

SERFF Tracking Number: UNUM-126145902 State: Arkansas
Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 42372
Company Tracking Number: CI-1.0-AR
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
Limited Benefit
Product Name: Individual Critical Illness - 1.0
Project Name/Number: Individual Critical Illness - 1.0/CI-1.0-AR

Filing at a Glance

Company: Colonial Life & Accident Insurance Company

Product Name: Individual Critical Illness - 1.0 SERFF Tr Num: UNUM-126145902 State: Arkansas

TOI: H071 Individual Health - Specified Disease SERFF Status: Closed-Approved- State Tr Num: 42372

- Limited Benefit Closed

Sub-TOI: H071.001 Critical Illness

Co Tr Num: CI-1.0-AR

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Cathy Brooks, Donna

Disposition Date: 08/25/2009

Mazloom, Angela Parker, Lauren

Sease, Annette Smith, Tonia

Garbutt, Tyra Marshall

Date Submitted: 05/11/2009

Disposition Status: Approved-

Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Individual Critical Illness - 1.0

Status of Filing in Domicile: Pending

Project Number: CI-1.0-AR

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/25/2009

Explanation for Other Group Market Type:

State Status Changed: 08/25/2009

Deemer Date:

Created By: Tonia Garbutt

Submitted By: Tonia Garbutt

Corresponding Filing Tracking Number: CI-1.0-AR

Filing Description:

Enclosed for your consideration and approval are the following new individual specified critical illness policy form and outline of coverage.

Form Description

Flesch Score

SERFF Tracking Number: UNUM-126145902 State: Arkansas
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Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Colonial Life & Accident Insurance Company	\$50.00	05/11/2009	27772337

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/25/2009	08/25/2009

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	08/10/2009	08/10/2009	Lauren Sease	08/19/2009	08/19/2009
Pending Industry Response	Rosalind Minor	05/15/2009	05/15/2009	Lauren Sease	08/07/2009	08/07/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request for Extension	Note To Reviewer	Annette Smith	07/27/2009	07/27/2009
Replacement pending	Note To Reviewer	Lauren Sease	05/14/2009	05/14/2009
Rquest for extension	Note To Filer	Rosalind Minor	07/27/2009	

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Disposition

Disposition Date: 08/25/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Submission Letter	Approved-Closed	Yes
Supporting Document (revised)	Revised Exhibit A	Approved-Closed	No
Supporting Document	Exhibit A	Replaced	No
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Compliance Certification	Approved-Closed	Yes
Supporting Document	NAIC Transmittal	Approved-Closed	Yes
Supporting Document	Resubmission letter	Approved-Closed	Yes
Supporting Document	Resubmisison letter 2-AR	Approved-Closed	Yes
Form (revised)	Individual Critical Illness Policy	Approved-Closed	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Individual Critical Illness Policy	Replaced	Yes
Form	Outline of Coverage	Replaced	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/10/2009
Submitted Date 08/10/2009

Respond By Date

Dear Tonia Garbutt,

This will acknowledge receipt of the captioned filing.

Objection 1

- Outline of Coverage (Supporting Document)
- Individual Critical Illness Policy, CI-1.0-AR (Form)

Comment:

On Page 11 of the policy and also on the outline, there is a statement that reads: "No benefits are payable for conditions other than the Specified Critical Illnesses defined in the policy".

Please add to this statement language that is outlined under Rule 18, APPENDIX 1 A (3) which reads: "Specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other conditions(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s)."

We appreciate your understanding and cooperation.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/19/2009
Submitted Date 08/19/2009

Dear Rosalind Minor,

SERFF Tracking Number: UNUM-126145902 State: Arkansas
Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 42372
Company Tracking Number: CI-1.0-AR
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Limited Benefit
Product Name: Individual Critical Illness - 1.0
Project Name/Number: Individual Critical Illness - 1.0/CI-1.0-AR

Comments:

We are responding to your August 10, 2009 disapproval letter.

Response 1

Comments: See resubmission letter.

Related Objection 1

Applies To:

- Outline of Coverage (Supporting Document)
- Individual Critical Illness Policy, CI-1.0-AR (Form)

Comment:

On Page 11 of the policy and also on the outline, there is a statement that reads: "No benefits are payable for conditions other than the Specified Critical Illnesses defined in the policy".

Please add to this statement language that is outlined under Rule 18, APPENDIX 1 A (3) which reads: "Specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other conditions(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s)."

We appreciate your understanding and cooperation.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Resubmission letter 2-AR

Comment: See attached.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you,

Lauren Sease

Sincerely,

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Product Name: Individual Critical Illness - 1.0
Project Name/Number: Individual Critical Illness - 1.0/CI-1.0-AR

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 05/15/2009
Submitted Date 05/15/2009

Respond By Date

Dear Tonia Garbutt,

This will acknowledge receipt of the captioned filing.

Objection 1

- Outline of Coverage (Supporting Document)
- Individual Critical Illness Policy, CI-1.0-AR (Form)

Comment:

On Page 11 there is a statement that reads: "No benefits are payable for conditions other than the Specified Critical Illnesses defined in the policy." Rule 18, APPENDIX 1. A. (3) states...."Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other conditions(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

On the same page, your attention is called to the 180 days. Rule 18, APPENDIX 1. A. (5) states...."No policy issued pursuant to this Section shall contain a waiting or probationary period greater than thirty (30) days.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 08/07/2009
Submitted Date 08/07/2009

Dear Rosalind Minor,

Comments:

SERFF Tracking Number: UNUM-126145902 State: Arkansas
 Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 42372
 Company Tracking Number: CI-1.0-AR
 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.001 Critical Illness
 Limited Benefit
 Product Name: Individual Critical Illness - 1.0
 Project Name/Number: Individual Critical Illness - 1.0/CI-1.0-AR

We are responding to your letter dated May 15, 2009.

Response 1

Comments: See revised forms.

Related Objection 1

Applies To:

- Outline of Coverage (Supporting Document)
- Individual Critical Illness Policy, CI-1.0-AR (Form)

Comment:

On Page 11 there is a statement that reads: "No benefits are payable for conditions other than the Specified Critical Illnesses defined in the policy." Rule 18, APPENDIX 1. A. (3) states...."Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified disease(s) but also for any other conditions(s) or disease(s), directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

On the same page, your attention is called to the 180 days. Rule 18, APPENDIX 1. A. (5) states...."No policy issued pursuant to this Section shall contain a waiting or probationary period greater than thirty (30) days.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Health - Actuarial Justification

Comment: We've attached a revised Actuarial Memorandum.

Satisfied -Name: Revised Exhibit A

Comment: See attached.

Satisfied -Name: Resubmission letter

Comment: See attached.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Individual Critical Illness Policy	CI-1.0-AR		Policy/Contract/Fraternal Certificate	Revised	same	51.800	CI-1.0-AR -

SERFF Tracking Number: UNUM-126145902 State: Arkansas
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71254.pdf

Previous Version

Individual Critical Illness Policy	CI-1.0-AR	Policy/Contract/Fraternal Certificate	Initial		51.800	CI-1.0-AR - 71254[1].pdf
Outline of Coverage	CI-1.0-O-AR	Outline of Coverage	Revised	same	50.300	CI-1.0-O-AR - 71255.pdf
Previous Version						
Outline of Coverage	CI-1.0-O-AR	Outline of Coverage	Initial		50.300	CI-1.0-O-AR - 71255[1].pdf

No Rate/Rule Schedule items changed.

Thank you in advance for your patience and help with this filing.

Sincerely,

Angela Parker, Annette Smith, Cathy Brooks, Donna Mazloom, Lauren Sease, Tonia Garbutt, Tyra Marshall

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Note To Reviewer

Created By:

Annette Smith on 07/27/2009 02:20 PM

Last Edited By:

Rosalind Minor

Submitted On:

08/25/2009 10:39 AM

Subject:

Request for Extension

Comments:

This note is to request an extension for our response to your objections on the CI-1.0-AR filing.

Thanks in advance for your consideration.

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Note To Reviewer

Created By:

Lauren Sease on 05/14/2009 09:09 AM

Last Edited By:

Rosalind Minor

Submitted On:

08/25/2009 10:39 AM

Subject:

Replacement pending

Comments:

An error has been discovered in the Actuarial Memorandum/rates sent with this filing.

We expect to be able to replace the corrected policy form and Actuarial Memorandum early next week.

We apologize for any inconvenience this may have caused.

Thank you in advance,
Lauren F. Sease

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/25/2009	CI-1.0-AR	Policy/Contract	Individual Critical Illness Policy Certificate	Revised	Replaced Form #: same Previous Filing #: same	51.800	CI-1.0-AR - 71254.pdf
Approved-Closed 08/25/2009	CI-1.0-O-AR	Outline of Coverage	Outline of Coverage	Revised	Replaced Form #: same Previous Filing #: same	50.300	CI-1.0-O-AR - 71255.pdf

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
[1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 www.coloniallife.com]
A Stock Company

LIMITED BENEFIT HEALTH COVERAGE FOR SPECIFIED CRITICAL ILLNESS

**THIS IS AN INDIVIDUAL SPECIFIED CRITICAL ILLNESS POLICY.
THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND
NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

Guaranteed Renewable Subject to Payment of the Maximum Benefit Amount for Specified Critical Illness

This policy is guaranteed renewable as long as you pay the premiums when they are due or within the grace period, up to the date of payment of the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule. Your premium can be changed only if we change it on all policies of this kind in force in the state where the policy was issued.

Please Read This Policy Carefully

This policy is a legal contract between you and us. Please read it carefully. We want you to be pleased with the coverage it provides. To understand your coverage, you must read this policy as a whole.

In this policy, the words *named insured* refer to the person identified on the Policy Schedule. The words *you* or *your* refer only to the named insured. The words *covered person* refer to any person covered under this policy as described on the Policy Schedule. The male pronoun includes the female whenever used. The words *we*, *us* or *our* refer to Colonial Life & Accident Insurance Company.

Your Right to Return This Policy Within 30 Days

If, for any reason, you are not satisfied with this policy, you can return it to us at our home office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this policy as if it never existed. Any premium paid will be refunded.



Secretary



President and CEO]

**This is a limited policy. Please read it carefully.
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

If you should have any questions, need information about your coverage or assistance in resolving complaints, please contact your agent or Colonial Life at 1800.325.4368. In the event that we fail to provide you with reasonable and adequate service, feel free to contact the Insurance Department.

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
501-371-2640
1-800-852-5494

SECTION II - POLICY GUIDE

SECTION I - FACE PAGE

SECTION II - POLICY GUIDE

SECTION III - POLICY SCHEDULE

SECTION IV - YOUR CONTRACT WITH US

SECTION V - YOUR PREMIUM PAYMENTS

SECTION VI - IMPORTANT WORDS IN THIS POLICY

SECTION VII - BENEFITS

SECTION VIII - WHAT IS NOT COVERED BY THIS POLICY

SECTION IX - YOUR CLAIM FOR BENEFITS

SECTION X - OTHER IMPORTANT PROVISIONS

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

SECTION III - POLICY SCHEDULE

Named Insured: [John Doe] **Policy Number:** [1234567890
YE9999999999]

Policy Coverage Effective Date: [January 20, 2009] **Monthly Premium:** [\$ 17.90]

Coverage Type: [Named Insured] [Named Insured and Spouse] [Named Insured and Dependent Children] [Named Insured, Spouse and Dependent Children]

BENEFITS

Face Amount for Named Insured [\$5,000-\$150,000 in \$1,000 increments]

[Face Amount for Spouse] [50% of Face Amount for Named Insured]

[Face Amount for Dependent Children] [25% of Face Amount for Named Insured]

The Face Amount(s) [and the Maximum Benefit Amount for Specified Critical Illness] will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75.

Specified Critical Illness	Percentage of Face Amount
[Cancer	100%
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Permanent Paralysis due to a Covered Accident	100%
Coma	100%
Blindness	100%
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%
[Coronary Artery Bypass Graft Surgery	25%
[Coronary Artery Disease	25%
[Carcinoma in Situ	25%

[Maximum Benefit Amount for Specified Critical Illness: 100% of the Face Amount for each covered person]

[Maximum Benefit Amount for Specified Critical Illness: [\$15,000-\$450,000 in \$3,000 increments]]

[Health Screening Benefit [\$25.00-\$150.00 in \$25.00 increments]
Payable once per calendar year, per covered person]

[Cancer Vaccine Benefit \$50
Payable once per covered person, per lifetime]

This page intentionally left blank.

SECTION IV - YOUR CONTRACT WITH US

Coverage Provided by This Policy

According to the provisions of this policy, we insure any covered person against the Specified Critical Illnesses [and for certain health screening tests].

When making a benefit determination under this policy, we have discretionary authority to determine the covered person's eligibility for the benefits and to interpret the terms and provisions of the policy. All benefit determinations must be reasonable and based on the terms of this policy and the facts and circumstances of each claim.

Entire Contract: Changes

This policy is a legal contract between you and us. We provide the insurance coverage stated, subject to the terms of this policy. We do this in return for your application and your first payment called a *premium*. The premium for this policy is shown on the Policy Schedule.

Whenever we use the word *policy*, we mean the entire contract. The entire contract consists of:

- the policy, including the Policy Schedule;
- the attached copy of the application; and
- any attached riders or endorsements.

Riders and endorsements add provisions or change the terms of the policy. Any changes made to this policy must be attached in writing and signed by one of our executive officers at our home office. No agent or anyone else can change this policy or waive any of its provisions.

Who is Covered By This Policy

If this is a named insured policy as shown on the Policy Schedule, we insure you, the named insured.

If this is a named insured and spouse policy as shown on the Policy Schedule, we insure you and your spouse.

If this is a named insured and dependent children policy as shown on the Policy Schedule, we insure you and your dependent children.

If this is a named insured, spouse and dependent children policy as shown on the Policy Schedule, we insure you, your spouse and your dependent children.

Spouse means the person married to you on the day we issue this policy.

Dependent children means any natural children, step-children, legally adopted children, foster children or children under your charge, care and control for whom you have filed a petition to adopt who are:

- unmarried;
- chiefly dependent on you or your spouse for support; and
- younger than age 26.

Children born to dependent children of the named insured or the named insured's spouse are not covered under this policy.

Coverage on your newborn children begins from the moment of birth. If this is a named insured policy or a named insured and spouse policy, this coverage on the newborn child will end 90 days later if you do not notify us in writing of the birth and complete the required application form. The first premium for named insured and dependent children or named insured, spouse and dependent children coverage is due on the next premium due date after the birth of the newborn.

Coverage on your adopted children begins with the earlier of:

1. the date of placement into your custody for adoption;
2. the moment of birth if the petition for adoption is filed within 60 days after the birth; or
3. the date of filing the petition for adoption if the petition for adoption is filed more than 60 days after the birth.

If this is a named insured policy or a named insured and spouse policy, this coverage on the adopted child will end 90 days later if you do not notify us in writing of the adoption or placement into your custody for adoption and complete the required application form. The first premium for named insured and dependent children or named insured, spouse and dependent children coverage is due on the next premium due date after the adoption or placement.

Coverage on a child placed in your custody for adoption will also terminate upon the dismissal or denial of a petition for adoption.

After the Policy Coverage Effective Date, if any members of your family are added to this policy, including a new spouse or child, you must:

- notify us that you wish to add a person to your coverage;
- complete the required application form; and
- pay any additional premium for him.

Effective Date of This Policy

This policy begins at 12:01 a.m. in the time zone where you live on the Policy Coverage Effective Date shown on the Policy Schedule.

SECTION V - YOUR PREMIUM PAYMENTS

When and Where to Pay Premiums

The premiums for this policy must be paid to us at our home office in advance and when they are due.

The premium due dates are based on:

- the date and month for which we first received premium; and
- the premium frequency.

The *premium frequency* is how often the premiums are paid.

Grace Period (If Premiums Are Not Paid When Due)

After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the *grace period*. During the grace period this policy will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate at the end of the grace period.

Refund of Unearned Premium

If this policy terminates because you, the named insured, die, we will refund any premiums you have paid for any period after the monthly anniversary date following termination. The monthly anniversary date occurs each month on the same date as the date for which we first received premium.

Our Right to Change Premiums

We have the right to change the premium we charge. However, we cannot single anyone out for a rate change. If we make a change, it will be made on all policies of this kind in force in the state where the policy was issued. If we plan to make a change, we will send a notice at least 31 days before we make it. We will not change premiums more than once in a 12-month period.

Unpaid Premium

When a claim is paid under this policy, any premium then due and unpaid may be deducted by us from the claim payment.

Reinstatement (How to Put This Policy Back in Force)

If the premium is not paid by the end of the grace period, this policy will no longer be in force. However, the policy may be put back in force. This is called *reinstatement*. You can ask us or one of our agents about reinstatement. If we accept the premium and do not require a reinstatement application, this policy will be reinstated on the date the premium is received.

If we do require a reinstatement application at the time we accept the premium, a conditional receipt will be given for the premium. If we approve the reinstatement application, this policy will be reinstated on the date we approve it. If we do not

notify you that we have approved or disapproved the reinstatement application, this policy will be reinstated on the 45th day after the date on the conditional receipt.

The reinstated policy will cover:

- Specified Critical Illnesses that have a Date of Diagnosis more than 10 days after the reinstatement date; and
- [covered health screening tests that occur] [and] [administration of a covered Cancer Vaccine] more than 10 days after the reinstatement date].

We have the right to make changes in this policy before we reinstate it. Any changes will be made in a rider to be attached to the reinstated policy. In every other way, your rights and our rights will be the same.

SECTION VI - IMPORTANT WORDS IN THIS POLICY

Accident

Accident means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Blindness

Blindness means clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity), or visual field restriction to 20° or less in both eyes.

The following are not to be construed as blindness for purposes of this policy:

- if in general medical opinion any procedure, device, or implant could result in the partial or total restoration of sight;
- if the covered person has not attained age three or above on the Date of Diagnosis, and
- if the covered person's reduction of sight as defined above occurs prior to the Policy Coverage Effective Date of the covered person's coverage under this policy.

Calendar Year

Calendar Year means the period beginning on the Policy Coverage Effective Date of coverage shown on the Policy Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

[Cancer

Cancer means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.

The following are not to be construed as Cancer for purposes of this policy:

- pre-malignant conditions or conditions with malignant potential;
- Carcinoma in Situ;
- basal cell carcinoma and squamous cell carcinoma of the skin; and
- melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Carcinoma in Situ

Carcinoma in Situ means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

- A *Pathological Diagnosis* of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified Pathologist, whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
- A *Clinical Diagnosis* of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:
 - a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
 - there is medical evidence to support the diagnosis; and

- a Doctor is treating the covered person for Cancer and/or Carcinoma in Situ.]

Cardiologist

Cardiologist means a Doctor who is licensed to practice medicine and who is also licensed to practice by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.

Coma

Coma means a continuous state of profound unconsciousness resulting from a Covered Accident or a Covered Sickness, characterized by the absence of:

- eye opening,
- motor response, and
- verbal response.

The condition must require intubation for respiratory assistance.

The term “Coma” does not include any medically induced coma.

Covered Accident

Covered Accident means an accident that:

- occurs on or after the Policy Coverage Effective Date of this policy;
- occurs while this policy is in force; and
- is not excluded by name or specific description in this policy.

Covered Sickness

Covered Sickness means an illness, infection, disease or any other abnormal physical condition, not caused by an accident, that:

- occurs on or after the Policy Coverage Effective Date of this policy;
- occurs while this policy is in force; and
- is not excluded by name or specific description in this policy.

Coronary Artery Bypass Graft Surgery

Coronary Artery Bypass Graft Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

[Coronary Artery Disease

Coronary Artery Disease means a narrowing or blockage of one or more coronary arteries for which a Cardiologist recommends that Coronary Artery Bypass Graft Surgery occur within 60 days following the date of the recommendation.]

Date of Diagnosis

- for Heart Attack (Myocardial Infarction), the date that the ischemic death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack (Myocardial Infarction) definition;
- for Stroke, the date a Stroke occurred based on neuroimaging or other neurodiagnostic study consistent with an acute or subacute infarction, hemorrhage, embolism, thrombosis and presence of neurological deficits persisting for a period of 30 days or greater;
- for End Stage Renal (Kidney) Failure, the date that regular hemodialysis or peritoneal dialysis begins;
- for Major Organ Failure, the date that the covered person is placed on the UNOS list for transplantation;
- for Permanent Paralysis due to a Covered Accident, the date the Doctor confirms the Permanent Paralysis due to a Covered Accident has continued for a period of 180 consecutive days;
- for Coma, the date a Doctor confirms a coma resulting from a Covered Accident or a Covered Sickness has lasted seven or more consecutive days;
- for Blindness, the date the Doctor confirms the irreversible reduction of sight has continued for a period of 180 consecutive days;
- for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D, the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests;

- [for Coronary Artery Bypass Graft Surgery, the date the covered person undergoes the open heart surgery;]
- [for Coronary Artery Disease, the date the Cardiologist recommends the covered person undergo Coronary Artery Bypass Graft Surgery within the 60 days following the date of the recommendation;] [and]
- [for Cancer or Carcinoma in Situ, the date the tissue specimen, blood samples or titer(s) are taken upon which the first diagnosis of Cancer or Carcinoma in Situ is based].

Doctor or Physician

Doctor or Physician means a person who:

- is licensed by the state to practice a healing art; and
- performs services for a covered person that are allowed by his license.

For purposes of this definition, *Doctor or Physician* does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

End Stage Renal (Kidney) Failure

End Stage Renal Failure means chronic irreversible failure of the function of both kidneys such that the covered person must undergo at least weekly hemodialysis or peritoneal dialysis.

Heart Attack (Myocardial Infarction)

Heart Attack (Myocardial Infarction) means the ischemic death of a portion of heart muscle as a result of obstruction of one or more of the coronary arteries. A positive diagnosis must be supported by three or more of the following:

- atypical chest pain;
- electrocardiographic (EKG) changes indicative of myocardial infarction; in the case of myocardial infarction associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria in establishing a diagnosis;
- elevation of biochemical markers of myocardial necrosis; and
- confirmatory imaging studies.

In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack (Myocardial Infarction) as the cause of death will be accepted.

A Heart Attack (Myocardial Infarction) is not congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B-, C- or D-contaminated body fluids as the result of a Covered Accident during the normal course of performing an occupation for which remuneration is earned.

We will pay this benefit if:

- within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the covered person's occupation or profession;
- the Covered Accident is investigated and a written investigation report is provided to us by the covered person's employer;
- a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the Covered Accident and HIV or Hepatitis B, C or D is not present;
- all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and
- a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the Covered Accident, and the result is positive.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D excludes:

- HIV or Hepatitis B, C or D infection as the result of IV drug use;
- HIV or Hepatitis B, C or D infection as the result of sexual transmission; and

- HIV or Hepatitis B, C or D infection determined not to have been the result of a Covered Accident.

Major Organ Failure

Major Organ Failure means diagnosis of major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the covered person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

Pathologist

Pathologist means a Doctor who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Permanent Paralysis due to a Covered Accident

Permanent Paralysis due to a Covered Accident means the complete and permanent loss of the use of two or more limbs through paralysis as the result of a Covered Accident as defined in the policy for a continuous period of 180 days, as confirmed by a Doctor. Loss of use of two or more limbs through paralysis as the result of a Stroke will not be construed as Permanent Paralysis due to a Covered Accident for purposes of this policy.

Policy Anniversary Date

Policy Anniversary Date occurs annually on the same date and in the same month as the date for which we first received premium.

Pre-existing Condition

Pre-existing Condition means having a sickness or physical condition for which any covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the Policy Coverage Effective Date of this policy.

Specified Critical Illness

Specified Critical Illness means one of the Specified Critical Illnesses shown on the Policy Schedule.

Stroke

A *Stroke* means an acute or subacute cerebrovascular incident, including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by:

- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

The following are not to be construed as a Stroke for purposes of this policy:

- transient ischemic attack;
- brain injury related to trauma or infection;
- brain injury associated with hypoxia/anoxia or hypotension;
- vascular disease affecting the eye or optic nerve; and
- ischemic disorders of the vestibular system.

In the event of death, an autopsy confirmation identifying Stroke as the cause of death will be accepted.

SECTION VII - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if a covered person is diagnosed with one of the Specified Critical Illnesses shown on the Policy Schedule if:

- the Date of Diagnosis is while this policy is in force; and
- it is not excluded by name or specific description in this policy.

We will pay the percentage of the Face Amount shown on the Policy Schedule for the Specified Critical Illness diagnosed, up to the Maximum Benefit Amount for Specified Critical Illness shown on the Policy Schedule.

We will pay the benefit for [Coronary Artery Bypass Graft Surgery][Coronary Artery Disease] only once per lifetime per covered person. [If a covered person receives a benefit for Coronary Artery Bypass Graft Surgery and is later diagnosed with a different Specified Critical Illness, we will pay the Face Amount less the amount received for Coronary Artery Bypass Graft Surgery.]

If, on the same day, a covered person is placed on the UNOS list for a transplant of two or more major organs listed above in the definition of Major Organ Failure (example: heart and lungs), a single benefit will be paid.

We will pay the benefit for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D only once per lifetime per covered person.

[We will pay the benefit for Carcinoma in Situ only once per lifetime per covered person. [If a covered person receives a benefit for Carcinoma in Situ and is later diagnosed with a different Specified Critical Illness, we will pay the Face Amount less the amount received for Carcinoma in Situ.]

We will pay the benefit for Cancer only once per lifetime per covered person.]

If the Date of Diagnosis of two or more Specified Critical Illnesses is the same day, we will pay only one Specified Critical Illness benefit. We will pay the larger of the Specified Critical Illness benefits.

No benefits are payable for conditions other than the Specified Critical Illnesses defined in the policy.

[Benefits Payable Upon Subsequent Diagnosis

If a covered person has been diagnosed with and received a benefit for a Specified Critical Illness and is subsequently diagnosed with a different Specified Critical Illness, we will pay an amount equal to 25% of the Face Amount for the covered person as shown on the Policy Schedule, up to the Maximum Benefit Amount for Specified Critical Illness, if:

- the Date of Diagnosis of the subsequent Specified Critical Illness is more than 30 days after any previous Date of Diagnosis for a Specified Critical Illness; and
- the subsequent Date of Diagnosis is while coverage under this policy is in force; and
- the Specified Critical Illness is not excluded by name or specific description in this policy.

If a covered person has been diagnosed with and received a benefit for a Specified Critical Illness and is subsequently diagnosed with the same Specified Critical Illness (other than [Coronary Artery Bypass Graft Surgery] [Coronary Artery Disease] [, Cancer, Carcinoma in Situ,] and Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D), we will pay an amount equal to 25% of the Face Amount for the covered person as shown on the Policy Schedule, up to the Maximum Benefit Amount for Specified Critical Illness, if:

- the Date of Diagnosis of the subsequent Specified Critical Illness is more than 30 days after any previous Date of Diagnosis for the same Specified Critical Illness; and
- the covered person has not received treatment during the 30 days between the Dates of Diagnosis for the same Specified Critical Illness. For purposes of the preceding sentence, treatment does not include medications and follow-up visits to the covered person's Doctor;
- the subsequent Date of Diagnosis is while coverage under this policy is in force; and
- the Specified Critical Illness is not excluded by name or specific description in this policy.]

We will not pay more than the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule.

This policy will terminate when the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule has been paid.

Benefit Reduction

The Face Amount(s) [and the Maximum Benefit Amount for Specified Critical Illness] will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75. All Specified Critical Illness benefits payable after that date will be based on the reduced Face Amount [and the reduced Maximum Benefit Amount].

[Cancer Vaccine Benefit

We will pay this benefit if a covered person incurs a charge for and receives any cancer vaccine that is FDA approved for the prevention of Cancer. The vaccine must be administered by licensed medical personnel while coverage under this policy is in force. We will pay the amount shown on the Policy Schedule. Payment of this benefit will not reduce the Maximum Benefit Amount for Specified Critical Illness. This benefit is limited to one payment per covered person, per lifetime.]

[Health Screening Benefit

We will pay this benefit if any covered person incurs a charge for and has one of the following screening tests performed while coverage under this policy is in force. We will pay the amount shown in the Policy Schedule for one of the following screening tests. Payment of this benefit will not reduce the Maximum Benefit Amount for Specified Critical Illness. This benefit is payable once per calendar year for each covered person.

Screening test is defined as:

- Stress test on a bicycle or treadmill,
- Fasting blood glucose test,
- Blood test for triglycerides,
- Serum cholesterol test to determine level of HDL and LDL,
- Bone marrow testing,
- Carotid doppler,
- Electrocardiogram (EKG, ECG),
- Echocardiogram (ECHO),
- Skin cancer biopsy,
- Breast ultrasound,
- CA 15-3 (blood test for breast cancer),
- CA125 (blood test for ovarian cancer),
- CEA (blood test for colon cancer),
- Chest x-ray,
- Colonoscopy,
- Flexible sigmoidoscopy,
- Hemoccult stool analysis,
- Mammography,
- Pap smear,
- PSA (blood test for prostate cancer),
- Serum protein electrophoresis (blood test for myeloma),
- Thermography,
- ThinPrep pap test, and
- Virtual colonoscopy.]

SECTION VIII - WHAT IS NOT COVERED BY THIS POLICY

We will not pay benefits for a Specified Critical Illness that occurs as a result of a covered person's:

Alcoholism or Drug Addiction

Addiction to alcohol or drugs, except for drugs administered on the advice of his Doctor.

Felonies or Illegal Occupations

Committing or attempting to commit a felony or engaging in an illegal occupation.

Intoxicants and Narcotics

Being intoxicated or under the influence of any narcotic unless administered on the advice of his Doctor.

Pre-existing Condition

Having a pre-existing condition as defined in this policy and limited by the Time Limits on Certain Defenses provision of this policy.

Psychiatric or Psychological Condition

Having a psychiatric or psychological condition, including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. However, Alzheimer's Disease and other organic senile dementias are covered under this policy.

Suicide or Self-Inflicted Injuries

Committing or trying to commit suicide or his injuring himself intentionally, while he is sane or not.

War or Armed Conflict

Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

SECTION IX - YOUR CLAIM FOR BENEFITS**Notice of Claim**

You must give us written notice of claim within 30 days after the covered loss begins or as soon as it is reasonably possible. Notice given by you or on your behalf to our home office or one of our authorized agents with the information sufficient to identify you shall be accepted.

Claim Forms

After the giving of such notice, we will send you a claim form. If you do not receive the claim form within 15 days after you notify us of your loss, you shall be deemed as having complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof meeting the requirements of the Proof of Loss section below.

Proof of Loss

You must give us written proof of loss within 90 days after the covered loss begins. Written proof of loss, provided at your expense and in English or Spanish, must include documentation furnished by a Doctor and supported by one or more of the following: clinical, radiological, histological, pathological and/or laboratory evidence of the Specified Critical Illness. [For the [Health Screening Benefit] [or][Cancer Vaccine Benefit] written proof of loss may include one or more of these: an attending Doctor's statement, a Doctor's bill or a hospital bill.] We may also require your statement, worker's compensation records and/or your employer's statement.

If you are not able to give us written proof of loss within 90 days, it will not have a bearing on your claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

Any additional proof that we require, such as medical records, will be at our expense. We also reserve the right to have the covered person interviewed by an authorized company representative.

Time of Payment of Claim

After we receive written proof of loss and process the covered person's claim, we will immediately pay any benefits due.

Payment of Claim

Benefits will be paid to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a Doctor's office. This is called *assignment*.

If we still owe you benefits at your death, we will pay them to your beneficiary, if any. The beneficiary is the person named in the application as the beneficiary, unless it was changed at a later date. This is the person who will receive any benefits due at the named insured's death. If no beneficiary has been named, or if the person is no longer living at the named insured's death, any benefits due will be paid in this order to the named insured's:

- spouse; or
- children; or
- parents; or

- brothers or sisters; or
- estate.

If benefits are payable to your estate or someone who cannot give a binding release, we can pay benefits up to \$1,000 to someone related to you by blood or marriage who we feel is fairly entitled to them. If we do this, we will have no responsibility for this payment because we made it in good faith.

Questions Concerning Your Claim

If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

Physical Exam and Autopsy

We can require that a Doctor examine the covered person as often as reasonably necessary while his claim is pending. We can also require an autopsy in the event of his death in those states where this is allowed. Either or both of these will be done at our expense.

Legal Action

We cannot be sued for benefits under this policy:

- until 60 days after we are sent written proof of loss; or
- more than three years after the time has passed in which we require written proof of loss.

How to Change Your Beneficiary

Unless you make an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to you, and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy, or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

SECTION X - OTHER IMPORTANT PROVISIONS

Time Limits on Certain Defenses

We rely on the statements made by you in the application to issue this policy and pay benefits.

After this policy has been in force for two years, we cannot contest it or refuse to pay benefits due to any untrue statement in the application unless a fraudulent statement was made.

Contest means that we question the validity of coverage under this policy through a letter to you. This contest is effective on the date we mail the letter and refund the premium.

After this policy has been in force for 12 months from the Policy Coverage Effective Date of this policy, we will pay benefits for any pre-existing condition not excluded by name or specific description if the Specified Critical Illness had a Date of Diagnosis more than 12 months after the Policy Coverage Effective Date.

Misstatement of Age or Tobacco Usage

If any covered person's age or usage of tobacco was stated incorrectly in the application, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age and tobacco usage status. If, based on his correct age and tobacco usage status, we would not have issued this policy, then we will refund the premiums paid.

Transfer of Rights

You can assign any rights you have under this policy. However, no assignment is binding on us until we receive a copy of it. We are not responsible for the validity of any assignment.

Conformity with State Statutes

Any provision of this policy that, on the Policy Coverage Effective Date, does not agree with state laws where you live will be amended to conform to the minimum requirements of those laws.

When Coverage Ends on Your Spouse and Your Children

If this is a named insured and spouse policy or a named insured, spouse and dependent children policy, coverage on your spouse will end on the earliest of the following dates:

- the date this policy terminates;
- the end of the grace period following the premium due date we fail to receive the required premium payment for your spouse;
- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you divorce your spouse or your marriage is annulled; or
- the date your spouse dies.

If this is a named insured and dependent children or a named insured, spouse and dependent children policy, coverage on your children insured by this policy will end:

- the date this policy terminates;
- the end of the grace period following the premium due date we fail to receive the required premium payment for your children;
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die and your spouse is not covered under this policy.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in this policy. Coverage on a child placed in your custody for adoption will also terminate upon the dismissal of a petition for adoption. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium for the time period for which they did not qualify.

Coverage will not end on a covered child who reaches age 26 if that child is and continues to be unable to support himself because of mental or physical handicap and is chiefly dependent on you or your spouse for support. If we require proof of mental or physical handicap, we will request it no more often than annually. However, you must continue to pay the premiums for named insured and dependent children or named insured, spouse and dependent children coverage to keep his coverage in force.

Your Spouse's Right to Continue Coverage

If this is a named insured and spouse policy or a named insured, spouse and dependent children policy and you die, [provided that your spouse has not received a benefit of 100% of his Face Amount under this policy,] your spouse can request to continue coverage as the named insured under a named insured policy or (only in the event this policy was a named insured, spouse and dependent children policy) a named insured and dependent children policy, without providing evidence of insurability to us. The premium for his new policy will be based upon the spouse's attained age at the date of issuance of his new policy. The new named insured or named insured and dependent children policy will have the same Face Amount for Named Insured as the spouse had under this policy (but no less than \$5,000 and rounded up to the next \$1,000 increment, if applicable), and the Face Amount for Dependent Children under the new policy will be 25% of the Face Amount for Named Insured under the new policy. Any period of time that the spouse was insured under this policy will be applied toward the Time Limits on Certain Defenses provision of the new policy.

[If we have paid a benefit for Cancer of the spouse under this policy, the new policy will not provide any Cancer or Carcinoma in Situ benefits.] [If we have paid a benefit for any Specified Critical Illness under this policy for which the percentage of the Face Amount payable, as shown on the Policy Schedule, was 100%, and the covered person is diagnosed with the same Specified Critical Illness while covered under the new policy, we will pay benefits as calculated under the Benefits Payable Upon Subsequent Diagnosis provision of the new policy for that Specified Critical Illness, if any.]

Your spouse must notify us in writing within 60 days after your death to continue coverage and begin paying premiums for his policy.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
[1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 www.coloniallife.com]
A Stock Company

LIMITED BENEFIT HEALTH COVERAGE FOR SPECIFIED CRITICAL ILLNESS

OUTLINE OF COVERAGE (Applicable to Policy Form CI-1.0-AR)

PRE-EXISTING CONDITIONS - PLEASE READ CAREFULLY

If you received treatment, testing or medical advice or took medication for a sickness or physical condition within 12 months before the effective date of this policy, we will not pay a benefit for a Specified Critical Illness that occurs as a result of that sickness or physical condition if the Specified Critical Illness has a Date of Diagnosis within the first 12 months after the effective date of the policy.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

Please Read The Policy Carefully. This outline provides a very brief description of the important features of the policy. This is not an insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and us. It is, therefore, important to **READ THE POLICY CAREFULLY.**

Guaranteed Renewable Subject to Payment of the Maximum Benefit Amount for Specified Critical Illness. The policy is guaranteed renewable as long as you pay the premiums when they are due or within the grace period, up to the date of payment of the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule. Your premium can be changed only if we change it on all policies of this kind in force in the state where the policy was issued.

Coverage Provided by The Policy. The policy is designed to provide coverage ONLY for Specified Critical Illnesses [and for certain health screening tests], subject to any limitations or exclusions in your policy. It does not provide coverage for basic hospital, basic medical-surgical or major medical expenses.

The policy provides benefits only if the Date of Diagnosis of Specified Critical Illness [or the performance of a [health screening test] [or] [Cancer Vaccine]] is while your policy is in force. [Any [health screening test] [or] [Cancer Vaccine] performed before the Policy Coverage Effective Date will not be covered.]

**Premiums vary depending on the amount of coverage you chose at time of application.
The amount of coverage you chose is shown on the Policy Schedule.**

BENEFITS

Specified Critical Illness Benefit

Face Amount for Named Insured	\$ _____
Face Amount for Spouse (if covered)	50% of face amount for Named Insured
Face Amount for Dependent Children (if covered)	25% of face amount for Named Insured

The Face Amount(s) [and the Maximum Benefit Amount for Specified Critical Illness] will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75.

We will pay this benefit if a covered person is diagnosed with one of the Specified Critical Illnesses shown below if: the Date of Diagnosis is while coverage under the policy is in force; and the Specified Critical Illness is not excluded by name or specific description in the policy.

[Cancer	100%]
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Permanent Paralysis due to a Covered Accident	100%
Coma	100%
Blindness	100%
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%
[Coronary Artery Bypass Graft Surgery	25%]
[Coronary Artery Disease	25%]
[Carcinoma in Situ	25%]

[Maximum Benefit Amount for Specified Critical Illness: 100% of the Face Amount for each covered person.]

[Maximum Benefit Amount for Specified Critical Illness: [\$15,000-\$450,000 in \$3,000 increments]]

We will pay the percentage of the Face Amount shown on the Policy Schedule for the Specified Critical Illness diagnosed, up to the Maximum Benefit Amount for Specified Critical Illness shown on the Policy Schedule.

We will pay the benefit for [Coronary Artery Bypass Graft Surgery][Coronary Artery Disease] only once per lifetime per covered person. [If a covered person receives a benefit for Coronary Artery Bypass Graft Surgery and is later diagnosed with a different Specified Critical Illness, we will pay the Face Amount less the amount you received for Coronary Artery Bypass Graft Surgery.]

If, on the same day, a covered person is placed on the UNOS list for a transplant of two or more major organs listed in the definition of Major Organ Failure (example: heart and lungs), a single benefit will be paid.

We will pay the benefit for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D only once per lifetime per covered person.

[We will pay the benefit for Carcinoma in Situ only once per lifetime per covered person. [If a covered person receives a benefit for Carcinoma in Situ and is later diagnosed with a different Specified Critical Illness, we will pay the Face Amount less the amount received for Carcinoma in Situ.]

We will pay the benefit for Cancer only once per lifetime per covered person.]

If the Date of Diagnosis of two or more Specified Critical Illnesses is the same day, we will pay only one Specified Critical Illness benefit. We will pay the larger of the Specified Critical Illness benefits.

No benefits are payable for conditions other than the Specified Critical Illnesses defined in the policy.

[Benefits Payable Upon Subsequent Diagnosis.

If a covered person has been diagnosed with and received a benefit for a Specified Critical Illness and is subsequently diagnosed with a different Specified Critical Illness, we will pay an amount equal to 25% of the Face Amount for the covered person as shown on the Policy Schedule, up to the Maximum Benefit Amount for Specified Critical Illness, if: the Date of Diagnosis of the subsequent Specified Critical Illness is more than 30 days after any previous Date of Diagnosis for a Specified Critical Illness; and the subsequent Date of Diagnosis is while coverage under this policy is in force; and the Specified Critical Illness is not excluded by name or specific description in this policy.

If a covered person has been diagnosed with and received a benefit for a Specified Critical Illness and is subsequently diagnosed with the same Specified Critical Illness (other than [Coronary Artery Bypass Graft Surgery][Coronary Artery Disease][, Cancer, Carcinoma in Situ,] and Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D), we will pay an amount equal to 25% of the Face Amount for the covered person as shown on the Policy Schedule, up to the Maximum Benefit Amount for Specified Critical Illness, if: the Date of Diagnosis of the subsequent Specified Critical Illness is more than 30 days after any previous Date of Diagnosis for the same Specified Critical Illness; and the covered person has not received treatment during the 30 days between the Dates of

Diagnosis for the same Specified Critical Illness. For purposes of the preceding sentence, treatment does not include medications and follow-up visits to the covered person's Doctor; the subsequent Date of Diagnosis is while coverage under this policy is in force; and the Specified Critical Illness is not excluded by name or specific description in this policy.]

We will not pay more than the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule.

This policy will terminate when the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule has been paid.

Benefit Reduction

The Face Amount(s) [and the Maximum Benefit Amount for Specified Critical Illness] will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75. All Specified Critical Illness benefits payable after that date will be based on the reduced Face Amount [and the reduced Maximum Benefit Amount].

[Cancer Vaccine Benefit

Amount: \$50

We will pay this benefit if a covered person incurs a charge for and receives any cancer vaccine that is FDA approved for the prevention of Cancer. The vaccine must be administered by licensed medical personnel while coverage under the policy is in force. Payment of this benefit will not reduce the Maximum Benefit Amount for Specified Critical Illness. This benefit is limited to one payment per covered person, per lifetime.]

[Health Screening Benefit

Amount: \$[25- \$150 in \$25 increments]/Year

We will pay this benefit if any covered person incurs a charge for and has one of the following screening tests performed while coverage under the policy is in force. We will pay the amount shown for one of the following screening tests. Payment of this benefit will not reduce the Maximum Benefit Amount for Specified Critical Illness. This benefit is payable once per calendar year for each covered person.

Health screening test is defined as: stress test on a bicycle or treadmill, fasting blood glucose test, blood test for triglycerides, serum cholesterol test to determine level of HDL and LDL, bone marrow testing, carotid doppler, electrocardiogram (EKG, ECG), echocardiogram (ECHO), skin cancer biopsy, breast ultrasound, CA 15-3 (blood test for breast cancer), CA125 (blood test for ovarian cancer), CEA (blood test for colon cancer), chest x-ray, colonoscopy, flexible sigmoidoscopy, hemoccult stool analysis, mammography, pap smear, PSA (blood test for prostate cancer), serum protein electrophoresis (blood test for myeloma), thermography, thinprep pap test, and virtual colonoscopy.]

DEFINITIONS

Accident means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Blindness means clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity), or visual field restriction to 20° or less in both eyes. The following are not to be construed as blindness for purposes of the policy: if in general medical opinion any procedure, device, or implant could result in the partial or total restoration of sight; if the covered person has not attained age three or above on the Date of Diagnosis, and if the covered person's reduction of sight as defined above occurs prior to the Policy Coverage Effective Date of the covered person's coverage under this policy.

Calendar Year means the period beginning on the Policy Coverage Effective Date of coverage shown on the Policy Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

[Cancer means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. The following are not to be construed as Cancer for purposes of this policy: pre-malignant conditions or conditions with malignant potential; Carcinoma in Situ; basal cell carcinoma and squamous cell carcinoma of the skin; and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.]

[Carcinoma in Situ means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified Pathologist, whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.

A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

- a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- there is medical evidence to support the diagnosis; and
- a Doctor is treating the covered person for Cancer and/or Carcinoma in Situ.]

Cardiologist means a Doctor who is licensed to practice medicine and who is also licensed to practice by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.

Coma means a continuous state of profound unconsciousness resulting from a Covered Accident or a Covered Sickness, characterized by the absence of: eye opening, motor response, and verbal response. The condition must require intubation for respiratory assistance. The term “Coma” does not include any medically induced coma.

A **Covered Accident** is an accident that occurs on or after the Policy Coverage Effective Date of the policy; occurs while the policy is in force; and, is not excluded by name or specific description in the policy.

A **Covered Sickness** means an illness, infection, disease or any other abnormal physical condition, not caused by an accident, that occurs on or after the Policy Coverage Effective Date of the policy; occurs while the policy is in force; and is not excluded by specific name or specific description in the policy.

Coronary Artery Bypass Graft Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

[Coronary Artery Disease means a narrowing or blockage of one or more coronary arteries for which a Cardiologist recommends that Coronary Artery Bypass Graft Surgery occur within 60 days following the date of the recommendation.]

Date of Diagnosis

- for Heart Attack (Myocardial Infarction), the date that the ischemic death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack (Myocardial Infarction) definition;
- for Stroke, the date a Stroke occurred based on neuroimaging or other neurodiagnostic study consistent with an acute or subacute infarction, hemorrhage, embolism, thrombosis and presence of neurological deficits persisting for a period of 30 days or greater;
- for End Stage Renal (Kidney) Failure, the date that regular hemodialysis or peritoneal dialysis begins;
- for Major Organ Failure, the date that the covered person is placed on the UNOS list for transplantation;
- for Permanent Paralysis due to a Covered Accident, the date the Doctor confirms the Permanent Paralysis due to a Covered Accident has continued for a period of 180 consecutive days;
- for Coma, the date a Doctor confirms a coma resulting from a Covered Accident or a Covered Sickness has lasted seven or more consecutive days;
- for Blindness, the date the Doctor confirms the irreversible reduction of sight has continued for a period of 180 consecutive days;
- for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D, the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests;
- [for Coronary Artery Bypass Graft Surgery, the date the covered person undergoes the open heart surgery;]
- [for Coronary Artery Disease, the date the Cardiologist recommends the covered person undergo Coronary Artery Bypass Graft Surgery within the 60 days following the date of the recommendation;] [and]
- [for Cancer or Carcinoma in Situ, the date the tissue specimen, blood samples or titer(s) are taken upon which the first diagnosis of Cancer or Carcinoma in Situ is based].

Dependent Children means any natural children, step-children, legally adopted children, foster children or children under your charge, care and control for whom you have filed a petition to adopt who are unmarried; chiefly dependent on you or your spouse for support; and younger than age 26.

A **Doctor or Physician** means a person who: is licensed by the state to practice a healing art; and performs services for a covered person that are allowed by his license. For purposes of this definition, Doctor or Physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that the covered person must undergo at least weekly hemodialysis or peritoneal dialysis.

Heart Attack (Myocardial Infarction) means the ischemic death of a portion of heart muscle as a result of obstruction of one or more of the coronary arteries. A positive diagnosis must be supported by three or more of the following: atypical chest pain; electrocardiographic (EKG) changes indicative of myocardial infarction; elevation of biochemical markers of myocardial necrosis; and confirmatory imaging studies. In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack (Myocardial Infarction) as the cause of death will be accepted.

A Heart Attack (Myocardial Infarction) is not congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B-, C- or D-contaminated body fluids as the result of a Covered Accident during the normal course of performing an occupation for which remuneration is earned.

We will pay this benefit if: within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the covered person's occupation or profession; the Covered Accident is investigated and a written investigation report is provided to us by the covered person's employer; a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the Covered Accident and HIV or Hepatitis B, C or D is not present; all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the Covered Accident, and the result is positive.

Occupational HIV or Hepatitis B, C or D excludes: HIV or Hepatitis B, C or D infection as the result of IV drug use; HIV or Hepatitis B, C or D infection as the result of sexual transmission; and HIV or Hepatitis B, C or D infection determined not to have been the result of a Covered Accident.

Major Organ Failure means diagnosis of major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the covered person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

A **Pathologist** means a Doctor who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Permanent Paralysis due to a Covered Accident means the complete and permanent loss of the use of two or more limbs through paralysis as the result of a Covered Accident as defined in the policy for a continuous period of 180 days, as confirmed by a Doctor. Loss of use of two or more limbs through paralysis as the result of a Stroke will not be construed as Permanent Paralysis due to a Covered Accident for purposes of the policy.

Policy Anniversary Date occurs annually on the same date and in the same month as the date for which we first received premium.

Pre-existing Condition means having a sickness or physical condition for which any covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the Policy Coverage Effective Date of this policy.

Specified Critical Illness means one of the Specified Critical Illnesses shown on the Policy Schedule.

Stroke means an acute or subacute cerebrovascular incident, including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis.

The diagnosis must be supported by: evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

The following are not to be construed as a Stroke for purposes of the policy: transient ischemic attack; brain injury related to trauma or infection; brain injury associated with hypoxia/anoxia or hypotension; vascular disease affecting the eye or optic nerve; and ischemic disorders of the vestibular system. In the event of death, an autopsy confirmation identifying Stroke as the cause of death will be accepted.

WHAT IS NOT COVERED BY THE POLICY

We will not pay benefits for a Specified Critical Illness that occurs as a result of a covered person's:

1. Addiction to alcohol or drugs, except for drugs administered on the advice of his Doctor.
2. Committing or attempting to commit a felony or engaging in an illegal occupation.
3. Being intoxicated or under the influence of any narcotic unless administered on the advice of his Doctor.
4. Having a pre-existing condition as defined in the policy and limited by the Time Limits on Certain Defenses provision of the policy.
5. Having a psychiatric or psychological condition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. However, Alzheimer's disease and other organic senile dementias are covered under the policy.
6. Committing or trying to commit suicide, or his injuring himself intentionally, while he is sane or insane.
7. Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

SERFF Tracking Number: UNUM-126145902 State: Arkansas
 Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 42372
 Company Tracking Number: CI-1.0-AR
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.001 Critical Illness
 Product Name: Individual Critical Illness - 1.0
 Project Name/Number: Individual Critical Illness - 1.0/CI-1.0-AR

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	08/25/2009
Comments: See attached.		
Attachment: Readability Compliance Certification - AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	08/25/2009
Comments: See attached.		
Attachment: AccHlth - AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	08/25/2009
Comments: Outline of Coverage attached under Form Schedule tab.		

	Item Status:	Status Date:
Satisfied - Item: Submission Letter	Approved-Closed	08/25/2009
Comments: See attached.		
Attachment: Submission Letter - AR.pdf		

	Item Status:	Status
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SERFF Tracking Number: UNUM-126145902 State: Arkansas
 Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 42372
 Company Tracking Number: CI-1.0-AR
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.001 Critical Illness
 Product Name: Individual Critical Illness - 1.0
 Project Name/Number: Individual Critical Illness - 1.0/CI-1.0-AR

Satisfied - Item: Statement of Variability **Item Status:** Approved-Closed **Date:** 08/25/2009
Comments:
 See attached.
Attachment:
 Statement of Variability - AR.pdf

Satisfied - Item: Compliance Certification **Item Status:** Approved-Closed **Status**
Date: 08/25/2009
Comments:
 See attached.
Attachment:
 Compliance Certification - AR.pdf

Satisfied - Item: NAIC Transmittal **Item Status:** Approved-Closed **Status**
Date: 08/25/2009
Comments:
 See attached.
Attachment:
 NAIC Transmittal - AR.pdf

Satisfied - Item: Resubmission letter **Item Status:** Approved-Closed **Status**
Date: 08/25/2009
Comments:
 See attached.
Attachment:
 Resubmission Letter - AR.pdf

Satisfied - Item: Resubmisison letter 2-AR **Item Status:** Approved-Closed **Status**
Date: 08/25/2009

READABILITY COMPLIANCE CERTIFICATION

<u>Form No.</u>	<u>Flesch Score</u>
CI-1.0-AR	51.8
CI-1.0-O-AR	50.3

This is to certify that the attached Forms (listed above) have achieved the above Flesch Reading Ease Score and comply with the requirements of Arkansas Stat. Ann. § §66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Tonia B. Garbutt
Compliance Contract Consultant

05/11/2009

Date

Applicant Section							
Applicant's Name (First, MI, Last)		Employee <input type="checkbox"/>	Spouse <input type="checkbox"/>	Dependent <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street		City	State	Zip Code	State of Birth	Employee ID/Payroll No.	
Date Employed	Occupation/ Job Title	Hrs. Worked/ Week	Annual Base Salary	Home Phone No. Business Phone No.			

Billing Section				
Payroll Deduction Employer Name	Employer Address (Street-City-State-Zip)		Section/Dept. No.	Employee Class
Payer or Owner if other than Applicant (Name, Address, Social Security No.)			<input type="checkbox"/> Payer <input type="checkbox"/> Owner <input type="checkbox"/> Both	

Spouse and Dependent Section				
Name of Spouse (First, MI, Last)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
Employer's Name for Spouse	Date Employed	Occupation / Job Title	Hours Worked/ Week	Annual Base Salary
1. Are there any eligible dependent children applying for coverage?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Number Deps:

Complete Question 2 for all Products	Applicant	Spouse
2.A. Are you actively working?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.B. If "No", is your spouse disabled or unable to work?		Yes <input type="checkbox"/> No <input type="checkbox"/>

Plan Section										
Indicate Type of Change (N) New (T) Transfer or (R) Rider Addition. Indicate Tax Status (P) for pre-tax or (A) for after tax										
Product	Type Coverage	Type of Change	Policy Plan Code	Units/ Amount	Rider Plan/ Units	Rider Plan/ Units	Rider Plan Code	Rider Plan Code	Tax Status	Monthly Premium
<input type="checkbox"/> Accident									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Hospital Confinement									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Cancer									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Int. Care									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Critical Illness									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Disability	Elim/Benefit period _____/_____/_____								P <input type="checkbox"/> A <input type="checkbox"/>	
Total Monthly Premium \$										

Replacement Section – Complete for all Products			
3. Will any health insurance, with this or any other company, be modified or discontinued if the coverage applied for is issued?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Insured's Name	Insurance Company	Type of Coverage	Policy Number

AIDS Section – Complete for all Products	Applicant	Spouse	Dependent
4. Have you tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or received medical advice or sought treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Simplified Issue Section – Disability and Hospital Confinement	Applicant	Spouse
5. Have you previously purchased disability coverage that will remain in force which, when combined with the coverage you are applying for, will exceed 70% of your gross annual income? This does not include employer paid group disability coverage.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Within the past 12 months, other than colds, flu or normal pregnancy, have you been off work (vacation or sick leave) for 10 or more consecutive work days due to an illness or injury, including back, neck, knee, joint or muscle?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Within the past 12 months, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI) Blood Pressure Reading of 160/100 or Above Hepatitis B, C Heart Surgery Kidney Disease except Stones Cirrhosis Congestive Heart Failure Insulin Dependent Diabetes Hodgkin's Disease Stroke Diabetes Diagnosed Prior to age 40 Leukemia Transient Ischemic Attack Cancer Other than Skin Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Dependent Health Section - Hospital Confinement			
8. Within the past 12 months, has any dependent been hospitalized for respiratory disorders, including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer) or seizures? Any dependent listed will not be covered under the Hospital Confinement policy to which a copy of the application is attached.			Yes <input type="checkbox"/> No <input type="checkbox"/>
Name (First, MI, Last)	Relationship	Birthdate (mm/dd/yyyy)	Social Security No.

Simplified Issue Section - Critical Illness and Intensive Care	Applicant	Spouse	Dependent
9. Within the past 10 years, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI) Hepatitis B, C Heart Surgery Blood Pressure Reading of 160/100 or Above Heart Disease Kidney Disease except Stones Emphysema Chronic Obstructive Pulmonary Disease Organ Transplant Cirrhosis or Liver Disease Congestive Heart Failure Transient Ischemic Attack Diabetes Cancer Other than Skin Cancer Stroke Abnormal Catherization	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any dependent listed will not be covered under the Intensive Care policy to which a copy of the application is attached.			
Name (First, MI, Last)	Relationship	Birthdate (mm/dd/yyyy)	Social Security No.
10. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery systems?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Cancer Section	Applicant	Spouse	Dependent
11. Have you ever been diagnosed with, or treated for, Cancer of any type or form?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. In the past 5 years, have you received medical advice or sought treatment for cancer, other than skin cancer; or, in the past 12 months have you received preventive Hormonal Therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any dependent listed will not be covered under the Cancer policy to which a copy of the application is attached.			
Name (First, MI, Last)	Relationship(s)	Birthdate (mm/dd/yyyy)	Social Security No.
13. Within the past 5 years, have you received medical advice or sought treatment for Skin Cancer, including basal cell carcinoma, squamous cell carcinoma, or melanoma of Clark's level I or II?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Other Section – Complete for all Products except Disability	
14. Are you Medicare eligible?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Has the Important Notice to Persons on Medicare been provided?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant's Beneficiary Information – Complete for all Products					
Beneficiary's Name (First, MI, Last)	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Applicant	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Applicant	Social Security No.

Height and Weight Section – Complete for all products at Simplified Issue Level 1 amounts
Indicate Applicant's Current: Height _____ Weight _____
Indicate Spouse's Current: Height _____ Weight _____

Medication Section - Complete for all products at Simplified Issue Level 1 amounts	Applicant	Spouse
M1. Are you currently prescribed any medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Simplified Issue Level 1 Section – Disability	Applicant		
D1. Within the past 5 years, have you received medical advice or sought treatment for any cancer, other than skin cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
D2. Within the past 5 years, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI) Transient Ischemic Attack Multiple Sclerosis Heart Surgery End Stage Kidney (Renal) Disease Neurological Disorder Heart Disease Emphysema Chronic Fatigue Syndrome Congestive Heart Failure Cirrhosis or Liver Disease Fibromyalgia Stroke Chronic Obstructive Pulmonary Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>		
D3. Within the past 5 years, have you received medical advice or sought treatment (including medication) for: Back Injury or Illness Joint Injury or Illness Diabetes Knee Injury or Illness Muscular Injury or Illness Hepatitis B, C Neck Injury or Illness Carpal Tunnel Syndrome Blood Pressure Reading of 140/90 or Above	Yes <input type="checkbox"/> No <input type="checkbox"/>		
D4. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease, mental or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
D5. Do you have any individual or group disability insurance now in force with any company, including Colonial Life & Accident Insurance Company?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Insurance Company	Monthly Disability Amount	Elimination Period/Benefit	Policy Number

Simplified Issue Level 1 Section - Hospital Confinement	Applicant	Spouse
H1. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease, mental or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Simplified Issue Level 1 Section - Critical Illness	Applicant
C1. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application?	Yes <input type="checkbox"/> No <input type="checkbox"/>
C2. Have you ever received medical advice or sought treatment for: Heart Disease Lung Disease Kidney Disease Cirrhosis or Liver Disease Hepatitis B, C Circulatory Disease Respiratory Disease Blood Pressure Reading of 140/90 or Above	Yes <input type="checkbox"/> No <input type="checkbox"/>

Health Details Section					
For yes answer, provide details below.					
For prescribed medication, indicate the condition it was prescribed for, medication name, dosage and date of onset.					
Condition Name	Medication Name/ Dosage	Date of Onset and Recovery	Doctor/Hospital Name, Address & Phone #	Date of Treatment	Type Treatment Received

Additional Data Section

Agreement Section

I understand that the policy applied for will not pay benefits for any loss incurred during the first _____ months after the issue date for a disease or physical condition that I now have or have had in the past.

THE APPLICANT AGREES AS FOLLOWS:

Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. To the best of my knowledge and belief, the answers and statements above are true and complete. I understand that this application will not be binding upon Colonial Life & Accident Insurance Company (Colonial) until both: 1) the policy is issued; and 2) the first premium is paid. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. If applicable, I have received an outline of coverage for the plan(s) applied for and I have been explained all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to pre-existing conditions, if applicable. I understand that any untrue statement or material misrepresentation may result in claim denial or rescission of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER. I certify that no person to be covered for specified diseases is also covered by any Title XIX program (Medicare, Medicaid or any similar name.) If applicable, I have received and read a copy of the Notice of Insurance Information Practices, (which includes MIB, Inc. Disclosure Notice). I hereby authorize Colonial Life & Accident Insurance Company to release information to the MIB. Yes No

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the Policy indicated. I hereby request cancellation

- of my Colonial Policy Number(s) _____ Transfer or cancellation of the base plan will also mean cancellation of all attached riders.
- of my rider only _____ as of the effective date and hour of my new coverage.

If, for any reason the policy applied for above is not issued, this request for cancellation shall be null and void.

Signed at: (City) _____ (State) _____ (Date) _____
mm/dd/yyyy

Signature of Applicant

Signature of Employee/Payer

Agent Section

Agent's Name (If Present) _____
(please print)

Do you have knowledge or reason to believe that the Applicant is intending to replace any existing insurance?
Yes No

I have explained to the Applicant all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to pre-existing conditions, if applicable. I hereby certify that I know nothing affecting the insurability of the Applicant, which is not fully set forth in this application. I have not made, nor agreed to make, any rebate of premium for insurance. I further certify that I am a licensed agent in the state where this application is being taken

Date _____ (x) _____ License No. _____ Code No. _____
mm/dd/yyyy Signature of Licensed Agent

**Colonial Life & Accident
Insurance Company**

1200 Colonial Life Boulevard
Columbia, SC 29210
803.798.7000
coloniallife.com

May 11, 2009

Jay Bradford
State Insurance Commissioner
Arkansas Insurance Dept.
Attention: Life and Health
1200 West 3rd Street
Little Rock AR 72201-1904

RE: NAIC#: 62049
Group#: 0565
Insurer: Colonial Life & Accident Insurance Company
Forms: CI-1.0-AR, et al.
Type of Filing: Individual Specified Critical Illness Policy

Dear Commissioner Bradford:

Enclosed for your consideration and approval are the following new individual specified critical illness policy form and outline of coverage.

<u>Form</u>	<u>Description</u>	<u>Flesch Score</u>
CI-1.0-	Limited Benefit Health Coverage for Specified Critical Illness	51.8
CI-1.0-O-	Outline of Coverage	50.3

The readability scores for these forms are listed above. The outline was scored with the policy form. The text is uniform and no less than ten (10) point font size.

This form will be offered and marketed primarily at the worksite as supplemental insurance. It will not be marketed as comprehensive coverage.

There are different benefit combinations as shown on **Exhibit A**. When a policy is issued, it will contain the appropriate benefit amounts on the Policy Schedule page.

This policy includes benefits for specified critical illnesses for the named insured. The specified critical illness benefit provided by this policy reduces on the first policy anniversary date after the named insured attains age 75. Specified Critical Illness benefits are also available for spouse and dependent children.

The policies contain bracketed information which will either appear in its entirety or not at all, depending on choices made by the applicant. No text within the brackets will change.

For policy forms that include a Subsequent Diagnosis Benefit:

- If an insured receives a benefit for a Specified Critical Illness and is diagnosed at least 180 days later with a *different* Specified Critical Illness, we will pay the Face Amount for that Specified Critical Illness for that insured as shown in the Policy Schedule up to the Maximum Benefit Amount payable.
- If an insured receives a benefit for a Specified Critical Illness and is diagnosed at least 180 days later with the *same* Specified Critical Illness, we will pay 25% of the Face Amount for that insured as shown in the Policy Schedule for that Specified Critical Illness up to the Maximum Benefit Amount payable. Critical Illnesses that do not qualify for the Subsequent Diagnosis of the same condition are: Coronary Artery Bypass Graft Surgery, Coronary Artery Disease, Occupational Infectious HIV or Occupational Infectious Hepatitis B, C, D, [Cancer and Carcinoma in Situ, if the Cancer option is chosen.

The Maximum Benefit Amount for policy forms that include a Subsequent Diagnosis Benefit is 3 times the Face Amount for the Named Insured's coverage for all covered persons combined. For example, if a Named Insured chooses a \$50,000 Face Amount, the Maximum Benefit Amount for this policy is \$150,000. The Named Insured and, if covered, Spouse and Dependent Children could receive benefits for Specified Critical Illnesses as shown on the Policy Schedule up to \$150,000 for all covered persons combined. Once the Maximum Benefit Amount has been paid, the policy will terminate.

The Maximum Benefit Amount for policy forms that *do not* include the Subsequent Diagnosis Benefit is 100% of the Face Amount for each covered person. For example, if the Named Insured chooses a \$50,000 Face Amount, the Maximum Benefit Amount for this policy is \$50,000 for the Named Insured. If covered, the Spouse could receive 50% of that Face Amount (\$25,000) for Specified Critical Illnesses, and Dependent Children could receive 25% of that Face Amount (\$12,500) for Specified Critical Illnesses. Once the Maximum Benefit Amount has been paid, the policy will terminate.

The applicant has the ability to choose a policy form that pays a benefit for Coronary Artery Disease rather than Coronary Artery Bypass Graft Surgery, if he wishes his policy to be considered permitted insurance for Health Savings Account purposes.

Application form, AccHlth-AR, approved on 04/07/2005 by your office will be used to apply for this coverage.

Enrollment methods include agent-assisted situations, in person or via call centers, and self-enrolled situations, using paper or electronic application processes, such as web-based. Electronic application processes may also be used in agent-assisted situations.

An actuarial memorandum is enclosed.

The form has been submitted to our domicile state, South Carolina.

If acceptable, we shall appreciate your notifying us via SERFF. If you have any questions, please contact me at (800) 845-7330, extension 7494. My email address is tbgarbutt@coloniallife.com. The fax number is (803) 750-7341.

Sincerely,



Tonia B. Garbutt
Compliance Contract Consultant

General and Specific Variables- CI-1.0-AR

Any modifications will be made within the confines of the laws of the governing jurisdiction.

Policy:

Face Page

1. Address and web address are bracketed. We will send an informational filing, if this changes.
2. If our officers change, these signatures will change.

Policy Schedule

1. John Doe information at the top of the Policy Schedule will change for each insured.
2. Coverage Type - all variables are on the Policy Schedule. The appropriate Coverage Type will show for each policy.

All Benefit Amounts are shown for each benefit on the Policy Schedule

3. Face Amount for Named Insured - \$5,000 to \$150,000 in \$1,000 increments.
4. Face Amount for Spouse – 50% of Face Amount for Named Insured. The spouse benefit is bracketed because it will only show if spouse coverage is selected.
5. Face Amount for Dependent Children - 25% of Face Amount for Named Insured. The dependent children benefit is bracketed because it will only show if dependent children coverage is selected.
6. The Maximum Benefit Amount for Specified Critical Illness will only show if the Benefits Payable Upon Subsequent Diagnosis Benefit (“Subsequent Diagnosis Benefit”) is chosen.
7. In the list of Specified Critical Illness conditions, if Cancer coverage is not selected, Cancer and Carcinoma in Situ will not show.
8. In the list of Specified Critical Illness conditions, some but not all of the policy forms will have the Coronary Artery Bypass Graft Surgery benefit. The HSA-compliant policy forms will not have the Coronary Artery Bypass Graft Surgery benefit. Instead, they will have the Coronary Artery Disease benefit.
9. Maximum Benefit Amount for Specified Critical Illness: 100% of the Face Amount for each covered person – this will only appear in policy forms without the Subsequent Diagnosis Benefit.
10. Maximum Benefit Amount for Specified Critical Illness: \$15,000-\$450,000 in \$3,000 increments - this will only appear in policy forms with the Subsequent Diagnosis Benefit. The brackets around the benefit amounts – all benefit amounts are shown within the brackets.
11. Health Screening Benefit: \$25.00-\$150.00 in \$25.00 increments; payable once per calendar year, per covered person – this is an optional benefit that will be included in some but not all of the policy forms. The brackets around the benefit amounts – all benefit amounts are shown within the brackets.

12. **Cancer Vaccine Benefit: \$50; payable once per lifetime, per covered person – this is an optional benefit that will be included in the policy forms with the Cancer Benefit.**

SECTION IV

1. Coverage provided by this policy in policy forms without the Health Screening Benefit, the bracketed statement at the end of this sentence will not appear.

SECTION V

1. In the third paragraph of the Reinstatement Provision, the beginning of the second bullet (covered health screening tests that occur) will not appear in policy forms without the Health Screening Benefit. Administration of a covered Cancer Vaccine will not appear in policy forms without the Cancer Benefit. The “ands” that are bracketed will appear when appropriate.

SECTION VI

1. The definitions for Cancer and Carcinoma in Situ will not appear when Cancer coverage is not selected.
2. The definition for Coronary Artery Disease will only appear in the HSA-compliant policy forms.
3. In the Date of Diagnosis definition, the ninth bullet that begins “for Coronary Artery Bypass Graft Surgery” will only appear in the policy forms that are not HSA compliant. The 10th bullet will appear in the policy forms that are HSA compliant. The 11th bullet will only appear in the policy forms that have Cancer coverage.

SECTION VII

1. Specified Critical Illness Benefit – third paragraph. In the HSA-compliant policy forms, Coronary Artery Disease will appear and the second sentence will not. In the non-HSA-compliant policy forms, Coronary Artery Bypass Graft Surgery and the second sentence will appear. The sixth and seventh paragraphs will appear when Cancer coverage is selected.
2. The Subsequent Diagnosis Benefit will appear when that benefit is chosen. The second paragraph will vary based on policy forms selected for the HSA-compliant policy forms, Coronary Artery Disease will appear. For the non-HSA-compliant policy forms, Coronary Artery Bypass Graft Surgery. Carcinoma in Situ will only appear when Cancer coverage is selected.
3. Benefit Reduction – the wording “and the Maximum Benefit Amount for Specified Critical Illness” and “the reduced Maximum Benefit Amount” will appear when the Subsequent Diagnosis Benefit is selected.
4. Cancer Vaccine Benefit will only appear when Cancer coverage is selected.
5. Health Screening Benefit will appear in the policy forms that contain that benefit.

SECTION IX

1. Proof of Loss – the third sentence will not appear in policy forms without Cancer coverage or the Health Screening Benefit. If only the Health Screening Benefit is selected, the words “or” and “Cancer Vaccine Benefit” will not appear. If only Cancer coverage is selected, the “Health Screening Benefit” and “or” will not appear.

SECTION X

1. Your Spouse’s Right to Continue Coverage – in the second paragraph, the first sentence will not appear if Cancer coverage is not selected. The second sentence will only appear when the Subsequent Diagnosis Benefit is selected.

Outline:

1. Address and web address are bracketed. We will send an informational filing, if this changes.
2. The Policy Form Number is bracketed. It will display the form number of the policy form corresponding to the outline.
3. In the “Coverage Provided by The Policy” section, first paragraph, the wording “and for certain health screening tests” will appear only if the Health Screening Benefit is selected. In the second paragraph, the wording “or the performance of a health screening test” will only appear if the Health Screening Benefit is selected. “Cancer Vaccine” will appear if only Cancer coverage is selected. “Or” will display when both Cancer and Health Screening are selected. In the second sentence, “Any health screening test” will appear only if the Health Screening Benefit is selected. “or Cancer Vaccine” will appear only if Cancer coverage is selected. The second paragraph will be excluded if neither the Cancer coverage nor the Health Screening Benefit is selected.

Specified Critical Illness Benefit

4. In the Benefits Section, the Maximum Benefit Amount for Specified Critical Illness will only show if the Subsequent Diagnosis Benefit is chosen.
5. In the list of Specified Critical Illness conditions, if Cancer coverage is not selected, Cancer and Carcinoma in Situ will not show.
6. In the list of Specified Critical Illness conditions, some but not all policy forms will have the Coronary Artery Bypass Graft Surgery benefit. The HSA-compliant policy forms will not have the Coronary Artery Bypass Graft Surgery benefit. Instead, they will have the Coronary Artery Disease benefit.
7. Maximum Benefit Amount for Specified Critical Illness: 100% of the Face Amount for each covered person – this will only appear in policy forms without the Subsequent Diagnosis Benefit. Policy forms with Subsequent Diagnosis Benefit will contain the sentence “Maximum Benefit Amount for Specified Critical Illness [\$15,000-\$450,000 in \$3,000 increments.]” This sentence contains the full range of benefit amounts.
8. In the HSA-compliant policy forms, Coronary Artery Disease will appear and the second sentence will not. In the non-HSA-compliant policy forms, Coronary Artery

Bypass Graft Surgery and the second sentence will appear. The ninth and 10th paragraphs will appear when Cancer coverage is selected.

Benefits Payable Upon Subsequent Diagnosis

9. Benefits Payable Upon Subsequent Diagnosis will appear when that benefit is chosen. The second paragraph will vary based on policy forms selected for the HSA-compliant policy forms, Coronary Artery Disease will appear; for the non-HSA-compliant policy forms, Coronary Artery Bypass Graft Surgery will appear. Carcinoma in Situ will only appear when Cancer coverage is selected.
10. Benefit Reduction – the wording “and the Maximum Benefit Amount for Specified Critical Illness” and “the reduced Maximum Benefit Amount” will appear when the Benefits Payable Upon Subsequent Diagnosis Benefit is selected.
11. Cancer Vaccine Benefit will only appear when Cancer coverage is selected.
12. Health Screening Benefit will appear in the policy forms that contain this benefit.
13. The definitions for Cancer and Carcinoma in Situ will not appear when Cancer coverage is not selected.
14. The definition for Coronary Artery Disease will only appear in the HSA-compliant policy forms.
15. In the Date of Diagnosis definition, the ninth bullet that begins “for Coronary Artery Bypass Graft Surgery” will only appear in the policy forms that are not HSA compliant. The 10th bullet will appear in the policy forms that are HSA compliant. The 11th bullet will only appear in the policy forms that have Cancer coverage.

COMPLIANCE CERTIFICATION

FORM: CI-1.0-AR
CI-1.0-O-AR

I certify that this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements.



05/11/2009

Date

Tonia B. Garbutt
Compliance Contract Consultant

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	AR
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2.	Department Use Only	
	State Tracking ID	

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Colonial Life & Accident Insurance Company 1200 Colonial Life Blvd Columbia, SC 29210	SC		0565	62049	57-0144607	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Tonia B. Garbutt P. O. Box 1365 Columbia, SC 29202	800.845.7330, ext. 7494	803.750.7341	tbgarbutt@coloniallife.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	MB3000-AR, et al
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise										
		<table style="width:100%;"> <tr> <td style="width:33%; text-align:center;">Group</td> <td style="width:33%;"> <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large </td> <td style="width:33%;"></td> </tr> <tr> <td></td> <td> <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket </td> <td></td> </tr> <tr> <td></td> <td> <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust </td> <td></td> </tr> <tr> <td></td> <td> <input type="checkbox"/> Other: _____ </td> <td></td> </tr> </table>	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large			<input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket			<input type="checkbox"/> Discretionary <input type="checkbox"/> Trust		
Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large											
	<input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket											
	<input type="checkbox"/> Discretionary <input type="checkbox"/> Trust											
	<input type="checkbox"/> Other: _____											

9.	Type of Insurance	H07I – Individual Health-Specified Disease-Limited Benefit
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10.	Product Coding Matrix Filing Code	H07I.001 – Critical Illness
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11.	Submitted Documents	<p><input checked="" type="checkbox"/> FORMS</p> <table style="width:100%;"> <tr> <td><input checked="" type="checkbox"/> Policy</td> <td><input checked="" type="checkbox"/> Outline of Coverage</td> <td><input type="checkbox"/> Certificate</td> </tr> <tr> <td><input type="checkbox"/> Application/Enrollment</td> <td><input checked="" type="checkbox"/> Rider/Endorsement</td> <td><input type="checkbox"/> Advertising</td> </tr> <tr> <td><input type="checkbox"/> Schedule of Benefits</td> <td><input type="checkbox"/> Other</td> <td></td> </tr> </table> <p>Rates</p> <input checked="" type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate	<input checked="" type="checkbox"/> Policy	<input checked="" type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate	<input type="checkbox"/> Application/Enrollment	<input checked="" type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising	<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other	
<input checked="" type="checkbox"/> Policy	<input checked="" type="checkbox"/> Outline of Coverage	<input type="checkbox"/> Certificate									
<input type="checkbox"/> Application/Enrollment	<input checked="" type="checkbox"/> Rider/Endorsement	<input type="checkbox"/> Advertising									
<input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Other										
		<input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____									
		<p>SUPPORTING DOCUMENTATION</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Articles of Incorporation</td> <td><input type="checkbox"/> Third Party Authorization</td> </tr> <tr> <td><input type="checkbox"/> Association Bylaws</td> <td><input type="checkbox"/> Trust Agreements</td> </tr> <tr> <td><input checked="" type="checkbox"/> Statement of Variability</td> <td><input type="checkbox"/> Certifications</td> </tr> <tr> <td><input checked="" type="checkbox"/> Actuarial Memorandum</td> <td></td> </tr> </table>	<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization	<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements	<input checked="" type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications	<input checked="" type="checkbox"/> Actuarial Memorandum		
<input type="checkbox"/> Articles of Incorporation	<input type="checkbox"/> Third Party Authorization										
<input type="checkbox"/> Association Bylaws	<input type="checkbox"/> Trust Agreements										
<input checked="" type="checkbox"/> Statement of Variability	<input type="checkbox"/> Certifications										
<input checked="" type="checkbox"/> Actuarial Memorandum											

		<input type="checkbox"/> Other _____
12.	Filing Submission Date	05/11/2009
13.	Filing Fee (If required)	Amount <u> \$50.00 </u> Check Date _____ Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	Pending
15.	Filing Description:	

Enclosed for your consideration and approval are the following new individual specified critical illness policy form and outline of coverage.

<u>Form</u>	<u>Description</u>	<u>Flesch Score</u>
CI-1.0-	Limited Benefit Health Coverage for Specified Critical Illness	51.8
CI-1.0-O-	Outline of Coverage	50.3

The readability scores for these forms are listed above. The outline was scored with the policy form. The text is uniform and no less than ten (10) point font size.

This form will be offered and marketed primarily at the worksite as supplemental insurance. It will not be marketed as comprehensive coverage.

There are different benefit combinations as shown on **Exhibit A**. When a policy is issued, it will contain the appropriate benefit amounts on the Policy Schedule page.

This policy includes benefits for specified critical illnesses for the named insured. The specified critical illness benefit provided by this policy reduces on the first policy anniversary date after the named insured attains age 75. Specified Critical Illness benefits are also available for spouse and dependent children.

The policies contain bracketed information which will either appear in its entirety or not at all, depending on choices made by the applicant. No text within the brackets will change.

For policy forms that include a Subsequent Diagnosis Benefit:

- If an insured receives a benefit for a Specified Critical Illness and is diagnosed at least 180 days later with a *different* Specified Critical Illness, we will pay the Face Amount for that Specified Critical Illness for that insured as shown in the Policy Schedule up to the Maximum Benefit Amount payable.
- If an insured receives a benefit for a Specified Critical Illness and is diagnosed at least 180 days later with the *same* Specified Critical Illness, we will pay 25% of the Face Amount for that insured as shown in the Policy Schedule for that Specified Critical Illness up to the Maximum Benefit Amount payable. Critical Illnesses that do not qualify for the Subsequent Diagnosis of the same condition are: Coronary Artery Bypass Graft Surgery, Coronary Artery Disease, Occupational Infectious HIV or Occupational Infectious Hepatitis B, C, D, [Cancer and Carcinoma in Situ, if the Cancer option is chosen.

The Maximum Benefit Amount for policy forms that include a Subsequent Diagnosis Benefit is 3 times the Face Amount for the Named Insured's coverage for all covered persons combined. For example, if a Named Insured chooses a \$50,000 Face Amount, the Maximum Benefit Amount for this policy is \$150,000. The Named Insured and, if covered, Spouse and Dependent Children could receive benefits for Specified Critical Illnesses as shown on the Policy Schedule up to \$150,000 for all covered persons combined. Once the Maximum Benefit Amount has been paid, the policy will terminate.

The Maximum Benefit Amount for policy forms that *do not* include the Subsequent Diagnosis Benefit is 100% of the Face Amount for each covered person. For example, if the Named Insured chooses a \$50,000 Face Amount, the Maximum Benefit Amount for this policy is \$50,000 for the Named Insured. If covered, the Spouse could receive 50% of that Face Amount (\$25,000) for Specified Critical Illnesses, and Dependent Children could receive 25% of that Face Amount (\$12,500) for Specified Critical Illnesses. Once the Maximum Benefit Amount has been paid, the policy will terminate.

The applicant has the ability to choose a policy form that pays a benefit for Coronary Artery Disease rather than Coronary Artery Bypass Graft Surgery, if he wishes his policy to be considered permitted insurance for Health Savings Account purposes.

Application form, AccHlth-AR, approved on 04/07/2005 by your office will be used to apply for this coverage.

Enrollment methods include agent-assisted situations, in person or via call centers, and self-enrolled situations, using paper or electronic application processes, such as web-based. Electronic application processes may also be used in agent-assisted situations.

An actuarial memorandum is enclosed.

The form has been submitted to our domicile state, South Carolina.

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Wendy Smith Title Assistant Secretary


Signature _____ Date: 05/11/2009

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		CI-1.0-AR, et al.
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Limited Benefit Health Coverage For Specified Critical Illness Policy	CI-1.0-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Individual Critical Illness Policy			
02	Limited Benefit Health Coverage For Specified Critical Illness Outline of Coverage	CI-1.0-O-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Outline of Coverage			
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18. Rate Filing Attachment				
This filing transmittal is part of company tracking number			CI-1.0-AR, et al	
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing			%	
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01	Actuarial Memorandum	CI-1.0-AR, et al.	<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1

August 07, 2009

Rosalind Minor
Arkansas Insurance Dept.
Attention: Life and Health
1200 West 3rd Street
Little Rock AR 72201-1904

RE: NAIC#: 62049
Group#: 0565
Insurer: Colonial Life & Accident Insurance Company
Forms: CI-1.0-AR, et al.
Type of Filing: Individual Specified Critical Illness Policy

Dear Ms. Minor:

We are responding to your disapproval letter dated May 15, 2009. The following are our responses to your objections:

1. We've addressed this objection by making changes to the "Subsequent Diagnosis Benefit" as stated below. We feel these changes will clarify our position.
2. As requested, we have amended the Subsequent Diagnosis Benefit to comply with Rule 18, Appendix 1. A. (5). The "180 day waiting period" has been changed to a "30" day waiting period.

If acceptable, we shall appreciate your notifying us via SERFF. If you have any questions, please contact me at (800) 845-7330, extension 6528. My email address is lfsease@coloniallife.com. The fax number is (803) 750-7341.

Sincerely,



Lauren F. Sease
Senior Compliance Contract Consultant

August 19, 2009

Rosalind Minor
Arkansas Insurance Dept.
Attention: Life and Health
1200 West 3rd Street
Little Rock AR 72201-1904

RE: NAIC#: 62049
Group#: 0565
Insurer: Colonial Life & Accident Insurance Company
Forms: CI-1.0-AR, et al.
Type of Filing: Individual Specified Critical Illness Policy

Dear Ms. Minor:

We are responding to your disapproval letter dated August 10, 2009 and to your telephone conversation today with Charles Piacentini.

The policy captioned above provides a lump-sum benefit upon diagnosis of one of the covered specified diseases which can be used to pay for treatment of any other conditions or diseases directly caused or aggravated by the specified disease or treatment of the specified disease. The policy only provides one payout for "Specified Critical Illness" and, if such coverage is purchased, additional payouts for "Subsequent Diagnosis".

This policy does not provide expense reimbursement benefits.

Once the Maximum Benefit Amount for Specified Critical Illness has been paid, the policy terminates.

If acceptable, we shall appreciate your notifying us via SERFF. If you have any questions, please contact me at (800) 845-7330, extension 6528. My email address is lfsease@coloniallife.com. The fax number is (803) 750-7341.

Sincerely,



Lauren F. Sease
Senior Compliance Contract Consultant

SERFF Tracking Number: UNUM-126145902 State: Arkansas
 Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 42372
 Company Tracking Number: CI-1.0-AR
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.001 Critical Illness
 Product Name: Individual Critical Illness - 1.0
 Project Name/Number: Individual Critical Illness - 1.0/CI-1.0-AR

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/11/2009	Form	Outline of Coverage	08/07/2009	CI-1.0-O-AR - 71255[1].pdf (Superseded)
05/11/2009	Form	Individual Critical Illness Policy	08/07/2009	CI-1.0-AR - 71254[1].pdf (Superseded)



COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
 [1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
 1.800.325.4368 www.coloniallife.com]
 A Stock Company

LIMITED BENEFIT HEALTH COVERAGE FOR SPECIFIED CRITICAL ILLNESS

OUTLINE OF COVERAGE (Applicable to Policy Form CI-1.0-AR)

PRE-EXISTING CONDITIONS - PLEASE READ CAREFULLY

If you received treatment, testing or medical advice or took medication for a sickness or physical condition within 12 months before the effective date of this policy, we will not pay a benefit for a Specified Critical Illness that occurs as a result of that sickness or physical condition if the Specified Critical Illness has a Date of Diagnosis within the first 12 months after the effective date of the policy.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

Please Read The Policy Carefully. This outline provides a very brief description of the important features of the policy. This is not an insurance contract and only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and us. It is, therefore, important to **READ THE POLICY CAREFULLY.**

Guaranteed Renewable Subject to Payment of the Maximum Benefit Amount for Specified Critical Illness. The policy is guaranteed renewable as long as you pay the premiums when they are due or within the grace period, up to the date of payment of the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule. Your premium can be changed only if we change it on all policies of this kind in force in the state where the policy was issued.

Coverage Provided by The Policy. The policy is designed to provide coverage ONLY for Specified Critical Illnesses [and for certain health screening tests], subject to any limitations or exclusions in your policy. It does not provide coverage for basic hospital, basic medical-surgical or major medical expenses.

The policy provides benefits only if the Date of Diagnosis of Specified Critical Illness [or the performance of a [health screening test] [or] [Cancer Vaccine]] is while your policy is in force. [Any [health screening test] [or] [Cancer Vaccine] performed before the Policy Coverage Effective Date will not be covered.]

**Premiums vary depending on the amount of coverage you chose at time of application.
 The amount of coverage you chose is shown on the Policy Schedule.**

BENEFITS

Specified Critical Illness Benefit

Face Amount for Named Insured	\$ _____
Face Amount for Spouse(if covered)	50% of face amount for Named Insured
Face Amount for Dependent Children (if covered)	25% of face amount for Named Insured

The Face Amount(s) [and the Maximum Benefit Amount for Specified Critical Illness] will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75.

We will pay this benefit if a covered person is diagnosed with one of the Specified Critical Illnesses shown below if: the Date of Diagnosis is while coverage under the policy is in force; and the Specified Critical Illness is not excluded by name or specific description in the policy.

[Cancer	100%]
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Permanent Paralysis due to a Covered Accident	100%
Coma	100%
Blindness	100%
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%
[Coronary Artery Bypass Graft Surgery	25%]
[Coronary Artery Disease	25%]
[Carcinoma in Situ	25%]

[Maximum Benefit Amount for Specified Critical Illness: 100% of the Face Amount for each covered person.]

[Maximum Benefit Amount for Specified Critical Illness: [\$15,000-\$450,000 in \$3,000 increments]]

We will pay the percentage of the Face Amount shown on the Policy Schedule for the Specified Critical Illness diagnosed, up to the Maximum Benefit Amount for Specified Critical Illness shown on the Policy Schedule.

We will pay the benefit for [Coronary Artery Bypass Graft Surgery][Coronary Artery Disease] only once per lifetime per covered person. [If a covered person receives a benefit for Coronary Artery Bypass Graft Surgery and is later diagnosed with a different Specified Critical Illness, we will pay the Face Amount less the amount you received for Coronary Artery Bypass Graft Surgery.]

If, on the same day, a covered person is placed on the UNOS list for a transplant of two or more major organs listed in the definition of Major Organ Failure (example: heart and lungs), a single benefit will be paid.

We will pay the benefit for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D only once per lifetime per covered person.

[We will pay the benefit for Carcinoma in Situ only once per lifetime per covered person. [If a covered person receives a benefit for Carcinoma in Situ and is later diagnosed with a different Specified Critical Illness, we will pay the Face Amount less the amount received for Carcinoma in Situ.]

We will pay the benefit for Cancer only once per lifetime per covered person.]

If the Date of Diagnosis of two or more Specified Critical Illnesses is the same day, we will pay only one Specified Critical Illness benefit. We will pay the larger of the Specified Critical Illness benefits.

No benefits are payable for conditions other than the Specified Critical Illnesses defined in the policy.

[Benefits Payable Upon Subsequent Diagnosis.

If a covered person has been diagnosed with and received a benefit for a Specified Critical Illness and is subsequently diagnosed with a different Specified Critical Illness, we will pay the Specified Critical Illness benefit as shown on the Policy Schedule, up to the Maximum Benefit Amount for Specified Critical Illness, if: the Date of Diagnosis of the subsequent Specified Critical Illness is more than 180 days after any previous Date of Diagnosis for a Specified Critical Illness; and the subsequent Date of Diagnosis is while coverage under this policy is in force; and the Specified Critical Illness is not excluded by name or specific description in this policy.

If a covered person has been diagnosed with and received a benefit for a Specified Critical Illness and is subsequently diagnosed with the same Specified Critical Illness (other than [Coronary Artery Bypass Graft Surgery][Coronary Artery Disease], Cancer, Carcinoma in Situ,) and Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D), we will pay an amount equal to 25% of the Face Amount for the covered person as shown on the Policy Schedule, up to the Maximum Benefit Amount for Specified Critical Illness, if: the Date of Diagnosis of the subsequent Specified Critical Illness is more than 180 days after any previous Date of Diagnosis for the same Specified Critical Illness; the covered person has not received treatment during the 180 days between the Dates of Diagnosis for the same Specified Critical Illness. For purposes of the preceding sentence, treatment does not include medications



and follow-up visits to the covered person's Doctor; the subsequent Date of Diagnosis is while coverage under this policy is in force; and the Specified Critical Illness is not excluded by name or specific description in this policy.]

We will not pay more than the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule.

This policy will terminate when the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule has been paid.

Benefit Reduction

The Face Amount(s) [and the Maximum Benefit Amount for Specified Critical Illness] will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75. All Specified Critical Illness benefits payable after that date will be based on the reduced Face Amount [and the reduced Maximum Benefit Amount].

[Cancer Vaccine Benefit

Amount: \$50

We will pay this benefit if a covered person incurs a charge for and receives any cancer vaccine that is FDA approved for the prevention of Cancer. The vaccine must be administered by licensed medical personnel while coverage under the policy is in force. Payment of this benefit will not reduce the Maximum Benefit Amount for Specified Critical Illness. This benefit is limited to one payment per covered person, per lifetime.]

[Health Screening Benefit

Amount: \$[25- \$150 in \$25 increments]/Year

We will pay this benefit if any covered person incurs a charge for and has one of the following screening tests performed while coverage under the policy is in force. We will pay the amount shown for one of the following screening tests. Payment of this benefit will not reduce the Maximum Benefit Amount for Specified Critical Illness. This benefit is payable once per calendar year for each covered person.

Health screening test is defined as: stress test on a bicycle or treadmill, fasting blood glucose test, blood test for triglycerides, serum cholesterol test to determine level of HDL and LDL, bone marrow testing, carotid doppler, electrocardiogram (EKG, ECG), echocardiogram (ECHO), skin cancer biopsy, breast ultrasound, CA 15-3 (blood test for breast cancer), CA125 (blood test for ovarian cancer), CEA (blood test for colon cancer), chest x-ray, colonoscopy, flexible sigmoidoscopy, hemocult stool analysis, mammography, pap smear, PSA (blood test for prostate cancer), serum protein electrophoresis (blood test for myeloma), thermography, thinprep pap test, and virtual colonoscopy.]

DEFINITIONS

Accident means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Blindness means clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity), or visual field restriction to 20° or less in both eyes. The following are not to be construed as blindness for purposes of the policy: if in general medical opinion any procedure, device, or implant could result in the partial or total restoration of sight; if the covered person has not attained age three or above on the Date of Diagnosis, and if the covered person's reduction of sight as defined above occurs prior to the Policy Coverage Effective Date of the covered person's coverage under this policy.

Calendar Year means the period beginning on the Policy Coverage Effective Date of coverage shown on the Policy Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

[Cancer means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. The following are not to be construed as Cancer for purposes of this policy: pre-malignant conditions or conditions with malignant potential; Carcinoma in Situ; basal cell carcinoma and squamous cell carcinoma of the skin; and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.]

[Carcinoma in Situ means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified Pathologist, whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.

A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

- a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- there is medical evidence to support the diagnosis; and
- a Doctor is treating the covered person for Cancer and/or Carcinoma in Situ.]

Cardiologist means a Doctor who is licensed to practice medicine and who is also licensed to practice by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.

Coma means a continuous state of profound unconsciousness resulting from a Covered Accident or a Covered Sickness, characterized by the absence of: eye opening, motor response, and verbal response. The condition must require intubation for respiratory assistance. The term “Coma” does not include any medically induced coma.

A **Covered Accident** is an accident that occurs on or after the Policy Coverage Effective Date of the policy; occurs while the policy is in force; and, is not excluded by name or specific description in the policy.

A **Covered Sickness** means an illness, infection, disease or any other abnormal physical condition, not caused by an accident, that occurs on or after the Policy Coverage Effective Date of the policy; occurs while the policy is in force; and is not excluded by specific name or specific description in the policy.

Coronary Artery Bypass Graft Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

[**Coronary Artery Disease** means a narrowing or blockage of one or more coronary arteries for which a Cardiologist recommends that Coronary Artery Bypass Graft Surgery occur within 60 days following the date of the recommendation.]

Date of Diagnosis

- for Heart Attack (Myocardial Infarction), the date that the ischemic death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack (Myocardial Infarction) definition;
- for Stroke, the date a Stroke occurred based on neuroimaging or other neurodiagnostic study consistent with an acute or subacute infarction, hemorrhage, embolism, thrombosis and presence of neurological deficits persisting for a period of 30 days or greater;
- for End Stage Renal (Kidney) Failure, the date that regular hemodialysis or peritoneal dialysis begins;
- for Major Organ Failure, the date that the covered person is placed on the UNOS list for transplantation;
- for Permanent Paralysis due to a Covered Accident, the date the Doctor confirms the Permanent Paralysis due to a Covered Accident has continued for a period of 180 consecutive days;
- for Coma, the date a Doctor confirms a coma resulting from a Covered Accident or a Covered Sickness has lasted seven or more consecutive days;
- for Blindness, the date the Doctor confirms the irreversible reduction of sight has continued for a period of 180 consecutive days;
- for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D, the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests;
- [for Coronary Artery Bypass Graft Surgery, the date the covered person undergoes the open heart surgery]
- [for Coronary Artery Disease, the date the Cardiologist recommends the covered person undergo Coronary Artery Bypass Graft Surgery within the 60 days following the date of the recommendation][, and]
- [for Cancer or Carcinoma in Situ, the date the tissue specimen, blood samples or titer(s) are taken upon which the first diagnosis of Cancer or Carcinoma in Situ is based.]

Dependent Children means any natural children, step-children, legally adopted children, foster children or children under your charge, care and control for whom you have filed a petition to adopt who are unmarried; chiefly dependent on you or your spouse for support; and younger than age 26.



A **Doctor or Physician** means a person who: is licensed by the state to practice a healing art; and performs services for a covered person that are allowed by his license. For purposes of this definition, Doctor or Physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that the covered person must undergo at least weekly hemodialysis or peritoneal dialysis.

Heart Attack (Myocardial Infarction) means the ischemic death of a portion of heart muscle as a result of obstruction of one or more of the coronary arteries. A positive diagnosis must be supported by three or more of the following: atypical chest pain; electrocardiographic (EKG) changes indicative of myocardial infarction; elevation of biochemical markers of myocardial necrosis; and confirmatory imaging studies. In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack (Myocardial Infarction) as the cause of death will be accepted.

A Heart Attack (Myocardial Infarction) is not congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B-, C- or D-contaminated body fluids as the result of a Covered Accident during the normal course of performing an occupation for which remuneration is earned.

We will pay this benefit if: within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the covered person's occupation or profession; the Covered Accident is investigated and a written investigation report is provided to us by the covered person's employer; a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the Covered Accident and HIV or Hepatitis B, C or D is not present; all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the Covered Accident, and the result is positive.

Occupational HIV or Hepatitis B, C or D excludes: HIV or Hepatitis B, C or D infection as the result of IV drug use; HIV or Hepatitis B, C or D infection as the result of sexual transmission; and HIV or Hepatitis B, C or D infection determined not to have been the result of a Covered Accident.

Major Organ Failure means diagnosis of major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the covered person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

A **Pathologist** means a Doctor who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Permanent Paralysis due to a Covered Accident means the complete and permanent loss of the use of two or more limbs through paralysis as the result of a Covered Accident as defined in the policy for a continuous period of 180 days, as confirmed by a Doctor. Loss of use of two or more limbs through paralysis as the result of a Stroke will not be construed as Permanent Paralysis due to a Covered Accident for purposes of the policy.

Policy Anniversary Date occurs annually on the same date and in the same month as the date for which we first received premium.

Pre-existing Condition means having a sickness or physical condition for which any covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the Policy Coverage Effective Date of this policy.

Specified Critical Illness means one of the Specified Critical Illnesses shown on the Policy Schedule.

Stroke means an acute or subacute cerebrovascular incident, including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis.

The diagnosis must be supported by: evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

The following are not to be construed as a Stroke for purposes of the policy: transient ischemic attack; brain injury related to trauma or infection; brain injury associated with hypoxia/anoxia or hypotension; vascular disease affecting the eye or optic nerve; and ischemic disorders of the vestibular system. In the event of death, an autopsy confirmation identifying Stroke as the cause of death will be accepted.

WHAT IS NOT COVERED BY THE POLICY

We will not pay benefits for a Specified Critical Illness that occurs as a result of a covered person's:

1. Addiction to alcohol or drugs, except for drugs administered on the advice of his Doctor.
2. Committing or attempting to commit a felony or engaging in an illegal occupation.
3. Being intoxicated or under the influence of any narcotic unless administered on the advice of his Doctor.
4. Having a pre-existing condition as defined in the policy and limited by the Time Limits on Certain Defenses provision of the policy.
5. Having a psychiatric or psychological condition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. However, Alzheimer's disease and other organic senile dementias are covered under the policy.
6. Committing or trying to commit suicide, or his injuring himself intentionally, while he is sane or insane.
7. Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.



COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
 [1200 Colonial Life Boulevard, P.O. Box 1365, Columbia, South Carolina 29202
 1.800.325.4368 www.coloniallife.com]
 A Stock Company

LIMITED BENEFIT HEALTH COVERAGE FOR SPECIFIED CRITICAL ILLNESS

**THIS IS AN INDIVIDUAL SPECIFIED CRITICAL ILLNESS POLICY.
 THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND
 NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

Guaranteed Renewable Subject to Payment of the Maximum Benefit Amount for Specified Critical Illness

This policy is guaranteed renewable as long as you pay the premiums when they are due or within the grace period, up to the date of payment of the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule. Your premium can be changed only if we change it on all policies of this kind in force in the state where the policy was issued.

Please Read This Policy Carefully

This policy is a legal contract between you and us. Please read it carefully. We want you to be pleased with the coverage it provides. To understand your coverage, you must read this policy as a whole.

In this policy, the words *named insured* refer to the person identified on the Policy Schedule. The words *you* or *your* refer only to the named insured. The words *covered person* refer to any person covered under this policy as described on the Policy Schedule. The male pronoun includes the female whenever used. The words *we*, *us* or *our* refer to Colonial Life & Accident Insurance Company.

Your Right to Return This Policy Within 30 Days

If, for any reason, you are not satisfied with this policy, you can return it to us at our home office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this policy as if it never existed. Any premium paid will be refunded.

Secretary

President and CEO]

**This is a limited policy. Please read it carefully.
 THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

If you should have any questions, need information about your coverage or assistance in resolving complaints, please contact your agent or Colonial Life at 1800.325.4368. In the event that we fail to provide you with reasonable and adequate service, feel free to contact the Insurance Department.

Arkansas Insurance Department
 Consumer Services Division
 1200 West Third Street
 Little Rock, AR 72201
 501-371-2640
 1-800-852-5494

SECTION II - POLICY GUIDE

SECTION I - FACE PAGE

SECTION II - POLICY GUIDE

SECTION III - POLICY SCHEDULE

SECTION IV - YOUR CONTRACT WITH US

SECTION V - YOUR PREMIUM PAYMENTS

SECTION VI - IMPORTANT WORDS IN THIS POLICY

SECTION VII - BENEFITS

SECTION VIII - WHAT IS NOT COVERED BY THIS POLICY

SECTION IX - YOUR CLAIM FOR BENEFITS

SECTION X - OTHER IMPORTANT PROVISIONS



COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

SECTION III - POLICY SCHEDULE

Named Insured: [John Doe]

Policy Number: [1234567890
E99999999999]

Policy Coverage Effective Date: [January 20, 2009]

Monthly Premium: [\$ 17.90]

Coverage Type: [Named Insured] [Named Insured and Spouse] [Named Insured and Dependent Children] [Named Insured, Spouse and Dependent Children]

BENEFITS

Face Amount for Named Insured [\$5,000-\$150,000 in \$1,000 increments]

[Face Amount for Spouse] [50% of Face Amount for Named Insured]

[Face Amount for Dependent Children] [25% of Face Amount for Named Insured]

The Face Amount(s) [and the Maximum Benefit Amount for Specified Critical Illness] will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75.

Specified Critical Illness	Percentage of Face Amount
[Cancer	100%
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Permanent Paralysis due to a Covered Accident	100%
Coma	100%
Blindness	100%
Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%
[Coronary Artery Bypass Graft Surgery	25%
[Coronary Artery Disease	25%
[Carcinoma in Situ	25%

[Maximum Benefit Amount for Specified Critical Illness: 100% of the Face Amount for each covered person]

[Maximum Benefit Amount for Specified Critical Illness: [\$15,000-\$450,000 in \$3,000 increments]]

[Health Screening Benefit [\$25.00-\$150.00 in \$25.00 increments]
Payable once per calendar year, per covered person]

[Cancer Vaccine Benefit \$50
Payable once per covered person, per lifetime]

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SECTION IV - YOUR CONTRACT WITH US

Coverage Provided by This Policy

According to the provisions of this policy, we insure any covered person against the Specified Critical Illnesses [and for certain health screening tests].

When making a benefit determination under this policy, we have discretionary authority to determine the covered person's eligibility for the benefits and to interpret the terms and provisions of the policy. All benefit determinations must be reasonable and based on the terms of this policy and the facts and circumstances of each claim.

Entire Contract: Changes

This policy is a legal contract between you and us. We provide the insurance coverage stated, subject to the terms of this policy. We do this in return for your application and your first payment called a *premium*. The premium for this policy is shown on the Policy Schedule.

Whenever we use the word *policy*, we mean the entire contract. The entire contract consists of:

- the policy, including the Policy Schedule;
- the attached copy of the application; and
- any attached riders or endorsements.

Riders and endorsements add provisions or change the terms of the policy. Any changes made to this policy must be attached in writing and signed by one of our executive officers at our home office. No agent or anyone else can change this policy or waive any of its provisions.

Who is Covered By This Policy

If this is a named insured policy as shown on the Policy Schedule, we insure you, the named insured.

If this is a named insured and spouse policy as shown on the Policy Schedule, we insure you and your spouse.

If this is a named insured and dependent children policy as shown on the Policy Schedule, we insure you and your dependent children.

If this is a named insured, spouse and dependent children policy as shown on the Policy Schedule, we insure you, your spouse and your dependent children.

Spouse means the person married to you on the day we issue this policy.

Dependent children means any natural children, step-children, legally adopted children, foster children or children under your charge, care and control for whom you have filed a petition to adopt who are:

- unmarried;
- chiefly dependent on you or your spouse for support; and
- younger than age 26.

Children born to dependent children of the named insured or the named insured's spouse are not covered under this policy.

Coverage on your newborn children begins from the moment of birth. If this is a named insured policy or a named insured and spouse policy, this coverage on the newborn child will end 90 days later if you do not notify us in writing of the birth and complete the required application form. The first premium for named insured and dependent children or named insured, spouse and dependent children coverage is due on the next premium due date after the birth of the newborn.

Coverage on your adopted children begins with the earlier of:

1. the date of placement into your custody for adoption;
2. the moment of birth if the petition for adoption is filed within 60 days after the birth; or
3. the date of filing the petition for adoption if the petition for adoption is filed more than 60 days after the birth.

If this is a named insured policy or a named insured and spouse policy, this coverage on the adopted child will end 90 days later if you do not notify us in writing of the adoption or placement into your custody for adoption and complete the required application form. The first premium for named insured and dependent children or named insured, spouse and dependent children coverage is due on the next premium due date after the adoption or placement.

Coverage on a child placed in your custody for adoption will also terminate upon the dismissal or denial of a petition for adoption.

After the Policy Coverage Effective Date, if any members of your family are added to this policy, including a new spouse or child, you must:

- notify us that you wish to add a person to your coverage;
- complete the required application form; and
- pay any additional premium for him.

Effective Date of This Policy

This policy begins at 12:01 a.m. in the time zone where you live on the Policy Coverage Effective Date shown on the Policy Schedule.

SECTION V - YOUR PREMIUM PAYMENTS

When and Where to Pay Premiums

The premiums for this policy must be paid to us at our home office in advance and when they are due.

The premium due dates are based on:

- the date and month for which we first received premium; and
- the premium frequency.

The *premium frequency* is how often the premiums are paid.

Grace Period (If Premiums Are Not Paid When Due)

After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the *grace period*. During the grace period this policy will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate at the end of the grace period.

Refund of Unearned Premium

If this policy terminates because you, the named insured, die, we will refund any premiums you have paid for any period after the monthly anniversary date following termination. The monthly anniversary date occurs each month on the same date as the date for which we first received premium.

Our Right to Change Premiums

We have the right to change the premium we charge. However, we cannot single anyone out for a rate change. If we make a change, it will be made on all policies of this kind in force in the state where the policy was issued. If we plan to make a change, we will send a notice at least 31 days before we make it. We will not change premiums more than once in a 12-month period.

Unpaid Premium

When a claim is paid under this policy, any premium then due and unpaid may be deducted by us from the claim payment.

Reinstatement (How to Put This Policy Back in Force)

If the premium is not paid by the end of the grace period, this policy will no longer be in force. However, the policy may be put back in force. This is called *reinstatement*. You can ask us or one of our agents about reinstatement. If we accept the premium and do not require a reinstatement application, this policy will be reinstated on the date the premium is received.

If we do require a reinstatement application at the time we accept the premium, a conditional receipt will be given for the premium. If we approve the reinstatement application, this policy will be reinstated on the date we approve it. If we do not



notify you that we have approved or disapproved the reinstatement application, this policy will be reinstated on the 45th day after the date on the conditional receipt.

The reinstated policy will cover:

- Specified Critical Illnesses that have a Date of Diagnosis more than 10 days after the reinstatement date; and
- [covered health screening tests that occur] [and] [administration of a covered Cancer Vaccine] more than 10 days after the reinstatement date].

We have the right to make changes in this policy before we reinstate it. Any changes will be made in a rider to be attached to the reinstated policy. In every other way, your rights and our rights will be the same.

SECTION VI - IMPORTANT WORDS IN THIS POLICY

Accident

Accident means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Blindness

Blindness means clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity), or visual field restriction to 20° or less in both eyes.

The following are not to be construed as blindness for purposes of this policy:

- if in general medical opinion any procedure, device, or implant could result in the partial or total restoration of sight;
- if the covered person has not attained age three or above on the Date of Diagnosis, and
- if the covered person's reduction of sight as defined above occurs prior to the Policy Coverage Effective Date of the covered person's coverage under this policy.

Calendar Year

Calendar Year means the period beginning on the Policy Coverage Effective Date of coverage shown on the Policy Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

[Cancer

Cancer means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.

The following are not to be construed as Cancer for purposes of this policy:

- pre-malignant conditions or conditions with malignant potential;
- Carcinoma in Situ;
- basal cell carcinoma and squamous cell carcinoma of the skin; and
- melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Carcinoma in Situ

Carcinoma in Situ means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

- A *Pathological Diagnosis* of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified Pathologist, whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
- A *Clinical Diagnosis* of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:
 - a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
 - there is medical evidence to support the diagnosis; and

- a Doctor is treating the covered person for Cancer and/or Carcinoma in Situ.]

Cardiologist

Cardiologist means a Doctor who is licensed to practice medicine and who is also licensed to practice by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.

Coma

Coma means a continuous state of profound unconsciousness resulting from a Covered Accident or a Covered Sickness, characterized by the absence of:

- eye opening,
- motor response, and
- verbal response.

The condition must require intubation for respiratory assistance.

The term “Coma” does not include any medically induced coma.

Covered Accident

Covered Accident means an accident that:

- occurs on or after the Policy Coverage Effective Date of this policy;
- occurs while this policy is in force; and
- is not excluded by name or specific description in this policy.

Covered Sickness

Covered Sickness means an illness, infection, disease or any other abnormal physical condition, not caused by an accident, that:

- occurs on or after the Policy Coverage Effective Date of this policy;
- occurs while this policy is in force; and
- is not excluded by name or specific description in this policy.

Coronary Artery Bypass Graft Surgery

Coronary Artery Bypass Graft Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

[Coronary Artery Disease

Coronary Artery Disease means a narrowing or blockage of one or more coronary arteries for which a Cardiologist recommends that Coronary Artery Bypass Graft Surgery occur within 60 days following the date of the recommendation.]

Date of Diagnosis

- for Heart Attack (Myocardial Infarction), the date that the ischemic death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack (Myocardial Infarction) definition;
- for Stroke, the date a Stroke occurred based on neuroimaging or other neurodiagnostic study consistent with an acute or subacute infarction, hemorrhage, embolism, thrombosis and presence of neurological deficits persisting for a period of 30 days or greater;
- for End Stage Renal (Kidney) Failure, the date that regular hemodialysis or peritoneal dialysis begins;
- for Major Organ Failure, the date that the covered person is placed on the UNOS list for transplantation;
- for Permanent Paralysis due to a Covered Accident, the date the Doctor confirms the Permanent Paralysis due to a Covered Accident has continued for a period of 180 consecutive days;
- for Coma, the date a Doctor confirms a coma resulting from a Covered Accident or a Covered Sickness has lasted seven or more consecutive days;
- for Blindness, the date the Doctor confirms the irreversible reduction of sight has continued for a period of 180 consecutive days;
- for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D, the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests;



- [for Coronary Artery Bypass Graft Surgery, the date the covered person undergoes the open heart surgery]
- [for Coronary Artery Disease, the date the Cardiologist recommends the covered person undergo Coronary Artery Bypass Graft Surgery within the 60 days following the date of the recommendation]; and]
- [for Cancer or Carcinoma in Situ, the date the tissue specimen, blood samples or titer(s) are taken upon which the first diagnosis of Cancer or Carcinoma in Situ is based.]

Doctor or Physician

Doctor or Physician means a person who:

- is licensed by the state to practice a healing art; and
- performs services for a covered person that are allowed by his license.

For purposes of this definition, *Doctor or Physician* does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

End Stage Renal (Kidney) Failure

End Stage Renal Failure means chronic irreversible failure of the function of both kidneys such that the covered person must undergo at least weekly hemodialysis or peritoneal dialysis.

Heart Attack (Myocardial Infarction)

Heart Attack (Myocardial Infarction) means the ischemic death of a portion of heart muscle as a result of obstruction of one or more of the coronary arteries. A positive diagnosis must be supported by three or more of the following:

- (a) atypical chest pain;
- (b) electrocardiographic (EKG) changes indicative of myocardial infarction; in the case of myocardial infarction associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria in establishing a diagnosis;
- (c) elevation of biochemical markers of myocardial necrosis; and
- (d) confirmatory imaging studies.

In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack (Myocardial Infarction) as the cause of death will be accepted.

A Heart Attack (Myocardial Infarction) is not congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D means diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B-, C- or D-contaminated body fluids as the result of a Covered Accident during the normal course of performing an occupation for which remuneration is earned.

We will pay this benefit if:

- within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the covered person's occupation or profession;
- the Covered Accident is investigated and a written investigation report is provided to us by the covered person's employer;
- a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the Covered Accident and HIV or Hepatitis B, C or D is not present;
- all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and
- a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the Covered Accident, and the result is positive.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D excludes:

- HIV or Hepatitis B, C or D infection as the result of IV drug use;
- HIV or Hepatitis B, C or D infection as the result of sexual transmission; and

- HIV or Hepatitis B, C or D infection determined not to have been the result of a Covered Accident.

Major Organ Failure

Major Organ Failure means diagnosis of major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the covered person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

Pathologist

Pathologist means a Doctor who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Permanent Paralysis due to a Covered Accident

Permanent Paralysis due to a Covered Accident means the complete and permanent loss of the use of two or more limbs through paralysis as the result of a Covered Accident as defined in the policy for a continuous period of 180 days, as confirmed by a Doctor. Loss of use of two or more limbs through paralysis as the result of a Stroke will not be construed as Permanent Paralysis due to a Covered Accident for purposes of this policy.

Policy Anniversary Date

Policy Anniversary Date occurs annually on the same date and in the same month as the date for which we first received premium.

Pre-existing Condition

Pre-existing Condition means having a sickness or physical condition for which any covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the Policy Coverage Effective Date of this policy.

Specified Critical Illness

Specified Critical Illness means one of the Specified Critical Illnesses shown on the Policy Schedule.

Stroke

A *Stroke* means an acute or subacute cerebrovascular incident, including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by:

- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

The following are not to be construed as a Stroke for purposes of this policy:

- transient ischemic attack;
- brain injury related to trauma or infection;
- brain injury associated with hypoxia/anoxia or hypotension;
- vascular disease affecting the eye or optic nerve; and
- ischemic disorders of the vestibular system.

In the event of death, an autopsy confirmation identifying Stroke as the cause of death will be accepted.

SECTION VII - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if a covered person is diagnosed with one of the Specified Critical Illnesses shown on the Policy Schedule if:

- the Date of Diagnosis is while this policy is in force; and
- it is not excluded by name or specific description in this policy.

We will pay the percentage of the Face Amount shown on the Policy Schedule for the Specified Critical Illness diagnosed, up to the Maximum Benefit Amount for Specified Critical Illness shown on the Policy Schedule.



We will pay the benefit for [Coronary Artery Bypass Graft Surgery] [Coronary Artery Disease] only once per lifetime per covered person. [If a covered person receives a benefit for Coronary Artery Bypass Graft Surgery and is later diagnosed with a different Specified Critical Illness, we will pay the Face Amount less the amount received for Coronary Artery Bypass Graft Surgery.]

If, on the same day, a covered person is placed on the UNOS list for a transplant of two or more major organs listed above in the definition of Major Organ Failure (example: heart and lungs), a single benefit will be paid.

We will pay the benefit for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D only once per lifetime per covered person.

[We will pay the benefit for Carcinoma in Situ only once per lifetime per covered person. [If a covered person receives a benefit for Carcinoma in Situ and is later diagnosed with a different Specified Critical Illness, we will pay the Face Amount less the amount received for Carcinoma in Situ.]

We will pay the benefit for Cancer only once per lifetime per covered person.]

If the Date of Diagnosis of two or more Specified Critical Illnesses is the same day, we will pay only one Specified Critical Illness benefit. We will pay the larger of the Specified Critical Illness benefits.

No benefits are payable for conditions other than the Specified Critical Illnesses defined in the policy.

[Benefits Payable Upon Subsequent Diagnosis

If a covered person has been diagnosed with and received a benefit for a Specified Critical Illness and is subsequently diagnosed with a different Specified Critical Illness, we will pay the Specified Critical Illness benefit as shown on the Policy Schedule, up to the Maximum Benefit Amount for Specified Critical Illness, if:

- the Date of Diagnosis of the subsequent Specified Critical Illness is more than 180 days after any previous Date of Diagnosis for a Specified Critical Illness; and
- the subsequent Date of Diagnosis is while coverage under this policy is in force; and
- the Specified Critical Illness is not excluded by name or specific description in this policy.

If a covered person has been diagnosed with and received a benefit for a Specified Critical Illness and is subsequently diagnosed with the same Specified Critical Illness (other than [Coronary Artery Bypass Graft Surgery] [Coronary Artery Disease] [, Cancer, Carcinoma in Situ,] and Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D), we will pay an amount equal to 25% of the Face Amount for the covered person as shown on the Policy Schedule, up to the Maximum Benefit Amount for Specified Critical Illness, if:

- the Date of Diagnosis of the subsequent Specified Critical Illness is more than 180 days after any previous Date of Diagnosis for the same Specified Critical Illness; and
- the covered person has not received treatment during the 180 days between the Dates of Diagnosis for the same Specified Critical Illness. For purposes of the preceding sentence, treatment does not include medications and follow-up visits to the covered person's Doctor;
- the subsequent Date of Diagnosis is while coverage under this policy is in force; and
- the Specified Critical Illness is not excluded by name or specific description in this policy.]

We will not pay more than the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule.

This policy will terminate when the Maximum Benefit Amount for Specified Critical Illness as shown on the Policy Schedule has been paid.

Benefit Reduction

The Face Amount(s) [and the Maximum Benefit Amount for Specified Critical Illness] will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75. All Specified Critical Illness benefits payable after that date will be based on the reduced Face Amount [and the reduced Maximum Benefit Amount].

[Cancer Vaccine Benefit

We will pay this benefit if a covered person incurs a charge for and receives any cancer vaccine that is FDA approved for the prevention of Cancer. The vaccine must be administered by licensed medical personnel while coverage under this policy is in force. We will pay the amount shown on the Policy Schedule. Payment of this benefit will not reduce the Maximum Benefit Amount for Specified Critical Illness. This benefit is limited to one payment per covered person, per lifetime.]

[Health Screening Benefit

We will pay this benefit if any covered person incurs a charge for and has one of the following screening tests performed while coverage under this policy is in force. We will pay the amount shown in the Policy Schedule for one of the following screening tests. Payment of this benefit will not reduce the Maximum Benefit Amount for Specified Critical Illness. This benefit is payable once per calendar year for each covered person.

Screening test is defined as:

- Stress test on a bicycle or treadmill,
- Fasting blood glucose test,
- Blood test for triglycerides,
- Serum cholesterol test to determine level of HDL and LDL,
- Bone marrow testing,
- Carotid doppler,
- Electrocardiogram (EKG, ECG),
- Echocardiogram (ECHO),
- Skin cancer biopsy,
- Breast ultrasound,
- CA 15-3 (blood test for breast cancer),
- CA125 (blood test for ovarian cancer),
- CEA (blood test for colon cancer),
- Chest x-ray,
- Colonoscopy,
- Flexible sigmoidoscopy,
- Hemoccult stool analysis,
- Mammography,
- Pap smear,
- PSA (blood test for prostate cancer),
- Serum protein electrophoresis (blood test for myeloma),
- Thermography,
- ThinPrep pap test, and
- Virtual colonoscopy.]

SECTION VIII - WHAT IS NOT COVERED BY THIS POLICY

We will not pay benefits for a Specified Critical Illness that occurs as a result of a covered person's:

Alcoholism or Drug Addiction

Addiction to alcohol or drugs, except for drugs administered on the advice of his Doctor.

Felonies or Illegal Occupations

Committing or attempting to commit a felony or engaging in an illegal occupation.

Intoxicants and Narcotics

Being intoxicated or under the influence of any narcotic unless administered on the advice of his Doctor.

Pre-existing Condition

Having a pre-existing condition as defined in this policy and limited by the Time Limits on Certain Defenses provision of this policy.



Psychiatric or Psychological Condition

Having a psychiatric or psychological condition, including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. However, Alzheimer's Disease and other organic senile dementias are covered under this policy.

Suicide or Self-Inflicted Injuries

Committing or trying to commit suicide or his injuring himself intentionally, while he is sane or not.

War or Armed Conflict

Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

SECTION IX - YOUR CLAIM FOR BENEFITS

Notice of Claim

You must give us written notice of claim within 30 days after the covered loss begins or as soon as it is reasonably possible. Notice given by you or on your behalf to our home office or one of our authorized agents with the information sufficient to identify you shall be accepted.

Claim Forms

After the giving of such notice, we will send you a claim form. If you do not receive the claim form within 15 days after you notify us of your loss, you shall be deemed as having complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof meeting the requirements of the Proof of Loss section below.

Proof of Loss

You must give us written proof of loss within 90 days after the covered loss begins. Written proof of loss, provided at your expense and in English or Spanish, must include documentation furnished by a Doctor and supported by one or more of the following: clinical, radiological, histological, pathological and/or laboratory evidence of the Specified Critical Illness. [For the [Health Screening Benefit] [or] [Cancer Vaccine Benefit] written proof of loss may include one or more of these: an attending Doctor's statement, a Doctor's bill or a hospital bill.] We may also require your statement, worker's compensation records and/or your employer's statement.

If you are not able to give us written proof of loss within 90 days, it will not have a bearing on your claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

Any additional proof that we require, such as medical records, will be at our expense. We also reserve the right to have the covered person interviewed by an authorized company representative.

Time of Payment of Claim

After we receive written proof of loss and process the covered person's claim, we will immediately pay any benefits due.

Payment of Claim

Benefits will be paid to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a Doctor's office. This is called *assignment*.

If we still owe you benefits at your death, we will pay them to your beneficiary, if any. The beneficiary is the person named in the application as the beneficiary, unless it was changed at a later date. This is the person who will receive any benefits due at the named insured's death. If no beneficiary has been named, or if the person is no longer living at the named insured's death, any benefits due will be paid in this order to the named insured's:

- spouse; or
- children; or
- parents; or

- brothers or sisters; or
- estate.

If benefits are payable to your estate or someone who cannot give a binding release, we can pay benefits up to \$1,000 to someone related to you by blood or marriage who we feel is fairly entitled to them. If we do this, we will have no responsibility for this payment because we made it in good faith.

Questions Concerning Your Claim

If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

Physical Exam and Autopsy

We can require that a Doctor examine the covered person as often as reasonably necessary while his claim is pending. We can also require an autopsy in the event of his death in those states where this is allowed. Either or both of these will be done at our expense.

Legal Action

We cannot be sued for benefits under this policy:

- until 60 days after we are sent written proof of loss; or
- more than three years after the time has passed in which we require written proof of loss.

How to Change Your Beneficiary

Unless you make an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to you, and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy, or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

SECTION X - OTHER IMPORTANT PROVISIONS

Time Limits on Certain Defenses

We rely on the statements made by you in the application to issue this policy and pay benefits.

After this policy has been in force for two years, we cannot contest it or refuse to pay benefits due to any untrue statement in the application unless a fraudulent statement was made.

Contest means that we question the validity of coverage under this policy through a letter to you. This contest is effective on the date we mail the letter and refund the premium.

After this policy has been in force for 12 months from the Policy Coverage Effective Date of this policy, we will pay benefits for any pre-existing condition not excluded by name or specific description if the Specified Critical Illness had a Date of Diagnosis more than 12 months after the Policy Coverage Effective Date.

Misstatement of Age or Tobacco Usage

If any covered person's age or usage of tobacco was stated incorrectly in the application, all amounts payable under this policy will be such as the premium paid would have purchased at the correct age and tobacco usage status. If, based on his correct age and tobacco usage status, we would not have issued this policy, then we will refund the premiums paid.

Transfer of Rights

You can assign any rights you have under this policy. However, no assignment is binding on us until we receive a copy of it. We are not responsible for the validity of any assignment.

Conformity with State Statutes

Any provision of this policy that, on the Policy Coverage Effective Date, does not agree with state laws where you live will be amended to conform to the minimum requirements of those laws.



When Coverage Ends on Your Spouse and Your Children

If this is a named insured and spouse policy or a named insured, spouse and dependent children policy, coverage on your spouse will end on the earliest of the following dates:

- the date this policy terminates;
- the end of the grace period following the premium due date we fail to receive the required premium payment for your spouse;
- the date the next premium is due after you ask us to end your spouse's coverage;
- the date you divorce your spouse or your marriage is annulled; or
- the date your spouse dies.

If this is a named insured and dependent children or a named insured, spouse and dependent children policy, coverage on your children insured by this policy will end:

- the date this policy terminates;
- the end of the grace period following the premium due date we fail to receive the required premium payment for your children;
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die and your spouse is not covered under this policy.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in this policy. Coverage on a child placed in your custody for adoption will also terminate upon the dismissal of a petition for adoption. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium for the time period for which they did not qualify.

Coverage will not end on a covered child who reaches age 26 if that child is and continues to be unable to support himself because of mental or physical handicap and is chiefly dependent on you or your spouse for support. If we require proof of mental or physical handicap, we will request it no more often than annually. However, you must continue to pay the premiums for named insured and dependent children or named insured, spouse and dependent children coverage to keep his coverage in force.

Your Spouse's Right to Continue Coverage

If this is named insured and spouse policy or a named insured, spouse and dependent children policy and you die, [provided that your spouse has not received a benefit of 100% of his Face Amount under this policy,] your spouse can request to continue coverage as the named insured under a named insured policy or (only in the event this policy was a named insured, spouse and dependent children policy) a named insured and dependent children policy, without providing evidence of insurability to us. The premium for his new policy will be based upon the spouse's attained age at the date of issuance of his new policy. The new named insured or named insured and dependent children policy will have the same Face Amount for Named Insured as the spouse had under this policy (but no less than \$5,000 and rounded up to the next \$1,000 increment, if applicable), and the Face Amount for Dependent Children under the new policy will be 25% of the Face Amount for Named Insured under the new policy. Any period of time that the spouse was insured under this policy will be applied toward the Time Limits on Certain Defenses provision of the new policy.

[If we have paid a benefit for Cancer of the spouse under this policy, the new policy will not provide any Cancer or Carcinoma in Situ benefits.] [If we have paid a benefit for any Specified Critical Illness under this policy for which the percentage of the Face Amount payable, as shown on the Policy Schedule, was 100%, and the covered person is diagnosed with the same Specified Critical Illness while covered under the new policy, we will pay benefits as calculated under the Benefits Payable Upon Subsequent Diagnosis provision of the new policy for that Specified Critical Illness, if any.]

Your spouse must notify us in writing within 60 days after your death to continue coverage and begin paying premiums for his policy.