinion.** If surgery or treatment is recommended by a physician and the covered person chooses to obtain the opinion of a second physician, we pay the amount shown on page 3A. This second opinion must be: rendered prior to surgery or treatment being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

**P. Inpatient Drugs and Medicine.** We pay the amount shown on page 3A for charges per day, made by the hospital for drugs and medicine while hospital confined, for each day of continuous hospital confinement. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy benefit (benefit G.) or the Anti-Nausea benefit (benefit AA.).

**Q. Physician's Attendance.** We pay the amount shown on page 3A for a visit by a physician while a covered person is receiving treatment during hospital confinement. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician. Admission to the hospital as an inpatient is required.

**R. Ambulance.** We pay the amount shown on page 3A per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined.

**S. Non-Local Transportation.** We pay the following benefit for transportation to receive treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally: (1) actual cost of round trip coach fare on a common carrier; or (2) the amount shown on page 3A, up to 700 miles, for round trip personal vehicle transportation. Mileage is measured from the covered person's home to the nearest treatment facility as described above. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

## BENEFIT INFORMATION (Continued)

**T. Outpatient Lodging.** We pay a daily lodging benefit when a covered person receives radiation or chemotherapy treatment (benefit G.) on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. The benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, for the amount shown on page 3A per day during treatment. This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

**U. Family Member Lodging and Transportation.** We pay the following benefits for one adult member of the covered person's family to be near the covered person, when they are confined in a non-local hospital for specialized treatment:

1. **Lodging** - The actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to the amount shown on page 3A per day. This benefit is limited to 60 days for each period of continuous hospital confinement; and

2. **Transportation** - The actual cost of round trip coach fare on a common carrier or a personal vehicle allowance of the amount shown on page 3A per mile, up to 700 miles per continuous hospital confinement. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation benefit (benefit S.), when the family member lives in the same city or town as the covered person.

**V. Physical or Speech Therapy.** We pay the amount shown on page 3A per day, for physical or speech therapy for restoration of normal body function.

**W. New or Experimental Treatment.** We pay the actual charges, up to the limit stated below, for new or experimental treatment for cancer or a specified disease when:

1. the treatment is judged necessary by the attending physician; and
2. no other generally accepted treatment produces superior results in the opinion of the attending physician.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in this Schedule of Benefits.

**X. Prosthesis.** We pay the actual charges up to the amount shown on page 3A for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation. This benefit is limited to the amount shown on page 3A per covered person, per amputation.

**Y. Hair Prosthesis.** We pay the amount shown on page 3A every 2 years, for a wig or hairpiece if the covered person experiences hair loss.

**Z. Nonsurgical External Breast Prosthesis.** We pay the actual costs up to the amount shown on page 3A for the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

**AA. Anti-Nausea Benefit.** We pay the actual costs up to the amount shown on page 3A per calendar year for anti-nausea medication prescribed for a covered person by a physician. We will not pay this benefit for medication administered while the covered person is an inpatient.

**BB. Waiver of Premium.** If, while this coverage is in force the insured employee or member, as defined, becomes disabled due to cancer first diagnosed after the effective date of coverage and remain disabled for 90 days, we pay premiums due after such 90 days for as long as the insured employee or member remains disabled. The term "disabled" means that you are:

1. unable to work at any job for which you are qualified by education, training or experience; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of cancer.

This benefit is only available to the insured employee or member, as defined. It does not apply to any other covered person.

## [OPTIONAL BENEFIT(S)]

**Cancer Initial Diagnosis.** We pay a one-time benefit when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. The benefit is the amount shown on page 3. The benefit is payable only once per covered person.

(This space intentionally left blank.)

## [OPTIONAL BENEFIT(S)]

### Intensive Care.

**A. Hospital Intensive Care Unit Confinement.** We pay the amount shown on page 3 for each day of hospital intensive care unit confinement, as defined, for any illness or accident. This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid. We do not pay for intensive care if a covered person is admitted because of:

1. an attempted suicide; or
2. intentional self-inflicted injury; or
3. intoxication or being under the influence of drugs not prescribed or recommended by a physician; or
4. alcoholism or drug addiction.

We do not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step down units and any other lesser care treatment units do not qualify as hospital intensive care units.

We do not pay this benefit for continuous hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

Children born within 10 months of the effective date are not covered for any continuous hospital intensive care unit confinement that occurs or begins during the first 30 days of such child's life.

**B. Step-Down Hospital Intensive Care Unit Confinement.** We pay the amount shown on page 3 for each day of step-down hospital intensive care unit confinement, as defined, for any illness or accident. This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid. We do not pay for step-down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms; post-anesthesia care units, progressive care units; intermediate care units; private monitored rooms; observation units located in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment; an emergency room; labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit.

We do not pay this benefit for continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage.

Children born within 10 months of the effective date are not covered for any step-down hospital intensive care unit confinement that occurs or begins during the first 30 days of such child's life.

**C. Ambulance.** We pay the actual charges, for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. We do not pay this benefit if an ambulance benefit is paid under the Ambulance Benefit (benefit R.) in the Schedule of Benefits.

### DEFINITIONS

As used in this section, the terms listed below have the following meanings:

**Hospital Intensive Care Unit.** A hospital area of special care including cardiac or coronary care units, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full time basis; and
2. direction and/or supervision by a full time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

**Hospital Intensive Care Unit Confinement.** Means one continuous confinement or two or more step-down hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

**Step-Down Hospital Intensive Care Unit.** Means a specifically designated facility of the hospital that provides a level of medical care below the highest level of acute medical care provided in the hospital, but the level of medical care is above the level of care provided in a regular private or semi-private room or ward. The facility must be separate from other hospital areas, permanently equipped with telemetry equipment and under continual observation by nurses specially trained for that level of care.

## OPTIONAL BENEFIT(S)

**Wellness.** We pay this benefit if a covered person has a wellness test performed. We pay the amount shown on page 3 per calendar year per covered person for any one of the wellness tests. Each covered person is covered for no more than the amount shown on page 3 per calendar year. We pay this benefit regardless of the result of the test. There is no limit as to the number of years we pay for wellness tests. The eligible wellness tests are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

**SCHEDULE OF SURGICAL PROCEDURES  
PER UNIT OF SURGERY COVERAGE**

[SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S.	PER UNIT OF SURGERY COVERAGE
<b>BRAIN</b>		
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma .....	61510 .....	\$1,250.00
Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial .....	61512 .....	\$1,500.00
Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion .....	61575 .....	\$1,250.00
Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography .....	61751 .....	\$1,400.00
<b>BREAST</b>		
Biopsy of breast; needle core (separate procedure) .....	19100 .....	\$ 25.00
Biopsy of breast; incisional .....	19101 .....	\$ 150.00
Excision of malignant tumor (except 19140), male or female, one or more lesions .....	19120 .....	\$ 150.00
Mastectomy, partial .....	19160 .....	\$ 150.00
Mastectomy, simple, complete .....	19180 .....	\$ 300.00
Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle .....	19240 .....	\$ 600.00
<b>DIGESTIVE SYSTEM</b>		
Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with collection of specimen(s) by brushing or washing (separate procedure) .....	43235 .....	\$ 150.00
Gastrectomy, total; with esophagoenterostomy .....	43620 .....	\$1,000.00
Colectomy, partial; with anastomosis .....	44140 .....	\$ 800.00
Proctectomy; complete, combined abdominoperineal, with colostomy, one or two stages .....	45110 .....	\$1,000.00
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure) .....	45378 .....	\$ 280.00
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique .....	45385 .....	\$ 500.00
<b>EXTERNAL GENITALIA</b>		
<b>FEMALE</b>		
Vulvectomy, simple; partial .....	56620 .....	\$ 400.00
Vulvectomy, simple; complete .....	56625 .....	\$ 550.00
Vulvectomy, radical, partial .....	56630 .....	\$ 800.00
Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy .....	56640 .....	\$1,000.00]

**SCHEDULE OF SURGICAL PROCEDURES (Continued)**  
**PER UNIT OF SURGERY COVERAGE**

[SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S.	PER UNIT OF SURGERY COVERAGE
<b>EXTERNAL GENITALIA (CONT)</b>		
<b>MALE</b>		
Biopsy of testis, needle (separate procedure) .....	54500 .....	\$ 20.00
Orchiectomy, radical, for tumor; inguinal approach .....	54530 .....	\$ 400.00
<b>LIVER</b>		
Biopsy of liver; percutaneous needle .....	47000 .....	\$ 50.00
Biopsy of liver, wedge (separate procedure) .....	47100 .....	\$ 400.00
Hepatectomy, resection of liver; partial lobectomy .....	47120 .....	\$ 800.00
<b>LUNG</b>		
Bronchoscopy; with biopsy .....	31625 .....	\$ 200.00
Biopsy, lung or mediastinum, percutaneous needle .....	32405 .....	\$ 50.00
Removal of lung, total pneumonectomy.....	32440 .....	\$1,000.00
<b>MUSCULOSKELETAL</b>		
Biopsy, bone, trocar or needle; superficial (e.g., ilium, sternum, spinous process, ribs) .....	20220 .....	\$ 50.00
Excision of tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular .....	21556 .....	\$ 100.00
Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical.....	63275 .....	\$1,000.00
<b>PROSTATE</b>		
Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included).....	52601 .....	\$ 800.00
Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy) .....	55801 .....	\$ 800.00
Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphaden- ectomy, including external iliac, hypogastric and obturator nodes .....	55845 .....	\$1,300.00
<b>SKIN</b>		
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion (pathology report required) .....	11100 .....	\$ 30.00
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); each separate/additional lesion (pathology report required).....	11101 .....	\$ 15.00]

**SCHEDULE OF SURGICAL PROCEDURES (CONTINUED)  
PER UNIT OF SURGERY COVERAGE**

[SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S.	PER UNIT OF SURGERY COVERAGE
<b>SKIN (CONT)</b>		
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm. or less .....	11600 .....	\$ 60.00
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 2.1 to 3.0 cm. ....	11603 .....	\$ 120.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm. or less .....	11620 .....	\$ 100.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm. ....	11623 .....	\$ 250.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less .....	11640 .....	\$ 150.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 2.1 to 3.0 cm. ....	11643 .....	\$ 300.00
Chemosurgery (Mohs' micrographic technique); first state, fresh tissue technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, and microscopic examination of specimens by the surgeon, of up to 5 specimens .....	17304 .....	\$ 200.00
<b>UTERUS</b>		
Colposcopy (vaginocopy); with biopsy(s) of the cervix and/or endocervical curettage .....	57454 .....	\$ 60.00
Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure) .....	58100 .....	\$ 30.00
Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical) .....	58120 .....	\$ 150.00
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s).....	58150 .....	\$ 600.00
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tubes, with or without removal of ovary(s).....	58210 .....	\$1,000.00
Vaginal hysterectomy.....	58260 .....	\$ 600.00
<b>VASCULAR INJECTION PROCEDURES</b>		
Placement of central venous catheter for therapeutic reasons (subclavian, jugular, or other vein) (e.g., for hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2.....	36489 .....	\$ 100.00
Insertion of implantable venous access port, with or without subcutaneous reservoir .....	36533 .....	\$ 400.00
Removal of implantable venous access port and/or subcutaneous reservoir.....	36535 .....	\$ 150.00]

## CLAIM INFORMATION

### NOTICE OF CLAIM

We encourage you to notify us of claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon as is reasonably possible. Notice given by, or on behalf of, you or the beneficiary to us at [1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687], or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If it is not received within 15 days of the request, written proof of the claim may be sent to us without waiting for the form.

### FILING A CLAIM

You and your employer must complete your own sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to us.

### PROOF OF CLAIM

If this certificate provides for periodic payment of a continuing loss, written proof of loss must be given to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given to us within 90 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

### COOPERATION OF BENEFICIARY

The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

### PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law.

### PAYMENT OF CLAIMS

After receiving written proof of claim, we pay all benefits then due under this certificate. Benefits for any other loss covered by this certificate are paid as soon as we receive proper written proof.

We will make payments to you unless you assign such payments. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to you or your beneficiary 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.

### ASSIGNMENT

An assignment of the coverage under this certificate is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

## **CLAIM INFORMATION (Continued)**

### **OVERPAID CLAIM**

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

### **CLAIM REVIEW**

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. the right to submit any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a fee, we will make copies of those reports.

### **APPEALS PROCEDURE**

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

**(This space intentionally left blank.)**

## GLOSSARY

**Active Employment.** Means you are working for the employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Class(es) in each plan. You will be deemed to be in active employment on a day which is not the employer's scheduled work days only if you were actively employed on the preceding scheduled work day.

Your work site must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your employer; or
3. a location to which the job requires you to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

**Actual Charge.** Means the amount billed for a treatment or service before any insurance discounts, other insurance payment, reductions or discounts of any kind.

**Actual Cost.** Means the amount actually paid by or on behalf of the covered person and accepted by the provider as full payment for the particular goods or services provided.

**Ambulatory Surgical Center.** Means a licensed surgical center consisting of: an operating room; facilities for the administration of general anesthesia; and a post surgery recovery room that the patient is admitted to and discharged from within the same working day. This includes an ambulatory surgical center that is a part of a hospital.

**Autologous Bone Marrow Transplant.** Means a procedure in which bone marrow is removed from a patient, stored, and then given back to the patient following intensive treatment.

**Bone Marrow Transplant.** Means a procedure to replace bone marrow destroyed by treatment with high doses of anticancer drugs or radiation. A transplant may be autologous (the person's own marrow saved before treatment), allogeneic (marrow donated by someone else), or syngeneic (marrow donated by an identical twin).

**Calendar Year.** Means a consecutive 12 month period beginning on January 1<sup>st</sup> of each year and ending on December 31<sup>st</sup> of the same year.

**Cancer.** Means a disease manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes: Hodgkin's Disease; leukemia; lymphoma; carcinoma; sarcoma; or malignant tumor. It does not include other conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions.

**Common Carrier.** Means only the following: commercial airlines; or passenger trains; or intercity buslines. It does not include taxis; or intracity buslines; or private charter planes.

**Covered Person.** Means any of the following:

1. any eligible family member (including you) named on the enrollment form [or evidence of insurability form] and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

**Date of Diagnosis.** Means the earliest of the date of: tentative diagnosis; or clinical diagnosis; or the day the tissue specimen, culture(s) and/or titer(s) are taken, upon which the positive or tentative diagnosis of cancer or specified disease is made.

## GLOSSARY (Continued)

**[Domestic Partner.** Means your same-sex or opposite-sex partner who is eligible for coverage providing that:

1. Both you and your same-sex or opposite sex partner must be considered as domestic partners according to the law of your state of residence; or
2. If your state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, you must satisfy the definition of domestic partner as defined by the policyholder; or
3. If your state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both you and your same-sex or opposite sex partner must:
  - a. have resided together in the same permanent residence; and
  - b. be at least 18 years of age; and
  - c. intend to remain each other's sole domestic partner indefinitely; and
  - d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon you for care and financial assistance; and
  - e. not be legally married to or the legal domestic partner of anyone else; and
  - f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.]

**Employee.** Means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

**Employer.** Means the individual, company or corporation where you are in active employment, and includes any division, subsidiary, or affiliated company named in the policy.

**[Evidence of Insurability.** Means a statement of your or your dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.]

**Extended Care Facility.** Means a licensed nursing facility under the direction of a physician which provides continuous skilled nursing service under the supervision of a graduate registered nurse (R.N.) and maintains daily medical records on each patient. It does not include any institution, or part thereof, used primarily as a place for the aged, drug addicts, alcoholics, or rest.

**Family Coverage.** Means coverage that includes you, your spouse [or domestic partner] and eligible children.

**Freestanding Hospice Care Center.** Means a center which is not a hospital, a wing, or section of a hospital, providing 24 hours a day care for the terminally ill under the medical direction of a physician.

**Grace Period.** Means a period of [31] days following the premium due date during which premium payment may be made.

**Hospital.** Means a legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24-hour nursing service. Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

**[Individual and Child(ren) Coverage.** Means coverage that includes only you, as defined and eligible children.]

**[Individual and Spouse Coverage.** Means coverage that includes only you, as defined, and your eligible spouse [or domestic partner].

**Individual Coverage.** Means coverage that includes only you, as defined.

## GLOSSARY (Continued)

**Initial Enrollment Period.** Means one of the following periods during which you may first apply in writing for coverage under the policy:

1. if you are eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if you become eligible for coverage after the policy effective date, the period ending [31] days after the date you are first eligible to apply for coverage.

**Insured Employee or Member.** Means the employee or member accepted for coverage by us who has completed and signed the enrollment form [or evidence of insurability] and whose name appears on the certificate specifications page.

**Intoxication.** Means a temporary state of being as determined by the laws of the state in which the loss occurred.

**Material and Substantial Duties.** Means duties that:

1. are normally required for the performance of your regular occupation; and
2. cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, we will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

**Member.** Means a member in good standing in the labor union or association named as the policyholder and who is: (1) a citizen or resident of the United States; and (2) is [(a)] engaged in [, or (b) able to engage in and currently seeking,] active employment.

**Non-Autologous Bone Marrow Transplant.** Means an allogeneic or syngeneic graft of living bone marrow from one human being to another.

**Nurse.** Means any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. a licensed practical nurse (L.P.N.); or
2. a licensed vocational nurse (L.V.N.); or
3. a graduate registered nurse (R.N.).

**Oncologist.** Means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified to practice in the field of Oncology.

**Pathologist.** Means a legally licensed Doctor of Medicine or Doctor of Osteopathic Medicine certified by the American Board of Pathology to practice Pathological Anatomy.

**Payable Claim.** Means a claim for which we are liable under the terms of the policy.

**Physician.** Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

We will not recognize you, your spouse, children, parents, or siblings as a physician for a claim.

**Policyholder.** Means the legal entity to whom the policy is issued.

**Positive Diagnosis (of cancer).** Means a diagnosis by a licensed doctor of medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on a microscopic examination of fixed tissue, or preparations from the hemic system (except for skin cancer). We accept clinical diagnosis of cancer as evidence that cancer existed in a covered person when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis and the covered person received definitive treatment for the cancer.

**Positive Diagnosis (of a specified disease).** Means a diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

## GLOSSARY (Continued)

**Pre-Existing Condition.** Means a disease or physical condition for which:

1. symptoms existed within the 12 month period prior to the effective date of coverage; or
2. medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage.

A pre-existing condition can exist even though a diagnosis has not yet been made.

**Radiologist.** Means a person who is licensed to administer X-ray therapy, radium therapy, or radio-active isotopes therapy and is certified by the American Board of Radiology.

**Re-Enrollment Period.** Means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if you are currently enrolled.

**Specified Disease.** Only any one of the following:

- |   |   |                                  |
|---|---|----------------------------------|
| 1. Addison's Disease  | 10. Legionnaire's Disease   | 19. Rabies                       |
| 2. Amyotrophic Lateral Sclerosis<br>(Lou Gehrig's Disease)              | (confirmation by culture or<br>sputum)                                | 20. Reye's Syndrome              |
| 3. Brucellosis  | 11. Lyme Disease  | 21. Rocky Mountain Spotted Fever |
| 4. Cerebrospinal Meningitis<br>(bacterial)                              | 12. Multiple Sclerosis  | 22. Scarlet Fever                |
| 5. Cystic Fibrosis  | 13. Muscular Dystrophy  | 23. Sickle Cell Anemia           |
| 6. Diphtheria   | 14. Myasthenia Gravis   | 24. Systemic Lupus Erythematosus |
| 7. Encephalitis   | 15. Osteomyelitis   | 25. Tetanus                      |
| 8. Hansen's Disease   | 16. Poliomyelitis   | 26. Thallasemia                  |
| 9. Hepatitis (Chronic B or Chronic<br>C with liver failure or hepatoma) | 17. Primary Biliary Cirrhosis   | 27. Tuberculosis                 |
|   | 18. Primary Sclerosing Cholangitis<br>(Walter Payton's Liver Disease) | 28. Tularemia                    |
|   |   | 29. Typhoid Fever                |

**Stem Cell Transplant.** Means a method of replacing immature blood and bone marrow cells that were destroyed by cancer treatment. The stem cells are given to the person after treatment to help the bone marrow recover and continue producing healthy blood cells.

**Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence.** Means you are absent from active employment for a period of time that has been agreed to in advance in writing by your current employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**Tentative Diagnosis.** Means a diagnosis based upon dated medical records which indicate a diagnosis of a probable or possible cancer or specified disease.

**We, Us, and Our.** Means American Heritage Life Insurance Company.

**You, Your or Yours.** Means a person who is eligible for American Heritage Life coverage.



**Allstate**<sup>®</sup>

Workplace Division ]

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

HOME OFFICE:

[1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687]

(904) 992-1776

A Stock Company

**THIS IS LIMITED BENEFIT CANCER AND SPECIFIED DISEASE COVERAGE  
WHICH ONLY PROVIDES BENEFITS FOR CANCER  
AND SPECIFIED DISEASES AS DEFINED AND  
OTHER OPTIONAL BENEFITS  
DESCRIBED HEREIN**



# AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

## APPLICATION FOR GROUP INSURANCE

Applicant/Policyholder

**[ABC Company]**

Address (street, city, state and zip)

**[Any City, Any State]**

Type of group:  Employer  Association  Union  Other

Type of coverage(s) applied for:

**Note:** Coverage applied for may be issued under one or more policies.

Requested Effective Date:

**[January 1, 2009]**

If this application is approved by the Company, group insurance will take effect: (a) on the Requested Effective Date; or (b) on the date the Company approves issuance of the group coverage, whichever is later. If this application is not approved, no insurance will take effect, and any premium submitted by the Applicant will be refunded.

As the applicant, I declare to the best of my knowledge and belief, that the statements and answers shown above are true and complete. I understand and agree that: (a) this application will form a part of any policy that is issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company, unless it is in writing on this application; (c) no waiver or modification will bind the Company, unless it is in writing and signed by an executive officer of the applicant; and (d) only those persons eligible under the terms of the policy or policies will be covered.

**Fraud Notice: Any person who knowingly presents a false or fraudulent claim for payment of 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.**

**[ABC COMPANY, INC.]**

*(Full or Corporate Name of Applicant)*

Dated at   **[Any City, Any State]**    
*(City and State)*

By   **[/s/ James Brown, President]**    
*(Authorized Signature and Title)*

On   **[January 1, 2009]**    
*(Date)*

Witness   **[/s/ Joe Smith]**  

  **[123456]**    
*(Agent's License Number)\**

Witness   **[Joe Smith]**    
*(Print Agent's Name as Shown on License\*)*

\*Where required by law.

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

Jacksonville, Florida  
(the "Company")

Amendment No.   1   to Group Policy No. [G-12345]  
issued to

[XYZ COMPANY, INC.]  
(the "Policyholder")

It is hereby agreed that, effective [January 01, 2009], the Group Policy is amended as follows:

I.

- 
- 
- 
- 
- 
- 

This Amendment will be attached to and form a part of the Group Policy, and will not be held to alter or affect any of the terms of such Policy other than as specifically stated, but not unless both the Company and the Policyholder have executed this Amendment.

Signed on \_\_\_\_\_ Signed on \_\_\_\_\_  
(Date) (Date)

**AMERICAN HERITAGE  
LIFE INSURANCE COMPANY**  
(the "Company")

**(XYZ COMPANY, INC.)**  
(the "Policyholder")

by \_\_\_\_\_ by \_\_\_\_\_  
(Signature of Officer) (Title) (Authorized Representative) (Title)



# AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

# Allstate

Workplace Division

New Certificate  
 Change/Increase Certificate # \_\_\_\_\_

## EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Remarks

### [GENERAL INFORMATION SECTION (Please complete entire section for all coverages)]

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.)		First	M.I.	SEX	SOCIAL SECURITY NUMBER		<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP	
BIRTHDATE (MM/DD/YEAR)		RESIDENT PHONE NUMBER		EMPLOYER		DATE OF HIRE (MM/DD/YEAR)	
HEIGHT	WEIGHT	JOB TITLE		PLANT OR DIVISION		REHIRE DATE (MM/DD/YEAR)	
BENEFICIARY'S NAME (Last, First, M.I.)				RELATIONSHIP			

Are you changing any of your existing coverage due to a qualifying event such as marriage, birth, or adoption?

**Group Voluntary Accident**  Yes  No     
**Group Voluntary Hospital Indemnity**  Yes  No  
**Group Voluntary Cancer/Specified Disease**  Yes  No     
**Heritage Choice Dental**  Yes  No

If "Yes", please complete the following: Qualifying Event \_\_\_\_\_  
Date of Qualifying Event \_\_\_\_\_ Current Certificate Number \_\_\_\_\_

Do you currently have any of the following individual products with AHL?  
Accident  Yes  No      Cancer  Yes  No      Hospital Indemnity  Yes  No

If you answered "Yes" to any of the products, please enter the Policy Number \_\_\_\_\_

Do you wish to terminate this coverage?  Yes  No    If "Yes", please enter effective date of termination \_\_\_\_\_ ]

### [PLEASE COMPLETE FOR PERSONS TO BE INSURED (Use additional paper if needed.)]

Choose Plan(s):				Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Actively At Work*
Accident	Cancer	Hospital	Dental					
					Employee			<input type="checkbox"/> Yes <input type="checkbox"/> No
					Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No
								N/A
								N/A
								N/A

\*Actively at work means that he/she is actively at work now for wage or profit and has worked at least [20] hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

<b>[Premium/Billing Mode]</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other  Date of Issue _____	Case Number	Agent Number	Percentage Credit
	Employee Number		
	Situs State		

# EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

## SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

<b>[Accident]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
<b>Optional Disability Riders for Employee</b>			Employee Monthly Salary	Rider Units
<input type="checkbox"/> Off the Job Accident <input type="checkbox"/> Off the Job Accident and Sickness <input type="checkbox"/> On and Off the Job Accident <input type="checkbox"/> On and Off the Job Accident and Sickness			\$ _____	_____
<b>Optional Disability Riders for Spouse</b>			Spouse Monthly Salary	Rider Units
<input type="checkbox"/> On and Off the Job Accident for Insured Spouse* <input type="checkbox"/> On and Off the Job Accident and Sickness for Insured Spouse* *Available only when family coverage is selected and the insured spouse has worked [25] hours per week for 3 or more consecutive months.			\$ _____	_____

<b>[Cancer/Specified Disease]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (GVCP2)		Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Family		Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	
<b>Benefits</b>	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Cancer Screening Option <input type="checkbox"/>
<b>Units</b>				1			

<b>[Cancer/Specified Disease]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (GVCP3)		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family			Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____	
<b>Benefits</b>	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Wellness Benefit Option <input type="checkbox"/>
<b>Units</b>				1			

<b>[Hospital Indemnity]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family			Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
<b>Benefits</b>	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option <input type="checkbox"/>	Prescription Drug Option <input type="checkbox"/>	Disability Rider <input type="checkbox"/>	Life Rider <input type="checkbox"/>
<b>Units</b>						1	

<b>[Heritage Choice Dental]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 3	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+One <input type="checkbox"/> Family		Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
Were you covered under your Employer's prior Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If "Yes", please enter the date coverage effective _____						

**[EVIDENCE OF INSURABILITY AND ENROLLMENT FORM  
EVIDENCE OF INSURABILITY SECTION**

(Please complete each question applicable to coverages selected. Does not apply to Dental.)

If any of the questions 1-6 below are answered "yes", please list the required health history on the next page.		
<b>Cancer, Hospital Indemnity &amp; Sickness Disability Riders</b>	1. Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sickness Disability Riders</b>	2a. Has any person to be insured, within the last 2 years, had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's Disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas or back; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	
	c. Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Has any person to be insured had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cancer &amp; Hospital Indemnity</b>	3a. Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. If the answer to the above question is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Has any person to be insured been diagnosed with or received treatment for any cancer (other than those listed in the above question and/or basal skin cancer) during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>[ Cancer</b>	4. Has any person to be insured ever been diagnosed with or treated for amyotrophic lateral sclerosis, muscular dystrophy, multiple sclerosis, encephalitis, tetanus, tuberculosis, osteomyelitis, cerebrospinal meningitis, brucellosis, sickle cell anemia, thalassemia, rocky mountain spotted fever, legionnaire's disease, Addison's disease, Hansen's disease, tularemia, hepatitis (Chronic B or Chronic C with liver failure or hepatoma), typhoid fever, myasthenia gravis, Reye's syndrome, primary sclerosing cholangitis, Lyme disease, systemic lupus erythematosus, cystic fibrosis, or primary biliary cirrhosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Intensive Care Option (Cancer Only) &amp; Hospital Indemnity</b>	5a. Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; or any abnormality of the heart (including artery disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hospital Indemnity</b>	6. Has any person to be insured, within the last 3 years, been treated for, or been told by a member of the medical profession that he or she has: epilepsy; hepatitis; muscular dystrophy or multiple sclerosis or any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs; paralysis; been counseled for alcohol or drug abuse; or had any medical or surgical procedure recommended but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>[All Health</b>	7. <b>Citizenship.</b> Is each person to be insured and others named in the application (i.e. payer, owner, beneficiaries) a U.S. citizen? If not, list person and country.  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

# EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

## [REQUIRED HEALTH HISTORY

**\*Include diagnosis, dates, and duration along with names and addresses of all attending physicians and medical facilities.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATES Including duration of illness	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

**Use this space for any additional explanation of questions 1-6 on page 3. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.]**

## [ELECTRONIC ACCEPTANCE

By checking the "Yes" box below, I agree and acknowledge that this transaction shall be conducted electronically for the limited purpose of my receipt of the Certificate (the "Certificate") outlining the terms of the Group Policy issued to my employer and all notices required to be delivered with the Certificate, including, but not limited to, federal and state privacy notices (the "Notices"). The Certificate and the Notices may be accessed by me via the AHL website at the following address: [www.ahlc.com]. I understand instructions will be provided to me by AHL. In order to access these documents, I understand that I must have access to the internet [in addition to the following minimum hardware and software requirements: to be determined. I must also have or install an Acrobat reader program.]. I understand that if at any time and for any reason I wish to withdraw my consent, or receive a paper copy of this Certificate and/or the Notices, free of charge, I may do so by calling AHL's toll-free number: [1-800-521-3535], or by writing to AHL at the following address: [Customer Service Department,] American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

YES, I agree to receive the Certificate and Notices electronically via the internet.

NO, I prefer to receive paper copies of the Certificate and Notices.]

## CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

**I CERTIFY** that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. · **I AUTHORIZE** any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, it's subsidiaries or its reinsurers any information. [A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so.] · **I ALSO AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

**FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of 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.**

Employee's Signature \_\_\_\_\_ Signed at \_\_\_\_\_ Date Signed \_\_\_\_\_  
(City and State)



# AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224

# Allstate

Workplace Division

New Certificate  
 Change/Increase Certificate # \_\_\_\_\_

## EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Remarks \_\_\_\_\_

### [GENERAL INFORMATION SECTION (Please complete entire section for all coverages)]

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.)		First	M.I.	SEX	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)				CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)		RESIDENT PHONE NUMBER	EMPLOYER		DATE OF HIRE (MM/DD/YEAR)	
HEIGHT	WEIGHT	JOB TITLE	PLANT OR DIVISION		REHIRE DATE (MM/DD/YEAR)	
BENEFICIARY'S NAME (Last, First, M.I.)				RELATIONSHIP		

Are you changing any of your existing coverage due to a qualifying event such as marriage, birth, or adoption?

**Group Voluntary Accident**  Yes  No     
**Group Voluntary Hospital Indemnity**  Yes  No  
**Group Voluntary Cancer/Specified Disease**  Yes  No     
**Heritage Choice Dental**  Yes  No

If "Yes", please complete the following: Qualifying Event \_\_\_\_\_

Date of Qualifying Event \_\_\_\_\_ Current Certificate Number \_\_\_\_\_

Do you currently have any of the following individual products with AHL?

Accident  Yes  No      Cancer  Yes  No      Hospital Indemnity  Yes  No

If you answered "Yes" to any of the products, please enter the Policy Number \_\_\_\_\_

Do you wish to terminate this coverage?  Yes  No      If "Yes", please enter effective date of termination \_\_\_\_\_ ]

### [PLEASE COMPLETE FOR PERSONS TO BE INSURED (Use additional paper if needed.)]

Choose Plan(s):				Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Actively At Work*
Accident	Cancer	Hospital	Dental					
					Employee			<input type="checkbox"/> Yes <input type="checkbox"/> No
					Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No
								N/A
								N/A
								N/A ]

\*Actively at work means that he/she is actively at work now for wage or profit and has worked at least [20] hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

<b>[Premium/Billing Mode]</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other  Date of Issue _____	Case Number	Agent Number	Percentage Credit
	Employee Number		
	Situs State		

## EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

### SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

<b>[Accident]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Base Units _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
<b>Optional Disability Riders for Employee</b> <input type="checkbox"/> Off the Job Accident <input type="checkbox"/> Off the Job Accident and Sickness <input type="checkbox"/> On and Off the Job Accident <input type="checkbox"/> On and Off the Job Accident and Sickness			Employee Monthly Salary \$ _____	Rider Units _____
<b>Optional Disability Riders for Spouse</b> <input type="checkbox"/> On and Off the Job Accident for Insured Spouse* <input type="checkbox"/> On and Off the Job Accident and Sickness for Insured Spouse* *Available only when family coverage is selected and the insured spouse has worked [25] hours per week for 3 or more consecutive months.			Spouse Monthly Salary \$ _____	Rider Units _____

<b>[Cancer/Specified Disease]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No      (GVCP3)	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____				
<b>Benefits</b>	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Wellness Benefit Option <input type="checkbox"/>
<b>Units</b>				1			

<b>[Hospital Indemnity]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan _____	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____			
<b>Benefits</b>	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option <input type="checkbox"/>	Prescription Drug Option <input type="checkbox"/>	Disability Rider <input type="checkbox"/>	Life Rider <input type="checkbox"/>
<b>Units</b>						1	

<b>[Heritage Choice Dental]</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 3	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+One <input type="checkbox"/> Family	Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Mode Premium \$ _____
Were you covered under your Employer's prior Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", please enter the date coverage effective _____				

**[EVIDENCE OF INSURABILITY AND ENROLLMENT FORM  
EVIDENCE OF INSURABILITY SECTION**

(Please complete each question applicable to coverages selected. Does not apply to Dental.)

If any of the questions 1-6 below are answered "yes", please list the required health history on the next page.		
<b>Cancer, Hospital Indemnity &amp; Sickness Disability Riders</b>	1. Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sickness Disability Riders</b>	2a. Has any person to be insured, within the last 2 years, had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's Disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas or back; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Has any person to be insured had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cancer &amp; Hospital Indemnity</b>	3a. Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. If the answer to the above question is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Has any person to be insured been diagnosed with or received treatment for any cancer (other than those listed in the above question and/or basal skin cancer) during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>[ Cancer</b>	4. Has any person to be insured ever been diagnosed with or treated for amyotrophic lateral sclerosis, muscular dystrophy, multiple sclerosis, encephalitis, tetanus, tuberculosis, osteomyelitis, cerebrospinal meningitis, brucellosis, sickle cell anemia, thalassemia, rocky mountain spotted fever, legionnaire's disease, Addison's disease, Hansen's disease, tularemia, hepatitis (Chronic B or Chronic C with liver failure or hepatoma), typhoid fever, myasthenia gravis, Reye's syndrome, primary sclerosing cholangitis, Lyme disease, systemic lupus erythematosus, cystic fibrosis, or primary biliary cirrhosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Intensive Care Option (Cancer Only) &amp; Hospital Indemnity</b>	5a. Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; or any abnormality of the heart (including artery disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hospital Indemnity</b>	6. Has any person to be insured, within the last 3 years, been treated for, or been told by a member of the medical profession that he or she has: epilepsy; hepatitis; muscular dystrophy or multiple sclerosis or any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs; paralysis; been counseled for alcohol or drug abuse; or had any medical or surgical procedure recommended but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>[All Health</b>	7. <b>Citizenship.</b> Is each person to be insured and others named in the application (i.e. payer, owner, beneficiaries) a U.S. citizen? If not, list person and country.  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

# EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

## [REQUIRED HEALTH HISTORY

**\*Include diagnosis, dates, and duration along with names and addresses of all attending physicians and medical facilities.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATES Including duration of illness	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

**Use this space for any additional explanation of questions 1-6 on page 3. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.]**

## [ELECTRONIC ACCEPTANCE

By checking the "Yes" box below, I agree and acknowledge that this transaction shall be conducted electronically for the limited purpose of my receipt of the Certificate (the "Certificate") outlining the terms of the Group Policy issued to my employer and all notices required to be delivered with the Certificate, including, but not limited to, federal and state privacy notices (the "Notices"). The Certificate and the Notices may be accessed by me via the AHL website at the following address: [www.ahllcorp.com]. I understand instructions will be provided to me by AHL. In order to access these documents, I understand that I must have access to the internet [in addition to the following minimum hardware and software requirements: to be determined. I must also have or install an Acrobat reader program.]. I understand that if at any time and for any reason I wish to withdraw my consent, or receive a paper copy of this Certificate and/or the Notices, free of charge, I may do so by calling AHL's toll-free number: [1-800-521-3535], or by writing to AHL at the following address: [Customer Service Department,] American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

YES, I agree to receive the Certificate and Notices electronically via the internet.

NO, I prefer to receive paper copies of the Certificate and Notices.]

## CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

**I CERTIFY** that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. · **I AUTHORIZE** any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, it's subsidiaries or its reinsurers any information. [A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so.] · **I ALSO AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

**FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of 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.**

Employee's Signature \_\_\_\_\_ Signed at \_\_\_\_\_ Date Signed \_\_\_\_\_  
(City and State)



# AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224

# Allstate

New Certificate  
 Change/Increase Certificate # \_\_\_\_\_

## Workplace Division EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Remarks

Please print with black ink

### [GENERAL INFORMATION SECTION

EMPLOYEE'S NAME Last (Sr, Jr, etc.) First		M.I.	SEX	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)			CITY	STATE	ZIP
BIRTHDAY (MM/DD/YEAR)	RESIDENT PHONE NUMBER	EMPLOYER		DATE OF HIRE (MM/DD/YEAR)	
JOB TITLE		PLANT OR DIVISION		REHIRE DATE (MM/DD/YEAR)	
HEIGHT	WEIGHT	BENEFICIARY'S NAME (Last, First, M.I.)		RELATIONSHIP	
Are you changing your existing coverage due to a qualifying event such as marriage, birth, or adoption? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please complete the following: Qualifying Event _____ Date of Qualifying Event _____ Current Certificate Number _____					
Do you currently have an individual Cancer product with AHL? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "Yes" to any of the products, please enter the Policy Number _____					
Do you wish to terminate this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter effective date of termination _____					

### [PLEASE COMPLETE FOR PERSONS TO BE INSURED

(Use additional paper if needed.)

Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Actively At Work*
	Employee			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No
				N/A
				N/A
				N/A

\*Actively at work means that he/she is actively at work now for wage or profit and has worked at least [20] hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

<b>[Premium/Billing Mode</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other  Date of Issue _____	Case Number	Agent Number	Percentage Credit
	Employee Number		
	Situs State		

**EVIDENCE OF INSURABILITY AND ENROLLMENT FORM  
SELECTION OF COVERAGE SECTION**

<b>[Cancer/Specified Disease</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (GVCP2)		Plan _____		<input type="checkbox"/> Employee Only <input type="checkbox"/> Family		Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Mode Premium \$ _____	
<b>Benefits</b>	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option <input type="checkbox"/>	Intensive Care Option <input type="checkbox"/>	Cancer Screening Option <input type="checkbox"/>		
<b>Units</b>				1					

**[EVIDENCE OF INSURABILITY SECTION**

**If any of the questions 1-3 below are answered "yes", please list the required health history on the next page.  
Complete question 3 if the Intensive Care Option is selected.**

1.	Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2a.	Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	If the answer to the above question is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	Has any person to be insured been diagnosed with or received treatment for any cancer (other than those listed in the above question and/or basal skin cancer) during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
[d.	Has any person to be insured ever been diagnosed with or treated for amyotrophic lateral sclerosis, muscular dystrophy, multiple sclerosis, encephalitis, tetanus, tuberculosis, osteomyelitis, cerebrospinal meningitis, brucellosis, sickle cell anemia, thalassemia, rocky mountain spotted fever, legionnaire's disease, Addison's disease, Hansen's disease, tularemia, hepatitis (Chronic B or Chronic C with liver failure or hepatoma), typhoid fever, myasthenia gravis, Reye's syndrome, primary sclerosing cholangitis, Lyme disease, systemic lupus erythematosus, cystic fibrosis, or primary biliary cirrhosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No]
3a.	Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; or any abnormality of the heart (including artery disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Has any person to be insured in the last year been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No
[4.	<b>Citizenship.</b> Is each person to be insured and others named in the application (i.e. payer, owner, beneficiaries) a U.S. citizen? If not, list person and country.  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No]

# EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

## [REQUIRED HEALTH HISTORY

**\*Include diagnosis, dates, and duration along with names and addresses of all attending physicians and medical facilities.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATES Including duration of illness	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

**Use this space for any additional explanation of questions 1-3 on page 2. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.]**

## [ELECTRONIC ACCEPTANCE

By checking the "Yes" box below, I agree and acknowledge that this transaction shall be conducted electronically for the limited purpose of my receipt of the Certificate (the "Certificate") outlining the terms of the Group Policy issued to my employer and all notices required to be delivered with the Certificate, including, but not limited to, federal and state privacy notices (the "Notices"). The Certificate and the Notices may be accessed by me via the AHL website at the following address: [www.ahllcorp.com]. I understand instructions will be provided to me by AHL. In order to access these documents, I understand that I must have access to the internet [in addition to the following minimum hardware and software requirements: to be determined. I must also have or install an acrobat reader program.]. I understand that if at any time and for any reason I wish to withdraw my consent, or receive a paper copy of this Certificate and/or the Notices, free of charge, I may do so by calling AHL's toll-free number: [1-800-521-3535], or by writing to AHL at the following address: [Customer Service Department,] American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

- YES, I agree to receive the Certificate and Notices electronically via the internet.
- NO, I prefer to receive paper copies of the Certificate and Notices.]

## CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

**I CERTIFY** that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. · **I AUTHORIZE** any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, it's subsidiaries or its reinsurers any information. [A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so.] · **I ALSO AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

**FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of 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.**

Employee's Signature \_\_\_\_\_ Signed at \_\_\_\_\_ Date Signed \_\_\_\_\_  
(City and State)

SERFF Tracking Number: ALST-125969969 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
 Company Tracking Number: GVCP3AR  
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
 Product Name: Group Cancer and Specified Disease  
 Project Name/Number: GVCP3AR/

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Statement of Variability	Approved-Closed	05/15/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	GVCP3 Statement of Variability.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Certification/Notice	Approved-Closed	05/15/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	AR Certification of Compliance.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	05/15/2009
<b>Bypass Reason:</b>	Applications are attached and listed in Forms Schedule		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Forms Listing	Approved-Closed	05/15/2009
<b>Comments:</b>			
<b>Attachment:</b>			
	AR GVCP3 Forms List.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Readability Certification	Approved-Closed	05/15/2009
<b>Comments:</b>			



## **American Heritage Life Insurance Company (AHL) Variables for Group Voluntary Cancer and Specified Disease Policy Form (GVCP3)**

This group policy will be available to issue to employer groups, labor union groups, associations and trusts. The following explain the variables included in the policy. The numbers correspond to the number within the boxes in the left margin of the text.

1. The logo and address of the company will be on all policies and will be the current logo of AHL.
2. The signature of the Secretary and President will be on all policies issued and will be that of the current Secretary and President of AHL.
3. If COBRA is deleted due to the size of the group, it will also be deleted from the Table of Contents. All other pages will be re-numbered accordingly.
4. The complete legal name of each policyholder will be inserted.
5. A unique alphanumeric number will be assigned to each group policy.
6. The effective date requested by the policyholder, and agreed to by AHL, will be inserted.
7. The policy anniversary date will be one year from the policy effective date.
8. The state in which the policy is delivered will be inserted.
9. The classes of employees or members who are eligible will be accurately described here. The number of hours may vary, and other categories of employees or members may be included. If the policyholder doesn't have any employees or members insured under an individual plan with AHL, we will delete the phrase "excluding employees or members who are insured under any individual cancer and specified disease policy through American Heritage Life Insurance Company".
10. The policyholder's eligibility waiting period, if any, will be described here.
11. The Optional Benefits consist of Cancer Initial Diagnosis, Intensive Care Unit and Wellness Benefits. The policyholder may elect to have any or all of these optional benefits. Any optional benefits not elected by the policyholder will be deleted. The benefit amounts shown are based on 1 unit of coverage. Benefit amounts may vary from 1 to 15 units of coverage if the benefits are elected by the policyholder.
12. The Initial Rate is per covered employee or member for individual, individual and spouse, individual and children or family coverage. Rates may vary according to the currently approved rates for these plans.
13. AHL may guarantee the initial rate for a period no less than 12 months from the policy effective date, but the period can be 24 months or 36 months subject to participation requirements agreed to by the policyholder.
14. The premium may be paid annually, semi-annually, quarterly, monthly, semi-monthly, bi-weekly or weekly. The first premium due date is the effective date of the policy.
15. Only one of these statements will be shown here, to indicate whether or not the policyholder shares in the cost of coverage under the policy.
16. Any of the policyholder's divisions, subsidiaries or affiliated companies whose employees or members are to be eligible for coverage under the policy will be named here.
17. The benefit amounts shown are based of 1 unit of coverage. Benefit amounts may vary from 1 to 20 units of coverage.

18. The percent of change in items 3 and 5 will be the percentage taken into consideration when underwriting the group and determining the initial rate. The time period for notice of change in premium rate may not be less than the time required by state law, but may be longer.
19. The time of notice of cancellation or offer to modify may not be less than the time required by state law, but may be longer. Item 1 may be deleted or the participation percentage and number of employees or members may be changed to any reasonable amounts taken into consideration when underwriting the group. In item 2, the policy will never be cancelled or modified within 12 months of the policy being effective. In item 5, employees or members participating will never be less than 5 and no more than 50% of the total group size. The grace period will never be less than 31 days but will be increased if mandated by state law.
20. Domestic Partner language will be deleted if the policyholder does not want coverage for such dependents.
21. The limiting age for children may be changed to comply with state laws or to match a policyholder's other plans. The age will never be lower than required by state law. The limiting age will be reflected throughout the policy.
22. The insurance coverage may be determined by the policyholder and may be extended to any of the following coverage types: Individual Coverage; Individual and Spouse Coverage; Individual and Child(ren) Coverage; or Family Coverage. Coverages not elected by the policyholder may be deleted. The coverage plans elected by the policyholders will be reflected throughout the policy.
23. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety. Changes made to the employee or member's coverage will be done at a time agreed to by the policyholder, either at any time during the year or during an annual enrollment period.
24. Evidence of Insurability requirements will vary by case size and may be required at any time after the initial enrollment period if the individual did not enroll when first eligible. For groups with 200 or more employees or members that meet participation requirements, no Evidence of Insurability will be required at initial enrollment. All members of a union or association may be subject to Evidence of Insurability at initial enrollment, regardless of the number of members within the group. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety.
25. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety.
26. Domestic Partner language will be deleted if the policyholder does not want coverage for such dependents.
27. The limiting age will be reflected throughout the policy as described in item 21.
28. Continuation of coverage due to a temporary layoff, leave of absence or family and medical leave of absence will continue for a period of time agreed to by the policyholder.
29. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety as described in item 24.
30. Discretionary Authority may be removed if not allowed by the state in which the policy is delivered.
31. If we are not replacing a prior carrier with similar benefits, the Effect of Prior Coverage On Losses For Pre-existing Conditions provision will be omitted.
32. The entire COBRA provision may be deleted if the employer group, union or association is not subject to COBRA.

33. Written notice of premium rates and due dates may be changed to comply with state law.
34. The Cancer Initial Diagnosis Benefit is an optional benefit only to be included in the policy if the policyholder elects it. Otherwise this benefit page will not be shown.
35. The Intensive Care Unit Benefit is an optional benefit only to be included in the policy if the policyholder elects it. Otherwise this benefit page will not be shown.
36. The Wellness Benefit is an optional benefit only to be included in the policy if the policyholder elects it. Otherwise this benefit page will not be shown.
37. The Schedule of Surgical Procedures may be updated to reflect what is reasonable and customary. They will never be decreased.
38. The address of the company will be listed and will be the current address of the company.
39. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety as described in item 24.
40. Domestic Partner language will be deleted if the policyholder does not want coverage for such dependents.
41. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety as described in item 24.
42. Domestic Partner language will be deleted if the policyholder does not want coverage for such dependents.
43. The grace period will never be less than 31 day but will be increased if mandated by state law.
44. Individual and Children Coverage may be deleted if not selected by the policyholder.
45. Individual and Spouse Coverage may be deleted if not selected by the policyholder.
46. The policyholder's eligibility waiting period, if any, will be described here.
47. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety as described in item 24.
48. If requested by the policyholder, the definition of member may be may be revised to remove the requirement that they be able to or currently seeking active employment.

### **Variables for Group Voluntary Cancer and Specified Disease Certificate Form (GVCC3)**

The variables in the certificate have the same explanation as the corresponding provisions of the policy.

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
Jacksonville, Florida 32224-6687

To the Policy Review Section, ARKANSAS Department of Insurance.

**Certification of Compliance**

For Filing Including:

GVCP3AR  
GVCC3AR  
GVC3APPAR  
ERAPPAR  
G-AMD  
AWD4502EAR  
AWD4502PAR  
AWD4515AR

I hereby certify that, to the best of my knowledge and belief, the forms referenced above  
comply with the applicable provisions of the state of Arkansas.

Date: May 6, 2009



---

Diane Ierna  
Assistant Vice-President  
Compliance Department

# AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6687

## List of Forms Included In Filing May 5, 2009

**Primary Form Number: GVCP3AR**

<b>Form Number</b>	<b>Description</b>
GVCP3AR	Policy
GVCC3AR	Certificate
GVC3APPAR	Employer Application
ERAPPAR	Employer Application
G-AMD	Amendment for Policy
AWD4502EAR	Evidence of Insurability and Enrollment Form
AWD4502PAR	Evidence of Insurability and Enrollment Form
AWD4515AR	Evidence of Insurability and Enrollment Form

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

Jacksonville, Florida 32224-6687

To the Policy Review Section, Arkansas Department of Insurance.

I certify that I have carefully reviewed the form(s) listed below and to the best of my knowledge and ability, find that the form(s) meet the minimum reading ease score on the test used.

<u>Form</u>	<u>Score</u>
GVCP3AR	50.7
GVCC3AR	50.1
GVC3APPAR	54.0
ERAPPAR	55.3
G-AMD	57.8
AWD4502EAR	53.7
AWD4502PAR	53.7
AWD4515AR	52.1

Date: May 6, 2009



---

Diane D. Ierna  
Assistant Vice-President Compliance Department

SERFF Tracking Number: ALST-125969969 State: Arkansas  
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 42305  
 Company Tracking Number: GVCP3AR  
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.002A Dread Disease - Cancer Only  
 Product Name: Group Cancer and Specified Disease  
 Project Name/Number: GVCP3AR/

## 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)
05/06/2009	Supporting	Statement of Variability Document	05/07/2009	GVC3 Statement of Variability.pdf (Superseded)

## **American Heritage Life Insurance Company (AHL) Variables for Group Voluntary Cancer and Specified Disease Policy Form (GVCP3)**

This group policy will be available to issue to employer groups, labor union groups, associations and trusts. The following explain the variables included in the policy. The numbers correspond to the number within the boxes in the left margin of the text.

1. The logo and address of the company will be on all policies and will be the current logo of AHL.
2. The signature of the Secretary and President will be on all policies issued and will be that of the current Secretary and President of AHL.
3. If COBRA is deleted due to the size of the group, it will also be deleted from the Table of Contents. All other pages will be re-numbered accordingly.
4. The complete legal name of each policyholder will be inserted.
5. A unique alphanumeric number will be assigned to each group policy.
6. The effective date requested by the policyholder, and agreed to by AHL, will be inserted.
7. The policy anniversary date will be one year from the policy effective date.
8. The state in which the policy is delivered will be inserted.
9. The classes of employees or members who are eligible will be accurately described here. The number of hours may vary, and other categories of employees or members may be included. If the policyholder doesn't have any employees or members insured under an individual plan with AHL, we will delete the phrase "excluding employees or members who are insured under any individual cancer and specified disease policy through American Heritage Life Insurance Company".
10. The policyholder's eligibility waiting period, if any, will be described here.
11. The Optional Benefits consist of Cancer Initial Diagnosis, Intensive Care Unit and Wellness Benefits. The policyholder may elect to have any or all of these optional benefits. Any optional benefits not elected by the policyholder will be deleted. The benefit amounts shown are based of 1 unit of coverage. Benefit amounts may vary from 1 to 15 units of coverage.
12. The Initial Rate is per covered employee or member for individual, individual and spouse, individual and children or family coverage. Rates may vary according to the currently approved rates for these plans.
13. AHL may guarantee the initial rate for a period no less than 12 months from the policy effective date, but the period can be 24 months or 36 months subject to participation requirements agreed to by the policyholder.
14. The premium may be paid annually, semi-annually, quarterly, monthly, semi-monthly, bi-weekly or weekly. The first premium due date is the effective date of the policy.
15. Only one of these statements will be shown here, to indicate whether or not the policyholder shares in the cost of coverage under the policy.
16. Any of the policyholder's divisions, subsidiaries or affiliated companies whose employees or members are to be eligible for coverage under the policy will be named here.
17. The benefit amounts shown are based of 1 unit of coverage. Benefit amounts may vary from 1 to 15 units of coverage.

18. The percent of change in items 3 and 5 will be the percentage taken into consideration when underwriting the group and determining the initial rate. The time period for notice of change in premium rate may not be less than 30 days, but may be more.
19. The time of notice of cancellation or offer to modify may be any period of 31 days or greater. Item 1 may be deleted or the participation percentage and number of employees or members may be changed to any reasonable amounts taken into consideration when underwriting the group. In item 2, the policy will never be cancelled or modified within 12 months of the policy being effective. In item 5, employees or members participating will never be less than 5 and no more than 50% of the total group size. The grace period will never be less than 31 day but will be increased if mandated by state law.
20. Domestic Partner language will be deleted if the policyholder does not want coverage for such dependents.
21. The limiting age for children may be changed to comply with state laws or to match a policyholder's other plans. The age will never be lower than required by state law. The limiting age will be reflected throughout the policy.
22. The insurance coverage may be determined by the policyholder and may be extended to any of the following coverage types: Individual Coverage; Individual and Spouse Coverage; Individual and Child(ren) Coverage; or Family Coverage. Coverages not elected by the policyholder may be deleted. The coverage plans elected by the policyholders will be reflected throughout the policy.
23. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety. Changes made to the employee or member's coverage will be done at a time agreed to by the policyholder, either at any time during the year or during an annual enrollment period.
24. Evidence of Insurability requirements will vary by case size and may be required at any time after the initial enrollment period if the individual did not enroll when first eligible. For groups with 200 or more employees or members that meet participation requirements, no Evidence of Insurability will be required at initial enrollment. All members of a union or association may be subject to Evidence of Insurability at initial enrollment, regardless of the number of members within the group. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety.
25. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety.
26. Domestic Partner language will be deleted if the policyholder does not want coverage for such dependents.
27. The limiting age will be reflected throughout the policy as described in item 21.
28. Continuation of coverage due to a temporary layoff, leave of absence or family and medical leave of absence will continue for a period of time agreed to by the policyholder.
29. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety as described in item 24.
30. Discretionary Authority may be removed if not allowed by the state in which the policy is delivered.
31. If we are not replacing a prior carrier with similar benefits, the Effect of Prior Coverage On Losses For Pre-existing Conditions provision will be omitted.
32. The entire COBRA provision may be deleted if the employer group, union or association is not subject to COBRA.

33. Written notice of premium rates and due dates may be changed to comply with state law.
34. The Cancer Initial Diagnosis Benefit is an optional benefit only to be included in the policy if the policyholder elects it. Otherwise this benefit page will not be shown.
35. The Intensive Care Unit Benefit is an optional benefit only to be included in the policy if the policyholder elects it. Otherwise this benefit page will not be shown.
36. The Wellness Benefit is an optional benefit only to be included in the policy if the policyholder elects it. Otherwise this benefit page will not be shown.
37. The Schedule of Surgical Procedures may be updated to reflect what is reasonable and customary. They will never be decreased.
38. The address of the company will be listed and will be the current address of the company.
39. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety as described in item 24.
40. Domestic Partner language will be deleted if the policyholder does not want coverage for such dependents.
41. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety as described in item 24.
42. Domestic Partner language will be deleted if the policyholder does not want coverage for such dependents.
43. The grace period will never be less than 31 day but will be increased if mandated by state law.
44. Individual and Children Coverage may be deleted if not selected by the policyholder.
45. Individual and Spouse Coverage may be deleted if not selected by the policyholder.
46. The policyholder's eligibility waiting period, if any, will be described here.
47. If requested by the policyholder and agreed to by AHL, Evidence of Insurability may be deleted in its entirety as described in item 24.
48. If requested by the policyholder, the definition of member may be may be revised to remove the requirement that they be able to or currently seeking active employment.

### **Variables for Group Voluntary Cancer and Specified Disease Certificate Form (GVCC3)**

The variables in the certificate have the same explanation as the corresponding provisions of the policy.