

SERFF Tracking Number: WAKE-126166446 State: Arkansas
Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
Company Tracking Number:
TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: LOA Accident Forms 2009
Project Name/Number: LOA/052009

Filing at a Glance

Company: Life Insurance Company of Alabama

Product Name: LOA Accident Forms 2009

TOI: H02I Individual Health - Accident Only

Sub-TOI: H02I.000 Health - Accident Only

Filing Type: Form/Rate

SERFF Tr Num: WAKE-126166446 State: ArkansasLH

SERFF Status: Closed

Co Tr Num:

Co Status:

Author: Jennifer Snell

Date Submitted: 05/27/2009

State Tr Num: 42502

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 06/15/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: LOA

Project Number: 052009

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/15/2009

Deemer Date:

Filing Description:

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

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.

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 06/15/2009

Corresponding Filing Tracking Number:

Submission

Accident Indemnity Policy – Form Number HA35A109 AR

Sickness Disability Rider – Form Number HA35S109

SERFF Tracking Number: WAKE-126166446 State: Arkansas
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Product Name: LOA Accident Forms 2009
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Off-the-Job Disability Rider – Form Number HA35N109
Accident Disability Income Plan Application – Form Number BHA35BW
Pre-Packaged Plan Application – Form Number BHA3504
Build A Plan Application – Form Number BHA35BAP

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

The Accident Policy being submitted provides an indemnity benefit when a covered person is transported by ambulance or confined to a hospital as an overnight resident bed patient.

Application form numbers BHA35BW, BHA3504 and BHA35BAP will be used with the above noted policy.

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-126070894.

The following forms submitted under SERFF filing number WAKE-126133880 for your Department's review will also be used with the above captioned policy.

| Form Name | Form Number |
|--|-------------|
| Combination Application | MPAH309 |
| Initial Hospital Confinement Rider | HA35I109 |
| Injury Treatment Rider | HA35T109 |
| Health Screening Rider | HA35W109 |
| Accidental Death & Dismemberment Rider | HA35D109 |
| Supplemental Injury Rider | HA35C109 |
| Specified Loss Rider | HA35B109 |
| On-the-Job Disability Rider | HA35O109 |

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

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 Product Name: LOA Accident Forms 2009
 Project Name/Number: LOA/052009

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 | |
| | ----- | |

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 | 28127013 |

SERFF Tracking Number: WAKE-126166446 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
 Company Tracking Number:
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: LOA Accident Forms 2009
 Project Name/Number: LOA/052009

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 |

SERFF Tracking Number: *WAKE-126166446* *State:* *Arkansas*
Filing Company: *Life Insurance Company of Alabama* *State Tracking Number:* *42502*
Company Tracking Number:
TOI: *H021 Individual Health - Accident Only* *Sub-TOI:* *H021.000 Health - Accident Only*
Product Name: *LOA Accident Forms 2009*
Project Name/Number: *LOA/052009*

Disposition

Disposition Date: 06/15/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: WAKE-126166446 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
 Company Tracking Number:
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: LOA Accident Forms 2009
 Project Name/Number: LOA/052009

| 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) | Accident Indemnity Policy | Approved-Closed | Yes |
| Form | Accident Indemnity Policy | Replaced | Yes |
| Form | Sickness Disability Rider | Approved-Closed | Yes |
| Form | Off-the-Job Disability Rider | Approved-Closed | Yes |
| Form | Application/Brochure | Approved-Closed | Yes |
| Form | Application/Brochure | Approved-Closed | Yes |
| Form | Application/Brochure | Approved-Closed | Yes |
| Rate | Rate Pages | Approved-Closed | Yes |

SERFF Tracking Number: WAKE-126166446 State: Arkansas
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TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
Product Name: LOA Accident Forms 2009
Project Name/Number: LOA/052009

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

- Accident Indemnity 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

- Accident Indemnity 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

Response Letter

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

SERFF Tracking Number: WAKE-126166446 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
 Company Tracking Number:
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: LOA Accident Forms 2009
 Project Name/Number: LOA/052009

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 of the policy has been revised to read a guarantee of 12 months.

Related Objection 1

Applies To:

- Accident Indemnity 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 Data | Readability Score | Attach Document |
|---------------------------|-----------------|--------------|---------------------------------------|---------|----------------------|-------------------|----------------------------------|
| Accident Indemnity Policy | HA35A10 9 AR | | Policy/Contract/Fraternal Certificate | Initial | | 44 | Accident Policy HA35A10 9 AR.pdf |
| Previous Version | | | | | | | |
| Accident Indemnity Policy | HA35A10 9 AR | | Policy/Contract/Fraternal Certificate | Initial | | 44 | Accident Policy HA35A10 9 AR.pdf |

SERFF Tracking Number: WAKE-126166446 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
 Company Tracking Number:
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: LOA Accident Forms 2009
 Project Name/Number: LOA/052009

No Rate/Rule Schedule items changed.

Response 2

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

Related Objection 1

Applies To:

- Accident Indemnity 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 |
|---------------------------|-----------------|--------------|---------------------------------------|---------|----------------------|-------------------|--|
| Accident Indemnity Policy | HA35A10 9 AR | | Policy/Contract/Fraternal Certificate | Initial | | 44 | Accident Policy HA35A10 9 AR.pdf |
| Previous Version | | | | | | | |
| Accident Indemnity Policy | HA35A10 9 AR | | Policy/Contract/Fraternal Certificate | Initial | | 44 | Accident Policy HA35A10 9 AR.pdf |

No Rate/Rule Schedule items changed.

SERFF Tracking Number: *WAKE-126166446* *State:* *Arkansas*
Filing Company: *Life Insurance Company of Alabama* *State Tracking Number:* *42502*
Company Tracking Number:
TOI: *H02I Individual Health - Accident Only* *Sub-TOI:* *H02I.000 Health - Accident Only*
Product Name: *LOA Accident Forms 2009*
Project Name/Number: *LOA/052009*

Feel free to contact me should further information be needed.

Thank you

Sincerely,
Jennifer Snell

SERFF Tracking Number: WAKE-126166446 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
 Company Tracking Number:
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: LOA Accident Forms 2009
 Project Name/Number: LOA/052009

Form Schedule

Lead Form Number: HA35A109 AR

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------|-------------|--------------|--|---------|----------------------|-------------|--|
| Approved-Closed | HA35A109 AR | Policy/Cont | Accident Indemnity ract/Fratern Policy al Certificate | Initial | | 44 | Accident Policy HA35A109 AR.pdf |
| Approved-Closed | HA35S109 | Policy/Cont | Sickness Disability ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | 43 | Sickness Disability Rider HA35S109.pdf |
| Approved-Closed | HA35N109 | Policy/Cont | Off-the-Job Disability ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider | Initial | | 42 | Off-the-Job Disability Rider HA35N109.pdf |
| Approved-Closed | BHA35BW | Application/ | Application/Brochure Enrollment Form | Initial | | | BHA35BW Billy West.pdf |
| Approved-Closed | BHA3504 | Application/ | Application/Brochure Enrollment Form | Initial | | | BHA3504 Plan 400.pdf |
| Approved-Closed | BHA35BAP | Application/ | Application/Brochure Enrollment Form | Initial | | | BHA35BAP Build a Plan.pdf |



Protecting your financial security

ACCIDENT INDEMNITY 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 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.

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

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Application..... Attached

POLICY SCHEDULE PAGE

Policy Number: [12345678]
Primary Insured: [John Doe]

Policy Effective Date: [July 1, 2008]

Premium Payment Modes:

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

Mode Selected: [Annual]

Coverage Type: [Individual, Individual and Spouse, One Parent Family, Two Parent Family]

| Benefit Description | Benefit Amount | Modal Premium |
|------------------------------|----------------|---------------|
| Base Policy | | |
| Ambulance | [\$ 50.00] | [\$ XX.XX] |
| Monthly Hospital Confinement | [\$ 100.00] | [\$ XX.XX] |

| Benefit Description ¹ | Monthly Benefit Amount | Elimination Period (Days) | Maximum Benefit Period (Months) | Modal Premium | Rider Effective Date |
|----------------------------------|------------------------|---------------------------|---------------------------------|---------------|----------------------|
| [Off-the-Job Disability Rider] | [\$ 100.00] | [7 Days] | [6 Months] | [\$ XX.XX] | [07/01/2008] |
| [On-the-Job Disability Rider] | [\$ 100.00] | [7 Days] | [6 Months] | [\$ XX.XX] | [07/01/2008] |
| [Sickness Disability Rider] | [\$ 100.00] | [7 Days] | [6 Months] | [\$ XX.XX] | [07/01/2008] |

| Benefit Description | Coverage Type | Benefit Amount | Modal Premium | Rider Effective Date |
|--|----------------|----------------|---------------|----------------------|
| [Injury Treatment Benefit Rider] | [Individual] | [\$ 50.00] | [\$ XX.XX] | [07/01/2008] |
| [Initial Hospital Confinement Benefit Rider] | [Family – 2] | [\$ 1,000.00] | [\$ XX.XX] | [07/01/2008] |
| [Health Screening Rider] | [Ind & Spouse] | [\$ 10.00] | [\$ XX.XX] | [07/01/2008] |

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

¹ Disability Riders are 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.

“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.

“Covered Injury” is an Injury resulting from a Covered Accident. If multiple Injuries occur as a result of a single Covered Accident, they will be considered as a single Covered Injury.

“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.

“Dentist” means one who has been professionally trained and licensed to practice Dentistry and is working within the scope of his/her license.

“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).

“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 Cover Person’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 a Covered Person 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.

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

“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. A Dentist is NOT considered a Physician.

“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.

“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.

“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 a Covered Person sustains a Covered Injury as the result of a Covered Accident after the Policy Effective Date as shown on the Policy Schedule Page and while this Policy 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 the Covered Injury while this Policy is in force, subject to:

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

Ambulance Indemnity Benefit

We will pay the Ambulance Indemnity Benefit as shown on the Policy Schedule Page if a Covered Person incurs the Specified Event required for the Ambulance Indemnity Benefit. The Specified Event required for the Ambulance Indemnity Benefit is transportation of a Covered Person by Ambulance to a Hospital for the

treatment of a Covered Injury as a result of a Covered Accident and occurs when the Covered Person is transported in the Ambulance.

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

Monthly Hospital Confinement Indemnity Benefit

We will pay the Monthly Hospital Confinement Indemnity Benefit as shown on the Policy Schedule Page for each month, up to 12 months, a Covered Person incurs the Specified Event required for the Monthly Hospital Confinement Indemnity Benefit. The Specified Event required for the Monthly Hospital Confinement Indemnity Benefit is confinement of a Covered Person in a Hospital as an inpatient for the treatment of a Covered Injury as the result of a Covered Accident as specified below and initially occurs on the first day the Covered Person is so confined. Subsequent Specified Events occur on the same day each month as long as the Covered Person remains continuously confined to the Hospital. 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. 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; or
- 4) the day of discharge from the Hospital except where the day of discharge and the day of admission are the same and the confinement was for at least 18 hours.

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

The Monthly Hospital Confinement Indemnity Benefit is payable for up to 12 months per Covered Accident per Covered Person.

LIMITATIONS AND EXCLUSIONS

This is an Accident Policy which only provides Indemnity Benefits for Specified Events occurring in connection with treatment of Covered Injuries as a result of a Covered Accident. It does not provide benefits for any other sickness, condition or incapacity.

We will NOT pay any Indemnity Benefit for Specified Events relating to Pre-existing Conditions except after two years from the Policy Effective Date or attached Rider Effective Dates.

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 Ambulance Indemnity Benefit is payable once per Covered Person per Covered Accident.

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

The Monthly Hospital Confinement Indemnity Benefit is payable for up to 12 months per Covered Accident per Covered Person.

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; or
- 4) the day of discharge from the Hospital except where the day of discharge and the day of admission are the same and the confinement was for at least 18 hours.

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 occurring prior to the Policy Effective Date; or
 - c) Injury 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 Covered Person 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 or physical infirmity or disease, or treatment for the infirmity or disease; or
 - o) pregnancy and childbirth or complications thereof; or
 - p) Sickness at any time; or
 - q) infection, except one caused by an accidental cut or wound; 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 Covered Person'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, 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 not terminate provided We receive a copy of Your death certificate and Written Notice to continue coverage within thirty (30) days of the date of Your death. If Your covered Legal Spouse or Dependent Child dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by this Policy on Your former Legal Spouse will automatically terminate on the 61st day following 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.

RIGHT OF CONVERSION

If You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was a Covered Person under this Policy, then Your former Legal Spouse may apply and receive, without evidence of insurability, a Policy providing coverage NOT greater than the terminated coverage. To obtain the Policy, Your former Legal Spouse must make application to Us within sixty (60) days following the date of the decree of dissolution of marriage. The Primary Insured under this Policy at the time of the dissolution of marriage shall remain the Primary Insured under this Policy. Coverage terminates automatically for the former Legal Spouse on the 61st day following the date of the decree of the dissolution of marriage. Any covered Dependent Children may be covered under either Policy, but NOT both.

A Covered Person whose dependency terminates and who desires to continue coverage as a Primary Insured under a separate Policy may do so by notifying Us of the request in writing. The Dependent Child will have the right to continue coverage as the Primary Insured under a separate Policy providing coverage NOT greater than the previous coverage without a requirement for evidence of insurability and without interruption in coverage. To obtain the Policy, the Dependent Child must make application to Us within thirty-one (31) days after the termination of insurance under this Policy.

In order to be considered for coverage, any Legal Spouse or Dependent Child not listed on the initial application must make written application.

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, qualified expenses and medical records, subject to the terms and conditions of the Proof of Loss provision. Additional documentation of Proof of 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 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:
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- 1) less than sixty (60) days after sufficient written Proof of Loss has been furnished as required; or
- 2) more than three (3) years after 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 Covered Person 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 may 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.

Pre-existing Conditions: The Indemnity 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 Loss: Written Proof of Loss must be given to Us within ninety (90) days after the date of such loss or the date of the Specified Event. Written Proof of Loss must include sufficient documentation furnished by the medical provider of the qualified treatment, expenses and medical records. If You are not able to give Us sufficient Proof of 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 loss or 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 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 incurred 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 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 Accident 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 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: Indemnity Benefits will be paid within thirty (30) working days once We receive sufficient written Proof of 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 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

SICKNESS 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.

“Covered Sickness” is a Sickness which:

- 1) manifests itself on or after the Rider Effective Date; and
- 2) manifests itself while the Rider 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 Rider Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Sickness Disability Rider Maximum Benefit Period will be limited to six (6) weeks for vaginal deliveries and eight (8) weeks of caesarean deliveries.

“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 a result of normal pregnancy and childbirth, the Sickness Disability Rider 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 Sickness Disability Rider Maximum Benefit Period will be limited to a maximum of three (3) months for one (1) Maximum Benefit Period.

“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 the onset of a Covered Sickness.

BENEFITS

If the Primary Insured becomes Totally Disabled as the result of a Covered Sickness 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 Sickness 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.

Sickness Monthly Disability Income Benefit

We will pay a Sickness Monthly Disability Income Benefit as shown on the Policy Schedule Page if the Primary Insured incurs the Specified Event required for the Sickness Monthly Disability Income Benefit. The Specified Event required for the Sickness Monthly Disability Income Benefit is continuous Total Disability of the Primary Insured for the length of the Sickness Disability Rider Elimination Period as shown on the Policy Schedule Page plus one (1) day as a result of a Covered Sickness as defined in this Rider. The Specified Event occurs on the day following the expiration of the Sickness Disability Rider Elimination Period and continues until the Primary Insured is no longer Totally Disabled due to a Covered Sickness and under a Physician’s care but in no case longer than the Sickness 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.

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

- 1) any Injury or Accident; or
- 2) normal pregnancy and childbirth except after ten (10) months from the Rider Effective Date; or
- 3) any cause other than a Covered Sickness; or
- 4) any Pre-existing Conditions except after two (2) years from the Rider Effective Date.

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

Normal pregnancy and childbirth, including caesarean deliveries, will NOT be considered a Covered Sickness under this Rider until ten (10) months after the Rider Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Sickness Disability Rider 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 Sickness Disability Rider Maximum Benefit Period shall be limited to a maximum of three (3) months for one Sickness Disability Rider Maximum Benefit Period.

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

Sickness 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 Sickness Disability Waiver of Premium Benefit. The Specified Event required for the Sickness Disability Waiver of Premium Benefit occurs on the day after the Primary Insured has been totally and continuously Disabled due to a Covered Sickness for which Sickness 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 Sickness and under a Physician's care OR the Sickness Monthly Disability Income Benefit is no longer payable. Premiums will NOT be waived beyond the Sickness 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 Sickness Disability Waiver of Premium Benefit. The Primary Insured's Physician must attest to the specific period of Total Disability and its cause.

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

- 1) any Injury or Accident; or
- 2) normal pregnancy and childbirth except after ten (10) months from the Rider Effective Date; or
- 3) any cause other than a Covered Sickness; or
- 4) any Pre-existing Conditions except after two (2) years from the Rider Effective Date.

Sickness 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 Sickness 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 Sickness and for as long as the Primary Insured remains continuously Totally Disabled due to a Covered Sickness but in no case beyond the Sickness 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 Injury or Accident; or
- 2) normal pregnancy and childbirth except after ten (10) months from the Rider Effective Date; or
- 3) any cause other than a Covered Sickness; or
- 4) 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.

Normal pregnancy and childbirth, including caesarean deliveries, will NOT be considered a Covered Sickness under this Rider until ten (10) months after the Rider Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Sickness Disability Rider 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 Sickness Disability Rider Maximum Benefit Period shall be limited to a maximum of three (3) months for one Sickness Disability Rider Maximum Benefit Period.

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

The Sickness 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 Sickness and for as long as the Primary Insured remains continuously Totally Disabled due to a Covered Sickness and under a Physician's care but in no case beyond the Sickness 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

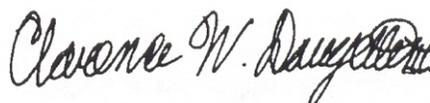
This Rider terminates at the earliest of:

- 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

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

OFF-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 Off-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 Off-The-Job Disability Rider Maximum Benefit Period will be limited to a maximum of three (3) months for one (1) Maximum Benefit Period.

“Off-The-Job” means NOT 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.

Off-The-Job Monthly Disability Income Benefit

We will pay an Off-The-Job Monthly Disability Income Benefit as shown on the Policy Schedule Page if the Primary Insured incurs the Specified Event required for the Off-The-Job Monthly Disability Income Benefit. The Specified Event required for the Off-The-Job Monthly Disability Income Benefit is continuous Total Disability of the Primary Insured for the length of the Off-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 Off-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 Off-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.

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

- 1) an Injury that occurred while working at any job for pay or benefits; or
- 2) any Sickness; or
- 3) any cause other than a Covered Injury as defined in this Rider occurring Off-The-Job; or
- 4) any Pre-existing Conditions except after two (2) years from the Rider Effective Date.

Off-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 Off-The-Job Disability Rider Maximum Benefit Period shall be limited to a maximum of three (3) months for one Off-The-Job Disability Rider Maximum Benefit Period.

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

Off-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 Off-The-Job Disability Waiver of Premium Benefit. The Specified Event required for the Off-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 Off-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 Off-The-Job Monthly Disability Income Benefit is no longer payable. Premiums will NOT be waived beyond the Off-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 Off-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 Off-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) an Injury that occurred while working at any job for pay or benefits; or
- 2) any Sickness; or
- 3) any cause other than a Covered Injury as defined in this Rider occurring Off-The-Job; or
- 4) any Pre-existing Conditions except after two (2) years from the Rider Effective Date.

Off-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 Off-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 Off-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) an Injury that occurred while working at any job for pay or benefits; or
- 2) any Sickness; or
- 3) any cause other than a Covered Injury as defined in this Rider occurring Off-The-Job; or
- 4) 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 Off-The-Job Disability Rider Maximum Benefit Period shall be limited to a maximum of three (3) months for one Off-The-Job Disability Rider Maximum Benefit Period.

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

The Off-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 Off-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

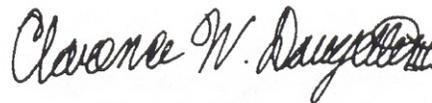
This Rider terminates at the earliest of:

- 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



WESTERN REGION

320-B EDGEWOOD TERRACE DRIVE

JACKSON, MS 39206

800-880-4233 • 601-982-4233

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

Accident Disability **INCOME PLAN**

- PROTECTS your most valuable asset...your ability to earn an income.
- PROVIDES an income...when you are disabled due to accidental injury on or off the job.
- PAYS 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 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

ACCIDENT DISABILITY INCOME PLAN

With Specific Loss Rider

This is not the insurance contract, and only the actual policy provisions will control. It is therefore important that you Read Your Policy Carefully.

Employee Monthly Off-The-Job Disability Income Benefit* [\$500 TO \$2,500]

Pays the disability income benefit each month the primary insured is totally disabled as a result of a covered accident occurring Off-the-job. Benefits begin the very first day of total disability and are payable for a period of up to one (1) year for each disability. You may choose any monthly disability amount up to 60% of your gross income.

Employee Monthly On-The-Job Disability Income Benefit* [\$500 TO \$2,500]

Pays the disability income benefit each month the primary insured is totally disabled as a result of a covered accident occurring On-the-job. Benefits begin the very first day of total disability and are payable for a period of up to one (1) year for each disability. You may choose any monthly disability amount up to 60% of your gross income.

■ **Initial Hospital Confinement Benefit [\$1,000]**

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, as an overnight resident bed patient. This benefit is paid once per confinement and only once per calendar year, per covered person.

■ **Monthly Hospital Confinement Benefit* [\$1,200]**

Pays the monthly hospital confinement benefit each month you are confined to a hospital as a result of a covered accident. Benefit is payable up to one year, per 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.

■ **Ambulance Benefit † [\$125]**

Pays the ambulance benefit for transportation by a licensed or professional ambulance company to a hospital. \$50 provided by the base accident plan and \$75 provided by the specified loss rider. 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.

■ **Injury Treatment Benefit [\$150]**

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

■ **Blood, Plasma or Platelets † [\$450]**

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

■ **Health Screening Benefit [\$50]**

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.

■ **Fractures - broken bones † . up to [\$1,500]**

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 [\$1,350]**

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.

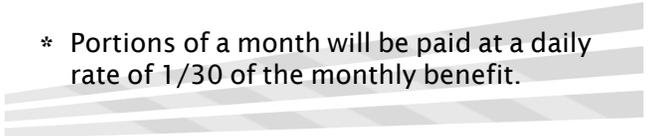
■ **Medical Equipment † [\$375]**

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

■ **Waiver of Premium**

After you are totally disabled for 90 consecutive days due to a covered injury, 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.

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



ACCIDENT DISABILITY INCOME PLAN

With Specific Loss Rider

Employee & Spouse Children

- **Accidental Death Benefit**[\$10,000 \$2,500]
 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.
- **Double Indemnity Benefit**[\$20,000 \$5,000]
 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.
- **Double Dismemberment Benefit**.....[\$10,000 \$2,500]
 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.
- **Single Dismemberment Benefit**.....[\$ 5,000 \$1,250]
 Payable in case of the loss of either hand, arm, foot, leg or sight in one eye.
- **Loss of Finger or Toe Benefit**..... [\$ 500 \$ 125]
 Payable in case of the loss of one or more entire fingers or toes.

| | | | | | | |
|-----------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
| MONTHLY DISABILITY INCOME: | \$500 | \$600 | \$700 | \$800 | \$900 | \$1,000 |
| Employee Monthly Premium: | [31.85 | 34.70 | 37.55 | 40.40 | 43.25 | 46.10] |
| Employee Weekly Premium: | [7.35 | 8.01 | 8.67 | 9.33 | 9.99 | 10.64] |
| MONTHLY DISABILITY INCOME: | \$1,200 | \$1,400 | \$1,600 | \$1,800 | \$2,000 | \$2,500 |
| Employee Monthly Premium: | [51.80 | 57.50 | 63.20 | 68.90 | 74.60 | 88.85] |
| Employee Weekly Premium: | [11.96 | 13.28 | 14.59 | 15.90 | 17.22 | 20.51] |

| | |
|-----------------------|-------------------|
| Add For Family | |
| Monthly | Weekly |
| Family [\$19.05 | Family \$ 4.40] |
| 1 Parent [\$10.70 | 1 Parent \$ 2.47] |
| Spouse [\$ 8.35 | Spouse \$ 1.93] |

* Monthly benefits are prorated on a daily basis. † Refers to benefits provided by Specific Loss Rider. The above benefits are provided by accident plan series HA35 and 3 units of Specific Loss Rider. Additional disability [\$2.85] per 100 per month.

List of Fractures & Dislocations

| Fractures | Dislocations |
|---|---|
| Each Hip [\$1500] | Each Hip [\$1350] |
| Each Thigh (<i>Femur</i>) [\$1500] | Each Knee [\$ 975] |
| Spinal Cord (<i>Complete severance with resulting paralysis</i>) [\$1500] | Each Shoulder [\$ 750] |
| Vertebrae, body of (<i>except Vertebral process</i>) [\$1350] | Each Ankle [\$ 600] |
| Pelvis(<i>excluding coccyx</i>) [\$1200] | Bone or Bones of the Foot (<i>excluding toes</i>) .. [\$ 600] |
| Skull <i>Depressed</i> [\$ 525] | Bone or Bones of the Hand (<i>excluding fingers</i>) [\$ 525] |
| <i>Simple</i> [\$1125] | Each Collar Bone [\$ 450] |
| Each Leg(<i>Tibia and/or Fibula</i>) [\$ 900] | Each Wrist [\$ 375] |
| Each Ankle [\$ 750] | Each Elbow [\$ 300] |
| Each Knee Cap(<i>Patella</i>) [\$ 750] | Each Toe or Each Finger [\$ 120] |
| 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] | |

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.

OPTIONAL EMPLOYEE SICKNESS DISABILITY INCOME BENEFIT RIDER

Form No. HA35S109

Employee Sickness Disability Benefit...per [\$100]
Pays the monthly employee sickness disability benefit each month you are totally disabled as a result of a covered sickness occurring on or off-the-job beginning after an elimination period of;

7th day, 14th day or 30th day
of total disability due to a sickness and is payable for a maximum period of;

6 months or 12 months
for each disability.

Monthly benefit is prorated on a daily basis. Portions of a month will be paid at a daily rate of 1/30th of the monthly benefit. A new disability is subject to a new elimination period, and a new 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 benefit period does not apply. Benefits will be paid for only one disability at a time even if it is caused by more than one covered sickness. Issue ages are 18-64 and coverage terminates at age 72.

\$100 Employee Sickness Disability Benefit

| Elim. Period | 6 Mo. Benefit | | 1 Yr Benefit | |
|-----------------|---------------|--------|--------------|---------|
| | MO. | WK. | MO. | WK. |
| 7 Days | [\$4.30 | \$1.00 | \$5.15 | \$1.19] |
| 14 Days | [\$3.35 | \$.78 | \$4.05 | \$.94] |
| 30 Days | [\$2.10 | \$.49 | \$2.50 | \$.58] |

BENEFIT SELECTED

Pay Periods Per Year _____ Amount of Monthly
52, 26, 24, 12, 10, etc _____ Disability \$ _____

Premium Amount Per Pay Period

Accident Disability Income Plan \$ _____
 Sickness Disability Benefit \$ _____
 Hospital Intensive Care \$ _____
Total Premium Per Period \$ _____

Additional Benefits Included

Initial Hospital Conf.
 Injury Treatment Benefit
 Health Screening Benefit
 Accidental Death
 Specific Loss Rider

This outline of coverage provides a brief description of the important features of the policy. This describes an Accident Insurance Policy Form HA35A109, Off-The-Job Disability rider HA35N109, On-The-Job Disability rider HA35O109, Initial Hospital Confinement rider HA35I109, Injury Treatment rider HA35T109, Wellness rider HA35W109, Accidental Death & Dismemberment rider HA35D109, Specific Loss Rider HA35B109.

LOCAL REPRESENTATIVE

OPTIONAL HOSPITAL INTENSIVE CARE Form # HI75I109

• Pays \$750.00, \$600.00 or \$450.00 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**

| | <u>\$750 per day</u> | | <u>\$600 per day</u> | | <u>\$450 per day</u> | |
|-------------------|----------------------|---------|----------------------|---------|----------------------|----------|
| | MO. | WK. | MO. | WK. | MO. | WK. |
| Ages 18-39 | | | | | | |
| Emp. | [\$ 3.35 | \$.78 | \$ 2.68 | \$.62 | \$ 2.01 | \$.47] |
| Emp./Ch. | [\$ 3.60 | \$.84 | \$ 2.88 | \$.67 | \$ 2.16 | \$.50] |
| Emp./Sp. | [\$ 5.15 | \$ 1.19 | \$ 4.12 | \$.96 | \$ 3.09 | \$.72] |
| Emp./Fam. | [\$ 6.75 | \$ 1.56 | \$ 5.40 | \$ 1.25 | \$ 4.05 | \$.94] |
| Ages 40-54 | | | | | | |
| Emp. | [\$ 8.55 | \$ 1.98 | \$ 6.84 | \$ 1.58 | \$ 5.13 | \$ 1.19] |
| Emp./Ch. | [\$ 9.20 | \$ 2.13 | \$ 7.36 | \$ 1.70 | \$ 5.52 | \$ 1.28] |
| Emp./Sp. | [\$13.25 | \$ 3.06 | \$10.60 | \$ 2.45 | \$ 7.95 | \$ 1.84] |
| Emp./Fam. | [\$17.30 | \$ 4.00 | \$13.84 | \$ 3.20 | \$10.38 | \$ 2.40] |
| Ages 55-64 | | | | | | |
| Emp. | [\$15.50 | \$ 3.58 | \$12.40 | \$ 2.87 | \$ 9.30 | \$ 2.15] |
| Emp./Ch. | [\$16.65 | \$ 3.85 | \$13.32 | \$ 3.08 | \$ 9.99 | \$ 2.31] |
| Emp./Sp. | [\$24.30 | \$ 5.61 | \$19.44 | \$ 4.49 | \$14.58 | \$ 3.37] |
| Emp./Fam. | [\$31.95 | \$ 7.38 | \$25.56 | \$ 5.90 | \$19.17 | \$ 4.43] |
| Ages 65-70 | | | | | | |
| Emp. | [\$21.60 | \$ 4.99 | \$17.28 | \$ 3.99 | \$12.96 | \$ 3.00] |
| Emp./Ch. | [\$22.95 | \$ 5.30 | \$18.36 | \$ 4.24 | \$13.77 | \$ 3.18] |
| Emp./Sp. | [\$33.75 | \$ 7.79 | \$27.00 | \$ 6.24 | \$20.25 | \$ 4.68] |
| Emp./Fam. | [\$43.85 | \$10.12 | \$35.08 | \$ 8.10 | \$26.31 | \$ 6.08] |

LIMITATIONS AND EXCLUSIONS

The Accident Disability Plan – This is an Accident Policy, which provides Indemnity Benefits for Specified Events occurring in connection with treatment of Covered Injuries as a result of a Covered Accident. It does not provide benefits for any other sickness, condition or incapacity including pregnancy and childbirth or complications thereof. We will pay Total Disability benefits for Covered Injuries for the Primary Insured only. Benefits will be paid for only one disability at a time even if more than one Covered Injury 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 and The Monthly Hospital Confinement Benefit are 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.

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 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 infection, except one caused by an accidental cut or wound: 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.

Sickness Disability Rider – We will pay Total Disability benefits for Covered Sicknesses for the Primary Insured only. Benefits will be paid for only one disability at a time even if more than one Covered Sickness causes it. This benefit will not pay for periods of disability due to normal pregnancy and childbirth, including caesarean deliveries, in which the disability begins during the first ten months after the Rider's Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Period of Disability will be limited to 6 weeks for vaginal deliveries and 8 weeks for caesarean deliveries.

All Shaded areas must be completed.

APPLICATION FOR ACCIDENT 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 Married Divorced Widowed Single Separated
 LAST NAME FIRST M.I.

| BIRTHDATE | | | AGE | STATE OF BIRTH | SEX | SOCIAL SECURITY # | HEIGHT | WEIGHT |
|-----------|-----|----|-----|----------------|-----|-------------------|--------|--------|
| MO | DAY | YR | | | | | | |

SPOUSE

DEPENDENT CHILDREN PROPOSED for INSURANCE

2. RESIDENCE ADDRESS STREET CITY COUNTY STATE ZIP

PHONE:
 RES: ()
 BUS: ()
 E-MAIL:

3. INSURED'S EMPLOYER *90 days of employment required* 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.

ACCIDENT DISABILITY w/ 3 Units Specific Loss Rider - \$_____ Monthly Disability Benefit

Emp Emp/Sp Emp/Ch Emp/Fam Answer questions 4 - 8

Applicant's Gross Monthly Income \$_____

INTENSIVE CARE - [\$450 \$600 \$750] \$_____

Emp Emp/Sp Emp/Ch Emp/Fam

Answer questions 9 and 10

PREMIUM

ACC. DIS. _____

Intensive Care _____

Sickness Dis. _____

TOTAL _____

Mode:
 MONTHLY PRD.

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 the Sickness Disability Rider on 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

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

5. Will the policy applied for replace any insurance in force on any proposed covered person? 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:

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

7. Primary Beneficiary & Relationship

8. Contingent Beneficiary & Relationship

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



Accident Disability



INCOME PLAN [400]

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

Pre-Packaged
Plan

Accident Disability **INCOME PLAN**

- PROTECTS your most valuable asset...your ability to earn an income.
- PROVIDES an income...when you are disabled due to accidental injury on or off the job.
- PAYS 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 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.

Underwritten by: Life Insurance Company of Alabama

ACCIDENT DISABILITY INCOME PLAN

With Optional Family Accident Benefit

This outline of coverage provides a brief description of the important features of the policy. This describes an Accident Insurance Policy Form HA35A109, Off-The-Job Disability rider HA35N109, On-The-Job Disability rider HA35O109, Initial Hospital Confinement rider HA35I109, Injury Treatment rider HA35T109, Wellness rider HA35W109, Accidental Death & Dismemberment rider HA35D109. *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 Off-The-Job Disability Income Benefit***

Pays the disability income benefit each month the primary insured is totally disabled as a result of a covered accident occurring Off-The-Job. Benefits begin the very first day of total disability and are payable for a period of up to one (1) year for each disability.

Employee [\$400.00]

■ **Monthly On-The-Job Disability Income Benefit***

Pays the disability income benefit each month the primary insured is totally disabled as a result of a covered accident occurring On-The-Job. Benefits begin the very first day of total disability and are payable for a period of up to one (1) year for each disability.

Employee [\$400.00]

■ **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, Spouse & Children [\$1,000.00]

■ **Monthly Hospital Confinement Benefit***

Pays the monthly hospital confinement benefit each month you are confined to a hospital as a result of a covered accident. Benefit is payable up to one year.

Employee, Spouse & Children [\$1,200.00]

■ **Injury Treatment Benefit**

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

Employee, Spouse & Children [\$100.00]

■ **Ambulance Benefit**

Pays the ambulance benefit for transportation by a licensed or professional ambulance company to a hospital. This benefit is payable once per covered accident.

Employee, Spouse & Children [\$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 calendar year.

Employee, Spouse & Children [\$50.00]

■ **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 & Spouse [\$10,000.00]

Children [\$ 2,500.00]

■ **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 & Spouse [\$20,000.00]

Children [\$ 5,000.00]

■ **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 & Spouse [\$10,000.00]

Children [\$ 2,500.00]

■ **Single Dismemberment Benefit**

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

Employee & Spouse [\$5,000.00]

Children [\$1,250.00]

■ **Loss of Finger or Toe Benefit**

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

Employee & Spouse [\$500.00]

Children [\$130.00]

■ **Waiver of Premium**

After you are totally disabled for 90 consecutive days, due to a covered injury, 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.

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

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

[24 HR. Coverage/400 - EMP 23.10 MO.5.34 WK. • EMP/SP 29.10 MO. 6.72 WK. • EMP/CH 29.30 MO.6.77 WK. • EMP/FAM 35.30 MO. 8.15 WK.]
 [Off-the-Job Only/400 - EMP 18.50 MO.4.27 WK. • EMP/SP 24.50 MO. 5.66 WK. • EMP/CH 24.70 MO.5.70 WK. • EMP/FAM 30.70 MO. 7.09 WK.]

OPTIONAL ACCIDENTAL BODILY INJURY SPECIFIC LOSS RIDER

Form No. HA35B109

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 EMPLOYEE SICKNESS DISABILITY INCOME BENEFIT RIDER

Form No. HA35S109

Employee Sickness Disability Benefit...[\$400]
Pays the monthly employee sickness disability benefit each month you are totally disabled as a result of a covered sickness occurring on or off-the-job beginning after an elimination period of;

7th day, 14th day or 30th day
of total disability due to a sickness and is payable for a maximum period of;

6 months or 12 months
for each disability.

Monthly benefit is prorated on a daily basis. Portions of a month will be paid at a daily rate of 1/30th of the monthly benefit. A new disability is subject to a new elimination period, and a new 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 benefit period does not apply. Benefits will be paid for only one disability at a time even if it is caused by more than one covered sickness. Issue ages are 18-64 and coverage terminates at age 72.

\$400 Employee Sickness Disability Benefit

| Elim. Period | 6 Mo. Benefit | | 1 Yr Benefit | |
|--------------|---------------|--------|--------------|---------|
| | MO. | WK. | MO. | WK. |
| 7 Days | [\$17.20 | \$3.97 | \$20.60 | \$4.76] |
| 14 Days | [\$13.40 | \$3.10 | \$16.20 | \$3.74] |
| 30 Days | [\$ 8.40 | \$1.94 | \$10.00 | \$2.31] |

OPTIONAL SUPPLEMENTAL INJURY BENEFIT

Form No. HA35C109

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] |

OPTIONAL HOSPITAL INTENSIVE CARE Form # HI751109

• [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

The Accident Disability Plan – This is an Accident Policy, which provides Indemnity Benefits for Specified Events occurring in connection with treatment of Covered Injuries as a result of a Covered Accident. It does not provide benefits for any other sickness, condition or incapacity including pregnancy and childbirth or complications thereof. We will pay Total Disability benefits for Covered Injuries for the Primary Insured only. Benefits will be paid for only one disability at a time even if more than one Covered Injury 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 and The Monthly Hospital Confinement Benefit are 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.

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 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 infection, except one caused by an accidental cut or wound: 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.

Sickness Disability Rider – We will pay Total Disability benefits for Covered Sicknesses for the Primary Insured only. Benefits will be paid for only one disability at a time even if more than one Covered Sickness causes it. This benefit will not pay for periods of disability due to normal pregnancy and childbirth, including caesarean deliveries, in which the disability begins during the first ten months after the Rider's Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Period of Disability will be limited to 6 weeks for vaginal deliveries and 8 weeks for caesarean deliveries.

BENEFIT SELECTED

Amount of Monthly Disability [**\$400**]

24 Hour Coverage Off-the-Job Only

Premium Amount Per Pay Period

Accident Disability Income Plan \$ _____

Specific Loss Rider \$ _____

Sickness Disability Benefit \$ _____

Supplemental Injury Benefit \$ _____

Hospital Intensive Care \$ _____

Total Premium Per Period \$ _____

Additional Benefits Included

Initial Hospital Confinement

Injury Treatment Benefit

Health Screening Benefit

Accidental Death

All Shaded areas must be completed.

APPLICATION FOR ACCIDENT 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

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.

ACCIDENT DISABILITY - Plan [400] Emp Emp/Sp Emp/Ch Emp/Fam *Answer questions 4 - 8*

SPECIFIC LOSS RIDER - 3 UNITS
 Emp Emp/Sp Emp/Ch Emp/Fam

SUPPLEMENTAL INJURY RIDER - 3 UNITS
 Emp Emp/Sp Emp/Ch Emp/Fam

INTENSIVE CARE - \$300 \$450 \$600 \$ _____
 Emp Emp/Sp Emp/Ch Emp/Fam

Answer questions 9 and 10

SICKNESS DISABILITY INCOME RIDER \$ _____
Benefit Period 6 months 1 year
Elimination Period 7 days 14 days 30 days
Answer question 11 & record height & weight above

Applicant's Gross Monthly Income \$ _____

PREMIUM

ACC. DIS. _____ 24 Hour Coverage
Specific Loss _____ Off-the-Job Only
Sup. Injury _____
Intensive Care _____
Sickness Dis. _____ Mode:
TOTAL _____ MONTHLY PRD.

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

Answer 4(b) for the Sickness Disability Rider on 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

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

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

7. Primary Beneficiary & Relationship

8. Contingent Beneficiary & Relationship

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

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

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

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:

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



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

Build
A Plan

Accident Disability **INCOME PLAN**

- PROTECTS your most valuable asset...your ability to earn an income.
- PROVIDES an income...when you are disabled due to accidental injury on or off the job.
- PAYS 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 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

ACCIDENT DISABILITY INCOME PLAN With Specific Loss Rider

This outline of coverage provides a brief description of the important features of the policy. This describes an Accident Insurance Policy Form HA35A109, Off-The-Job Disability rider HA35N109, On-The-Job Disability rider HA35O109, Initial Hospital Confinement rider HA35I109, Injury Treatment rider HA35T109, Wellness rider HA35W109, Accidental Death & Dismemberment rider HA35D109, Specific Loss Rider HA35B109. *This is not the insurance contract, and only the actual policy provisions will control. It is therefore important that you Read Your Policy Carefully.*

Employee Monthly Off-The-Job Disability Income Benefit*[\$400 TO \$2,400]
Pays the disability income benefit each month the primary insured is totally disabled as a result of a covered accident occurring Off-the-job. Benefits begin the very first day of total disability and are payable for a period of up to one (1) year for each disability. You may choose any monthly disability amount up to 60% of your gross income.

Employee Monthly On-The-Job Disability Income Benefit* [\$400 TO \$2,400]
Pays the disability income benefit each month the primary insured is totally disabled as a result of a covered accident occurring On-the-job. Benefits begin the very first day of total disability and are payable for a period of up to one (1) year for each disability. You may choose any monthly disability amount up to 60% of your gross income.

■ **Initial Hospital Confinement Benefit [\$1,000]**
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, as an overnight resident bed patient. This benefit is paid once per confinement and only once per calendar year, per covered person.

■ **Monthly Hospital Confinement Benefit* [\$1,200]**
Pays the monthly hospital confinement benefit each month you are confined to a hospital as a result of a covered accident. Benefit is payable up to one year, per 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.

■ **Ambulance Benefit † [\$125]**
Pays the ambulance benefit for transportation by a licensed or professional ambulance company to a hospital. \$50 provided by the base accident plan and \$75 provided by the specified loss rider. 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.

■ **Injury Treatment Benefit [\$100]**
Pays the injury treatment benefit for treatment in a Emergency Room, Physician's Office or Urgent Care Facility for any one covered accident. This benefit is payable for each covered person per 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.

■ **Blood, Plasma or Platelets † [\$450]**
This benefit will pay for blood, plasma or platelets due to a covered accident. This benefit is payable for each covered person per covered accident.

■ **Health Screening Benefit [\$50]**
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.

■ **Fractures - broken bones † . up to [\$1,500]**
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 [\$1,350]**
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.

■ **Medical Equipment † [\$375]**
We will pay for medical equipment prescribed by a doctor as a result of a dislocation or fracture. Equipment eligible: crutches, wheelchair, back brace, leg brace, neck brace, cast, splint and walker. This benefit is payable for each covered person per covered accident. Use must begin within the first 90 days after a covered accident.

■ **Waiver of Premium**
After you are totally disabled for 90 consecutive days due to a covered injury, 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.

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

ACCIDENT DISABILITY INCOME PLAN

With Specific Loss Rider

Employee & Spouse Children

- **Accidental Death Benefit**[\$10,000 \$2,500]
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.
- **Double Indemnity Benefit**[\$20,000 \$5,000]
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.
- **Double Dismemberment Benefit**[\$10,000 \$2,500]
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.
- **Single Dismemberment Benefit**[\$ 5,000 \$1,250]
Payable in case of the loss of either hand, arm, foot, leg or sight in one eye.
- **Loss of Finger or Toe Benefit** [\$ 500 \$ 125]
Payable in case of the loss of one or more entire fingers or toes.

MONTHLY DISABILITY INCOME

| 24-HOUR COVERAGE | \$400 | \$600 | \$800 | \$1,000 | \$1,200 | \$1,400 | \$1,600 | \$1,800 | \$2,000 | \$2,200 | \$2,400 |
|---------------------------|--------|-------|-------|---------|---------|---------|---------|---------|---------|---------|---------|
| Employee Monthly Premium: | [27.10 | 32.80 | 38.50 | 44.20 | 49.90 | 55.60 | 61.30 | 67.00 | 72.70 | 78.40 | 84.10] |
| Employee Weekly Premium: | [6.26 | 7.57 | 8.89 | 10.20 | 11.52 | 12.84 | 14.15 | 15.47 | 16.78 | 18.10 | 19.41] |

| OFF-THE-JOB ONLY | \$400 | \$600 | \$800 | \$1,000 | \$1,200 | \$1,400 | \$1,600 | \$1,800 | \$2,000 | \$2,200 | \$2,400 |
|---------------------------|--------|-------|-------|---------|---------|---------|---------|---------|---------|---------|---------|
| Employee Monthly Premium: | [22.50 | 25.90 | 29.30 | 32.70 | 36.10 | 39.50 | 42.60 | 46.30 | 49.70 | 53.10 | 56.50] |
| Employee Weekly Premium: | [5.20 | 5.98 | 6.77 | 7.55 | 8.34 | 9.12 | 9.90 | 10.69 | 11.47 | 12.26 | 13.04] |

Add For Family [\$17.45 mo. / \$4.03 wk. **1 Parent** \$9.75 mo. / \$2.25 wk. **Spouse** \$7.70 mo. / \$1.78 wk.]

[*Monthly benefits are prorated on a daily basis. ** 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 Injury Treatment Benefit for Emp (for Emp/Fam, add another \$3.50 per month per \$50 of Injury Treatment Benefit, for Emp/Ch add another \$2.85 per \$50, for Emp/Sp add another \$2.55 per \$50). † Refers to benefits provided by Specific Loss Rider.]

Partial List of Fractures & Dislocations

Fractures

Dislocations

| | |
|--|---|
| Each Hip [\$1500] | Each Hip [\$1350] |
| Each Thigh (<i>Femur</i>) [\$1500] | Each Knee [\$ 975] |
| Skull <i>Depressed</i> [\$ 525] | Each Shoulder [\$ 750] |
| <i>Simple</i> [\$1125] | Each Ankle [\$ 600] |
| Each Leg (<i>Tibia and/or Fibula</i>) [\$ 900] | Bone or Bones of the Foot (<i>excluding toes</i>).. [\$ 600] |
| Each Ankle [\$ 750] | Bone or Bones of the Hand (<i>excluding fingers</i>) [\$ 525] |
| Each Knee Cap (<i>Patella</i>) [\$ 750] | Each Collar Bone [\$ 450] |
| Each Forearm (<i>Radius and/or Ulna</i>) [\$ 750] | Each Wrist [\$ 375] |
| Each Foot (<i>except toes</i>) [\$ 750] | Each Elbow [\$ 300] |
| Each Hand [\$ 750] | Each Toe or Each Finger [\$ 120] |
| Each Wrist (<i>except fingers</i>) [\$ 750] | |
| Lower Jaw (<i>except Alveolar process</i>) [\$ 600] | 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. |
| 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] | |

OPTIONAL EMPLOYEE SICKNESS DISABILITY INCOME BENEFIT RIDER

Form No. HA35S109

Employee Sickness Disability Benefit...per [\$100]
Pays the monthly employee sickness disability benefit each month you are totally disabled as a result of a covered sickness occurring on or off-the-job beginning after an elimination period of;

7th day, 14th day or 30th day
of total disability due to a sickness and is payable for a maximum period of;

6 months or 12 months
for each disability.

Monthly benefit is prorated on a daily basis. Portions of a month will be paid at a daily rate of 1/30th of the monthly benefit. A new disability is subject to a new elimination period, and a new 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 benefit period does not apply. Benefits will be paid for only one disability at a time even if it is caused by more than one covered sickness. Issue ages are 18-64 and coverage terminates at age 72.

\$100 Employee Sickness Disability Benefit

| Elim. Period | 6 Mo. Benefit | | 1 Yr Benefit | |
|-----------------|---------------|--------|--------------|---------|
| | MO. | WK. | MO. | WK. |
| 7 Days | [\$4.30 | \$1.00 | \$5.15 | \$1.19] |
| 14 Days | [\$3.35 | \$.78 | \$4.05 | \$.94] |
| 30 Days | [\$2.10 | \$.49 | \$2.50 | \$.58] |

OPTIONAL SUPPLEMENTAL INJURY BENEFIT

Form No. HA35C109

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] |

OPTIONAL HOSPITAL INTENSIVE CARE Form # HI751109

• 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

The Accident Disability Plan – This is an Accident Policy, which provides Indemnity Benefits for Specified Events occurring in connection with treatment of Covered Injuries as a result of a Covered Accident. It does not provide benefits for any other sickness, condition or incapacity including pregnancy and childbirth or complications thereof. We will pay Total Disability benefits for Covered Injuries for the Primary Insured only. Benefits will be paid for only one disability at a time even if more than one Covered Injury 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 and The Monthly Hospital Confinement Benefit are 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.

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 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 infection, except one caused by an accidental cut or wound: 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.

Sickness Disability Rider – We will pay Total Disability benefits for Covered Sicknesses for the Primary Insured only. Benefits will be paid for only one disability at a time even if more than one Covered Sickness causes it. This benefit will not pay for periods of disability due to normal pregnancy and childbirth, including caesarean deliveries, in which the disability begins during the first ten months after the Rider’s Effective Date. If the Total Disability is a result of normal pregnancy and childbirth, the Maximum Period of Disability will be limited to 6 weeks for vaginal deliveries and 8 weeks for caesarean deliveries.

| BENEFIT SELECTED | |
|--|---|
| Amount of Monthly Disability \$_____ | |
| <input type="checkbox"/> 24 Hour Coverage | <input type="checkbox"/> Off-the-Job Only |
| Premium Amount Per Pay Period | |
| Accident Disability Income Plan | \$_____ |
| <input type="checkbox"/> Sickness Disability Benefit | \$_____ |
| <input type="checkbox"/> Supplemental Injury Benefit | \$_____ |
| <input type="checkbox"/> Hospital Intensive Care | \$_____ |
| Total Premium Per Period | \$_____ |
| Additional Benefits Included | |
| Specific Loss Rider • Accidental Death | |
| Initial Hospital Confinement | |
| Injury Treatment Benefit | |
| Health Screening Benefit | |

All Shaded areas must be completed.

APPLICATION FOR ACCIDENT 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

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.

ACCIDENT DISABILITY w/ 3 Units Specific Loss Rider - \$_____ Monthly Disability Benefit
 Emp Emp/Sp Emp/Ch Emp/Fam *Answer questions 4 - 8*

ADDITIONAL INJURY TREATMENT BENEFIT
 [\$150 \$200 \$250 \$300]

SUPPLEMENTAL INJURY RIDER - 3 UNITS
 Emp Emp/Sp Emp/Ch Emp/Fam

INTENSIVE CARE - [\$300 \$450 \$600] \$_____
 Emp Emp/Sp Emp/Ch Emp/Fam *Answer questions 9 & 10*

SICKNESS DISABILITY INCOME RIDER \$_____
Benefit Period 6 months 1 year
Elimination Period 7 days 14 days 30 days *Answer question 11 & record height & weight above*

| | |
|---|---|
| 4. Is any proposed insured currently in the hospital or receiving disability payments? <i>If yes, give name of person(s) and details.</i> <input type="checkbox"/> YES <input type="checkbox"/> 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)? <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|---|

Answer 4(b) for the Sickness Disability Rider on 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)? <input type="checkbox"/> YES <input type="checkbox"/> NO | 9a. If this is a Two Parent Family Rider, is any person to be insured currently pregnant or taking fertility drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|---|

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

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

| | |
|--|--|
| 5. Will the policy applied for replace any insurance in force on any proposed covered person? <input type="checkbox"/> YES <input type="checkbox"/> 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: |
|--|--|

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

| | |
|--|---|
| 7. Primary Beneficiary & Relationship | <i>Any person named will not be covered by this policy/rider.</i> |
| 8. Contingent Beneficiary & Relationship | |

APPLICATION FOR ACCIDENT 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Had driver's license suspended or revoked in past 24 months? | <input type="checkbox"/> | <input type="checkbox"/> | | (g) Disease or disorder of stomach, liver, intestines, bladder, kidney, or reproductive organs, hemorrhoids or hernia? | <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"/> | | (h) Cancer, tumor, diabetes, Leukemia, gland or blood disorders? | <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"/> | | (i) Alcohol or drug usage or abuse? | <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"/> | | (j) Within the last five years, has any person to be covered had any ailment of the back? | <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.

| | |
|---|---|
| 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? | Home/Office Phone: Cell Phone: Email address: |
|---|---|

CERTIFICATION- The Applicant hereby makes application to Life Insurance Company of Alabama for a policy or policies of insurance and represents that the statements and answers set forth under Parts 1 and 2 of this application by whomsoever written, are full, complete and true to the best of Applicant's knowledge and belief and agrees that they shall be considered as the basis of any insurance which may be issued hereon. The undersigned applicant and agent acknowledge that the applicant has read, or had read to him/her, the completed application and that he/she realizes that policy issuance is based upon statements and answers provided herein. I further understand that the policy and rider(s) is not effective until the effective date specified in the policy and that the policy applied for will not pay benefits for any claims which occur prior to the effective date of the policy.

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.

Arkansas Only:
No person to be covered for specified disease is also covered by any Title XIX program Medicaid or similar coverage. Yes No

Signed at _____
City State

Date _____
Month Day Year

X _____
Signature of Proposed Primary Insured

AGENT'S STATEMENT: To the best of your knowledge does this insurance replace any existing insurance? Yes No
If Yes, give name of company and policy number.

SERFF Tracking Number: *WAKE-126166446* *State:* *Arkansas*
Filing Company: *Life Insurance Company of Alabama* *State Tracking Number:* *42502*
Company Tracking Number:
TOI: *H02I Individual Health - Accident Only* *Sub-TOI:* *H02I.000 Health - Accident Only*
Product Name: *LOA Accident Forms 2009*
Project Name/Number: *LOA/052009*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: WAKE-126166446 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
 Company Tracking Number:
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: LOA Accident Forms 2009
 Project Name/Number: LOA/052009

Rate/Rule Schedule

| Review Status: | Document Name: | Affected Form Numbers: (Separated with commas) | Rate Action: | Rate Action Information: | Attachments |
|-----------------|----------------|---|--------------|--------------------------|--------------------------------|
| Approved-Closed | Rate Pages | HA35A109 AR, HA35N109, HA35S109 | New | | Accident Rates 04232009.pdf |

LIFE INSURANCE COMPANY OF ALABAMA
Accident Product
Exhibit B - Monthly Gross Premium Rates per Unit

Base Coverage - Form HA35A109

| <u>Coverage</u> | <u>Per Unit</u> | |
|------------------------|------------------|-----------------|
| | <u>Ambulance</u> | <u>Hospital</u> |
| Named Insured | \$0.20 | \$0.10 |
| Named Insured & Spouse | \$0.60 | \$0.15 |
| One Parent Family | \$1.15 | \$0.15 |
| Two Parent Family | \$1.55 | \$0.20 |

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
Accident Product
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-126166446 State: Arkansas
Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
Company Tracking Number:
TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
Product Name: LOA Accident Forms 2009
Project Name/Number: LOA/052009

Supporting Document Schedules

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

READABILITY COMPLIANCE CERTIFICATION

Name and Address of Insurer:

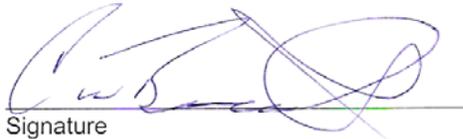
Life Insurance Company of Alabama
302 Broad Street
Gadsden, Alabama 35901

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 |
|------------------------------|----------------|--------------|
| Accident Indemnity Policy | HA35A109 AR | 43.5 |
| Sickness Disability Rider | HA35S109 | 42.7 |
| Off-the-Job Disability Rider | HA35N109 | 42.3 |

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

**ARKANSAS
Rule and Regulation 19 Certification**

| <u>Title of Form(s)</u> | <u>Form Number</u> |
|------------------------------|--------------------|
| Accident Indemnity Policy | HA35A109 AR |
| Sickness Disability Rider | HA35S109 |
| Off-the-Job Disability Rider | HA35N109 |
| Application/Brochure | BHD75 |
| Combination Application | MPAH309 |

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



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-126166446 State: Arkansas
 Filing Company: Life Insurance Company of Alabama State Tracking Number: 42502
 Company Tracking Number:
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: LOA Accident Forms 2009
 Project Name/Number: LOA/052009

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 | Accident Indemnity Policy | 05/27/2009 | Accident Policy HA35A109 AR.pdf |



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

Protecting your financial security

ACCIDENT INDEMNITY 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 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.

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

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Right of Conversion 9

General Provisions 9

Application..... Attached

POLICY SCHEDULE PAGE

Policy Number: [12345678]
Primary Insured: [John Doe]

Policy Effective Date: [July 1, 2008]

Premium Payment Modes:

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

Mode Selected: [Annual]

Coverage Type: [Individual, Individual and Spouse, One Parent Family, Two Parent Family]

| Benefit Description | Benefit Amount | Modal Premium |
|------------------------------|----------------|---------------|
| Base Policy | | |
| Ambulance | [\$ 50.00] | [\$ XX.XX] |
| Monthly Hospital Confinement | [\$ 100.00] | [\$ XX.XX] |

| Benefit Description ¹ | Monthly Benefit Amount | Elimination Period (Days) | Maximum Benefit Period (Months) | Modal Premium | Rider Effective Date |
|----------------------------------|------------------------|---------------------------|---------------------------------|---------------|----------------------|
| [Off-the-Job Disability Rider] | [\$ 100.00] | [7 Days] | [6 Months] | [\$ XX.XX] | [07/01/2008] |
| [On-the-Job Disability Rider] | [\$ 100.00] | [7 Days] | [6 Months] | [\$ XX.XX] | [07/01/2008] |
| [Sickness Disability Rider] | [\$ 100.00] | [7 Days] | [6 Months] | [\$ XX.XX] | [07/01/2008] |

| Benefit Description | Coverage Type | Benefit Amount | Modal Premium | Rider Effective Date |
|--|----------------|----------------|---------------|----------------------|
| [Injury Treatment Benefit Rider] | [Individual] | [\$ 50.00] | [\$ XX.XX] | [07/01/2008] |
| [Initial Hospital Confinement Benefit Rider] | [Family – 2] | [\$ 1,000.00] | [\$ XX.XX] | [07/01/2008] |
| [Health Screening Rider] | [Ind & Spouse] | [\$ 10.00] | [\$ XX.XX] | [07/01/2008] |

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

¹ Disability Riders are 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.

“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.

“Covered Injury” is an Injury resulting from a Covered Accident. If multiple Injuries occur as a result of a single Covered Accident, they will be considered as a single Covered Injury.

“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.

“Dentist” means one who has been professionally trained and licensed to practice Dentistry and is working within the scope of his/her license.

“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).

“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 Cover Person’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 a Covered Person 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.

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

“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. A Dentist is NOT considered a Physician.

“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.

“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.

“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 a Covered Person sustains a Covered Injury as the result of a Covered Accident after the Policy Effective Date as shown on the Policy Schedule Page and while this Policy 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 the Covered Injury while this Policy is in force, subject to:

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

Ambulance Indemnity Benefit

We will pay the Ambulance Indemnity Benefit as shown on the Policy Schedule Page if a Covered Person incurs the Specified Event required for the Ambulance Indemnity Benefit. The Specified Event required for the Ambulance Indemnity Benefit is transportation of a Covered Person by Ambulance to a Hospital for the

treatment of a Covered Injury as a result of a Covered Accident and occurs when the Covered Person is transported in the Ambulance.

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

Monthly Hospital Confinement Indemnity Benefit

We will pay the Monthly Hospital Confinement Indemnity Benefit as shown on the Policy Schedule Page for each month, up to 12 months, a Covered Person incurs the Specified Event required for the Monthly Hospital Confinement Indemnity Benefit. The Specified Event required for the Monthly Hospital Confinement Indemnity Benefit is confinement of a Covered Person in a Hospital as an inpatient for the treatment of a Covered Injury as the result of a Covered Accident as specified below and initially occurs on the first day the Covered Person is so confined. Subsequent Specified Events occur on the same day each month as long as the Covered Person remains continuously confined to the Hospital. 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. 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; or
- 4) the day of discharge from the Hospital except where the day of discharge and the day of admission are the same and the confinement was for at least 18 hours.

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

The Monthly Hospital Confinement Indemnity Benefit is payable for up to 12 months per Covered Accident per Covered Person.

LIMITATIONS AND EXCLUSIONS

This is an Accident Policy which only provides Indemnity Benefits for Specified Events occurring in connection with treatment of Covered Injuries as a result of a Covered Accident. It does not provide benefits for any other sickness, condition or incapacity.

We will NOT pay any Indemnity Benefit for Specified Events relating to Pre-existing Conditions except after two years from the Policy Effective Date or attached Rider Effective Dates.

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 Ambulance Indemnity Benefit is payable once per Covered Person per Covered Accident.

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

The Monthly Hospital Confinement Indemnity Benefit is payable for up to 12 months per Covered Accident per Covered Person.

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; or
- 4) the day of discharge from the Hospital except where the day of discharge and the day of admission are the same and the confinement was for at least 18 hours.

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 occurring prior to the Policy Effective Date; or
 - c) Injury 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 Covered Person 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 or physical infirmity or disease, or treatment for the infirmity or disease; or
 - o) pregnancy and childbirth or complications thereof; or
 - p) Sickness at any time; or
 - q) infection, except one caused by an accidental cut or wound; 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 Covered Person'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, 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 not terminate provided We receive a copy of Your death certificate and Written Notice to continue coverage within thirty (30) days of the date of Your death. If Your covered Legal Spouse or Dependent Child dies, You may request in writing to remove them from Your coverage.

If Your Legal Spouse is a Covered Person under this Policy and You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage, insurance coverage provided by this Policy on Your former Legal Spouse will automatically terminate on the 61st day following 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.

RIGHT OF CONVERSION

If You and Your Legal Spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your Legal Spouse was a Covered Person under this Policy, then Your former Legal Spouse may apply and receive, without evidence of insurability, a Policy providing coverage NOT greater than the terminated coverage. To obtain the Policy, Your former Legal Spouse must make application to Us within sixty (60) days following the date of the decree of dissolution of marriage. The Primary Insured under this Policy at the time of the dissolution of marriage shall remain the Primary Insured under this Policy. Coverage terminates automatically for the former Legal Spouse on the 61st day following the date of the decree of the dissolution of marriage. Any covered Dependent Children may be covered under either Policy, but NOT both.

A Covered Person whose dependency terminates and who desires to continue coverage as a Primary Insured under a separate Policy may do so by notifying Us of the request in writing. The Dependent Child will have the right to continue coverage as the Primary Insured under a separate Policy providing coverage NOT greater than the previous coverage without a requirement for evidence of insurability and without interruption in coverage. To obtain the Policy, the Dependent Child must make application to Us within thirty-one (31) days after the termination of insurance under this Policy.

In order to be considered for coverage, any Legal Spouse or Dependent Child not listed on the initial application must make written application.

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, qualified expenses and medical records, subject to the terms and conditions of the Proof of Loss provision. Additional documentation of Proof of 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 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:
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- 1) less than sixty (60) days after sufficient written Proof of Loss has been furnished as required; or
- 2) more than three (3) years after 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 Covered Person 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 may 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.

Pre-existing Conditions: The Indemnity 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 Loss: Written Proof of Loss must be given to Us within ninety (90) days after the date of such loss or the date of the Specified Event. Written Proof of Loss must include sufficient documentation furnished by the medical provider of the qualified treatment, expenses and medical records. If You are not able to give Us sufficient Proof of 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 loss or 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 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 incurred 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 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 Accident 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 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: Indemnity Benefits will be paid within thirty (30) working days once We receive sufficient written Proof of 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 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.