

SERFF Tracking Number: WAKE-126133880 State: Arkansas
Filing Company: Life Insurance Company of Alabama State Tracking Number: 42499
Company Tracking Number:
TOI: H111 Individual Health - Disability Income Sub-TOI: H111.006 Short Term - Related to marketing with employer or association groups
Product Name: LOA Disability Form 2009
Project Name/Number: LOA/042009

Filing at a Glance

Company: Life Insurance Company of Alabama

Product Name: LOA Disability Form 2009

SERFF Tr Num: WAKE-126133880 State: ArkansasLH

TOI: H111 Individual Health - Disability Income

SERFF Status: Closed

State Tr Num: 42499

Sub-TOI: H111.006 Short Term - Related to marketing with employer or association groups

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form/Rate

Co Status:

Reviewer(s): Rosalind Minor

Author: Jennifer Snell

Disposition Date: 06/15/2009

Date Submitted: 05/27/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: LOA

Project Number: 042009

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: This filing is currently pending in the home domicile state of Alabama.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 06/15/2009

Explanation for Other Group Market Type:

State Status Changed: 06/15/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: NAIC Number: 65412/Life Insurance Company of Alabama

Submission

Disability Income Policy – Form Number HD75109 AR

SERFF Tracking Number: WAKE-126133880 *State:* Arkansas
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Initial Hospital Confinement Rider – Form Number HA35I109

Injury Treatment Rider – Form Number HA35T109

Health Screening Rider – Form Number HA35W109

Accidental Death or Dismemberment Rider – Form Number HA35D109

Supplemental Injury Rider – Form Number HA35C109

Specified Loss Rider – Form Number HA35B109

On-the-Job Disability Rider – Form Number HA35O109

Sickness & Accident Disability Income Plan Brochure/Application – Form Number BHD75

Combination Application – Form Number MPAH309

Wakely Actuarial Services, Inc. has been retained by Life Insurance Company of Alabama to assist them in obtaining approval of the above-captioned forms.

Form HD75109 AR is a Disability Income policy that provides benefits for the primary insured if they become totally disabled as a result of a covered accident occurring Off-the-Job only or a covered sickness On- or Off-the-Job. Coverage terminates at age 72 regardless of whether the insured is still a member of the group.

Form HA35I109 is an Initial Hospital confinement Rider that provides an indemnity benefit for admission of a covered person to a hospital and confinement as an overnight resident bed patient. This benefit pays once per a confinement and only once per calendar year, per covered person.

Form HA35T109 is an Injury Treatment Rider which pays an indemnity benefit for the expense of treatment in a Hospital Emergency Room, Physician's Office, Urgent Care Facility or Chiropractor's Office for any one covered accident.

Form HA35W109 is a Health Screening Rider which pays an indemnity benefit for examinations or other preventative testing after premiums have been paid for 30 days. This benefit is payable once per person and twice per family per policy per calendar year.

Form HA35D109 is an Accidental Death and Dismemberment Rider which pays specified benefits for accidental death

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or dismemberment. The benefit is doubled if the loss occurs while the Insured is a fare-paying passenger in or on a licensed conveyance operated by a common carrier for the regular transportation of passengers.

Form HA35C109 is a Supplemental Injury Rider which pays indemnity benefits for burns and lacerations.

Form HA35B109 is a Specified Loss Rider which pays an indemnity benefit for any one covered injury.

Form HA35O109 is a On-the-Job Disability Rider which provides benefits if the primary insured becomes totally disabled as a result of a covered accident occurring On-the-Job only.

Application form numbers BH75 and MPAH309 will be used with the above noted forms.

Hospital Intensive Care Indemnity Policy, form number HI75I0109 AR, will also be used with the above noted forms. This policy was approved by your Department on April 10, 2009 under SERFF filing number WAKE-126070939.

The policies will be marketed to individuals by contracted agents and brokers.

Wakely Actuarial Services, Inc. appreciates the Department's time and consideration in the review of this filing for the Life Insurance Company of Alabama.

Company and Contact

Filing Contact Information

(This filing was made by a third party - WAS01)

Jennifer Snell, Compliance Analyst jennifer.snell@wakelyactuarial.com
34125 US Highway N (727) 373-4558 [Phone]
Palm Harbor, FL 34684 (727) 373-4559[FAX]

Filing Company Information

Life Insurance Company of Alabama	CoCode: 65412	State of Domicile: Alabama
302 Broad Street	Group Code: -99	Company Type:
Gadsden, AL 35901	Group Name:	State ID Number:
(256) 543-2022 ext. [Phone]	FEIN Number: 63-0321291	

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Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Life Insurance Company of Alabama	\$100.00	05/27/2009	28128072

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/15/2009	06/15/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/03/2009	06/03/2009	Jennifer Snell	06/10/2009	06/10/2009

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Disposition

Disposition Date: 06/15/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form (revised)	Disability Income Policy	Approved-Closed	Yes
Form	Disability Income Policy	Replaced	Yes
Form	Initial Hospital Confinement Rider	Approved-Closed	Yes
Form	Injury Treatment Rider	Approved-Closed	Yes
Form	Health Screening Rider	Approved-Closed	Yes
Form	Accidental Death or Dismemberment Rider	Approved-Closed	Yes
Form	Supplemental Injury Rider	Approved-Closed	Yes
Form	Specified Loss Rider	Approved-Closed	Yes
Form	On-the-Job Rider	Approved-Closed	Yes
Form	Application/Brochure	Approved-Closed	Yes
Form	Combination Application	Approved-Closed	Yes
Rate	Rate Pages	Approved-Closed	Yes

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Product Name: LOA Disability Form 2009
Project Name/Number: LOA/042009

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/03/2009
Submitted Date 06/03/2009

Respond By Date

Dear Jennifer Snell,

This will acknowledge receipt of the captioned filing.

Objection 1

- Disability Income Policy (Form)

Comment:

On the face page of the policy under Renewal and Premium Provision, it is stated that "Premium for this Policy is guaranteed not to change during the first twelve (12) months of coverage and shall not be increased more than once in a six (6) month period.

After the first annual anniversary of the policy, our Department will allow for rates to be increased, upon approval, once in a twelve (12) month period.

Objection 2

- Disability Income Policy (Form)

Comment:

The definition of "accident" does not comply with Rule 18, Section 5D.

"Accident", "Accidental Injury", "Accidental Means", may be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Company Tracking Number:
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 Product Name: LOA Disability Form 2009
 Project Name/Number: LOA/042009

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 06/10/2009
 Submitted Date 06/10/2009

Dear Rosalind Minor,

Comments:

This letter is in response to your letter dated June 3, 2009 in regards to the above captioned filing.

Response 1

Comments: The renewal and premium provision has been revised to reflect a 12 month guarantee.

Related Objection 1

Applies To:

- Disability Income Policy (Form)

Comment:

On the face page of the policy under Renewal and Premium Provision, it is stated that "Premium for this Policy is guaranteed not to change during the first twelve (12) months of coverage and shall not be increased more than once in a six (6) month period.

After the first annual anniversary of the policy, our Department will allow for rates to be increased, upon approval, once in a twelve (12) month period.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific	Readability Score	Attach Document
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SERFF Tracking Number: WAKE-126133880 State: Arkansas
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Data

Disability Income Policy	HD75109	Policy/Contract/Fraternal	Initial	44	Disability
	AR	Certificate			Income
					Policy
					HD75109
					AR.pdf
Previous Version					
Disability Income Policy	HD75109	Policy/Contract/Fraternal	Initial	44	Disability
	AR	Certificate			Income
					Policy
					HD75109
					AR.pdf

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 Product Name: LOA Disability Form 2009
 Project Name/Number: LOA/042009

No Rate/Rule Schedule items changed.

Response 2

Comments: The accident definition has been revised to comply with Rule 18, Section 5D.

Related Objection 1

Applies To:

- Disability Income Policy (Form)

Comment:

The definition of "accident" does not comply with Rule 18, Section 5D.

"Accident", "Accidental Injury", "Accidental Means", may be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Disability Income Policy	HD75109 AR		Policy/Contract/Fraternal Certificate	Initial		44	Disability Income Policy HD75109 AR.pdf
Previous Version							
Disability Income Policy	HD75109 AR		Policy/Contract/Fraternal Certificate	Initial		44	Disability Income Policy HD75109

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AR.pdf

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TOI: H111 Individual Health - Disability Income *Sub-TOI:* H111.006 Short Term - Related to marketing with
employer or association groups
Product Name: LOA Disability Form 2009
Project Name/Number: LOA/042009

No Rate/Rule Schedule items changed.

Feel free to contact me should further information be needed.

Thank you

Sincerely,
Jennifer Snell

SERFF Tracking Number: WAKE-126133880 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42499
 Company Tracking Number:
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.006 Short Term - Related to marketing with employer or association groups
 Product Name: LOA Disability Form 2009
 Project Name/Number: LOA/042009

Form Schedule

Lead Form Number: HD75109 AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	HD75109 AR	Policy/Cont	Disability Income ract/Fratern Policy al Certificate	Initial		44	Disability Income Policy HD75109 AR.pdf
Approved-Closed	HA351109	Policy/Cont	Initial Hospital ract/Fratern Confinement Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		44	Initial Hospital Confinement Rider HA351109.pdf
Approved-Closed	HA35T109	Policy/Cont	Injury Treatment ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		46	Injury Treatment Rider HA35T109.pdf
Approved-Closed	HA35W109	Policy/Cont	Health Screening ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		48	Health Screening Rider HA35W109.pdf

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<i>Filing Company:</i>	Life Insurance Company of Alabama	<i>State Tracking Number:</i>	42499
<i>Company Tracking Number:</i>			
<i>TOI:</i>	H111 Individual Health - Disability Income	<i>Sub-TOI:</i>	H111.006 Short Term - Related to marketing with employer or association groups
<i>Product Name:</i>	LOA Disability Form 2009		
<i>Project Name/Number:</i>	LOA/042009		
Closed	Enrollment Form		Sickness Disability Submission Copy AL AR MS NC.pdf
Approved- Closed	MPAH309 Application/Combination Enrollment Application Form	Initial	MPAH309 AL, AR, LA, MS, NC.pdf



LICOA
 Life Insurance Company of Alabama
 HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

DISABILITY INCOME POLICY

LIFE INSURANCE COMPANY OF ALABAMA agrees to pay the benefits according to the provisions of this Policy. All benefits are subject to its provisions and limitations.

Signed for the Company at Gadsden, Alabama.

Secretary

President

CONSIDERATION

This Policy is issued in consideration of the application and payment in advance of the initial premium. This Policy begins at 12:01 a.m. standard time at Your residence on the Effective Date shown on the Policy Schedule Page. It ends, subject to the Grace Period, at 12:00 midnight, on the date any renewal premium is due and not paid. The dates and premiums are shown on the Policy Schedule Page.

RIGHT TO EXAMINE POLICY FOR 10 DAYS

Within ten (10) days from receipt of this Policy, You may return it for any reason. If returned, this Policy is void. Any premiums or policy fee paid for this Policy will be refunded. The Policy may be returned to Us or the agent who sold it.

RENEWAL AND PREMIUM PROVISIONS

This Policy is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. It may be renewed on any premium due date, prior to the Month-a-versary after Your 72nd birthday, by paying the renewal premium. It must be paid on or before its due date, or within the thirty-one (31) days that follow. We cannot refuse to renew this Policy prior to the Month-a-versary after Your 72nd birthday or place any restrictions on it if the premium is paid on time.

We may change the premium rates for this Policy. We cannot change the premium rates unless We change them for this Policy form for every Insured within a state in the same class. If We change the premium rates, We will notify the Insured before the change becomes effective in accordance with the statutes of the state where this Policy was issued. We will notify the Insured at his last known address according to Our records. Premium for this Policy is guaranteed not to change during the first twelve (12) months of coverage and shall not be increased more than once in a twelve (12) month period.

***** IMPORTANT NOTICE *****

Please read the copy of the application attached to this Policy. Carefully check the application. Write to Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, within ten (10) days, if any information shown on it is not correct and complete or if any past medical history has been left out on the application. This application is a part of the Policy. The Policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

**DISABILITY INCOME POLICY
 GUARANTEED RENEWABLE TO AGE 72
 SUBJECT TO COMPANY'S RIGHT TO CHANGE
 THE APPLICABLE TABLE OF PREMIUM RATES**

TABLE OF CONTENTS

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General Provisions 11

Application..... Attached

POLICY SCHEDULE PAGE

Policy Number: **[12345]**

Policy Effective Date: **[07/01/2008]**

Primary Insured: **[Insured]**

Injury Elimination Period (days): **[7]**

Sickness Elimination Period (days): **[14]**

Maximum Benefit Period (months): **[6]**

Monthly Benefit: **[\$1,000]**

Policy Modal Premium: **[\$ XX.XX]**

Total Modal Premium Payment

Annual: **[\$ xx.xx]** Semi Annual: **[\$ xx.xx]** Special Monthly: **[\$ xx.xx]**
 Quarterly: **[\$ xx.xx]** Monthly: **[\$ xx.xx]**

Mode Selected: **[Annual]**

Coverage Type: **Individual**

Benefit Description ¹	Monthly Benefit Amount	Elimination Period (Days)	Maximum Benefit Period (Months)	Modal Premium	Rider Effective Date
[On-the-Job Disability Rider]	[\$ 1,000.00]	[7 Days]	[6 Months]	[\$XX.XX]	[07/01/2008]

Benefit Description	Coverage Type	Benefit Amount	Modal Premium	Rider Effective Date
[Initial Hospital Confinement Rider]	[Individual]	[\$ 1,000.00]	[\$ XX.XX]	[07/01/2008]
[Injury Treatment Benefit Rider]	[Ind & Spouse]	[\$ 50.00]	[\$ XX.XX]	[07/01/2008]
[Health Screening Rider]	[Family -1]	[\$ 10.00]	[\$ XX.XX]	[07/01/2008]

Benefit Description ²	Coverage Type	Units	Modal Premium	Rider Effective Date
[Accidental Death and Dismemberment Benefit]	[Family -2]	[1]	[\$ XX.XX]	[07/01/2008]
[Specified Loss Rider]	[Individual]	[1]	[\$ XX.XX]	[07/01/2008]
[Supplemental Injury Rider]	[Ind & Spouse]	[1]	[\$ XX.XX]	[07/01/2008]

¹ The On-the-Job Disability Rider is only available as Individual coverage.]

² See Rider for the Benefit Amount per Unit of Coverage]

DEFINITIONS

“Accident” means bodily harm resulting from a non-intentional action and is independent of any Sickness, illness, infection or disease.

“Ambulance” means a specially equipped automobile or other vehicle providing transportation of the sick or injured. The Ambulance service must be a licensed Ambulance service or a Hospital owned Ambulance for transporting a sick or injured person.

“Beneficiary” means the person, persons or party designated to receive any Policy proceeds in the event of Your death. The Beneficiary for this Policy is as named on the application unless changed by You and endorsed by Us.

“Concurrent Disability” means one continuous period of Total Disability that is caused or is continued by more than one Covered Injury or Covered Sickness. Benefits for a Concurrent Disability will be paid as if the Concurrent Disability was caused by one (1) Covered Injury or one (1) Covered Sickness. In no event will an Insured be considered to have more than one continuous period of Total Disability as the same time.

“Covered Accident” is one which:

- 1) occurs after the Policy Effective Date; and
- 2) occurs while the Policy is in force; and
- 3) is not excluded by name or specific description in the Policy.

A Covered Injury is an Injury which:

- 1) occurs after the Policy Effective Date; and
- 2) occurs Off-The-Job; and
- 3) occurs while the Policy is in force; and
- 4) is not excluded by name or specific description in this Policy.

“Covered Persons” are indicated by the Coverage Type as shown on the Policy Schedule Page as follows:

- 1) Individual: Only the Primary Insured listed on the Policy Schedule Page is covered.
- 2) Individual and Spouse: The Primary Insured and the Primary Insured’s Legal Spouse as listed on the application or added/changed by endorsement are covered.
- 3) One Parent Family: The Primary Insured and all of the Primary Insured’s legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.
- 4) Two Parent Family: The Primary Insured, the Primary Insured’s Legal Spouse as listed on the application or added/changed by endorsement and all of the Primary Insured’s legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.

Any person specifically excluded by name from coverage is NOT included as a Covered Person.

“Covered Sickness” is a Sickness which:

- 1) manifests itself on or after the Policy Effective Date; and
- 2) manifests itself while the Policy is in force; and
- 3) is not excluded by name or specific description in the Policy.

Normal pregnancy and childbirth is covered as a Covered Sickness starting ten (10) months after the Policy Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks of caesarean deliveries.

“Dependent Child” or “Dependent Children” means any unmarried child (natural, step or adopted) of Yours who:

- 1) is less than nineteen (19) years old and living with You; or
- 2) is less than twenty-four (24) years old and attending an accredited school as a full time student. Such child must be legally dependent upon You for principal support and maintenance; or
- 3) is or becomes incapable of self-support because of mental or physical handicap while covered under this Policy and prior to attaining limiting age for Dependent Child(ren) under (1) or (2) above. The child must be legally dependent upon You for support and maintenance. We must receive proof of incapacity otherwise the insurance will terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be requested from time to time but not more often than once a year after the child attains age twenty-four (24); or
- 4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent Child(ren) does NOT include grandchild(ren) unless required by law.

Proof of legal status may be required from time to time on covered Dependent Child(ren).

“Elimination Period” means, subject to the satisfaction of all Policy terms and conditions by the Insured, the length of time an Insured must be Totally Disabled before Monthly Disability Income Benefit amounts are payable.

“Emergency Room” or “Emergency Department” means the part of a Hospital designed and used for the treatment of people requiring immediate medical attention, such as victims of accidents, heart attacks or other acute medical conditions. Emergency care must be available twenty-four (24) hours a day and seven (7) days a week.

“Hospice” or “Hospice Unit” means a licensed agency, organization, or unit that provides a centrally administered and autonomous continuum of palliative and supportive care to terminally ill persons and their families. The care must be directed and coordinated by the Hospice organization and received primarily in the Insured’s home or on an outpatient or inpatient basis in a Hospice unit.

“Hospital” means a licensed institution located within the United States of America and its territories that:

- 1) has on its premises:
 - a) laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by a licensed Physician; and
 - b) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician; and
 - c) 24-hour-a-day nursing service by graduate registered nurses; and
 - d) the patient’s written history and medical records;

or;

- 2) is accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall NOT include any institution used by an Insured as a place for rehabilitation; a place for rest, or for the aged; a nursing or convalescent home; a long term nursing unit or geriatrics ward; Hospice or Hospice unit; extended care facility; or facilities for the care of convalescent, rehabilitative, physical therapy or ambulatory patients.

“Immediate Family” or **“Immediate Family Member”** includes anyone related to You or Your Legal Spouse in the following manner: spouse; brothers or sisters (including stepbrothers, stepsisters, half-brothers and half-sisters); children (including stepchildren); parents (including stepparents); grandparents (including step-grandparents); grandchildren (including step-grandchildren); aunts and uncles; nieces and nephews; and spouses, as applicable, of any of the above.

“Incarcerated” means arrested and confined to a correctional facility for any period of time.

“Indemnity Benefit” means any insurance benefit paid under this Policy as a result of the occurrence of a Specified Event. The benefit amount is a stated fixed amount in this Policy and is NOT dependent on any external monetary amount or cost.

“Injury” means an accidental bodily Injury that is independent of any Sickness, illness, infection or disease.

“Insured” means the person(s) whose life is insured under this Policy. The Primary Insured is as named in the application and shown on the Policy Schedule Page.

“Legal Spouse” means Your spouse as recognized by federal law. Once this Policy has been issued, any consideration of an addition of a spouse, whether by first marriage or remarriage, requires the submission of a completed application and is subject to Our approval. Spouse coverage terminates upon divorce of marriage. Proof of legal status may be required upon Our request from time to time on a covered spouse.

“Maximum Benefit Period” means, subject to the satisfaction of all Policy terms and conditions by the Insured, the maximum length of time for which a Totally Disabled Insured can be paid Monthly Disability Income Benefit amounts.

If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks of caesarean deliveries.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the Maximum Benefit Period will be limited to a maximum of three (3) months for one (1) Maximum Benefit Period.

“Month-a-versary” means the monthly recurring date of your Policy Effective Date.

“Off-The-Job” means not occurring while at work at any job for pay or benefits.

“Physician” means a licensed practitioner of the healing arts, as recognized by the American Medical Association, operating within the scope of his or her license other than You or an Immediate Family Member.

“Physician’s Office” means the room or rooms in which the Physician and support staff provide patient care. The offices include all rooms in the Physician’s office suite. A Dentist office is NOT considered a Physician’s Office.

“Policy Effective Date” means the date the Policy is issued by Us and coverage begins. The Policy Effective Date is shown on the Policy Schedule Page.

“Pre-existing Condition” means a condition for which symptoms existed up to five years prior to the Policy Effective Date that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by a Physician or received from a Physician.

“Primary Insured” means the person named in the application and shown on the Policy Schedule Page.

“Recurrent Disability” means any period of continuous Total Disability after the first period of continuous Total Disability.

A Recurrent Disability will be treated as:

- 1) a continuation of the previous disability, NOT a new disability, if the Insured has returned to work for less than 6 months;
- 2) a new disability, if the Insured has returned to work for 6 months or more; and
- 3) a continuation of the previous disability for any circumstances not specifically listed above.

Whether a Recurrent Disability is a continuation of a previous disability or a new disability is determined by the length of time the Insured has returned to work, NOT the cause(s) of the disabilities.

A new disability is subject to a new Elimination Period and a new Maximum Benefit Period applies. A disability that is considered a continuation of a previous disability is NOT subject to a new Elimination Period and a new Maximum Benefit Period does NOT apply.

“Reinstatement Date” means the date coverage under this Policy and any attached Riders becomes effective following Reinstatement. This date will be the next Month-a-versary following Our approval in writing of the Reinstatement of any coverage.

“Rider Effective Date” means the date the Rider is issued by Us and coverage begins. The Rider Effective Date is shown on the Policy Schedule Page.

“Sickness” means any illness, including complications of pregnancy as defined by the Insured’s Physician, infection, disease or any other abnormal physical condition which is not caused by an Injury.

“Specified Event” means a treatment, confinement, service, expense, or diagnosis as specified in the Policy or attached Rider that causes a Covered Person to be eligible for one or more benefits of the Policy or attached Riders.

“Total Disability” or **“Totally Disabled”** means:

- 1) the Insured is unable to work at his/her current job; and
- 2) the Insured is, in fact, unable to work at any job for pay or profit; and
- 3) the Insured is under the regular care of a Physician. The Physician must attest to the specific period of Total Disability and its cause.

Any period of Total Disability must occur within thirty (30) days of a Covered Injury or the onset of a Covered Sickness.

“Urgent Care” means the delivery of ambulatory medical care outside of a Hospital Emergency Department on a walk-in basis without a scheduled appointment. This does NOT include the care of a Dentist or a Dentist’s office.

“We”, “Us”, “Company” and **“Our”** mean the Life Insurance Company of Alabama.

“Written Notice” means a communication in writing from You on forms furnished by or acceptable to the Company. All correspondence should be sent to Our Home Office at P.O. Box 349, Gadsden, Alabama 35902.

“You”, “Your”, and **“Yours”** mean the Primary Insured named on the Policy Schedule Page.

BENEFITS

If the Primary Insured becomes Totally Disabled as the result of a Covered Injury or Covered Sickness following the Policy Effective Date as shown on the Policy Schedule Page and while this Policy is in force, We will pay the following benefits as shown on the Policy Schedule Page if the Primary Insured incurs a Specified Event required for the given benefit while Totally Disabled and this Policy is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of this Policy, the Covered Injury or Covered Sickness occurred after the Policy Effective Date; and
- 2) all other limitations, conditions and provisions of the Policy.

Monthly Disability Income Benefit

We will pay a Monthly Disability Income Benefit as shown on the Policy Schedule Page if the Primary Insured incurs the Specified Event required for the Monthly Disability Income Benefit. The Specified Event required for the Monthly Disability Income Benefit is continuous Total Disability of the Primary Insured for the length of the appropriate Elimination Period plus one (1) day as a result of a Covered Injury or Covered Sickness. The Specified Event occurs on the day following the expiration of the appropriate Elimination Period and continues until the Primary Insured is no longer Totally Disabled due to a Covered Injury or Covered Sickness and under a Physician's care but in no case longer than the Maximum Benefit Period as shown on the Policy Schedule Page. If the Total Disability is a result of a Covered Injury, the Injury Elimination Period, as shown on the Policy Schedule Page, applies. If the Total Disability is due to a Covered Sickness, the Sickness Elimination Period, as shown on the Policy Schedule Page, applies. The Primary Insured's Physician must attest to the specific period of Total Disability and its cause. Benefit periods involving partial months will have the partial month benefit paid at a daily rate of one-thirtieth (1/30th) of the full monthly amount.

Monthly Disability Income Benefits are NOT payable under this Policy if the Primary Insured is Totally Disabled due to or as the result of any cause other than a Covered Injury or a Covered Sickness.

Monthly Disability Income Benefits are NOT payable under this Policy if the Primary Insured is Totally Disabled due to an Injury that occurred while working at any job for pay or benefits.

Monthly Disability Income Benefits are NOT payable for Disability of any Covered Person other than the Primary Insured.

Normal pregnancy and childbirth, including caesarean deliveries, will NOT be considered a Covered Sickness under this Policy until ten (10) months after the Policy Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks of caesarean deliveries.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the Maximum Benefit Period shall be limited to a maximum of three (3) months for one Maximum Benefit Period.

We will NOT pay Disability Benefits under multiple Policy and/or Rider forms simultaneously.

Waiver of Premium Benefit

We will waive future premiums due for this Policy and any attached Riders when the Primary Insured incurs the Specified Event required for the Waiver of Premium Benefit. The Specified Event required for the Waiver of Premium Benefit occurs on the day after the Primary Insured has been totally and continuously Disabled due to a Covered Injury or Covered Sickness for which Monthly Disability Income Benefits are payable for a period of ninety (90) consecutive days and continues until the Primary Insured is no longer Totally Disabled due to the Covered Injury or Covered Sickness and under a Physician's care OR the Monthly Disability Income Benefit is

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no longer payable. Premiums will NOT be waived beyond the Maximum Benefit Period as shown on the Policy Schedule Page. We will waive the premium beginning on the Month-a-versary following the onset of the Specified Event required for the Waiver of Premium Benefit. The Primary Insured's Physician must attest to the specific period of Total Disability and its cause.

The Waiver of Premium Benefit is NOT payable for Total Disability of the Primary Insured due to any cause other than a Covered Injury or a Covered Sickness.

The Waiver of Premium Benefit is NOT payable for Total Disability of the Primary Insured due to an Injury that occurred while working at any job for pay or benefits.

The Waiver of Premium Benefit is NOT payable for Disability of any Covered Person other than the Primary Insured.

The Waiver of Premium Benefit is only payable after the Primary Insured has been continuously Totally Disabled for ninety (90) consecutive days due to a Covered Injury or a Covered Sickness and for as long as the Primary Insured remains continuously Totally Disabled due to a Covered Injury or a Covered Sickness and under a Physician's care but in no case beyond the Maximum Benefit Period.

LIMITATIONS AND EXCLUSIONS

We will NOT pay ANY benefits under this Policy if the Primary Insured is Totally Disabled due to an Injury that occurs while working at any job for pay or benefits.

We will NOT pay ANY benefits under this Policy if the Primary Insured is Totally Disabled due to Pre-existing Conditions except after two (2) years from the Policy Effective Date.

We will NOT pay ANY benefits under this Policy if the Primary Insured is Totally Disabled due to any cause other than a Covered Injury or a Covered Sickness.

We will NOT pay ANY benefits under this Policy for Disability of any Covered Person other than the Primary Insured.

Normal pregnancy and childbirth, including caesarean deliveries, will NOT be considered a Covered Sickness under this Policy until ten (10) months after the Policy Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks for caesarean deliveries.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the Maximum Benefit Period shall be limited to a maximum of three (3) months for one (1) Maximum Benefit Period.

We will NOT pay Disability Benefits under multiple Policy and/or Rider forms simultaneously.

The Waiver of Premium Benefit is only payable after the Primary Insured has been continuously Totally Disabled for ninety (90) consecutive days due to a Covered Injury or a Covered Sickness and for as long as the Primary Insured remains continuously Totally Disabled due to a Covered Injury or a Covered Sickness and under a Physician's care but in no case beyond the Maximum Benefit Period.

We will NOT pay any loss that:

- 1) results from any of the following:
 - a) Pre-existing Conditions except after two (2) years from the Policy Effective Date; or
 - b) Injury or Sickness occurring prior to the Policy Effective Date; or
 - c) Injury or Sickness occurring while Incarcerated; or
 - d) committing or attempting to commit suicide while sane or insane; or
 - e) commission of or an attempt to commit an assault or felony; or
 - f) engaging in any illegal activity; or
 - g) practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received; or
 - h) driving or riding in any race of speed or endurance or testing a motorized vehicle on any racetrack, raceway, race course or speedway; or
 - i) declared or undeclared war, or any cause or act of war or regular military training, whether the Insured is a member of any armed force or a civilian; or
 - j) travel in an aircraft, including those which are not motor-driven, or hot air balloon other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; or
 - k) alcoholism or drug addiction; or
 - l) voluntarily taking, inhaling or absorbing any poison, gas or fumes; or
 - m) any intentionally self-inflicted Injury; or
 - n) mental infirmity or disease, or treatment for the infirmity or disease; or
 - o) normal pregnancy and childbirth except after ten (10) months from the Policy Effective Date; or
- 2) occurs while:
 - a) taking or using any hallucinogen, narcotic or drugs except on the advice of a licensed Physician; or
 - b) intoxicated. "Intoxicated" means under the influence of alcohol or narcotics unless administered on the advice of the Insured's Physician or having a prohibited concentration of alcohol in the blood, breath, urine or other bodily substance, as determined by the law of the jurisdiction in which the Accident occurred; or
 - c) engaging in hang-gliding, bungee jumping, parachuting, sky-diving, sail gliding, parasailing, parakiting or any similar activities.

TERMINATION OF INSURANCE

Insurance coverage for You and Your Legal Spouse, if covered on any attached Riders, will continue until the earliest of:

- 1) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 2) the date any premium for this Policy is in default beyond the end of its Grace Period; or
- 3) the premium due date following Your written request for its termination.

In the event of Your death, coverage on any remaining Covered Persons will terminate as of the date of Your death. If Your covered Legal Spouse or Dependent dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under a Rider attached to this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by any Rider attached to this Policy on Your former Legal Spouse will automatically terminate on the date of the decree of the dissolution of marriage.

Insurance coverage on a Dependent Child will terminate automatically on the earliest of the following:

- 1) the Month-a-versary following the Dependent Child's marriage; or
- 2) the Month-a-versary following the Dependent Child's nineteenth (19th) birthday, if not a full-time student at an accredited school; or
- 3) the Month-a-versary following the Dependent Child's twenty-fourth (24th) birthday, if a full-time student at an accredited school and legally dependent on You for principal support and maintenance.

Insurance coverage will not terminate due to the Dependent Child's age if the child is both:

- 1) incapable of self-sustaining employment because of mental or physical handicap; and
- 2) currently dependent upon You for support and maintenance.

You *must* provide proof of the Dependent Child's mental or physical handicap and dependence upon You.

GENERAL PROVISIONS

Claim Forms: Upon receipt of a Notice of Claim, We will send You claim forms. If these forms are not sent within fifteen (15) days, Your claim may be initiated by giving Us a written statement with sufficient documentation of the Specified Events, the cause of the Total Disability and the date of onset of the Total Disability, subject to the terms and conditions of the Proof of Total Disability/Loss provision. Additional documentation of Proof of Total Disability/Loss may be required.

Conformity With State Statutes: Any provision of the Policy which, on the Policy Effective Date, is in conflict with the laws of the state in which the Policy was issued on such date is hereby amended to conform to the minimum requirements of such statutes.

Entire Contract; Changes: The contract is made up of this Policy, its application and any attached Riders or endorsements. A copy of the application is attached. No change in this Policy will be valid unless it is approved and signed by one of Our executive officers. No agent may change this Policy or waive any of its provisions.

Fraudulent Misstatements: If You make a Fraudulent Misstatement in the application for this Policy, We may reduce or deny any claim or void the Policy at any time.

Grace Period: This Policy has a thirty-one (31) day Grace Period for paying premium. This means that if a renewal premium is not paid by the date due, it may be paid during the following thirty-one (31) days. Any otherwise payable claim incurred during the Grace Period will NOT be paid until the past due premiums are paid provided the Policy has not lapsed or terminated. If You do not pay Your premium by the end of the thirty-one (31) day Grace Period, Your Policy will terminate as of the date the premium was due.

Legal Action: No legal action can be taken to receive benefits under this Policy:

- 1) less than sixty (60) days after sufficient written Proof of Total Disability/Loss has been furnished as required; or
- 2) more than three (3) years after the onset of Total Disability and/or the date of the Specified Event.

Misstatement of Age or Sex: If the age or sex of the Primary Insured has been misstated, all amounts payable under this Policy shall be as much as the premium paid would have purchased at the correct age and sex. If, according to the correct age, We would not have issued this Policy, We will not pay any benefits and will refund all premiums paid.

Notice of Claim: We must receive Written Notice of a claim, including the name of the Insured and Policy Number. Written Notice must be given within sixty (60) days of the Specified Event, or as soon as reasonably possible. Written Notice given by or on behalf of You to Our home office at P.O. Box 349, Gadsden, AL 35902, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

Payment of Claims: We will pay all benefits to You; benefits under this Policy are not subject to assignment. Upon receipt of Your death certificate, any benefits that have not been paid at the time of Your death may be paid to Your estate or Your designated beneficiary. We have the right to pay up to \$3,000 of those benefits to any Immediate Family Member who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

Payment of Premium: The due date of the initial premium is the Policy Effective Date. The initial premium may be paid to the Home Office or to one of the Company's authorized agents. Premiums after the initial premium must be paid to the Home Office at P.O. Box 349, Gadsden, AL 35902. Upon receipt of Your death certificate, We will refund any premium paid for any monthly period beyond the Month-a-versary following the date of death. The refund may be paid to Your estate or designated Beneficiary. Upon receipt of Your Written Notice to discontinue coverage, We will refund any premium paid for any monthly period beyond the Month-a-versary following the date We received the Written Notice from You. The refund will be paid to You.

This Policy is not effective until the Policy Effective Date regardless of the date of the first premium payment if any premium is paid prior to the Policy Effective Date. Any premium received prior to issue of the Policy will be held pending issue of the Policy. If the Policy is not issued by Us, We will refund any premium being held.

If We or any third party on Our behalf receives premiums by any method (including payroll deduction and bank draft) prior to the issue of this Policy, We assume NO liability for coverage until this Policy is issued by Us.

Physical Examinations: The Company, at Our own expense, reserves the right and opportunity to examine the person of the Insured when and as often as it may be reasonably necessary for the duration of the claim under this Policy.

Pre-existing Conditions: Benefits of this Policy and all attached Riders will NOT be payable for any Specified Events due to or resulting from Pre-existing Conditions during the first two (2) years from the Policy Effective Date and any attached Rider Effective Dates.

Proof of Total Disability/Loss: Written Proof of Total Disability/Loss must be given to Us within ninety (90) days after the date of the Specified Event. Written Proof of Total Disability/Loss must include sufficient documentation furnished by the Physician attesting to the Total Disability and/or the Specified Event. If You are not able to give Us sufficient Proof of Total Disability/Loss within ninety (90) days of the Specified Event, the claim will not be reduced or denied if:

- 1) it was not reasonably possible to give proof in that timeframe; and
- 2) the proof is filed as soon as reasonably possible.

In no event, except the absence of legal capacity, may proof be given to Us later than one (1) year after the date of the Specified Event.

We have the right to investigate all claims thoroughly and require that You provide Us with sufficient Proof of Total Disability/Loss.

Reinstatement: If this Policy terminates, the Policy may be reinstated within six (6) months of termination if an application for Reinstatement is submitted to Us and all past due premiums are paid to Us. Any premium We receive after the Policy termination will be held pending approval or denial of the Reinstatement. Reinstatement must be approved or denied by Us in writing. If Reinstatement is denied by Us, any premium We received after the termination date of the Policy will be refunded.

The reinstated Policy shall provide benefits for Specified Events incurred after the Reinstatement Date and while the Policy is in force. In all other respects, You and We will have the same rights as before termination, subject to any added endorsements. Benefits will NOT be payable for Specified Events prior to the Reinstatement Date.

Suspension of Coverage While in Active Military Service: If the Insured is in military service, they may have their coverage suspended during a period of active military service. There will be no coverage or premiums due during the period of suspension. Upon termination of active military duty, the Insured shall have the right to resume coverage without providing evidence of insurability and the resumption of coverage shall be on the same basis as before the coverage suspension. To be entitled to coverage suspension, an Insured shall:

- 1) be in the military service of any nation or international authority or in a reserve component of the armed forces of the United States, including the National Guard; and
- 2) have entered upon active duty or had active duty extended, for a minimum of three (3) months (other than for the purpose of determining physical fitness and/or training).

Time Limit on Certain Defenses (Contestable Period): After two (2) years from the Policy Effective Date (or the Reinstatement Date, if the Policy has been reinstated), no misstatements, except Fraudulent Misstatements, made by You in the application (or reinstatement application) shall be used to void this Policy or to deny a claim resulting from a Covered Injury or a Covered Sickness occurring after the expiration of such two (2) year period. During this two (2) year contestable period, if We do not receive sufficient documentation from You to properly investigate Your claim, We retain the right to void the Policy and refund all premiums We have received. We will provide You with Written Notice fifteen (15) days before the Policy is voided. The date of the Covered Injury or onset of the Covered Sickness determines whether or not a claim is within the Contestable Period, NOT when the claim is received by Us. Misstatements, including Fraudulent Misstatements, made by You on the Application (or reinstatement application) may be used by Us to void this Policy or to deny a claim resulting from a Covered Injury or Covered Sickness within two (2) years after the Policy Effective Date or within two (2) years after the Reinstatement of this Policy.

Time of Payment of Claims: Benefits will be paid within thirty (30) working days once We receive sufficient written Proof of Total Disability/Loss.

If We do not pay benefits upon receipt of your claim, We shall have thirty (30) working days thereafter within which to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, and which also gives You a notice of any documents or other information needed to process the claim. When We have received sufficient written Proof of Total Disability/Loss from You, We shall then have thirty (30) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

INITIAL HOSPITAL CONFINEMENT RIDER

We will provide the Indemnity Benefit stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

INITIAL HOSPITAL CONFINEMENT INDEMNITY BENEFIT

If a Covered Person incurs a Covered Injury or Covered Sickness after the Rider Effective Date as shown on the Policy Schedule Page and while this Rider is in force, We will pay the following Indemnity Benefit as shown on the Policy Schedule Page if the Covered Person incurs a Specified Event required for the Initial Hospital Confinement Indemnity Benefit in the course of treatment for the Covered Injury or Covered Sickness while this Rider is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of the Policy to which this Rider is attached; and
- 2) all other limitations, conditions and provisions of the Rider and the Policy to which it is attached.

We will pay the Initial Hospital Confinement Indemnity Benefit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Initial Hospital Confinement Indemnity Benefit. The Specified Event required for the Initial Hospital Confinement Indemnity Benefit is the first admission of a Covered Person to a Hospital and confinement of at least one (1) Day as a resident bed patient as the result of a Covered Accident or Covered Sickness in a calendar year. A Day is defined as a 24-hour period with a minimum of an 18-hour confinement.

Confinement in a Hospital as an inpatient does NOT include:

- 1) confinements of less than 18-hours; or
- 2) treatment on an out-patient basis; or
- 3) Emergency Room or Urgent Care treatment.

The Initial Hospital Confinement Indemnity Benefit is payable only once per Hospital confinement per Covered Person.

The Initial Hospital Confinement Indemnity Benefit is payable only once per calendar year per Covered Person.

LIMITATIONS AND EXCLUSIONS

Confinement in a Hospital as an inpatient does NOT include:

- 1) confinements of less than 18-hours; or
- 2) treatment on an out-patient basis; or
- 3) Emergency Room or Urgent Care treatment.

The Initial Hospital Confinement Indemnity Benefit is payable only once per Hospital confinement per Covered Person.

The Initial Hospital Confinement Indemnity Benefit is payable only once per calendar year per Covered Person.

GENERAL PROVISIONS

The following provisions apply to this Rider:

- 1) this Rider is made part of the Policy to which it is attached; and
- 2) this benefit is subject to all the provisions of this Rider and the Policy to which it is attached; and
- 3) the Rider Effective Date is as shown on the Policy Schedule Page; and
- 4) the premium for this Rider is as shown on the Policy Schedule Page.

TERMINATION OF RIDER

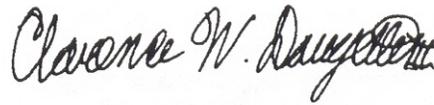
This Rider terminates at the earliest of:

- 1) the date the Policy is terminated for any reason; or
- 2) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 3) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
- 4) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.



Secretary



President

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

INJURY TREATMENT RIDER

We will provide the Indemnity Benefit stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

INJURY TREATMENT INDEMNITY BENEFIT

If a Covered Person incurs a Covered Injury after the Rider Effective Date as shown on the Policy Schedule Page and while this Rider is in force, We will pay the following Indemnity Benefit as shown on the Policy Schedule Page if the Covered Person incurs a Specified Event required for the Injury Treatment Indemnity Benefit in the course of treatment for the Covered Injury while this Rider is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of the Policy to which this Rider is attached; and
- 2) all other limitations, conditions and provisions of the Rider and the Policy to which it is attached.

We will pay the Injury Treatment Indemnity Benefit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Injury Treatment Indemnity Benefit. The Specified Event required for the Injury Treatment Indemnity Benefit is treatment of the Covered Person in an Emergency Room, Urgent Care facility or Physician's Office for one or more Covered Injuries as a result of a Covered Accident.

We will only pay one (1) Injury Treatment Indemnity Benefit per Covered Person per Covered Accident.

LIMITATIONS AND EXCLUSIONS

We will only pay one (1) Injury Treatment Indemnity Benefit per Covered Person per Covered Accident.

GENERAL PROVISIONS

The following provisions apply to this Rider:

- 1) this Rider is made part of the Policy to which it is attached; and
- 2) this benefit is subject to all the provisions of this Rider and the Policy to which it is attached; and
- 3) the Rider Effective Date is as shown on the Policy Schedule Page; and
- 4) the premium for this Rider is as shown on the Policy Schedule Page.

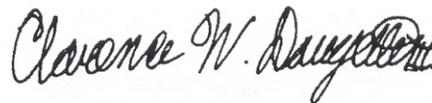
TERMINATION OF RIDER

This Rider terminates at the earliest of:

- 1) the date the Policy is terminated for any reason; or
- 2) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 3) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
- 4) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.


Secretary


President

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

HEALTH SCREENING RIDER

We will provide the Indemnity Benefit stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

HEALTH SCREENING INDEMNITY BENEFIT

If a Covered Person incurs a routine examination or other preventive testing after the 30th day following the Rider Effective Date as shown on the Policy Schedule Page and while this Rider is in force, We will pay the following Indemnity Benefit as shown on the Policy Schedule Page if that Covered Person incurs a Specified Event required for the given Indemnity Benefit while this Rider is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of the Policy to which this Rider is attached; and
- 2) all other limitations, conditions and provisions of the Rider and the Policy to which it is attached.

We will pay the Health Screening Indemnity Benefit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Health Screening Indemnity Benefit. The Specified Event required for the Health Screening Indemnity Benefit occurs when a routine examination or other preventative testing is ordered and performed on a Covered Person.

The Health Screening Indemnity Benefit is payable once per Covered Person or twice per Rider per calendar year.

LIMITATIONS AND EXCLUSIONS

The Health Screening Indemnity Benefit is payable once per Covered Person or twice per Rider per calendar year.

GENERAL PROVISIONS

The following provisions apply to this Rider:

- 1) this Rider is made part of the Policy to which it is attached; and
- 2) this benefit is subject to all the provisions of this Rider and the Policy to which it is attached; and
- 3) the Rider Effective Date is as shown on the Policy Schedule Page; and
- 4) the premium for this Rider is as shown on the Policy Schedule Page.

TERMINATION OF RIDER

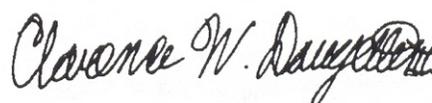
This Rider terminates at the earliest of:

- 1) the date the Policy is terminated for any reason; or
- 2) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 3) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
- 4) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.



Secretary



President

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

ACCIDENTAL DEATH OR DISMEMBERMENT RIDER

We will provide the Indemnity Benefits stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

DEFINITIONS

“**Arm**” means the upper extremity from shoulder to the hand including the wrist.

“**Common Carrier**” means only the following: commercial airlines, passenger trains, or intercity bus-lines. It does NOT include taxis, intra-city bus lines or private charter aircraft.

“**Finger**” means one of five digits attached to the hand.

“**Foot**” means the terminal portion of the lower extremity, not including toes.

“**Hand**” means the body part attached to the forearm at the wrist, not including fingers.

“**Leg**” means the lower extremity from the hip to the foot including the ankle.

“**Loss of Function**” means complete and total impairment of use of the extremity or body part.

“**Regular Transportation of Passengers**” means a Common Carrier used for the main purpose of transporting passengers.

“**Toe**” means one of five digits attached to the foot.

ACCIDENTAL DEATH OR DISMEMBERMENT INDEMNITY BENEFIT

If a Covered Person incurs a Covered Injury after the Rider Effective Date as shown on the Policy Schedule Page and while this Rider is in force, We will pay the following Indemnity Benefit per unit of coverage as shown on the Policy Schedule Page if the Covered Person incurs a Specified Event required for the Accidental Death or Dismemberment Indemnity Benefit in the course of treatment for or as a result of the Covered Injury or Covered Sickness while this Rider is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of the Policy to which this Rider is attached; and
- 2) all other limitations, conditions and provisions of the Rider and the Policy to which it is attached.

We will pay the Accidental Death or Dismemberment Indemnity Benefit listed below per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Accidental Death or Dismemberment Indemnity Benefit. The Specified Event required for the Accidental Death or Dismemberment Indemnity Benefit is a Loss, from the list below, due to an accidental bodily Injury of a Covered Person occurring within 90 days after the date of a Covered Accident. The Losses considered under this benefit are total and permanent Losses.

Loss	Indemnity Benefit Per Unit of Coverage
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	Insured	Spouse	Each Child
Life	\$5,000	\$5,000	\$1,250
Sight in Both Eyes	\$5,000	\$5,000	\$1,250
Sight in One Eye	\$2,500	\$2,500	\$625
Both Hands or Both Arms	\$5,000	\$5,000	\$1,250
Both Feet or Both Legs	\$5,000	\$5,000	\$1,250
One Hand or Arm and One Foot or Leg	\$5,000	\$5,000	\$1,250
One Hand or One Arm	\$2,500	\$2,500	\$625
One Foot or One Leg	\$2,500	\$2,500	\$625
One or More Entire Toes	\$250	\$250	\$65
One or More Entire Fingers	\$250	\$250	\$65

By the term "Loss", We mean loss of function:

- 1) of the arm, the Loss of function of the entire arm from the shoulder to the hand; or
- 2) of the leg, the Loss of function of the entire leg from hip to the foot; or
- 3) of sight, one or both eyes are totally blind and no sight can be restored.

The Indemnity Benefits Per Unit of Coverage above will be doubled if the Loss occurs while the Covered Person is a fare-paying passenger in or on a licensed conveyance operated by a Common Carrier for the Regular Transportation of Passengers.

LIMITATIONS AND EXCLUSIONS

See Policy to which this Rider is attached.

GENERAL PROVISIONS

The following provisions apply to this Rider:

- 1) this Rider is made part of the Policy to which it is attached; and
- 2) this benefit is subject to all the provisions of this Rider and the Policy to which it is attached; and
- 3) the Rider Effective Date is as shown on the Policy Schedule Page; and
- 4) the premium for this Rider is as shown on the Policy Schedule Page.

TERMINATION OF INSURANCE

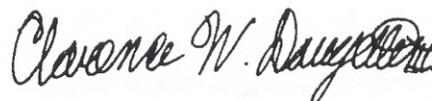
This Rider terminates at the earliest of:

- 1) the date the Policy is terminated for any reason; or
- 2) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 3) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
- 4) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.



Secretary



President

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

SUPPLEMENTAL INJURY RIDER

We will provide the Indemnity Benefits stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

DEFINITIONS

“**Laceration**” means a cut or irregular tear of the flesh.

“**Second Degree Burn**” means a burn damaging epidermal and some dermal tissues but does not damage the lower-lying hair follicles, sweat, or sebaceous glands.

“**Third Degree Burn**” means a burn that extends through the full thickness of the skin layer and often into underlying tissues.

BENEFITS

If a Covered Person incurs a Covered Injury after the Rider Effective Date as shown on the Policy Schedule Page and while this Rider is in force, We will pay the following Indemnity Benefits as shown on the Policy Schedule Page if the Covered Person incurs a Specified Event required for the given Indemnity Benefit in the course of treatment for or as a result of the Covered Injury while this Rider is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of the Policy to which this Rider is attached; and
- 2) all other limitations, conditions and provisions of the Rider and the Policy to which it is attached.

Burn Indemnity Benefit

We will pay the Burn Indemnity Benefit of \$375 per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Burn Indemnity Benefit. The Specified Event required for the Burn Indemnity Benefit is initial treatment by a Physician of Second and/or Third Degree Burns covering the required specified portions of the Covered Person’s body surface within 72 hours after a Covered Accident. Second Degree Burns must cover at least 36% of the body surface of the Covered Person and Third Degree Burns must cover at least nine (9) square inches of the body surface of the Covered Person. Initial treatment of the burns by a Physician *must* be received by the Covered Person within 72 hours after the Covered Accident. The Covered Person’s attending Physician must attest to the degree and extent of the burns.

The Burn Indemnity Benefit is payable once per Covered Person per Covered Accident.

Lacerations Indemnity Benefit

We will pay the Lacerations Indemnity Benefit of \$60 per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Lacerations Indemnity Benefit. The Specified Event required for the Lacerations Indemnity Benefit is the required use of stitches or staples by a Physician to close one or more Lacerations on a Covered Person within 72 hours after a Covered Accident. Stitches or staples must be required to close the Laceration(s).

Initial treatment by a Physician *must* be received by the Covered Person within 72 hours after the Covered Accident.

The Lacerations Indemnity Benefit is payable once per Covered Person per Covered Accident.

Tendon/Ligament/Rotator Cuff Indemnity Benefit

We will pay the Tendon/Ligament/Rotator Cuff Indemnity Benefit of \$150 per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Tendon/Ligament/Rotator Cuff Indemnity Benefit. The Specified Event required for the Tendon/Ligament/Rotator Cuff Indemnity Benefit is the surgical repair of one or more torn, ruptured, or severed tendon(s), ligament(s), or rotator cuff(s) of a Covered Person as a result of a Covered Accident within 90 days after the Covered Accident. The Specified Event occurs on the day of the surgical repair. Initial treatment by a Physician *must* be received by the Covered Person within 72 hours after the Covered Accident with surgical repair of the torn, ruptured, or severed tendon(s), ligament(s), or rotator cuff(s) within ninety (90) days after the Covered Accident.

The Tendon/Ligament/Rotator Cuff Indemnity Benefit is payable once per Covered Person per Covered Accident.

If a Covered Person who is also covered by a Specified Loss Rider receives a fracture or dislocation and tears, ruptures or severs a tendon, ligament or rotator cuff, benefits will be payable under the Rider providing the greater benefit but NOT both.

LIMITATIONS AND EXCLUSIONS

Initial treatment by a Physician *must* be received by the Covered Person within 72 hours after the Covered Accident.

The Burn Indemnity Benefit is payable only once per Covered Person per Covered Accident.

The Lacerations Indemnity Benefit is payable only once per Covered Person per Covered Accident.

The Tendon/Ligament/Rotator Cuff Indemnity Benefit is payable only once per Covered Person per Covered Accident.

If a Covered Person who is also covered by a Specified Loss Rider receives a fracture or dislocation and tears, ruptures or severs a tendon, ligament or rotator cuff, benefits will be payable under the Rider providing the greater benefit but NOT both.

GENERAL PROVISIONS

The following provisions apply to this Rider:

- 1) this Rider is made part of the Policy to which it is attached; and
- 2) benefits are subject to all the provisions of this Rider and the Policy to which it is attached; and
- 3) the Rider Effective Date is as shown on the Policy Schedule Page; and
- 4) the premium for this Rider is as shown on the Policy Schedule Page.

TERMINATION OF RIDER

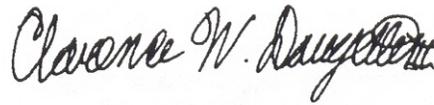
This Rider terminates at the earliest of:

- 1) the date the Policy is terminated for any reason; or
- 2) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 3) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
- 4) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.



Secretary



President

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

SPECIFIED LOSS RIDER

We will provide the Indemnity Benefits stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

DEFINITIONS

“**Closed Reduction**” means the treatment of bone Fractures and joint Dislocations by placing the bones in their proper position without surgery.

“**Common Carrier**” means only the following: commercial airlines, passenger trains, or intercity bus lines. It does NOT include taxis, intra-city bus lines or private charter aircraft.

“**Dislocation**” means the temporary displacement of a bone from its normal position in a joint.

“**Fracture**” means a break of a bone.

“**Hospital Intensive Care Unit**” means only that specifically designated facility of the Hospital that provides the highest level of medical care which is restricted to those patients who are critically ill or injured. Such facilities must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be permanently equipped with special life-saving equipment for the care of the critically ill or injured. They must be under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to the Intensive Care Unit.

“**Open Reduction**” means the treatment of bone Fractures and joint Dislocations by the use of surgery to place the bones in their proper position.

“**Reduction**” means the restoration to a normal position.

BENEFITS

If a Covered Person incurs a Covered Injury after the Rider Effective Date as shown on the Policy Schedule Page and while this Rider is in force, We will pay the following Indemnity Benefits per unit of coverage as shown on the Policy Schedule Page if the Covered Person incurs a Specified Event required for the given Indemnity Benefit in the course of treatment for the Covered Injury while this Rider is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of the Policy to which this Rider is attached; and
- 2) all other limitations, conditions and provisions of the Rider and the Policy to which it is attached.

Hospital Intensive Care Indemnity Benefit

We will pay the Hospital Intensive Care Indemnity Benefit of \$50 per day per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Hospital Intensive Care Indemnity Benefit. The Specified Event required for the Hospital Intensive Care Indemnity Benefit is confinement of a Covered Person in a Hospital Intensive Care Unit due to or for the treatment of Covered Injuries as a result of a Covered Accident. A day is defined as a 24-hour period with a minimum of an 18-hour confinement.

Confinement in a Hospital Intensive Care Unit does NOT include:

- 1) confinements of less than 18-hours; or
- 2) treatment on an out-patient basis; or
- 3) Emergency Room treatment; or
- 4) the day of discharge from the Hospital except where the day of discharge and the day of admission are the same day and the confinement was for at least 18-hours; or
- 5) confinements due to a Sickness.

The Hospital Intensive Care Indemnity Benefit is payable for up to sixteen (16) days of confinement in a Hospital Intensive Care Unit per Covered Person per Covered Accident.

The Hospital Intensive Care Indemnity Benefit is payable for only one Hospital Intensive Care Unit confinement at a time per Covered Person even if the confinement is caused by multiple Covered Injuries.

Hospital Intensive Care Indemnity Benefits will NOT be payable for the same day any Monthly Hospital Confinement Indemnity Benefits of the attached Policy or other attached Riders is payable.

Medical Equipment Indemnity Benefit

We will pay the Medical Equipment Indemnity Benefit of \$125 per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Medical Equipment Indemnity Benefit. The Specified Event required for the Medical Equipment Indemnity Benefit is use of eligible medical equipment prescribed by a Physician by a Covered Person as a result of a Dislocation or Fracture due to a Covered Accident within the first ninety (90) days after the Covered Accident. Eligible medical equipment must be prescribed by a Physician and is limited to crutches, wheel chair, back brace, leg brace, neck brace, cast, splint and walker.

The Medical Equipment Indemnity Benefit is payable only once per Covered Person per Covered Accident.

The Medical Equipment Indemnity Benefit is only payable if there is either a Dislocation Indemnity Benefit or a Fracture Indemnity Benefit payable for the same Covered Person and the same Covered Accident.

Specified Loss Rider Ambulance Indemnity Benefit

We will pay the Specified Loss Rider Ambulance Indemnity Benefit of \$25 per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Specified Loss Rider Ambulance Indemnity Benefit. The Specified Event required for the Specified Loss Rider Ambulance Indemnity Benefit is transportation by Ambulance to a Hospital of a Covered Person for the treatment of a Covered Injury as a result of a Covered Accident.

The Specified Loss Rider Ambulance Indemnity Benefit is payable only once per Covered Person per Covered Accident.

X-Ray Indemnity Benefit

We will pay the X-Ray Indemnity Benefit of \$25 per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the X-Ray Indemnity Benefit. The Specified Event required for the X-Ray Indemnity Benefit is X-ray examination of a Covered Person due to a Covered Injury.

The X-Ray Indemnity Benefit is payable only once per Covered Person per Covered Accident.

Blood, Plasma or Platelets Indemnity Benefit

We will pay the Blood, Plasma or Platelets Indemnity Benefit of \$150 per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Blood, Plasma or Platelets Indemnity Benefit. The Specified Event required for the Blood, Plasma or Platelets Indemnity Benefit is the receipt of blood, plasma or platelets by a Covered Person for the treatment of a Covered Injury as the result of a Covered Accident.

The Blood, Plasma or Platelets Indemnity Benefit is payable only once per Covered Person per Covered Accident.

Transportation Indemnity Benefit

We will pay the Transportation Indemnity Benefit of \$150 per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Transportation Indemnity Benefit. The Specified Event required for the Transportation Indemnity Benefit is transportation by Common Carrier of a Covered Person to or from another city for treatment or diagnostic study of Covered Injuries and occurs when the Injured Covered Person is transported. The transportation must be recommended by the Physician making the diagnosis.

The Transportation Indemnity Benefit is payable only once per Covered Person per Covered Accident.

Dislocation Indemnity Benefit

We will pay the Dislocation Indemnity Benefit based upon the category of the Dislocation as shown in the chart below per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Dislocation Indemnity Benefit. The Specified Event required for the Dislocation Indemnity Benefit is the Reduction of a Dislocation of a joint of a Covered Person by a Physician required as a result of a Covered Accident. The Dislocation must be diagnosed and treated by a Physician within 90 days after the Covered Accident and must require either Open or Closed Reduction by a Physician.

<u>Category*</u>	<u>Closed Reduction Benefit Amount Per Unit</u>
Each Hip	\$450
Each Knee	\$325
Each Shoulder	\$250
Each Ankle	\$200
Bone or Bones of the Foot, excluding Toes	\$200
Bone or Bones of the Hand, excluding Fingers	\$175
Each Collar Bone	\$150
Each Wrist	\$125
Each Elbow	\$100
Each Toe or Each Finger	\$40

* Left and right are each separate Categories, as are individual fingers and toes.

The benefit amounts per unit shown above are for Closed Reductions. If an Open Reduction is required, the Company will pay 150% of the benefit amount per unit that would have been paid for a Closed Reduction of the same joint.

If the Reduction is done without anesthesia, the Company will pay 25% of the benefit amount per unit that would have been paid for a Closed Reduction of the same joint.

The Dislocation Indemnity Benefit is payable only once per Category shown above per Covered Person's lifetime.

If a Covered Person who is also covered by a Supplemental Injury Rider receives a Fracture or Dislocation and tears, ruptures or severs a tendon, ligament or rotator cuff, benefits will be payable under the Rider providing the greater benefit but NOT both.

Fracture Indemnity Benefit

We will pay the Fracture Indemnity Benefit based upon the category of the Fracture as shown in the chart below per unit as shown on the Policy Schedule Page if a Covered Person incurs a Specified Event required for the Fracture Indemnity Benefit. The Specified Event required for the Fracture Indemnity Benefit is the Reduction of a Fracture of a bone of a Covered Person by a Physician required as a result of a Covered Accident. The Fracture must be diagnosed and treated by a Physician within 90 days after the Covered Accident and must require either Open or Closed Reduction by a Physician.

<u>Category*</u>	<u>Closed Reduction Benefit Amount Per Unit</u>
Each Hip	\$500
Each Thigh (Femur)	\$500
Spinal Cord (Complete severance with resulting paralysis)	\$500
Vertebrae, body of (except Vertebral process)	\$450
Pelvis (excluding coccyx)	\$400
Skull Depressed	\$175
Simple	\$375
Each Leg (Tibia and/or Fibula)	\$300
Each Ankle	\$250
Each Knee Cap (Patella)	\$250
Each Forearm (Radius and/or Ulna)	\$250
Each Foot (except Toes)	\$250
Each Hand (except Fingers)	\$250
Each Wrist	\$250
Lower Jaw (except Alveolar process)	\$200
Each Shoulder Blade	\$200
Each Collar Bone	\$200
Each Arm (Elbow to Shoulder)	\$175
Upper Jaw	\$175
Bones of Face (Except Upper and Lower Jaw)	\$150
Vertebral Process	\$100
Coccyx	\$40
Each Rib, Finger or Toe	\$40

*Left and right are each separate Categories, as are individual fingers, toes, ribs and vertebrae.

The benefit amounts per unit shown above are for Closed Reductions. If an Open Reduction is required, the Company will pay 150% of the benefit amount per unit that would have been paid for a Closed Reduction of the same category.

If the Physician diagnoses the Fracture as a chip Fracture, the Company will pay 25% of the benefit amount per unit that would have been paid for a Closed Reduction of the same bone.

The Fracture Indemnity Benefit is payable only once per Category shown above per Covered Person per Covered Accident.

If a Covered Person who is also covered by a Supplemental Injury Rider receives a Fracture or Dislocation and tears, ruptures or severs a tendon, ligament or rotator cuff, benefits will be payable under the Rider providing the greater benefit but NOT both.

LIMITATIONS AND EXCLUSIONS

The Hospital Intensive Care Indemnity Benefit is payable for up to sixteen (16) days of confinement in a Hospital Intensive Care Unit per Covered Person per Covered Accident .

The Hospital Intensive Care Indemnity Benefit is payable for only one Hospital Intensive Care Unit confinement at a time per Covered Person even if the confinement is caused by multiple Covered Injuries.

Hospital Intensive Care Indemnity Benefits will NOT be payable for the same day any Monthly Hospital Confinement Indemnity Benefits of the attached Policy or other attached Riders is payable.

The Medical Equipment Indemnity Benefit is only payable if there is either a Dislocation Indemnity Benefit or a Fracture Indemnity Benefit payable for the same Covered Person and the same Covered Accident.

The Medical Equipment Indemnity Benefit is payable only once per Covered Person per Covered Accident.

The Specified Loss Rider Ambulance Indemnity Benefit is payable only once per Covered Person per Covered Accident.

The X-Ray Indemnity Benefit is payable only once per Covered Person per Covered Accident.

The Blood, Plasma or Platelets Indemnity Benefit is payable only once per Covered Person per Covered Accident.

The Transportation Indemnity Benefit is payable only once per Covered Person per Covered Accident.

The Dislocation Indemnity Benefit is payable only once per Category per Covered Person's lifetime.

The Fracture Indemnity Benefit is payable only once per Category per Covered Person per Covered Accident.

If a Covered Person who is also covered by a Supplemental Injury Rider receives a Fracture or Dislocation and tears, ruptures or severs a tendon, ligament or rotator cuff, benefits will be payable under the Rider providing the greater benefit but NOT both.

GENERAL PROVISIONS

The following provisions apply to this Rider:

- 1) this Rider is made part of the Policy to which it is attached; and
- 2) benefits are subject to all the provisions of this Rider and the Policy to which it is attached; and
- 3) the Rider Effective Date is as shown on the Policy Schedule Page; and
- 4) the premium for this Rider is as shown on the Policy Schedule Page.

TERMINATION OF RIDER

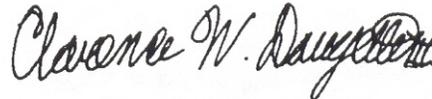
This Rider terminates at the earliest of:

- 1) the date the Policy is terminated for any reason; or
- 2) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 3) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
- 4) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.



Secretary



President

LIFE INSURANCE COMPANY OF ALABAMA
P.O. Box 349
Gadsden, Alabama 35902

ON-THE-JOB DISABILITY RIDER

We will provide the benefits stated in this Rider, subject to the terms and conditions contained in this Rider and in the Policy to which it is attached. Terms and definitions for this Rider are the same as used in the Policy to which this Rider is attached except when explicitly stated in this Rider.

RIDER RENEWAL PROVISION

This Rider is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. We retain the right to change the applicable table of premium rates for this Rider as provided on the first page of the Policy.

DEFINITIONS

“Concurrent Disability” means one continuous period of Total Disability that is caused or is continued by more than one Covered Injury or Covered Sickness. Benefits for a Concurrent Disability will be paid as if the Concurrent Disability was caused by one (1) Covered Injury or one (1) Covered Sickness. In no event will an Insured be considered to have more than one continuous period of Total Disability at the same time.

A **Covered Injury** is an Injury which:

- (1) occurs after the Rider Effective Date; and
- (2) occurs On-The-Job; and
- (3) occurs while the Rider is in force; and
- (4) is not excluded by name or specific description in this Rider or in the Policy to which this Rider is attached.

“Elimination Period” means, subject to the satisfaction of all Policy and Rider terms and conditions by the Insured, the length of time an Insured must be Totally Disabled before monthly income benefit amounts are payable.

“Maximum Benefit Period” means, subject to satisfaction of all Policy and Rider terms and conditions by the Insured, the maximum length of time for which a Totally Disabled Insured can be paid monthly income benefit amounts.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the On-The-Job Disability Rider Maximum Benefit Period will be limited to a maximum of three (3) months for one (1) Maximum Benefit Period.

“On-The-Job” means occurring while at work at any job for pay or benefits.

“Recurrent Disability” means any period of continuous Total Disability after the first period of continuous Total Disability.

A Recurrent Disability will be treated as:

- 1) a continuation of the previous disability, NOT a new disability, if the Insured has returned to work for less than 6 months;
- 2) a new disability, if the Insured has returned to work for 6 months or more; and
- 3) a continuation of the previous disability for any circumstances not specifically listed above.

Whether a Recurrent Disability is a continuation of a previous disability or a new disability is determined by the length of time the Insured has returned to work, NOT the cause(s) of the disabilities.

A new disability is subject to a new Elimination Period and a new Maximum Benefit Period applies. A disability that is considered a continuation of a previous disability is NOT subject to a new Elimination period and a new Maximum Benefit Period does NOT apply.

“Sickness” means any illness, including complications of pregnancy as defined by the Insured’s Physician, infection, disease or any other abnormal physical condition which is NOT caused by an Injury.

“Total Disability” or **“Totally Disabled”** means:

- 1) the Insured is unable to work at his/her current job; and
- 2) the Insured is, in fact, unable to work at any job for pay or profit; and
- 3) the Insured is under the regular care of a Physician. The Physician must attest to the specific period of Total Disability and its cause.

Any period of Total Disability must occur within thirty (30) days of a Covered Injury as defined in this Rider.

BENEFITS

If the Primary Insured becomes Totally Disabled as the result of a Covered Injury following the Rider Effective Date as shown on the Policy Schedule Page and while this Rider is in force, We will pay the following benefits as shown on the Policy Schedule Page if the Primary Insured incurs a Specified Event required for the given benefit while Totally Disabled and this Rider is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of this Policy, the Covered Injury occurred after the Rider Effective Date; and
- 2) all other limitations, conditions and provisions of the Rider and the Policy to which it is attached.

On-The-Job Monthly Disability Income Benefit

We will pay an On-The-Job Monthly Disability Income Benefit as shown on the Policy Schedule Page if the Primary Insured incurs the Specified Event required for the On-The-Job Monthly Disability Income Benefit. The Specified Event required for the On-The-Job Monthly Disability Income Benefit is continuous Total Disability of the Primary Insured for the length of the On-The-Job Disability Rider Elimination Period as shown on the Policy Schedule Page plus one (1) day as a result of a Covered Injury as defined in this Rider. The Specified Event occurs on the day following the expiration of the On-The-Job Disability Rider Elimination Period and continues until the Primary Insured is no longer Totally Disabled due to a Covered Injury as defined in this Rider and under a Physician’s care but in no case longer than the On-The-Job Disability Rider Maximum Benefit Period as shown on the Policy Schedule Page. The Primary Insured’s Physician must attest to the specific period of Total Disability and its cause. Benefit periods involving partial months will have the partial month benefit paid at a daily rate of one-thirtieth (1/30th) of the full monthly amount.

On-The-Job Monthly Disability Income Benefits are NOT payable if the Primary Insured is Totally Disabled due to or as the result of:

- 1) any Sickness; or
- 2) any cause other than a Covered Injury as defined in this Rider occurring On-The-Job; or
- 3) any Pre-existing Conditions except after two (2) years from the Rider Effective Date.

On-The-Job Monthly Disability Income Benefits are NOT payable for Disability of any person covered by the attached Policy other than the Primary Insured.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the On-The-Job Disability Rider Maximum Benefit Period shall be limited to a maximum of three (3) months for one On-The-Job Disability Rider Maximum Benefit Period.

We will NOT pay Disability Benefits under multiple Policy and/or Rider forms simultaneously.

On-The-Job Disability Waiver of Premium Benefit

We will waive future premiums due for this Rider, the Policy to which this Rider is attached and any other attached Riders when the Primary Insured incurs the Specified Event required for the On-The-Job Disability Waiver of Premium Benefit. The Specified Event required for the On-The-Job Disability Waiver of Premium Benefit occurs on the day after the Primary Insured has been totally and continuously Disabled due to a Covered Injury for which On-The-Job Monthly Disability Income Benefits are payable for a period of ninety (90) consecutive days and continues until the Primary Insured is no longer Totally Disabled due to the Covered Injury and under a Physician's care OR the On-The-Job Monthly Disability Income Benefit is no longer payable. Premiums will NOT be waived beyond the On-The-Job Disability Rider Maximum Benefit Period as shown on the Policy Schedule Page. We will waive the premium beginning on the Month-a-versary following the onset of the Specified Event required for the On-The-Job Disability Waiver of Premium Benefit. The Primary Insured's Physician must attest to the specific period of Total Disability and its cause.

The On-The-Job Disability Waiver of Premium Benefit is NOT payable if the Primary Insured is Total Disabled due to or as the result of:

- 1) any Sickness; or
- 2) any cause other than a Covered Injury as defined in this Rider occurring On-The-Job; or
- 3) any Pre-existing Conditions except after two (2) years from the Rider Effective Date.

On-The-Job Monthly Disability Waiver of Premium Benefits are NOT payable for Disability of any person covered by the attached Policy other than the Primary Insured.

The On-The-Job Disability Waiver of Premium Benefit is only payable after the Primary Insured has been continuously Totally Disabled for ninety (90) consecutive days due to a Covered Injury as defined in this Rider and for as long as the Primary Insured remains continuously Totally Disabled due to a Covered Injury as defined in this Rider but in no case beyond the On-The-Job Disability Rider Maximum Benefit Period.

LIMITATIONS AND EXCLUSIONS

We will NOT pay ANY benefits under this Rider if the Primary Insured is Totally Disabled due to or as the result of:

- 1) any Sickness; or
- 2) any cause other than a Covered Injury as defined in this Rider occurring On-The-Job; or
- 3) any Pre-existing Conditions except after two (2) years from the Rider Effective Date.

We will NOT pay ANY benefits under this Rider for Disability of any person covered by the attached Policy other than the Primary Insured.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the On-The-Job Disability Rider Maximum Benefit Period shall be limited to a maximum of three (3) months for one On-The-Job Disability Rider Maximum Benefit Period.

We will NOT pay any Disability Benefits under multiple Policy and/or Rider forms simultaneously.

The On-The-Job Disability Waiver of Premium Benefit is only payable after the Primary Insured has been continuously Totally Disabled for ninety (90) consecutive days due to a Covered Injury as defined in this Rider and for as long as the Primary Insured remains continuously Totally Disabled due to a Covered Injury as defined in this Rider and under a Physician's care but in no case beyond the On-The-Job Disability Rider Maximum Benefit Period.

GENERAL PROVISIONS

The following provisions apply to this Rider:

- 1) this Rider is made part of the Policy to which it is attached; and
- 2) benefits are subject to all the provisions of this Rider and the Policy to which it is attached; and
- 3) the Rider Effective Date is as shown on the Policy Schedule Page; and
- 4) the premium for this Rider is as shown on the Policy Schedule Page.

TERMINATION OF RIDER

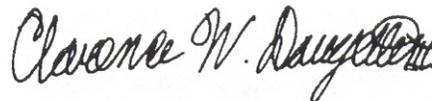
This Rider terminates at the earliest of:

- 1) the date the Policy is terminated for any reason; or
- 2) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 3) the date any premium for this Rider or the Policy is in default beyond the end of its Grace Period; or
- 4) the premium due date following Your written request for its termination.

Signed for the Company at its Home Office.



Secretary



President



SICKNESS & ACCIDENT



DISABILITY INCOME PLAN

IMPORTANT FEATURES

- Provides Immediate Coverage
- Benefits Begin With First Day
- 24-Hour Coverage (on & off the job)
- Low Group Rates
- Pays in Addition To All Other Insurance (Including Workers Compensation)
- Issued thru age 69 - Guaranteed Renewable to Age 72
- Can Take Plan With You If You Leave Your Present Employer

Sickness & Accident Disability **INCOME PLAN**

- HELPS PROTECT one of your most valuable assets... your ability to earn an income.
- PROVIDES an income...when you are disabled due to accidental injury on or off the job.
- PAYS tax free cash benefits directly to you... when disabled at home or in the hospital.



If your ability to earn a regular income was destroyed by
A DISABLING ACCIDENT
WHAT WOULD YOU DO?

Wipe Out Your Savings?

Do you realize that even if you saved 5% of your income each year - 6 MONTHS of total disability could WIPE OUT 10 YEARS OF SAVINGS?

Borrow Money?

Who is going to lend money to a DISABLED Person?

Send Your Spouse To Work?

Could you and your family live on just the income your spouse could earn? Do you want your spouse to be parent, private nurse, and employee - ALL AT THE SAME TIME?

Liquidate Assets?

Could you get a fair market price if you are FORCED TO LIQUIDATE your most valuable assets?

THE IDEAL SOLUTION

THE SICKNESS & ACCIDENT DISABILITY INCOME PLAN

**A Plan Made Available Only Through
The Cooperation Of Your Employer**

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

Underwritten by: Life Insurance Company of Alabama

SICKNESS & ACCIDENT DISABILITY INCOME PLAN

This outline of coverage provides a brief description of the important features of the policy. This describes a Sickness and Accident Disability Insurance Policy Form HD75608, On-The-Job Disability rider HA35O608, Initial Hospital Confinement rider HA35H608, Injury Treatment rider HA35T608, Wellness rider HA35W608, Accidental Death & Dismemberment rider HA35D608. *This is not the insurance contract, and only the actual policy provisions will control. It is therefore important that you Read Your Policy Carefully.*

■ **Monthly On or Off-The-Job Disability Income Benefit (Sickness or Accident)*** \$ _____
 Pays the monthly disability income benefit stated each month the primary insured is totally disabled as a result of a covered Sickness or Accident occurring On or Off-the-job. Monthly Income Selected

Accident Elimination Period

Benefits begin the 1st day, 8th day or 15th day of total disability due to an Accident.

Sickness Elimination Period

Benefits begin the 8th, 15th, 31st, 61st, 91st or 181st day of total disability due to a covered Sickness.

Disability Benefit Period

Benefits are payable for a period of up to 3 months, 6 months, 1 year or 2 years for each disability.

(Check selected benefit period.)

■ **Waiver of Premium**

After you are totally disabled for 90 consecutive days due to a covered injury or accident, future premiums that fall due for the base policy and all riders will be waived for as long as the monthly disability income benefit is payable.

Optional Benefits

■ **Accidental Death Benefit**

Payable in case of any type of accidental death due to accidental bodily injury which occurs within 90 days from the date of the accident.

Employee [\$10,000.00]

■ **Double Indemnity Benefit**

Payable when loss of life occurs due to accidental bodily injury within 90 days of injury sustained while riding as a fare-paying passenger in or on a licensed conveyance operated by a common carrier for the regular transportation of passengers.

Employee [\$20,000.00]

■ **Double Dismemberment Benefit**

Payable in case of the loss of both hands or both arms or both feet or sight in both eyes. Or the loss of one hand or arm and one foot or leg.

Employee [\$10,000.00]

■ **Single Dismemberment Benefit**

Payable in case of the loss of either hand, arm, foot, leg or sight in one eye.

Employee [\$5,000.00]

■ **Loss of Finger or Toe Benefit**

Payable in case of the loss of one or more entire fingers or toes.

Employee [\$500.00]

■ **Initial Hospital Confinement Benefit**

Pays the initial hospital confinement benefit when you are admitted to a hospital for at least 1 day, as a result of a covered accident. This benefit is paid once per confinement and only once per calendar year, per covered person.

Employee [\$1,000.00]

■ **Injury Treatment Benefit****

Pays the injury treatment benefit for treatment in a Emergency Room, Physician's Office or Urgent Care Facility for any one covered accident.

Employee [\$100.00]

■ **Health Screening Benefit**

Pays the health screening benefit for routine examinations or other preventative testing after premiums have been paid for 30 days beyond the policy effective date. This benefit is payable once per person and twice per family per policy per calendar year.

Employee [\$50.00]

* Portions of a month will be paid at a daily rate of 1/30 of the monthly benefit.

** Injury Treatment Benefit can be increased to \$150 for Monthly Disability Amounts of \$600 per month. Increased to \$200 for Monthly Disability Amounts of \$600 per month. Increased to \$250 for Monthly Disability Amounts of \$800 per month. Increased to \$300 for Monthly Disability Amounts of \$1,000 per month or more. Premiums must be increased by \$1.90 per month per \$50 of additional Injury Treatment Benefit.

ALL THESE BENEFITS ARE AVAILABLE TO YOU FOR A MONTHLY PREMIUM OF ONLY \$ _____ PER MONTH

OPTIONAL ACCIDENTAL BODILY INJURY SPECIFIC LOSS RIDER

Form No. HA35B608

Fractures- (broken bones) up to [\$1500]

This benefit is payable if the fracture is diagnosed and treated by a doctor within 90 days after the covered accident. This benefit is payable for each covered person.

Dislocations- (separated joints) up to [\$1350]

This benefit is payable if the dislocation is diagnosed by a doctor within 90 days after the covered accident. This benefit is payable for each covered person.

Hospital Intensive Care Benefit [\$150]

Pays up to 16 days per confinement per covered accident. This benefit is payable for each covered person per covered accident.

Blood, Plasma or Platelets [\$450]

This benefit will pay for blood, plasma or platelets due to a covered accident and is payable for each covered person per covered accident.

Medical Equipment [\$375]

We will pay for medical equipment prescribed by a doctor as a result of a dislocation or fracture. This benefit is payable for each covered person per covered accident. Equipment eligible: crutches, wheelchair, back brace, leg brace, neck brace, cast, splint and walker. Use must begin within the first 90 days after a covered accident.

X-Rays [\$75]

This benefit will pay for x-ray examinations performed due to a covered injury. This benefit is payable for each covered person per covered accident.

Ambulance [\$75]

For transportation by a licensed professional ambulance company to a hospital. This benefit is payable once for each covered person per covered accident.

Transportation [\$450]

By common carrier (air, rail or bus), to or from another city, for treatment or diagnostic study, when recommended by the physician making the diagnosis. This benefit is payable for each covered person per covered accident.

Fractures

Each Hip	[\$1500]
Each Thigh (<i>Femur</i>)	[\$1500]
Spinal Cord (<i>Complete severance with resulting paralysis</i>)	[\$1500]
Vertebrae, body of (<i>except Vertebral process</i>)	[\$1350]
Pelvis(<i>excluding coccyx</i>)	[\$1200]
Skull <i>Depressed</i>	[\$ 525]
<i>Simple</i>	[\$1125]
Each Leg(<i>Tibia and/or Fibula</i>)	[\$ 900]
Each Ankle	[\$ 750]
Each Knee Cap(<i>Patella</i>)	[\$ 750]
Each Forearm (<i>Radius and/or Ulna</i>)	[\$ 750]
Each Foot (<i>except toes</i>)	[\$ 750]
Each Hand	[\$ 750]
Each Wrist (<i>except fingers</i>)	[\$ 750]
Lower Jaw (<i>except Alveolar process</i>)	[\$ 600]
Each Shoulder Blade	[\$ 600]
Each Collar Bone	[\$ 600]
Each Arm (<i>elbow to shoulder</i>)	[\$ 525]
Upper Jaw	[\$ 525]
Bones of Face (<i>except upper and lower jaw</i>)	[\$ 450]
Vertebral Process	[\$ 300]
Coccyx	[\$ 120]
Each Rib, Finger, or Toe	[\$ 120]

Dislocations

Each Hip	[\$1350]
Each Knee	[\$ 975]
Each Shoulder	[\$ 750]
Each Ankle	[\$ 600]
Bone or Bones of the Foot (<i>excluding toes</i>) ..	[\$ 600]
Bone or Bones of the Hand (<i>excluding fingers</i>)	[\$ 525]
Each Collar Bone	[\$ 450]
Each Wrist	[\$ 375]
Each Elbow	[\$ 300]
Each Toe or Each Finger	[\$ 120]

Benefit amounts shown above are for Closed Reductions. Fractures and dislocations requiring OPEN reductions are paid at 150% of the levels shown If the Reduction is done without anesthesia or if the Physician diagnoses the Fracture as a chip Fracture, the Company will pay 25% of the benefit amount per unit that would have been paid for a Closed Reduction of the same joint. The Company will pay a benefit for only one Fracture or Dislocation per Injured Category shown above per Covered Person per Covered Accident.

Premium	MO.	WK.
Employee	[4.20	.97]
Employee & Spouse	[6.30	1.46]
Employee & Children	[8.70	2.01]
Employee & Family	[10.80	2.50]

OPTIONAL SUPPLEMENTAL INJURY BENEFIT

Form No. HA35C608

BURNS.....[\$1,125]

Pays the amount shown for a second degree burn which covers at least 36% of the body surface or for a third degree burn which covers at least nine square inches of the body surface. Burns must be treated by a doctor within 72 hours after the accident. This benefit is payable once per covered person per covered accident.

LACERATIONS.....[\$180]

This benefit will pay for the treatment of a laceration. The laceration must require the use of stitches or staples to repair and be treated by a doctor within 72 hours after the accident. This benefit is payable once per covered person per covered accident.

TENDON/LIGAMENT/ROTATOR CUFF...[\$450]

This benefit will pay for the surgical repair of one or more torn, ruptured, or severed tendon(s), or ligament(s), or rotator cuff(s). If a Covered Person who is also covered by a Specified Loss Rider receives a fracture or dislocation and tears, ruptures or severs a tendon, ligament or rotator cuff, benefits will be payable under the Rider providing the greater benefit but NOT both. This benefit is payable once per covered person per covered accident.

PREMIUM	MO.	WK.
Employee Only	[\$1.05	\$.25]
Employee & Spouse	[\$1.65	\$.39]
Employee & Children	[\$2.10	\$.49]
Employee & Family	[\$2.70	\$.63]

BENEFIT SELECTED

Amount of Monthly Disability \$ _____

Accident Elimination 0 7 14 days

Sickness Elimination 7 14 30 60 90 180 days

Premium Amount Per Pay Period

Sickness & Acc. Disability Inc. \$ _____

Initial Hospital Confinement \$ _____

Injury Treatment Benefit \$ _____

Health Screening Benefit \$ _____

Supplemental Injury Benefit \$ _____

Accidental Death \$ _____

Specific Loss Rider \$ _____

Intensive Care \$ _____

Total Premium Per Period \$ _____

Local Representative:

OPTIONAL HOSPITAL INTENSIVE CARE Form # HI75I0109

• [Pays \$600.00, \$450.00 or \$300.00] per day (depending on amount selected) for Hospital Intensive Care Unit Confinement. (The term, "Intensive Care Unit" shall mean only that specifically designed facility of the hospital that provides the highest level of medical care and which is restricted to those patients who are physically, critically ill or injured.)

• Pays a benefit of one-half (½) the amount selected above per day for Confinement in a "Step Down" Hospital Intensive Care Unit. The term, "Step Down Hospital Intensive Care Unit" shall mean progressive care, subacute intensive care or other facilities which do not meet the standards for "Hospital Intensive Care Unit."

• Pays Triple the amount selected above per day Pays Triple the amount selected above per day for Intensive Care Confinement which occurs within 48 hours of an accident in which any covered insured is the operator or passenger of; an automobile, motor home, bus, motorcycle, or any truck with a load capacity of 2,000 pounds or less or as a fare paying passenger on any vehicle, boat, ship, aircraft, or train, or a school bus operated by or under the direction and supervision of school authorities.

• **First Day Coverage** Benefits are payable from first day of confinement due to injury or due to illness to include congenital anomalies of newborn children.

• Issued through age 70. Guaranteed renewable for life.

• Pays benefits for up to 30 days of Intensive Care Confinement in connection with any one hospital admission. If less than 30 days separates two periods of confinement, the second confinement will be considered a continuation of the initial confinement.

• Daily Hospital Intensive Care benefits will be reduced by 50% (one-half) at age 70. **No Maximum Lifetime Benefit Limit**

	[\$600 per day]		[\$450 per day]		[\$300 per day]	
	MO.	WK.	MO.	WK.	MO.	WK.
Ages 18-39						
Emp.	[\$ 2.68	\$.62	\$ 2.01	\$.47	\$ 1.34	\$.31]
Emp./Sp.	[\$ 4.12	\$.96	\$ 3.09	\$.72	\$ 2.06	\$.48]
Emp./Ch.	[\$ 2.88	\$.67	\$ 2.16	\$.50	\$ 1.44	\$.34]
Emp./Fam.	[\$ 5.40	\$ 1.25	\$ 4.05	\$.94	\$ 2.70	\$.63]
Ages 40-54						
Emp.	[\$ 6.84	\$ 1.58	\$ 5.13	\$ 1.19	\$ 3.42	\$.79]
Emp./Sp.	[\$10.60	\$ 2.45	\$ 7.95	\$ 1.84	\$ 5.30	\$ 1.23]
Emp./Ch.	[\$ 7.36	\$ 1.70	\$ 5.52	\$ 1.28	\$ 3.68	\$.85]
Emp./Fam.	[\$13.84	\$ 3.20	\$10.38	\$ 2.40	\$ 6.92	\$ 1.60]
Ages 55-64						
Emp.	[\$12.40	\$ 2.87	\$ 9.30	\$ 2.15	\$ 6.20	\$ 1.44]
Emp./Sp.	[\$19.44	\$ 4.49	\$14.58	\$ 3.37	\$ 9.72	\$ 2.25]
Emp./Ch.	[\$13.32	\$ 3.08	\$ 9.99	\$ 2.31	\$ 6.66	\$ 1.54]
Emp./Fam.	[\$25.56	\$ 5.90	\$19.17	\$ 4.43	\$12.78	\$ 2.95]
Ages 65-70						
Emp.	[\$17.28	\$ 3.99	\$12.96	\$ 3.00	\$ 8.64	\$ 2.00]
Emp./Sp.	[\$27.00	\$ 6.24	\$20.25	\$ 4.68	\$13.50	\$ 3.12]
Emp./Ch.	[\$18.36	\$ 4.24	\$13.77	\$ 3.18	\$ 9.18	\$ 2.12]
Emp./Fam.	[\$35.08	\$ 8.10	\$26.31	\$ 6.08	\$17.54	\$ 4.05]

LIMITATIONS AND EXCLUSIONS

Sickness and Accident Disability Income Plan – This is a Sickness and Accident Disability Income Policy, which provides Indemnity Benefits for Specified Events occurring in connection with treatment of a Covered Injury or Sickness. We will pay Total Disability benefits for a Covered Injury or Sickness for the Primary Insured only. Benefits will be paid for only one disability at a time even if more than one Covered Injury or Sickness causes it. Indemnity Benefits under this Policy or any attached Riders are not payable for Specified Events that occur outside the United States of America or its territories. The Initial Hospital Confinement Benefit is not payable for the following: Emergency Room Treatment, Outpatient Treatment or Hospital Confinement of less than 18 hours. Only one Hospital Confinement Benefit will be paid per day of confinement. **If Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the Maximum Benefit Period shall be limited to a maximum of three (3) months for one (1) Maximum Benefit Period.**

Total Disability / Totally Disabled – You are considered Totally Disabled if 1) you are unable to work at your current job; and 2) you are not, in fact, working at any job for pay or profit; and 3) you are under the regular care of a Physician. The Physician must attest to the specific period of Total Disability.

Recurrent Disability – Recurrent disabilities will be treated as: a) a continuation of the previous disability, not a new disability, if you have returned to work for less than 6 months. b) a new disability, if you have returned to work for 6 months or more. c) a continuation of the previous disability for any circumstances not specifically listed above.

Concurrent Disability – means one continuous period of Total Disability that is caused or is continued by more than one covered injury or covered sickness. Benefits for a Concurrent Disability will be paid as if the Concurrent Disability was caused by one Injury or one Sickness. In no event will an insured be considered to have more than one continuous period of Total Disability at the same time.

Policy Effective Date – means the date the Policy is issued by Us and coverage begins. The Policy Effective Date is shown on the Policy Schedule Page.

Renewability – Coverage for You and Your spouse, if covered, will continue until the monthly Policy Anniversary following the Primary Insured's 72nd birthday. Insurance coverage will terminate on the nineteenth (19th) birthday of a Dependent Child or the date of that child's twenty-fourth (24th) birthday, if a full-time student or the monthly Policy Anniversary following the child's marriage. We may change the premium rates for this policy. We cannot change the premium rates unless we change them for this policy form for every insured within a state in the same class. The initial premium for this policy is guaranteed not to change for a period of twelve (12) months.

We will not pay any loss that results from any of the following: Conditions for which symptoms existed prior to the Policy Effective Date that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by a physician or received from a physician. These conditions will not be covered until your policy has been in force for two years (five years for the Hospital Intensive Care). Injury or sickness occurring prior to the Policy Effective Date; or Injury or Sickness occurring while Incarcerated; or committing or attempting to commit suicide while sane or insane; or commission of or an attempt to commit an assault or felony; or engaging in any illegal activity; or practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received; or driving or riding in any race of speed or endurance, or testing a motorized vehicle on any racetrack, raceway, race course or speedway; or declared or undeclared war, or any cause or act of war or regular military training, whether the covered person is a member of any armed force or a civilian; or travel in an aircraft, including those which are not motordriven, or hot air balloon other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; or alcoholism or drug addiction; or voluntarily taking, inhaling or absorbing any poison, gas or fumes; or any intentionally self-inflicted Injury; or mental or physical infirmity or disease or treatment for the infirmity or disease; or normal pregnancy and childbirth except after ten (10) months from the Policy Effective Date, if the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks for caesarean deliveries; or taking or using any hallucinogen, narcotic or drugs except on the advice of a licensed Physician; or occurs while intoxicated. "Intoxicated" means under the influence of alcohol or narcotics unless administered on the advice of the Insured's Physician or having a prohibited concentration of alcohol in the blood, breath, urine or other bodily substance, as determined by the law of the jurisdiction in which the loss occurred; or engaging in hang-gliding, bungee jumping, parachuting, sky-diving, sail gliding, parasailing, Para kiting or any similar activities.

Hospital Intensive Care – Children born less than 10 months after the effective date of this Benefit are excluded from coverage until they are 31 days old. Children born more than 10 months after the effective date of the Intensive Care Benefit are covered as any other insured.

All Shaded areas must be completed.

APPLICATION FOR DISABILITY INSURANCE - PART 1

Life Insurance Company of Alabama

P. O. Box 349 · Gadsden, Alabama 35902

Please Use Dark Ink Suitable for Photocopying.

Do you have a current Medicaid eligibility card or other state sponsored insurance program? Yes No

1. PROPOSED INSURED <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Separated LAST NAME FIRST M.I.	BIRTHDATE			AGE	STATE OF BIRTH	SEX	SOCIAL SECURITY #	HEIGHT	WEIGHT
	MO	DAY	YR						

SPOUSE

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DEPENDENT CHILDREN PROPOSED for INSURANCE

2. RESIDENCE ADDRESS STREET	CITY	COUNTY	STATE	ZIP	PHONE: RES: () BUS: () E-MAIL:
3. INSURED'S EMPLOYER <i>90 days of employment required</i>	EMPLOYMENT DATE	OCCUPATION (Describe and give exact duties)			

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.

SICKNESS & ACCIDENT DISABILITY - \$_____ Monthly Disability Benefit Benefit Period <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years Accident Elimination Period <input type="checkbox"/> 0 <input type="checkbox"/> 7 <input type="checkbox"/> 14 days Sickness Elimination Period <input type="checkbox"/> 7 <input type="checkbox"/> 14 <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 180 days <i>Answer questions 4-6 & 11</i> Applicant's Gross Monthly Income \$_____		PREMIUM Disability _____ Int. Conf. _____ Inj. Treatment _____ Heath Scr. _____ Sup. Injury _____ AD&D _____ Spec. Loss _____ Intensive Care _____ TOTAL _____
<input type="checkbox"/> INITIAL HOSPITAL CONFINEMENT [\$1000]	AD&D BENEFIT _____ # Units <input type="checkbox"/> [\$10k <input type="checkbox"/> \$15k <input type="checkbox"/> \$20k <input type="checkbox"/> \$25k <input type="checkbox"/> \$30k]	
INJURY TREATMENT BENEFIT \$ <input type="checkbox"/> [\$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300]	<input type="checkbox"/> SPECIFIC LOSS RIDER - 3 UNITS	
<input type="checkbox"/> HEALTH SCREENING BENEFIT [\$50]	INTENSIVE CARE - <input type="checkbox"/> [\$300 <input type="checkbox"/> \$450 <input type="checkbox"/> \$600] <input type="checkbox"/> \$_____ <input type="checkbox"/> Emp <input type="checkbox"/> Emp/Sp <input type="checkbox"/> Emp/Ch <input type="checkbox"/> Emp/Fam <i>Answer questions 9 and 10</i>	
<input type="checkbox"/> SUPPLEMENTAL INJURY RIDER - 3 UNITS		

4. Is any proposed insured currently in the hospital or receiving disability payments? *If yes, give name of person(s) and details.* YES NO

9. Has any proposed insured ever been diagnosed or treated for Heart Disease, Heart Attack, Any Heart Condition, Heart Trouble or Any Abnormality of the Heart, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)? YES NO

Answer 4(b) for E-Z Underwriting

4b. In the past 5 years has any proposed insured had any known indication of or been treated for a heart attack, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV)? YES NO

9a. If this is a Two Parent Family Rider, is any person to be insured currently pregnant or taking fertility drugs? YES NO

9b. If this is a One Parent Family Rider, are you, your fiancée or companion currently pregnant or taking fertility drugs? YES NO

5. Will the policy applied for replace any insurance in force on any proposed covered person? YES NO

If yes to question 9a or 9b, we will issue an individual rider on the adult male family member only.

6. Do you have any other accident disability insurance in force at this time? If yes, state name of company and amount. YES NO

10. If answered "yes" to questions 9, 9a or 9b, the name of person(s) diagnosed or treated for any of the above must be listed in the following space:

7. Primary Beneficiary & Relationship

8. Contingent Beneficiary & Relationship

Any person named will not be covered by this policy/rider.

APPLICATION FOR DISABILITY INSURANCE - PART 2

11. HAS ANY PERSON to be covered ever had or been told or been treated for:		(f) Disease or disorder of the respiratory system to include emphysema or asthma?	Yes	No
(a) Had any application or policy for life or health insurance been declined, special rated, restricted, postponed, cancelled or reinstatement denied?	Yes No	(g) Disease or disorder of stomach, liver, intestines, bladder, kidney, or reproductive organs, hemorrhoids or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Had driver's license suspended or revoked in past 24 months?	<input type="checkbox"/> <input type="checkbox"/>	(h) Cancer, tumor, diabetes, Leukemia, gland or blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) by a medical professional?	<input type="checkbox"/> <input type="checkbox"/>	(i) Alcohol or drug usage or abuse?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Disease or disorder of the heart or blood vessels, chest pain, high or low blood pressure?	<input type="checkbox"/> <input type="checkbox"/>	(j) Within the last five years, has any person to be covered had any ailment of the back?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Disease or disorder of the nervous system to include mental disorder, epilepsy or paralysis?	<input type="checkbox"/> <input type="checkbox"/>	(k) Had any other medical advice, treatment or surgery not already listed?	<input type="checkbox"/>	<input type="checkbox"/>
		(l) Is proposed primary insured working at least 30 hours per week?	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS of questions 4-11 answered "yes" including question number, names and addresses of physicians and individuals to whom history pertains.

<p>As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?</p>	Home/Office Phone:
	Cell Phone:
	Email address:

AUTHORIZATION- By this form (or a photographic copy of it), I authorize any licensed physician, medical practitioner, clinic hospital, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of anyone proposed for coverage for whom insurance application is made, to give to The Life Insurance Company of Alabama, or it's reinsurers, any such information and to testify as to such information, all to the extent permitted by law. Should my application for insurance be denied due to an adverse underwriting decision, I have the right to obtain this information from Life Insurance Company of Alabama. I may request this information in writing within 90 business days from the date I am notified of such a decision. Life Insurance Company of Alabama must respond to my request within 21 days from the date of receipt of my request. This authorization shall be valid for 30 months from the date it is signed.

I, the agent, hereby certify by my signature below that, I have truly and accurately recorded on this application the information supplied by the applicant.

X _____
 Agent Agent's No.

X _____
 Agent Agent's No.

<p>Arkansas Only: No person to be covered for specified disease is also covered by any Title XIX program Medicaid or similar coverage. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Signed at _____
 City State

Date _____
 Month Day Year

X _____
 Signature of Proposed Primary Insured

<p>AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give name of company and policy number.</p>
--

APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 1

Please Use Dark Ink Suitable for Photocopying.
All Shaded areas must be completed.

Life Insurance Company of Alabama
P. O. Box 349 • Gadsden, Alabama 35902

1. PROPOSED INSURED <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Separated LAST NAME FIRST M.I.				BIRTHDATE MO DAY YR			AGE	STATE OF BIRTH	SEX	SOCIAL SECURITY #	HEIGHT (FT. IN.)	WEIGHT (LBS.)
SPOUSE PROPOSED for INSURANCE												
DEPENDENT CHILDREN PROPOSED for INSURANCE												
2. RESIDENCE ADDRESS STREET		CITY		COUNTY		STATE	ZIP		How long at this address? _____ Years Months If less than 2 years, give previous address in Part 5			
PHONE: RES: () BUS: ()			E-MAIL:									
3. INSURED'S EMPLOYER			EMPLOYMENT DATE		OCCUPATION (Describe and give exact duties)							
IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be subject to fines and confinement in prison.												
4. Do you have a current Medicaid eligibility card or other state sponsored insurance program? <input type="checkbox"/> Yes <input type="checkbox"/> No					8. PREMIUM MODE & METHOD: Monthly Direct Bill Not Available <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Bank Draft <input type="checkbox"/> Payroll Deduction <input type="checkbox"/> Direct Bill <input type="checkbox"/> Family Bill							
5. Will the policy applied for replace any insurance in force on any proposed covered person? <input type="checkbox"/> Yes <input type="checkbox"/> No					9. Has any person listed above and proposed for coverage ever tested positive, been diagnosed as having or been treated for acquired immune deficiency syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," persons named will be excluded from coverage.							
6. Health and Disability Insurance in force (if none, so state) <i>Company Amount Year Issued</i>					Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage. HOME OFFICE USE							
7. Primary Beneficiary & Relationship												
7b. Contingent Beneficiary & Relationship												

E-Z UNDERWRITING PARTICIPATION REQUIREMENTS

Eligible Fulltime Employees	Minimum For E-Z Underwriting	Eligible Fulltime Employees	Minimum For E-Z Underwriting	Eligible Fulltime Employees	Minimum For E-Z Underwriting	Eligible Fulltime Employees	Minimum For E-Z Underwriting
6	6	30	18	54	26	78	30
7	7	31	18	55	27	79	30
8	8	32	19	56	27	80	30
9	8	33	19	57	27	81	30
10	8	34	19	58	27	82	30
11	8	35	20	59	28	83	30
12	8	36	20	60	28	84	30
13	9	37	21	61	28	85	30
14	9	38	21	62	28	86	30
15	10	39	21	63	28	87	30
16	11	40	22	64	29	88	30
17	11	41	22	65	29	89	30
18	12	42	23	66	29	90	30
19	12	43	23	67	29	91	30
20	13	44	23	68	29	92	30
21	13	45	24	69	30	93	30
22	14	46	24	70	30	94	30
23	14	47	24	71	30	95	30
24	15	48	25	72	30	96	30
25	15	49	25	73	30	97	30
26	16	50	25	74	30	98	30
27	16	51	26	75	30	99	30
28	17	52	26	76	30	100	30
29	17	53	26	77	30		

HEIGHT AND MAXIMUM WEIGHT CHART

Height	Lump Sum Heart / Heart Stroke Plan	Sickness & Accident Disability Income	Sickness Disability Rider	Inpatient + Outpatient Indemnity Plan
4'10"	160	178	198	198
11"	164	181	201	205
5'0"	168	185	205	212
1"	176	190	210	218
2"	180	195	215	227
3"	188	200	220	235
4"	196	206	225	241
5"	202	212	230	248
6"	208	217	236	256
7"	215	222	242	263
8"	222	228	249	271
9"	230	234	256	279
10"	238	240	263	286
11"	246	246	271	293
6'0"	254	252	279	297
1"	260	258	287	305
2"	267	265	295	313
3"	273	272	303	321
4"	280	279	311	330
5"	286	287	319	341
6"	293	293	327	351
7"		300	335	360
8"		307	343	368

CANCER INDEMNITY * Advantage * Choice
 Health & Wellness Benefit \$100 \$50
 Daily Room \$300 \$200 \$100
 Rad. & Chemo. Option A Option B Option C
 Individual Individual/Spouse 1 Parent 2 Parent

*Answer Question 11 \$ _____

First Occurrence Rider 2 Units 1 Unit / Level Building
 Individual Individual/Spouse 1 Parent 2 Parent
 \$ _____

Intensive Care Benefit: I75 *Rider *Stand Alone
 \$300 \$450 \$600 Other _____ \$ _____
 Individual Individual/Spouse 1 Parent 2 Parent

*Answer Question 12 *Answer Question 18

Specified Disease Benefit Rider* (Dread Disease) \$ _____
 Individual Individual/Spouse 1 Parent 2 Parent
 *Answer Question 13 Cancer Indemnity Total \$ _____

THE MAJOR EXPENSE PLAN *

Lump Sum Cancer & Heart Combo \$ _____ FACE AMOUNT
 Lump Sum Cancer Only \$ _____ FACE AMOUNT
 Lump Sum Heart Only \$ _____ FACE AMOUNT
 Non-Tobacco User Tobacco User
 Dread Disease Rider *Answer Question 13
 Individual One Parent Two Parent \$ _____
 Record Height & Weight above for Lump Sum Heart Benefit
 *Answer Questions 14 & 16 for Cancer/Questions 15 & 16 for Heart

Intensive Care Benefit: I63 *
 \$300 \$450 \$600 Other _____ \$ _____
 Individual One Parent Two Parent
 *Answer Question 12 Major Expense Plan Total \$ _____

HEART STROKE EXPENSE PLAN *

Hospital Confinement Units 1 2 3 4 5
 Dread Disease Rider *Answer Question 13
 Individual One Parent Two Parent \$ _____
 *Record Height & Weight above & answer Question 17

Intensive Care Benefit: I66 *
 \$300 \$450 \$600 Other _____ \$ _____
 Individual One Parent Two Parent
 *Answer Question 12 Heart Stroke Plan Total \$ _____

INPATIENT + OUTPATIENT HOSPITAL INDEMNITY PLAN²

Payroll Only Plan (HI67) Individual Non-Payroll Plan (HI68)
 Individual One Parent Emp. & Spouse Two Parent
 OPTIONAL BENEFITS: Initial Conf. \$ _____
 Surg. Benefit \$ _____ Emer. Acc. \$ _____
 Outpat. Sickness \$ _____ Other \$ _____
 Major Injury (Broken Bones) Units 1 2 3 \$ _____
²Record Height & Weight Above & Answer Questions 10(a) & 18 \$ _____

Intensive Care Benefit: I63 *
 \$300 \$450 \$600 Other _____ \$ _____
 Individual One Parent Two Parent
 *Answer Question 12 Inpatient + Outpatient Plan Total \$ _____

ACCIDENT INCOME PROVIDER * \$3000 \$1500
SENIOR ACC. INCOME PROVIDER * \$3000 \$1500
 Individual One Parent Two Parent Two Adult
 *Answer Question 10(a) Accident Income Provider Total \$ _____

ACCIDENT DISABILITY PLAN * (90 Day Employment Required)
 Pre-Packaged Plan 400 600 800 1000 1200
 Applicant's Gross Monthly Income \$ _____
 24 Hour Coverage Off-The-Job Only
 Emp Emp/Sp Emp/Ch Emp/Fam \$ _____
 *Answer Question 10(a)

***BUILDA PLAN** Monthly Income \$ _____ FACE AMOUNT
 Applicant's Gross Monthly Income \$ _____
 24 Hour Coverage Off-The-Job Only
 Benefit Period 6 months 1 Year
 Accident Elimination Period 0 7 14 Days
 Emp Emp/Sp Emp/Ch Emp/Fam \$ _____
 *Answer Question 10(a) *Does not apply to Packaged Accident Disability Plans

***Sickness Disability Rider Mo. Inc.** \$ _____ FACE AMOUNT
 Benefit Period 6 month 1 year
 Elimination 7 or 14 days 30 days \$ _____
²Record Height & Weight Above & Answer Question 18

SICKNESS & ACCIDENT DISABILITY INCOME PLAN *
 Standard Preferred (90 Day Employment Required)
²Monthly Disability Benefit \$ _____ FACE AMOUNT
 Applicant's Gross Monthly Income \$ _____
 Benefit Period 3 months 6 months 1 Year 2 Years
 Accident Elimination Period 0 7 14 Days
 Sickness Elimination Period 7 14 30 60 90 180 Days
²Record Height & Weight Above & Answer Questions 10(a) and 18 \$ _____

Optional Benefits for Sickness &/or Accident Disability Plan:
 Level of coverage (i.e. Emp, Emp/Sp, Emp/Ch, Emp/Fam) for optional benefits is determined by the level of coverage selected for base policy.

*Initial Hospital Confinement Benefit \$1000 \$ _____
²Injury Treatment Benefit \$ _____
 \$100 \$150 \$200 \$250 \$300
 *Health Screening Benefit \$ _____
 Supplemental Injury Benefit \$ _____
 Specific Loss Rider (Broken Bone) \$ _____

Intensive Care Benefit* I75 \$ _____
 \$300 \$450 \$600 Other _____
 *Answer Question 12
²Does not apply to Pre-Packaged Accident Disability Plans
 Sickness &/or Accident Disability Income Plan Total \$ _____

APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 3

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

10a. Is any proposed insured currently in the hospital or receiving disability payments? Yes No

Answer 10(b) when offering a plan approved for E-Z Underwriting

10b. In the past 5 years has any proposed insured had any known indication of or been treated for a heart attack, internal cancer, melanoma, disease or disorder of the lungs or hepatitis? Yes No

11. CANCER ADVANTAGE & CHOICE

Answer Question 14 for The Major Expense Plan (Lump Sum Cancer)

11a. Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.)? Yes No

11b. Has any person proposed for coverage under this Policy **within the last five years**, been diagnosed as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form? Yes No

11c. Has any person proposed for coverage under this Policy been diagnosed, as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form **over five years ago**? Yes No

If yes to question 11a or b any person(s) so designated will not be covered under the policy.

If yes to question 11c, you are eligible for a policy that provides Option C Radiation & Chemotherapy Benefits and \$100 per day Daily Room Benefit for the treatment of cancer. No additional amounts will be issued.

12. INTENSIVE CARE: Has any proposed insured ever been diagnosed or treated for heart disease, heart attack, any heart condition, heart trouble or any abnormality of the heart? Yes No

(b) If this is a Two Parent Family Policy/Rider, is any person to be insured currently pregnant or taking fertility drugs? Yes No

(c) If this is a One Parent Family Policy/Rider, are you, your fiancée or companion currently pregnant or taking fertility drugs? Yes No

If yes to question (b) or (c), we will issue an individual policy / rider on the adult male family member only.

Answer Question 18 for Intensive Care Stand Alone Policy

13. SPECIFIED DISEASE:

Has any person proposed for coverage under this Policy ever had treatment or diagnosis of: • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Botulism • Bubonic Plague • Cerebral Palsy • Cholera • Cystic Fibrosis • Diphtheria • Encephalitis (including encephalitis contracted from West Nile virus) • Huntington's Chorea • Lyme Disease • Malaria • Meningitis (Bacterial) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Necrotizing Fasciitis • Osteomyelitis • Polio • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever • Scleroderma • Sickle Cell Anemia • Smallpox • Systemic Lupus • Tetanus • Toxic Shock Syndrome • Tuberculosis • Tularemia • Typhoid Fever • Variant Creutzfeldt-Jakob Disease (Mad Cow Disease) • Yellow Fever? Yes No

14. MAJOR EXPENSE PLAN (Lump Sum Cancer):

(a) Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.)? Yes No

(b) Has any person proposed for coverage under this Policy ever been diagnosed as having or been treated for cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form? Yes No

Answer Question 16

15. MAJOR EXPENSE PLAN (Lump Sum Heart):

(a) Has any person proposed for coverage under this Policy ever been diagnosed as having or ever been treated for any of the following conditions in any form: (a) myocardial infarction or heart attack; (b) any disease, disorder or abnormality of the heart or coronary arteries, or any heart related condition; or (c) stroke or transient ischemic attack (TIA); or (d) diabetes; or (e) lung disease? Yes No

(b) Has any person proposed for coverage under this Policy ever had or ever been advised to have: (a) any form of heart surgery, coronary artery surgery, or heart related surgery; or (b) an arteriogram, angioplasty, or pacemaker installed? Yes No

Record Height & Weight of all proposed for coverage in Part 1 and/or 4 of Application and answer Question 16

16. HAS ANY PERSON proposed for insurance in Part 1 on reverse side used tobacco in any form within the past 24 months? (If yes, give name and details in Part 5 of this application) Yes No

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 4

17. HEART STROKE EXPENSE PLAN:

- (a) Has any person proposed for coverage under this Policy ever been diagnosed as having, been treated for, received medical advice, or taken prescription medication for High Blood Pressure? Yes No

If NO to question (a), proceed with questions b through d.

If YES to question (a), answer question (a1).

- (a1) Has any person proposed for coverage used tobacco in any form within the past 24 months? Yes No

If YES to question (a1), coverage for that insured will be declined.

If NO to question (a1), proceed with questions b through e.

- (b) Has any person proposed for coverage under this Policy ever been diagnosed as having, or been treated for, received medical advice or taken prescription medication for Stroke, transient ischemic attack (TIA), or any disease, disorder or abnormality of the brain or circulatory system (arteries, veins, lymph nodes, and vessels) (a) myocardial infarction or heart attack; (b) any disease, disorder or abnormality of the heart or coronary arteries, or any heart related condition? Yes No
- (c) Has any person proposed for coverage under this Policy ever been diagnosed as having, been treated for, received medical advice or taken prescription medication for: (a) diabetes; or b) lung or respiratory system disease or disorder? Yes No
- (d) Has any person proposed for coverage under this Policy ever had or been advised to have: (a) any form of heart surgery, coronary artery surgery, or heart related surgery; (b) an arteriogram, angioplasty, or pace maker installed? Yes No

If YES to questions (a1), (b), (c) or (d), coverage for that insured will be declined.

Record Height & Weight of all proposed for coverage in Part 1 of Application

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

NOTE: Question 18 must be answered when applying for:

- **Inpatient + Outpatient Medical Expense Plan**
- **Intensive Care Stand Alone Policy**
- **Sickness Disability Rider** and
- **The Sickness and Accident Disability Income Plan**

unless approved for E-Z Underwriting.

Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 5 of this application. Persons named may be excluded from coverage.

18. HAS ANY PERSON to be covered ever had or been told or been treated for:

- (a) Had any application or policy for life or health insurance been declined, special rated, restricted, postponed, cancelled or reinstatement denied? Yes No
- (b) Had driver's license suspended or revoked in past 24 months? Yes No
- (c) Disease or disorder of the heart or blood vessels, chest pain, high or low blood pressure? Yes No
- (d) Disease or disorder of the nervous system to include mental disorder, epilepsy or paralysis? Yes No
- (e) Disease or disorder of the respiratory system to include emphysema or asthma? Yes No
- (f) Disease or disorder of stomach, liver, intestines, bladder, kidney, or reproductive organs, hemorrhoids or hernia? Yes No
- (g) Cancer, tumor, diabetes, Leukemia, gland or blood disorders? Yes No
- (h) Alcohol or drug usage or abuse? Yes No
- (i) Is any person to be covered, currently pregnant or taking fertility drugs? Yes No

(If yes, answer question 12 b & c)
- (j) Within the last five years, has any person to be covered had any ailment of the back? Yes No
- (k) Had any other medical advice, treatment or surgery not already listed? Yes No
- (l) Is proposed primary insured working at least 30 hours per week? Yes No

DETAILS of questions 9-18 answered "yes" including question number, names and addresses of physicians and individuals to whom history pertains, should be listed in Part 5 of this Application.

IMPORTANT NOTICE

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including your own statements, the results of your physical examination (if required), and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the MIB, Inc. formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642.) If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

Should your application for insurance be denied due to an adverse underwriting decision, you have the right to obtain this information from Life Insurance Company of Alabama. You may request this information in writing within 90 business days from the date you are notified of such a decision. Life Insurance Company of Alabama must respond to your request within 21 days from the date of receipt of your request. You may request this information by writing to the Manager - Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, AL 35902 or through our field representative.

Cut along dotted line. 

BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (PLEASE PRINT OR TYPE)	SOCIAL SECURITY NO.
EFFECTIVE DATE	NAME OF EMPLOYEE
DEPT. NO.	NAME OF EMPLOYER
EMP. NO.	INDICATE TYPE OF COVERAGE
	MONTHLY PREMIUM
	WEEKLY PREMIUM

PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama (LICOA). These deductions are to cover the premiums on the insurance policy I have applied for if the policy is issued by LICOA.

I acknowledge that this authorization is being signed at the same time I am applying for insurance coverage with LICOA, but IN NO EVENT WILL ANY INSURANCE BE IN FORCE UNTIL THE EFFECTIVE DATE OF ANY POLICY WHICH MAY BE ISSUED BY LICOA. This authorization also allows you to increase my deduction for any premium increases on the policy which may be made by LICOA.

DATE _____ **X** _____ SIGNATURE OF EMPLOYEE

AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

To _____ Bank
 Branch Name , if any _____
 Bank Address _____

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date _____ Bank Account _____ **X** _____ Bank Signature of Depositor

INVESTIGATIVE CONSUMER REPORTS

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided.

Date _____
Signature of Proposed Primary Insured

Date _____
Signature of Applicant or Owner,
if other than Proposed Insured

THIS NOTIFICATION MUST BE DELIVERED TO THE PERSON NAMED ABOVE.

Life Insurance Company of Alabama

Home Office, Gadsden, Alabama

 Cut along dotted line.

To: The Bank named on the reverse side.
Life Insurance Company of Alabama agrees:

- (1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- (2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
- (3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama


Clarence W. August
President

Authorized in resolution adopted by the Executive Board of
The Life Insurance Company of Alabama on April 29, 1974



SERFF Tracking Number: WAKE-126133880 *State:* Arkansas
Filing Company: Life Insurance Company of Alabama *State Tracking Number:* 42499
Company Tracking Number:
TOI: H111 Individual Health - Disability Income *Sub-TOI:* H111.006 Short Term - Related to marketing with
employer or association groups
Product Name: LOA Disability Form 2009
Project Name/Number: LOA/042009

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: WAKE-126133880 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42499
 Company Tracking Number:
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.006 Short Term - Related to marketing with employer or association groups
 Product Name: LOA Disability Form 2009
 Project Name/Number: LOA/042009

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed	Rate Pages	HD75109 AR, HA35I109, HA35T109, HA35W109, HA35D109, HA35C109, HA35B109, HA35O109	New		Disability Rates 04232009.pdf

LIFE INSURANCE COMPANY OF ALABAMA
Disability Policy
Monthly Premiums - Base Policy - Form HD75109

3 Month Benefit Period
Sickness Elimination Period

Issue Age	7 Days		14 Days		30 Days		60 Days		90 Days		180 Days	
	Standard	Preferred										
18-29	4.31	3.24	3.15	2.37	2.05	1.47	1.32	0.97	0.92	0.69	0.63	0.48
30-39	4.67	3.69	3.10	2.69	2.19	1.67	1.48	1.14	1.07	0.84	0.73	0.59
40-49	4.85	3.86	3.75	2.96	2.53	1.90	1.80	1.36	1.33	1.02	0.94	0.72
50-59	5.79	4.20	4.68	3.43	3.41	2.47	2.53	1.83	1.95	1.40	1.46	1.04
60-64	7.44	5.29	6.07	4.39	4.03	2.99	3.24	2.23	2.72	1.72	2.29	1.30

6 Month Benefit Period
Sickness Elimination Period

Issue Age	7 Days		14 Days		30 Days		60 Days		90 Days		180 Days	
	Standard	Preferred										
18-29	4.79	3.60	3.50	2.63	2.28	1.64	1.47	1.08	1.02	0.76	0.70	0.54
30-39	5.19	4.10	3.44	2.98	2.43	1.85	1.64	1.26	1.19	0.93	0.81	0.65
40-49	5.39	4.29	4.16	3.29	2.81	2.11	2.00	1.51	1.48	1.13	1.04	0.80
50-59	6.43	4.67	5.20	3.81	3.79	2.75	2.81	2.03	2.16	1.55	1.62	1.15
60-64	8.26	5.87	6.74	4.87	4.48	3.32	3.60	2.47	3.02	1.91	2.54	1.44

12 Month Benefit Period
Sickness Elimination Period

Issue Age	7 Days		14 Days		30 Days		60 Days		90 Days		180 Days	
	Standard	Preferred										
18-29	5.67	4.19	4.09	3.03	2.62	1.88	1.73	1.25	1.23	0.90	0.88	0.66
30-39	6.22	4.87	4.50	3.55	2.89	2.21	2.01	1.55	1.50	1.17	1.08	0.86
40-49	6.61	5.18	5.11	3.98	3.50	2.62	2.59	1.94	2.01	1.50	1.53	1.14
50-59	8.26	5.96	6.72	4.88	5.05	3.63	3.96	2.81	3.23	2.27	2.63	1.82
60-64	10.83	7.59	9.08	6.45	6.48	4.65	5.47	3.84	4.79	3.31	4.23	2.86

24 Month Benefit Period
Sickness Elimination Period

Issue Age	7 Days		14 Days		30 Days		60 Days		90 Days		180 Days	
	Standard	Preferred										
18-29	6.50	4.70	4.68	3.41	3.04	2.17	2.08	1.49	1.53	1.19	1.16	0.86
30-39	7.26	5.59	5.29	4.11	3.50	2.66	2.52	1.93	1.99	1.53	1.55	1.20
40-49	7.99	6.11	6.26	4.76	4.49	3.31	3.51	2.58	2.88	2.12	2.37	1.73
50-59	10.62	7.52	8.81	6.27	7.02	4.92	5.86	4.05	5.09	3.48	4.44	2.99
60-64	14.50	9.98	12.60	8.72	9.83	6.78	8.68	5.89	7.92	5.30	7.28	4.80

Adjust the above rates by the following factors for the various accident elimination periods:

Accident Elimination Period	Benefit Period			
	3 Month	6 Month	12 Month	24 Month
0	1.00	1.00	1.00	1.00
7	0.90	0.92	0.92	0.94
14	0.67	0.70	0.72	0.74

LIFE INSURANCE COMPANY OF ALABAMA
Proposed Disability Income Product
Monthly Premiums - On the Job Rider - Form HA350109

3 Month Benefit Period
Sickness Elimination Period

Issue Age	7 Days		14 Days		30 Days		60 Days		90 Days		180 Days	
	Standard	Preferred										
18-29	1.08	0.81	0.79	0.60	0.52	0.37	0.33	0.25	0.23	0.18	0.16	0.12
30-39	1.17	0.93	0.78	0.68	0.55	0.42	0.37	0.29	0.27	0.21	0.19	0.15
40-49	1.22	0.97	0.94	0.74	0.64	0.48	0.45	0.34	0.34	0.26	0.24	0.18
50-59	1.45	1.05	1.17	0.86	0.86	0.62	0.64	0.46	0.49	0.35	0.37	0.26
60-64	1.86	1.33	1.52	1.10	1.01	0.75	0.81	0.56	0.68	0.43	0.58	0.33

6 Month Benefit Period
Sickness Elimination Period

Issue Age	7 Days		14 Days		30 Days		60 Days		90 Days		180 Days	
	Standard	Preferred										
18-29	1.20	0.90	0.88	0.66	0.57	0.41	0.37	0.27	0.26	0.19	0.18	0.14
30-39	1.30	1.03	0.86	0.75	0.61	0.47	0.41	0.32	0.30	0.24	0.21	0.17
40-49	1.35	1.08	1.04	0.83	0.71	0.53	0.50	0.38	0.37	0.29	0.26	0.20
50-59	1.61	1.17	1.30	0.96	0.95	0.69	0.71	0.51	0.54	0.39	0.41	0.29
60-64	2.07	1.47	1.69	1.22	1.12	0.83	0.90	0.62	0.76	0.48	0.64	0.36

12 Month Benefit Period
Sickness Elimination Period

Issue Age	7 Days		14 Days		30 Days		60 Days		90 Days		180 Days	
	Standard	Preferred										
18-29	1.42	1.05	1.03	0.76	0.66	0.47	0.44	0.32	0.31	0.23	0.22	0.17
30-39	1.56	1.22	1.13	0.89	0.73	0.56	0.51	0.39	0.38	0.30	0.27	0.22
40-49	1.66	1.30	1.28	1.00	0.88	0.66	0.65	0.49	0.51	0.38	0.39	0.29
50-59	2.07	1.49	1.68	1.22	1.27	0.91	0.99	0.71	0.81	0.57	0.66	0.46
60-64	2.71	1.90	2.27	1.62	1.62	1.17	1.37	0.96	1.20	0.83	1.06	0.72

24 Month Benefit Period
Sickness Elimination Period

Issue Age	7 Days		14 Days		30 Days		60 Days		90 Days		180 Days	
	Standard	Preferred										
18-29	1.63	1.18	1.17	0.86	0.76	0.55	0.52	0.38	0.39	0.30	0.29	0.22
30-39	1.82	1.40	1.33	1.03	0.88	0.67	0.63	0.49	0.50	0.39	0.39	0.30
40-49	2.00	1.53	1.57	1.19	1.13	0.83	0.88	0.65	0.72	0.53	0.60	0.44
50-59	2.66	1.88	2.21	1.57	1.76	1.23	1.47	1.02	1.28	0.87	1.11	0.75
60-64	3.63	2.50	3.15	2.18	2.46	1.70	2.17	1.48	1.98	1.33	1.82	1.20

Adjust the above rates by the following factors for the various accident elimination periods:

Accident Elimination Period	Benefit Period			
	3 Month	6 Month	12 Month	24 Month
0	1.00	1.00	1.00	1.00
7	0.90	0.92	0.92	0.94
14	0.67	0.70	0.72	0.74

LIFE INSURANCE COMPANY OF ALABAMA
Disability Policy
Exhibit B - Monthly Gross Premium Rates per Unit

Optional Riders

Initial Hospital Confinement Rider - Form HA35I109

<u>Coverage</u>	<u>Per Unit</u>
Named Insured	\$1.80
Named Insured & Spouse	\$2.45
One Parent Family	\$2.75
Two Parent Family	\$3.40

Injury Treatment Rider - Form HA35T109

<u>Coverage</u>	<u>Per Unit</u>
Named Insured	\$1.90
Named Insured & Spouse	\$2.55
One Parent Family	\$2.85
Two Parent Family	\$3.50

Health Screening Benefit Rider - Form HA35W109

<u>Coverage</u>	<u>Per Unit</u>
Named Insured	\$0.50
Named Insured & Spouse	\$0.95
One Parent Family	\$0.55
Two Parent Family	\$1.00

Accidental Death and Dismemberment Rider - Form HA35D109

<u>Coverage</u>	<u>Per Unit</u>
Named Insured	\$1.00
Named Insured & Spouse	\$1.20
One Parent Family	\$1.30
Two Parent Family	\$1.50

Severe Injury Rider - Form HA35C109

<u>Coverage</u>	<u>Per Unit</u>
Named Insured	\$0.35
Named Insured & Spouse	\$0.55
One Parent Family	\$0.70
Two Parent Family	\$0.90

LIFE INSURANCE COMPANY OF ALABAMA
Disability Policy
Exhibit B - Monthly Gross Premium Rates per Unit

Specified Loss Rider - Form HA35B109

<u>Coverage</u>	<u>Per Unit</u>
Named Insured	\$1.40
Named Insured & Spouse	\$2.10
One Parent Family	\$2.90
Two Parent Family	\$3.60

On-the-job Disability Rider (Named Insured Only) - Form HA35O109

<u>Elimination Period</u>	<u>\$100 Monthly Benefit</u>	
	<u>6 Month BP</u>	<u>12 Month BP</u>
0 Days	\$0.90	\$1.15
7 Days	\$0.75	\$1.00

Off-the-job Disability Rider (Named Insured Only) - Form HA35N109

<u>Elimination Period</u>	<u>\$100 Monthly Benefit</u>	
	<u>6 Month BP</u>	<u>12 Month BP</u>
0 Days	\$1.35	\$1.70
7 Days	\$1.15	\$1.45

Sickness Disability Rider (Named Insured Only) - Form HA35S109

<u>Elimination Period</u>	<u>\$100 Monthly Benefit</u>	
	<u>6 Month BP</u>	<u>12 Month BP</u>
7 Days	\$4.30	\$5.15
14 Days	\$3.35	\$4.05
30 Days	\$2.10	\$2.50

SERFF Tracking Number: WAKE-126133880 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42499
 Company Tracking Number:
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.006 Short Term - Related to marketing with employer or association groups
 Product Name: LOA Disability Form 2009
 Project Name/Number: LOA/042009

Supporting Document Schedules

<p>Satisfied -Name: Flesch Certification Comments: Attachments: Certification Disability.pdf AR Readability Disability.pdf</p>	<p>Review Status: Approved-Closed 06/15/2009</p>
<p>Bypassed -Name: Application Bypass Reason: See Form Schedule Comments:</p>	<p>Review Status: Approved-Closed 06/15/2009</p>
<p>Bypassed -Name: Outline of Coverage Bypass Reason: See Form Schedule Comments:</p>	<p>Review Status: Approved-Closed 06/15/2009</p>
<p>Satisfied -Name: Authorization Letter Comments: Attachment: LOA Auth Ltr 2009.PDF</p>	<p>Review Status: Approved-Closed 06/15/2009</p>

**ARKANSAS
Rule and Regulation 19 Certification**

<u>Title of Form(s)</u>	<u>Form Number</u>
Disability Income Policy	HD75109 AR
Initial Hospital Confinement Rider	HA35I109
Injury Treatment Rider	HA35T109
Health Screening Rider	HA35W109
Accidental Death or Dismemberment Rider	HA35D109
Supplemental Injury Rider	HA35C109
Specified Loss Rider	HA35B109
On-the-Job Disability Rider	HA35O109
Brochure/Application	BHA35BW
Brochure/Application	BHA3504
Brochure/Application	BHA35BAP

I hereby certify that the above noted forms meet the provisions of Rule and Regulation 19, the Unfair Sex Discrimination in the Sale of Insurance.



Signature

Jennifer G. Snell

Name

Compliance Analyst

Title

05/27/2009

Date

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

Life Insurance Company of Alabama
302 Broad Street
Gadsden, Alabama 35901

I hereby certify that the Flesch Reading Ease Test Score of the listed forms are as follows:

Type and/or Title of Form(s)	Form Number(s)	Flesch Score
Disability Income Policy	HD75109 AR	43.7
Initial Hospital Confinement Rider	HA35I109	43.8
Injury Treatment Rider	HA35T109	46.2
Health Screening Rider	HA35W109	47.5
Accidental Death or Dismemberment Rider	HA35D109	49.4
Supplemental Injury Rider	HA35C109	45.8
Specified Loss Rider	HA35B109	42.3
On-the-Job Disability Rider	HA35O109	42.6

The type size of the text is at least 10-pointed leaded.

I also certify to the best of my knowledge and belief that the form is in compliance with the Insurance Code and with all other applicable requirements of the Insurance Department in this state.


Signature

Clarence W. Bracewell, Jr.
Name

Vice President & Agency Director
Title



LIFE INSURANCE COMPANY
of Alabama

M. LYNN LOWE
Executive Vice President
& Treasurer

HOME OFFICE
P. O. BOX 349
GADSDEN, ALABAMA 35902
Phone: (256) 439-3205
Email: llowe@licoa.com

May 11, 2009

Wakely Actuarial Services, Inc.
34125 US Highway 19 North, Suite 310
Palm Harbor, Florida 34684

To Whom It May Concern:

The firm of Wakely Actuarial Services, Inc. is hereby authorized to submit forms, rate filings or other filings requiring actuarial certification for approval to the Department of Insurance on behalf of Life Insurance Company of Alabama. Revisions to the filings, as may be necessary to gain approval, are included in this authorization.

Sincerely,

M. Lynn Lowe
Executive Vice President & Treasurer

MLL/js

SERFF Tracking Number: WAKE-126133880 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42499
 Company Tracking Number:
 TOI: H111 Individual Health - Disability Income Sub-TOI: H111.006 Short Term - Related to marketing with employer or association groups
 Product Name: LOA Disability Form 2009
 Project Name/Number: LOA/042009

Superseded Attachments

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

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Disability Income Policy	05/27/2009	Disability Income Policy HD75109 AR.pdf



LICOA
Life Insurance Company of Alabama
HOME OFFICE • GADSDEN, ALABAMA 35902

Protecting your financial security

DISABILITY INCOME POLICY

LIFE INSURANCE COMPANY OF ALABAMA agrees to pay the benefits according to the provisions of this Policy. All benefits are subject to its provisions and limitations.

Signed for the Company at Gadsden, Alabama.

Secretary

President

CONSIDERATION

This Policy is issued in consideration of the application and payment in advance of the initial premium. This Policy begins at 12:01 a.m. standard time at Your residence on the Effective Date shown on the Policy Schedule Page. It ends, subject to the Grace Period, at 12:00 midnight, on the date any renewal premium is due and not paid. The dates and premiums are shown on the Policy Schedule Page.

RIGHT TO EXAMINE POLICY FOR 10 DAYS

Within ten (10) days from receipt of this Policy, You may return it for any reason. If returned, this Policy is void. Any premiums or policy fee paid for this Policy will be refunded. The Policy may be returned to Us or the agent who sold it.

RENEWAL AND PREMIUM PROVISIONS

This Policy is Guaranteed Renewable until the Month-a-versary following Your 72nd birthday. It may be renewed on any premium due date, prior to the Month-a-versary after Your 72nd birthday, by paying the renewal premium. It must be paid on or before its due date, or within the thirty-one (31) days that follow. We cannot refuse to renew this Policy prior to the Month-a-versary after Your 72nd birthday or place any restrictions on it if the premium is paid on time.

We may change the premium rates for this Policy. We cannot change the premium rates unless We change them for this Policy form for every Insured within a state in the same class. If We change the premium rates, We will notify the Insured before the change becomes effective in accordance with the statutes of the state where this Policy was issued. We will notify the Insured at his last known address according to Our records. Premium for this Policy is guaranteed not to change during the first twelve (12) months of coverage and shall not be increased more than once in a six (6) month period.

***** IMPORTANT NOTICE *****

Please read the copy of the application attached to this Policy. Carefully check the application. Write to Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, within ten (10) days, if any information shown on it is not correct and complete or if any past medical history has been left out on the application. This application is a part of the Policy. The Policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

**DISABILITY INCOME POLICY
GUARANTEED RENEWABLE TO AGE 72
SUBJECT TO COMPANY'S RIGHT TO CHANGE
THE APPLICABLE TABLE OF PREMIUM RATES**

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Benefits 8

Limitations and Exclusions 9

Termination of Insurance 10

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Application..... Attached

POLICY SCHEDULE PAGE

Policy Number: **[12345]**

Policy Effective Date: **[07/01/2008]**

Primary Insured: **[Insured]**

Injury Elimination Period (days): **[7]**

Sickness Elimination Period (days): **[14]**

Maximum Benefit Period (months): **[6]**

Monthly Benefit: **[\$1,000]**

Policy Modal Premium: **[\$ XX.XX]**

Total Modal Premium Payment

Annual: **[\$ xx.xx]** Semi Annual: **[\$ xx.xx]** Special Monthly: **[\$ xx.xx]**
 Quarterly: **[\$ xx.xx]** Monthly: **[\$ xx.xx]**

Mode Selected: **[Annual]**

Coverage Type: **Individual**

Benefit Description ¹	Monthly Benefit Amount	Elimination Period (Days)	Maximum Benefit Period (Months)	Modal Premium	Rider Effective Date
[On-the-Job Disability Rider]	[\$ 1,000.00]	[7 Days]	[6 Months]	[\$XX.XX]	[07/01/2008]

Benefit Description	Coverage Type	Benefit Amount	Modal Premium	Rider Effective Date
[Initial Hospital Confinement Rider]	[Individual]	[\$ 1,000.00]	[\$ XX.XX]	[07/01/2008]
[Injury Treatment Benefit Rider]	[Ind & Spouse]	[\$ 50.00]	[\$ XX.XX]	[07/01/2008]
[Health Screening Rider]	[Family -1]	[\$ 10.00]	[\$ XX.XX]	[07/01/2008]

Benefit Description ²	Coverage Type	Units	Modal Premium	Rider Effective Date
[Accidental Death and Dismemberment Benefit]	[Family -2]	[1]	[\$ XX.XX]	[07/01/2008]
[Specified Loss Rider]	[Individual]	[1]	[\$ XX.XX]	[07/01/2008]
[Supplemental Injury Rider]	[Ind & Spouse]	[1]	[\$ XX.XX]	[07/01/2008]

¹ The On-the-Job Disability Rider is only available as Individual coverage.]

² See Rider for the Benefit Amount per Unit of Coverage]

DEFINITIONS

“Accident” means bodily harm caused by external and unexpected means and not contributed to by any other cause.

“Ambulance” means a specially equipped automobile or other vehicle providing transportation of the sick or injured. The Ambulance service must be a licensed Ambulance service or a Hospital owned Ambulance for transporting a sick or injured person.

“Beneficiary” means the person, persons or party designated to receive any Policy proceeds in the event of Your death. The Beneficiary for this Policy is as named on the application unless changed by You and endorsed by Us.

“Concurrent Disability” means one continuous period of Total Disability that is caused or is continued by more than one Covered Injury or Covered Sickness. Benefits for a Concurrent Disability will be paid as if the Concurrent Disability was caused by one (1) Covered Injury or one (1) Covered Sickness. In no event will an Insured be considered to have more than one continuous period of Total Disability as the same time.

“Covered Accident” is one which:

- 1) occurs after the Policy Effective Date; and
- 2) occurs while the Policy is in force; and
- 3) is not excluded by name or specific description in the Policy.

A Covered Injury is an Injury which:

- 1) occurs after the Policy Effective Date; and
- 2) occurs Off-The-Job; and
- 3) occurs while the Policy is in force; and
- 4) is not excluded by name or specific description in this Policy.

“Covered Persons” are indicated by the Coverage Type as shown on the Policy Schedule Page as follows:

- 1) Individual: Only the Primary Insured listed on the Policy Schedule Page is covered.
- 2) Individual and Spouse: The Primary Insured and the Primary Insured’s Legal Spouse as listed on the application or added/changed by endorsement are covered.
- 3) One Parent Family: The Primary Insured and all of the Primary Insured’s legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.
- 4) Two Parent Family: The Primary Insured, the Primary Insured’s Legal Spouse as listed on the application or added/changed by endorsement and all of the Primary Insured’s legal Dependent Child(ren) as listed on the application or added/changed by endorsement are covered.

Any person specifically excluded by name from coverage is NOT included as a Covered Person.

“Covered Sickness” is a Sickness which:

- 1) manifests itself on or after the Policy Effective Date; and
- 2) manifests itself while the Policy is in force; and
- 3) is not excluded by name or specific description in the Policy.

Normal pregnancy and childbirth is covered as a Covered Sickness starting ten (10) months after the Policy Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks of caesarean deliveries.

“Dependent Child” or **“Dependent Children”** means any unmarried child (natural, step or adopted) of Yours who:

- 1) is less than nineteen (19) years old and living with You; or
- 2) is less than twenty-four (24) years old and attending an accredited school as a full time student. Such child must be legally dependent upon You for principal support and maintenance; or
- 3) is or becomes incapable of self-support because of mental or physical handicap while covered under this Policy and prior to attaining limiting age for Dependent Child(ren) under (1) or (2) above. The child must be legally dependent upon You for support and maintenance. We must receive proof of incapacity otherwise the insurance will terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be requested from time to time but not more often than once a year after the child attains age twenty-four (24); or
- 4) is not living with You, but You are legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent Child(ren) does NOT include grandchild(ren) unless required by law.

Proof of legal status may be required from time to time on covered Dependent Child(ren).

“Elimination Period” means, subject to the satisfaction of all Policy terms and conditions by the Insured, the length of time an Insured must be Totally Disabled before Monthly Disability Income Benefit amounts are payable.

“Emergency Room” or **“Emergency Department”** means the part of a Hospital designed and used for the treatment of people requiring immediate medical attention, such as victims of accidents, heart attacks or other acute medical conditions. Emergency care must be available twenty-four (24) hours a day and seven (7) days a week.

“Hospice” or **“Hospice Unit”** means a licensed agency, organization, or unit that provides a centrally administered and autonomous continuum of palliative and supportive care to terminally ill persons and their families. The care must be directed and coordinated by the Hospice organization and received primarily in the Insured’s home or on an outpatient or inpatient basis in a Hospice unit.

“Hospital” means a licensed institution located within the United States of America and its territories that:

- 1) has on its premises:
 - a) laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by a licensed Physician; and
 - b) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician; and
 - c) 24-hour-a-day nursing service by graduate registered nurses; and
 - d) the patient’s written history and medical records;

or;

- 2) is accredited by the Joint Commission on Accreditation of Hospitals.

The term Hospital shall NOT include any institution used by an Insured as a place for rehabilitation; a place for rest, or for the aged; a nursing or convalescent home; a long term nursing unit or geriatrics ward; Hospice or Hospice unit; extended care facility; or facilities for the care of convalescent, rehabilitative, physical therapy or ambulatory patients.

“Immediate Family” or **“Immediate Family Member”** includes anyone related to You or Your Legal Spouse in the following manner: spouse; brothers or sisters (including stepbrothers, stepsisters, half-brothers and half-sisters); children (including stepchildren); parents (including stepparents); grandparents (including step-grandparents); grandchildren (including step-grandchildren); aunts and uncles; nieces and nephews; and spouses, as applicable, of any of the above.

“Incarcerated” means arrested and confined to a correctional facility for any period of time.

“Indemnity Benefit” means any insurance benefit paid under this Policy as a result of the occurrence of a Specified Event. The benefit amount is a stated fixed amount in this Policy and is NOT dependent on any external monetary amount or cost.

“Injury” means an accidental bodily Injury that is independent of any Sickness, illness, infection or disease.

“Insured” means the person(s) whose life is insured under this Policy. The Primary Insured is as named in the application and shown on the Policy Schedule Page.

“Legal Spouse” means Your spouse as recognized by federal law. Once this Policy has been issued, any consideration of an addition of a spouse, whether by first marriage or remarriage, requires the submission of a completed application and is subject to Our approval. Spouse coverage terminates upon divorce of marriage. Proof of legal status may be required upon Our request from time to time on a covered spouse.

“Maximum Benefit Period” means, subject to the satisfaction of all Policy terms and conditions by the Insured, the maximum length of time for which a Totally Disabled Insured can be paid Monthly Disability Income Benefit amounts.

If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks of caesarean deliveries.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the Maximum Benefit Period will be limited to a maximum of three (3) months for one (1) Maximum Benefit Period.

“Month-a-versary” means the monthly recurring date of your Policy Effective Date.

“Off-The-Job” means not occurring while at work at any job for pay or benefits.

“Physician” means a licensed practitioner of the healing arts, as recognized by the American Medical Association, operating within the scope of his or her license other than You or an Immediate Family Member.

“Physician’s Office” means the room or rooms in which the Physician and support staff provide patient care. The offices include all rooms in the Physician’s office suite. A Dentist office is NOT considered a Physician’s Office.

“Policy Effective Date” means the date the Policy is issued by Us and coverage begins. The Policy Effective Date is shown on the Policy Schedule Page.

“Pre-existing Condition” means a condition for which symptoms existed up to five years prior to the Policy Effective Date that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by a Physician or received from a Physician.

“Primary Insured” means the person named in the application and shown on the Policy Schedule Page.

“Recurrent Disability” means any period of continuous Total Disability after the first period of continuous Total Disability.

A Recurrent Disability will be treated as:

- 1) a continuation of the previous disability, NOT a new disability, if the Insured has returned to work for less than 6 months;
- 2) a new disability, if the Insured has returned to work for 6 months or more; and
- 3) a continuation of the previous disability for any circumstances not specifically listed above.

Whether a Recurrent Disability is a continuation of a previous disability or a new disability is determined by the length of time the Insured has returned to work, NOT the cause(s) of the disabilities.

A new disability is subject to a new Elimination Period and a new Maximum Benefit Period applies. A disability that is considered a continuation of a previous disability is NOT subject to a new Elimination Period and a new Maximum Benefit Period does NOT apply.

“Reinstatement Date” means the date coverage under this Policy and any attached Riders becomes effective following Reinstatement. This date will be the next Month-a-versary following Our approval in writing of the Reinstatement of any coverage.

“Rider Effective Date” means the date the Rider is issued by Us and coverage begins. The Rider Effective Date is shown on the Policy Schedule Page.

“Sickness” means any illness, including complications of pregnancy as defined by the Insured’s Physician, infection, disease or any other abnormal physical condition which is not caused by an Injury.

“Specified Event” means a treatment, confinement, service, expense, or diagnosis as specified in the Policy or attached Rider that causes a Covered Person to be eligible for one or more benefits of the Policy or attached Riders.

“Total Disability” or **“Totally Disabled”** means:

- 1) the Insured is unable to work at his/her current job; and
- 2) the Insured is, in fact, unable to work at any job for pay or profit; and
- 3) the Insured is under the regular care of a Physician. The Physician must attest to the specific period of Total Disability and its cause.

Any period of Total Disability must occur within thirty (30) days of a Covered Injury or the onset of a Covered Sickness.

“Urgent Care” means the delivery of ambulatory medical care outside of a Hospital Emergency Department on a walk-in basis without a scheduled appointment. This does NOT include the care of a Dentist or a Dentist’s office.

“We”, “Us”, “Company” and **“Our”** mean the Life Insurance Company of Alabama.

“Written Notice” means a communication in writing from You on forms furnished by or acceptable to the Company. All correspondence should be sent to Our Home Office at P.O. Box 349, Gadsden, Alabama 35902.

“You”, “Your”, and **“Yours”** mean the Primary Insured named on the Policy Schedule Page.

BENEFITS

If the Primary Insured becomes Totally Disabled as the result of a Covered Injury or Covered Sickness following the Policy Effective Date as shown on the Policy Schedule Page and while this Policy is in force, We will pay the following benefits as shown on the Policy Schedule Page if the Primary Insured incurs a Specified Event required for the given benefit while Totally Disabled and this Policy is in force, subject to:

- 1) the Time Limit on Certain Defenses provision of this Policy, the Covered Injury or Covered Sickness occurred after the Policy Effective Date; and
- 2) all other limitations, conditions and provisions of the Policy.

Monthly Disability Income Benefit

We will pay a Monthly Disability Income Benefit as shown on the Policy Schedule Page if the Primary Insured incurs the Specified Event required for the Monthly Disability Income Benefit. The Specified Event required for the Monthly Disability Income Benefit is continuous Total Disability of the Primary Insured for the length of the appropriate Elimination Period plus one (1) day as a result of a Covered Injury or Covered Sickness. The Specified Event occurs on the day following the expiration of the appropriate Elimination Period and continues until the Primary Insured is no longer Totally Disabled due to a Covered Injury or Covered Sickness and under a Physician's care but in no case longer than the Maximum Benefit Period as shown on the Policy Schedule Page. If the Total Disability is a result of a Covered Injury, the Injury Elimination Period, as shown on the Policy Schedule Page, applies. If the Total Disability is due to a Covered Sickness, the Sickness Elimination Period, as shown on the Policy Schedule Page, applies. The Primary Insured's Physician must attest to the specific period of Total Disability and its cause. Benefit periods involving partial months will have the partial month benefit paid at a daily rate of one-thirtieth (1/30th) of the full monthly amount.

Monthly Disability Income Benefits are NOT payable under this Policy if the Primary Insured is Totally Disabled due to or as the result of any cause other than a Covered Injury or a Covered Sickness.

Monthly Disability Income Benefits are NOT payable under this Policy if the Primary Insured is Totally Disabled due to an Injury that occurred while working at any job for pay or benefits.

Monthly Disability Income Benefits are NOT payable for Disability of any Covered Person other than the Primary Insured.

Normal pregnancy and childbirth, including caesarean deliveries, will NOT be considered a Covered Sickness under this Policy until ten (10) months after the Policy Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks of caesarean deliveries.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the Maximum Benefit Period shall be limited to a maximum of three (3) months for one Maximum Benefit Period.

We will NOT pay Disability Benefits under multiple Policy and/or Rider forms simultaneously.

Waiver of Premium Benefit

We will waive future premiums due for this Policy and any attached Riders when the Primary Insured incurs the Specified Event required for the Waiver of Premium Benefit. The Specified Event required for the Waiver of Premium Benefit occurs on the day after the Primary Insured has been totally and continuously Disabled due to a Covered Injury or Covered Sickness for which Monthly Disability Income Benefits are payable for a period of ninety (90) consecutive days and continues until the Primary Insured is no longer Totally Disabled due to the Covered Injury or Covered Sickness and under a Physician's care OR the Monthly Disability Income Benefit is

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no longer payable. Premiums will NOT be waived beyond the Maximum Benefit Period as shown on the Policy Schedule Page. We will waive the premium beginning on the Month-a-versary following the onset of the Specified Event required for the Waiver of Premium Benefit. The Primary Insured's Physician must attest to the specific period of Total Disability and its cause.

The Waiver of Premium Benefit is NOT payable for Total Disability of the Primary Insured due to any cause other than a Covered Injury or a Covered Sickness.

The Waiver of Premium Benefit is NOT payable for Total Disability of the Primary Insured due to an Injury that occurred while working at any job for pay or benefits.

The Waiver of Premium Benefit is NOT payable for Disability of any Covered Person other than the Primary Insured.

The Waiver of Premium Benefit is only payable after the Primary Insured has been continuously Totally Disabled for ninety (90) consecutive days due to a Covered Injury or a Covered Sickness and for as long as the Primary Insured remains continuously Totally Disabled due to a Covered Injury or a Covered Sickness and under a Physician's care but in no case beyond the Maximum Benefit Period.

LIMITATIONS AND EXCLUSIONS

We will NOT pay ANY benefits under this Policy if the Primary Insured is Totally Disabled due to an Injury that occurs while working at any job for pay or benefits.

We will NOT pay ANY benefits under this Policy if the Primary Insured is Totally Disabled due to Pre-existing Conditions except after two (2) years from the Policy Effective Date.

We will NOT pay ANY benefits under this Policy if the Primary Insured is Totally Disabled due to any cause other than a Covered Injury or a Covered Sickness.

We will NOT pay ANY benefits under this Policy for Disability of any Covered Person other than the Primary Insured.

Normal pregnancy and childbirth, including caesarean deliveries, will NOT be considered a Covered Sickness under this Policy until ten (10) months after the Policy Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks for caesarean deliveries.

If the Total Disability is due to a sprained, strained or lame back or for any cervical, thoracic or lumbar condition, the Maximum Benefit Period shall be limited to a maximum of three (3) months for one (1) Maximum Benefit Period.

We will NOT pay Disability Benefits under multiple Policy and/or Rider forms simultaneously.

The Waiver of Premium Benefit is only payable after the Primary Insured has been continuously Totally Disabled for ninety (90) consecutive days due to a Covered Injury or a Covered Sickness and for as long as the Primary Insured remains continuously Totally Disabled due to a Covered Injury or a Covered Sickness and under a Physician's care but in no case beyond the Maximum Benefit Period.

We will NOT pay any loss that:

- 1) results from any of the following:
 - a) Pre-existing Conditions except after two (2) years from the Policy Effective Date; or
 - b) Injury or Sickness occurring prior to the Policy Effective Date; or
 - c) Injury or Sickness occurring while Incarcerated; or
 - d) committing or attempting to commit suicide while sane or insane; or
 - e) commission of or an attempt to commit an assault or felony; or
 - f) engaging in any illegal activity; or
 - g) practicing for or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received; or
 - h) driving or riding in any race of speed or endurance or testing a motorized vehicle on any racetrack, raceway, race course or speedway; or
 - i) declared or undeclared war, or any cause or act of war or regular military training, whether the Insured is a member of any armed force or a civilian; or
 - j) travel in an aircraft, including those which are not motor-driven, or hot air balloon other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; or
 - k) alcoholism or drug addiction; or
 - l) voluntarily taking, inhaling or absorbing any poison, gas or fumes; or
 - m) any intentionally self-inflicted Injury; or
 - n) mental infirmity or disease, or treatment for the infirmity or disease; or
 - o) normal pregnancy and childbirth except after ten (10) months from the Policy Effective Date; or
- 2) occurs while:
 - a) taking or using any hallucinogen, narcotic or drugs except on the advice of a licensed Physician; or
 - b) intoxicated. "Intoxicated" means under the influence of alcohol or narcotics unless administered on the advice of the Insured's Physician or having a prohibited concentration of alcohol in the blood, breath, urine or other bodily substance, as determined by the law of the jurisdiction in which the Accident occurred; or
 - c) engaging in hang-gliding, bungee jumping, parachuting, sky-diving, sail gliding, parasailing, parakiting or any similar activities.

TERMINATION OF INSURANCE

Insurance coverage for You and Your Legal Spouse, if covered on any attached Riders, will continue until the earliest of:

- 1) the Month-a-versary following the Primary Insured's 72nd birthday; or
- 2) the date any premium for this Policy is in default beyond the end of its Grace Period; or
- 3) the premium due date following Your written request for its termination.

In the event of Your death, coverage on any remaining Covered Persons will terminate as of the date of Your death. If Your covered Legal Spouse or Dependent dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under a Rider attached to this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by any Rider attached to this Policy on Your former Legal Spouse will automatically terminate on the date of the decree of the dissolution of marriage.

Insurance coverage on a Dependent Child will terminate automatically on the earliest of the following:

- 1) the Month-a-versary following the Dependent Child's marriage; or
- 2) the Month-a-versary following the Dependent Child's nineteenth (19th) birthday, if not a full-time student at an accredited school; or
- 3) the Month-a-versary following the Dependent Child's twenty-fourth (24th) birthday, if a full-time student at an accredited school and legally dependent on You for principal support and maintenance.

Insurance coverage will not terminate due to the Dependent Child's age if the child is both:

- 1) incapable of self-sustaining employment because of mental or physical handicap; and
- 2) currently dependent upon You for support and maintenance.

You *must* provide proof of the Dependent Child's mental or physical handicap and dependence upon You.

GENERAL PROVISIONS

Claim Forms: Upon receipt of a Notice of Claim, We will send You claim forms. If these forms are not sent within fifteen (15) days, Your claim may be initiated by giving Us a written statement with sufficient documentation of the Specified Events, the cause of the Total Disability and the date of onset of the Total Disability, subject to the terms and conditions of the Proof of Total Disability/Loss provision. Additional documentation of Proof of Total Disability/Loss may be required.

Conformity With State Statutes: Any provision of the Policy which, on the Policy Effective Date, is in conflict with the laws of the state in which the Policy was issued on such date is hereby amended to conform to the minimum requirements of such statutes.

Entire Contract; Changes: The contract is made up of this Policy, its application and any attached Riders or endorsements. A copy of the application is attached. No change in this Policy will be valid unless it is approved and signed by one of Our executive officers. No agent may change this Policy or waive any of its provisions.

Fraudulent Misstatements: If You make a Fraudulent Misstatement in the application for this Policy, We may reduce or deny any claim or void the Policy at any time.

Grace Period: This Policy has a thirty-one (31) day Grace Period for paying premium. This means that if a renewal premium is not paid by the date due, it may be paid during the following thirty-one (31) days. Any otherwise payable claim incurred during the Grace Period will NOT be paid until the past due premiums are paid provided the Policy has not lapsed or terminated. If You do not pay Your premium by the end of the thirty-one (31) day Grace Period, Your Policy will terminate as of the date the premium was due.

Legal Action: No legal action can be taken to receive benefits under this Policy:

- 1) less than sixty (60) days after sufficient written Proof of Total Disability/Loss has been furnished as required; or
- 2) more than three (3) years after the onset of Total Disability and/or the date of the Specified Event.

Misstatement of Age or Sex: If the age or sex of the Primary Insured has been misstated, all amounts payable under this Policy shall be as much as the premium paid would have purchased at the correct age and sex. If, according to the correct age, We would not have issued this Policy, We will not pay any benefits and will refund all premiums paid.

Notice of Claim: We must receive Written Notice of a claim, including the name of the Insured and Policy Number. Written Notice must be given within sixty (60) days of the Specified Event, or as soon as reasonably possible. Written Notice given by or on behalf of You to Our home office at P.O. Box 349, Gadsden, AL 35902, or to any authorized agent of Us, with information sufficient to identify You, shall be deemed notice to Us.

Payment of Claims: We will pay all benefits to You; benefits under this Policy are not subject to assignment. Upon receipt of Your death certificate, any benefits that have not been paid at the time of Your death may be paid to Your estate or Your designated beneficiary. We have the right to pay up to \$3,000 of those benefits to any Immediate Family Member who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

Payment of Premium: The due date of the initial premium is the Policy Effective Date. The initial premium may be paid to the Home Office or to one of the Company's authorized agents. Premiums after the initial premium must be paid to the Home Office at P.O. Box 349, Gadsden, AL 35902. Upon receipt of Your death certificate, We will refund any premium paid for any monthly period beyond the Month-a-versary following the date of death. The refund may be paid to Your estate or designated Beneficiary. Upon receipt of Your Written Notice to discontinue coverage, We will refund any premium paid for any monthly period beyond the Month-a-versary following the date We received the Written Notice from You. The refund will be paid to You.

This Policy is not effective until the Policy Effective Date regardless of the date of the first premium payment if any premium is paid prior to the Policy Effective Date. Any premium received prior to issue of the Policy will be held pending issue of the Policy. If the Policy is not issued by Us, We will refund any premium being held.

If We or any third party on Our behalf receives premiums by any method (including payroll deduction and bank draft) prior to the issue of this Policy, We assume NO liability for coverage until this Policy is issued by Us.

Physical Examinations: The Company, at Our own expense, reserves the right and opportunity to examine the person of the Insured when and as often as it may be reasonably necessary for the duration of the claim under this Policy.

Pre-existing Conditions: Benefits of this Policy and all attached Riders will NOT be payable for any Specified Events due to or resulting from Pre-existing Conditions during the first two (2) years from the Policy Effective Date and any attached Rider Effective Dates.

Proof of Total Disability/Loss: Written Proof of Total Disability/Loss must be given to Us within ninety (90) days after the date of the Specified Event. Written Proof of Total Disability/Loss must include sufficient documentation furnished by the Physician attesting to the Total Disability and/or the Specified Event. If You are not able to give Us sufficient Proof of Total Disability/Loss within ninety (90) days of the Specified Event, the claim will not be reduced or denied if:

- 1) it was not reasonably possible to give proof in that timeframe; and
- 2) the proof is filed as soon as reasonably possible.

In no event, except the absence of legal capacity, may proof be given to Us later than one (1) year after the date of the Specified Event.

We have the right to investigate all claims thoroughly and require that You provide Us with sufficient Proof of Total Disability/Loss.

Reinstatement: If this Policy terminates, the Policy may be reinstated within six (6) months of termination if an application for Reinstatement is submitted to Us and all past due premiums are paid to Us. Any premium We receive after the Policy termination will be held pending approval or denial of the Reinstatement. Reinstatement must be approved or denied by Us in writing. If Reinstatement is denied by Us, any premium We received after the termination date of the Policy will be refunded.

The reinstated Policy shall provide benefits for Specified Events incurred after the Reinstatement Date and while the Policy is in force. In all other respects, You and We will have the same rights as before termination, subject to any added endorsements. Benefits will NOT be payable for Specified Events prior to the Reinstatement Date.

Suspension of Coverage While in Active Military Service: If the Insured is in military service, they may have their coverage suspended during a period of active military service. There will be no coverage or premiums due during the period of suspension. Upon termination of active military duty, the Insured shall have the right to resume coverage without providing evidence of insurability and the resumption of coverage shall be on the same basis as before the coverage suspension. To be entitled to coverage suspension, an Insured shall:

- 1) be in the military service of any nation or international authority or in a reserve component of the armed forces of the United States, including the National Guard; and
- 2) have entered upon active duty or had active duty extended, for a minimum of three (3) months (other than for the purpose of determining physical fitness and/or training).

Time Limit on Certain Defenses (Contestable Period): After two (2) years from the Policy Effective Date (or the Reinstatement Date, if the Policy has been reinstated), no misstatements, except Fraudulent Misstatements, made by You in the application (or reinstatement application) shall be used to void this Policy or to deny a claim resulting from a Covered Injury or a Covered Sickness occurring after the expiration of such two (2) year period. During this two (2) year contestable period, if We do not receive sufficient documentation from You to properly investigate Your claim, We retain the right to void the Policy and refund all premiums We have received. We will provide You with Written Notice fifteen (15) days before the Policy is voided. The date of the Covered Injury or onset of the Covered Sickness determines whether or not a claim is within the Contestable Period, NOT when the claim is received by Us. Misstatements, including Fraudulent Misstatements, made by You on the Application (or reinstatement application) may be used by Us to void this Policy or to deny a claim resulting from a Covered Injury or Covered Sickness within two (2) years after the Policy Effective Date or within two (2) years after the Reinstatement of this Policy.

Time of Payment of Claims: Benefits will be paid within thirty (30) working days once We receive sufficient written Proof of Total Disability/Loss.

If We do not pay benefits upon receipt of your claim, We shall have thirty (30) working days thereafter within which to mail to You a letter or notice which states the reasons We have for not paying the claim, either in whole or in part, and which also gives You a notice of any documents or other information needed to process the claim. When We have received sufficient written Proof of Total Disability/Loss from You, We shall then have thirty (30) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.