

SERFF Tracking Number: BNLA-126219064 State: Arkansas
 Filing Company: Colonial Penn Life Insurance Company State Tracking Number: 43127
 Company Tracking Number: CPL-GR-A80A ET AL
 TOI: MS071 Individual Medicare Supplement - Sub-TOI: MS071.001 Plan A 2010
 Medicare Select 2010
 Product Name: 2008 MIPAA Medicare Supplement Plans
 Project Name/Number: 2008 MIPAA Medicare Supplement Plans/CPL-GR-A80A et al

Filing at a Glance

Company: Colonial Penn Life Insurance Company

Product Name: 2008 MIPAA Medicare Supplement Plans SERFF Tr Num: BNLA-126219064 State: Arkansas

TOI: MS071 Individual Medicare Supplement - Medicare Select 2010 SERFF Status: Closed-Approved-Closed State Tr Num: 43127

Sub-TOI: MS071.001 Plan A 2010 Co Tr Num: CPL-GR-A80A ET AL State Status: Approved-Closed
 Filing Type: Form/Rate Reviewer(s): Stephanie Fowler

Authors: Thomas Kimble, Sandra Pufpaf, Janice Fron Disposition Date: 09/18/2009

Date Submitted: 08/05/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
 State Filing Description:

Implementation Date:

General Information

Project Name: 2008 MIPAA Medicare Supplement Plans

Project Number: CPL-GR-A80A et al

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/18/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/18/2009

Created By: Thomas Kimble

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Janice Fron

Filing Description:

COMPANY: COLONIAL PENN LIFE INSURANCE COMPANY

FEIN # 23-1628836 NAIC # 233-62065

RE: STANDARDIZED MEDICARE SUPPLEMENT INSURANCE

Individual Policy Forms: CPL-GR-A80A; CPL-GR-A80B; CPL-GR-A80F; CPL-GR-A80FH; CPL-GR-A80G;
 CPL-GR-A80K; CPL-GR-A80L; CPL-GR-A80M; CPL-GR-A80N

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Actuarial Memorandum and Rates

Outline of Coverage: CPL-17740-AR

Application Form: CPL-28300-AR

Continuation of Application: CPL-28301

Replacement Notice: CPL-4043-SUP

Amendment Rider - Appeal of Decisions: CPL-16150

Change Form: CPL-5451

Change Form: CPL-5453

Change Application: CPL-405

Policy Change Form: CPL-424

Policy Change Form: CPL-424CCA

Application For Reinstatement: CPL-1364

Policy Change Form: CPL-7146

Dear Sir or Madam:

We are filing the above captioned forms for your consideration and approval. These are new forms and are not intended to replace any other forms with your Department. These fully underwritten policies will be sold by our licensed agents.

The policy forms are standardized individual Medicare supplement policies which are designed in accordance with the new Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and will be used by our licensed agents in your state to solicit new business. We intend to start selling the new Medicare supplement plans as of January 1, 2010 with effective dates beginning June 1, 2010 and thereafter.

Application CPL-28300-AR is designed to be used to solicit these standardized Medicare supplement products. We would like to file Sections 1.A., Policy Information and 12, Applicant's Acknowledgment of Notices in this form as variable so that we can use this application with any future policy forms or notices that may be developed. These two sections contain the only variable information in the application. This application is designed to be used in paper and electronic environments. When used in an electronic environment, the spacing and font may vary from the paper form, but the text will remain the same.

Replacement Notice CPL-4043-SUP varies from the Model Regulation in that the questions to the applicant regarding duplication of Medicare supplement coverage are included in Application Form CPL-28300-AR, Number 7, "Replacement of Existing Coverage, Section B. We chose to embed the questions mandated by the Model Regulation into the application where they were more relevant to the application process.

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Form CPL-16150 is an Amendment Rider which explains the internal appeals and mediation process which the insured should follow in any dispute.

Outline of Coverage Form CPL-17740-AR follows the format and language from the model regulation. This form will be updated each year to contain the most up-to-date rates, deductibles, coinsurance, co-payment and out-of-pocket limits. The current amounts are inserted into this outline, but are being filed as variable.

The miscellaneous forms are administrative forms that are intended to be used in the servicing of any approved health insurance forms in your state.

The name and electronic signature of the officers, shown on these forms may change in the future as officers change within the company.

This filing contains no unusual or controversial items from normal company or industry standards. We have submitted these forms to our home state of Pennsylvania and they are currently pending approval.

We respectfully request your favorable consideration and approval of this filing. If you have questions on any aspect of this filing, please call me.

Company and Contact

Filing Contact Information

Tom Kimble, Filing Project Leader t.kimble@banklife.com
 222 Merchandise Mart Plaza 312-396-6130 [Phone]
 19th Floor 312-396-5907 [FAX]
 Chicago, IL 60654

Filing Company Information

Colonial Penn Life Insurance Company	CoCode: 62065	State of Domicile: Pennsylvania
Adm. Address: 600 West Chicago Ave	Group Code: 233	Company Type:
Chicago, IL 60654-2800	Group Name:	State ID Number:
(312) 396-6000 ext. [Phone]	FEIN Number: 23-1628836	

Filing Fees

Fee Required? Yes
 Fee Amount: \$900.00

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Retaliatory? No

Fee Explanation: \$50.00 for each policy and forms =

\$50.00 x 9 policies = \$450.00

\$50.00 for rates for each policy =

\$50.00 x 9 = \$450.00

TOTAL DUE: \$900.00

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Colonial Penn Life Insurance Company	\$900.00	08/05/2009	29643134

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	09/18/2009	09/18/2009

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Actuarial Exhibits	Accepted for Informational Purposes	No
Supporting Document	Actuarial Certification	Accepted for Informational Purposes	No
Form	Medicare Supplement Policy - Plan A	Approved	Yes
Form	Medicare Supplement Policy - Plan B	Approved	Yes
Form	Medicare Supplement Policy - Plan F	Approved	Yes
Form	Medicare Supplement Policy - High Deductible - Plan F	Approved	Yes
Form	Medicare Supplement Policy - Plan G	Approved	Yes
Form	Medicare Supplement Policy - Plan K	Approved	Yes
Form	Medicare Supplement Policy - Plan L	Approved	Yes
Form	Medicare Supplement Policy - Plan M	Approved	Yes
Form	Medicare Supplement Policy - Plan N	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Form	Application	Approved	Yes
Form	Application	Approved	Yes
Form	Replacement Notice	Approved	Yes
Form	Amendment Rider - Appeal of Decisions	Approved	Yes
Form	Change Form	Approved	Yes
Form	Change Form	Approved	Yes
Form	Change Application	Approved	Yes
Form	Policy Change Form	Approved	Yes
Form	Policy Change Form	Approved	Yes
Form	Application For Reinstatement	Approved	Yes
Form	Policy Change Form	Approved	Yes
Rate	Policy Rates	Approved	Yes

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Form Schedule

Lead Form Number: CPL-GR-A80A

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 09/18/2009	CPL-GR-A80A	Policy/Cont	Medicare ract/Fratern Supplement Policy - al Plan A Certificate	Initial		47.720	AR - Plan A.pdf
Approved 09/18/2009	CPL-GR-A80B	Policy/Cont	Medicare ract/Fratern Supplement Policy - al Plan B Certificate	Initial		48.020	AR - Plan B.pdf
Approved 09/18/2009	CPL-GR-A80F	Policy/Cont	Medicare ract/Fratern Supplement Policy - al Plan F Certificate	Initial		46.530	AR - Plan F.pdf
Approved 09/18/2009	CPL-GR-A80FH	Policy/Cont	Medicare ract/Fratern Supplement Policy - al High Deductible - Certificate Plan F	Initial		45.630	AR - Plan FH.pdf
Approved 09/18/2009	CPL-GR-A80G	Policy/Cont	Medicare ract/Fratern Supplement Policy - al Plan G Certificate	Initial		46.390	AR - Plan G.pdf
Approved 09/18/2009	CPL-GR-A80K	Policy/Cont	Medicare ract/Fratern Supplement Policy - al Plan K Certificate	Initial		48.360	AR - Plan K.pdf
Approved 09/18/2009	CPL-GR-A80L	Policy/Cont	Medicare ract/Fratern Supplement Policy - al Plan L Certificate	Initial		48.690	AR - Plan L.pdf
Approved 09/18/2009	CPL-GR-A80M	Policy/Cont	Medicare ract/Fratern Supplement Policy -	Initial		46.150	AR - Plan M.pdf

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<i>TOI:</i>	<i>MS071 Individual Medicare Supplement - Medicare Select 2010</i>	<i>Sub-TOI:</i>	<i>MS071.001 Plan A 2010</i>	
<i>Product Name:</i>	<i>2008 MIPAA Medicare Supplement Plans</i>			
<i>Project Name/Number:</i>	<i>2008 MIPAA Medicare Supplement Plans/CPL-GR-A80A et al</i>			
	<i>al</i>	<i>Plan M</i>		
	<i>Certificate</i>			
Approved 09/18/2009	CPL-GR-A80N	Policy/Cont Medicare ract/Fratern Supplement Policy - al Plan N Certificate	Initial 46.590	AR - Plan N.pdf
Approved 09/18/2009	CPL-17740-AR	Outline of Coverage	Outline of Coverage Initial 46.270	CPL-17740- AR OC.pdf
Approved 09/18/2009	CPL-28300-AR	Application/ Enrollment Form	Application Initial 45.160	CPL-28300- AR.pdf
Approved 09/18/2009	CPL-28301	Application/ Enrollment Form	Application Initial 46.940	CPL- 28301.pdf
Approved 09/18/2009	CPL-4043- SUP	Other Replacement Notice	Initial 46.660	CPL4043sup. pdf
Approved 09/18/2009	CPL-16150	Policy/Cont ract/Fratern Appeal of Decisions al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial 48.680	CPL- 16150.pdf
Approved 09/18/2009	CPL-5451	Other Change Form	Initial 61.450	CPL-5451.pdf
Approved 09/18/2009	CPL-5453	Other Change Form	Initial 57.580	CPL-5453.pdf
Approved 09/18/2009	CPL-405	Application/ Enrollment Form	Change Application Initial 45.440	CPL-405.pdf
Approved 09/18/2009	CPL-424	Other Policy Change Form	Initial 46.000	CPL-424.pdf
Approved 09/18/2009	CPL-424CCA	Other Policy Change Form	Initial 49.800	CPL- 424cca.pdf
Approved	CPL-1364	Application/ Application For	Initial 54.840	CPL-1364.pdf

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<i>TOI:</i>	<i>MS071 Individual Medicare Supplement - Medicare Select 2010</i>	<i>Sub-TOI:</i>	<i>MS071.001 Plan A 2010</i>
<i>Product Name:</i>	<i>2008 MIPAA Medicare Supplement Plans</i>		
<i>Project Name/Number:</i>	<i>2008 MIPAA Medicare Supplement Plans/CPL-GR-A80A et al</i>		
09/18/2009	Enrollment Reinstatement Form		
Approved	CPL-7146	Other	Policy Change Form Initial
09/18/2009			46.300
			CPL-7146.pdf

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181
Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032
(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80A POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY- PLAN A

We, **Colonial Penn Life Insurance Company**, promise to pay You the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary  President 

POLICY GUIDE

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APPLICATION NO. CPL-GR-A80A

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80A	POLICY FORM

INSURED:	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80A	\$ XXX.XX

TOTAL ANNUAL PREMIUM \$XXXX.XX

EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

DEFINITIONS (Continued)

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily injury to You caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Reserve Days" means the extra 60 Hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Copayment Amount" means the fixed amount per day Medicare does not pay from the 61st through the 90th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part A Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease which results in Your loss covered by this policy. The loss must begin while the policy is in force.

"We", "Us", and "Our" refer to the Colonial Penn Life Insurance Company.

"You", "Your," and "Yours" refer to the Insured named on Page 1 of this policy.

BENEFITS

We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

We will pay as follows:

1. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days, one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. The reasonable cost under Medicare Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

EXPLANATION OF MEDICARE BENEFITS FORM (Continued)
"HOW WE PAY BENEFITS"

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

UNIFORM PROVISIONS (Continued)

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181
Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032
(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80B POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY- PLAN B

We, **Colonial Penn Life Insurance Company**, promise to pay You, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

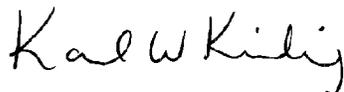
IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary



President



POLICY GUIDE

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APPLICATION NO.CPL-GR-A80B

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80B	POLICY FORM

INSURED:	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80B	\$ XXX.XX

TOTAL ANNUAL PREMIUM	\$XXXX.XX
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EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

DEFINITIONS (Continued)

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily injury to You caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Reserve Days" means the extra 60 Hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Copayment Amount" means the fixed amount per day Medicare does not pay from the 61st through the 90th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part A Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease which results in Your loss covered by this policy. The loss must begin while the policy is in force.

"We", "Us", and "Our" refer to the Colonial Penn Life Insurance Company.

"You", "Your," and "Yours" refer to the Insured named on Page 1 of this policy.

BENEFITS

We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

BASIC COVERAGE

We will pay as follows:

1. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days, one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. The reasonable cost under Medicare Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

ADDITIONAL COVERAGE

We will pay as follows:

Medicare Part A Deductible: One hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per benefit period.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

UNIFORM PROVISIONS (Continued)

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181

Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80F POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY- PLAN F

We, **Colonial Penn Life Insurance Company**, promise to pay You the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary



President



POLICY GUIDE

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APPLICATION NO.CPL-GR-A80F

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80F	POLICY FORM

INSURED:	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80F	\$ XXX.XX

TOTAL ANNUAL PREMIUM \$XXXX.XX

EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

DEFINITIONS (Continued)

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily injury to You caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Reserve Days" means the extra 60 Hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Copayment Amount" means the fixed amount per day Medicare does not pay from the 61st through the 90th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part A Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease which results in Your loss covered by this policy. The loss must begin while the policy is in force.

"Skilled Nursing Copayment Amount" means the fixed amount per day Medicare does not pay during the 21st through 100th day of Skilled Nursing Facility confinement. This amount is set each year by Medicare.

"Skilled Nursing Facility" means a place, which is defined, recognized and approved for payment by Medicare.

"We", **"Us"**, and **"Our"** refer to the Colonial Penn Life Insurance Company.

"You", **"Your,"** and **"Yours"** refer to the Insured named on Page 1 of this policy.

BENEFITS

We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

BASIC COVERAGE

We will pay as follows:

1. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days, one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. The reasonable cost under Medicare Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

ADDITIONAL COVERAGE

We will pay as follows:

1. Medicare Part A Deductible: One hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: The actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital skilled nursing facility care eligible under Medicare Part A.

BENEFITS (Continued)

3. Medicare Part B Deductible: One hundred percent (100%) of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement.
4. One Hundred Percent (100%) of the Medicare Part B Excess Charges: All of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
5. Medically Necessary Emergency Care in a Foreign Country: Expenses to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency Hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached signed application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

UNIFORM PROVISIONS (Continued)

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181

Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80FH POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY- HIGH DEDUCTIBLE PLAN F

We, **Colonial Penn Life Insurance Company**, promise to pay You benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary



President



POLICY GUIDE

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APPLICATION NO.CPL-GR-A80FH

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80FH	POLICY FORM

ANNUAL DEDUCTIBLE PER CALENDAR YEAR: AS OF [2009], \$[2000.00].

INSURED:	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80FH	\$ XXX.XX

TOTAL ANNUAL PREMIUM \$XXXX.XX

EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Annual Deductible" means the amount of expenses covered by the policy which You must incur in a Calendar Year before We can begin to pay benefits for You during the same Calendar Year. We do not pay for expenses which make up the Annual Deductible. Amounts applied against the separate specific deductible for Medically Necessary Emergency Care in a Foreign Country will not count toward satisfying the Annual Deductible.

The amount of the Annual Deductible for the current Calendar Year is shown in the Schedule. The amount for later Calendar Years will be determined by the Secretary of the United States Department of Health and Human Services pursuant to applicable federal laws and regulations.

DEFINITIONS (Continued)

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily Injury to You caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Reserve Days" means the extra 60 Hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Copayment Amount" means the fixed amount per day Medicare does not pay from the 61st through the 90th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

DEFINITIONS (Continued)

"Medicare Part A Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease which results in Your loss covered by this policy. The loss must begin while the policy is in force.

"Skilled Nursing Copayment Amount" means the fixed amount per day Medicare does not pay during the 21st through 100th day of Skilled Nursing Facility confinement. This amount is set each year by Medicare.

"Skilled Nursing Facility" means a place, which is defined, recognized and approved for payment by Medicare.

"We", **"Us"**, and **"Our"** refer to the Colonial Penn Life Insurance Company.

"You", **"Your,"** and **"Yours"** refer to the Insured named on Page 1 of this policy.

BENEFITS

Subject to the Annual Deductible, We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

BENEFITS (Continued)

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

BASIC COVERAGE

Subject to the Annual Deductible, We will pay as follows:

1. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days, one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. The reasonable cost under Medicare Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

ADDITIONAL COVERAGE

Subject to the Annual Deductible, We will pay as follows:

1. Medicare Part A Deductible: One hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: The actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital Skilled Nursing Facility Care eligible under Medicare Part A.
3. Medicare Part B Deductible: One hundred percent (100%) of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

BENEFITS (Continued)

4. One Hundred Percent (100%) of the Medicare Part B Excess Charges: All of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
5. Medically Necessary Emergency Care in a Foreign Country: Expenses to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency Hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached signed application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

UNIFORM PROVISIONS (Continued)

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181

Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80G POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN G

We, **Colonial Penn Life Insurance Company**, promise to pay You, the Insured, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary



President



POLICY GUIDE

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APPLICATION NO.CPL-GR-A80G

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80G	POLICY FORM

INSURED:	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80G	\$ XXX.XX

TOTAL ANNUAL PREMIUM \$XXXX.XX

EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

DEFINITIONS (Continued)

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily injury to You caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Reserve Days" means the extra 60 Hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Copayment Amount" means the fixed amount per day Medicare does not pay from the 61st through the 90th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part A Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease which results in Your loss covered by this policy. The loss must begin while the policy is in force.

"Skilled Nursing Copayment Amount" means the fixed amount per day Medicare does not pay during the 21st through 100th day of Skilled Nursing Facility confinement. This amount is set each year by Medicare.

DEFINITIONS (Continued)

"**Skilled Nursing Facility**" means a place, which is defined, recognized and approved for payment by Medicare.

"**We**", "**Us**", and "**Our**" refer to the Colonial Penn Life Insurance Company.

"**You**", "**Your**," and "**Yours**" refer to the Insured named on Page 1 of this policy.

BENEFITS

We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

BASIC COVERAGE

We will pay as follows:

1. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days, one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. The reasonable cost under Medicare Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

BENEFITS (Continued)

ADDITIONAL COVERAGE

We will pay as follows:

1. Medicare Part A Deductible: One hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per benefit period.
2. Skilled Nursing Facility Care: The actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
3. One Hundred Percent (100%) of the Medicare Part B Excess Charges: All of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
4. Medically Necessary Emergency Care in a Foreign Country: Expenses to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency Hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date. Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice Your state requires.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached signed application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

UNIFORM PROVISIONS (Continued)

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181
Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032
(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80K POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY- PLAN K

We, **Colonial Penn Life Insurance Company**, promise to pay You, the Insured, the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary  President 

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APPLICATION NO.CPL-GR-A80K

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80K	POLICY FORM

OUT-OF-POCKET LIMIT PER CALENDAR YEAR: AS OF [2009], \$[4620.00].

INSURED::	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80K	\$ XXX.XX

TOTAL ANNUAL PREMIUM \$XXXX.XX

EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

DEFINITIONS (Continued)

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily injury to You caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Reserve Days" means the extra 60 Hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Hospital Coinsurance" means the fixed amount per day Medicare does not pay from the 61st through the 90th day and the 91st through 150th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part A Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Out-of-Pocket Limit" means the maximum amount You may pay in a Calendar Year for cost sharing of Medicare Part A and Part B covered expenses defined in the policy.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease which results in Your loss covered by this policy. The loss must begin while the policy is in force.

"Skilled Nursing Copayment Amount" means the fixed amount per day Medicare does not pay during the 21st through 100th day of Skilled Nursing Facility confinement. This amount is set each year by Medicare.

"Skilled Nursing Facility" means a place, which is defined, recognized and approved for payment by Medicare.

DEFINITIONS (Continued)

"We", "Us", and "Our" refer to the Colonial Penn Life Insurance Company.

"You", "Your," and "Yours" refer to the Insured named on Page 1 of this policy.

BENEFITS

We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

We will pay as follows:

1. Part A Hospital Coinsurance, 61st through 90th days: One hundred percent (100%) of the Part A Hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare Benefit Period.
2. Part A Hospital Coinsurance, 91st through 150th days: One hundred percent (100%) of the Part A Hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare Benefit Period.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days: One hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. Medicare Part A Deductible: Fifty percent (50%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period until the Out-of-Pocket limit is met as described in Number 10.
5. Skilled Nursing Facility Care: Fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility Care eligible under Medicare Part A until the Out-of-Pocket Limit is met as described in Number 10.
6. Hospice Care: Fifty percent (50%) of cost sharing for all Part A Medicare Eligible Expenses and respite care until the Out-of-Pocket Limit is met as described in Number 10.

BENEFITS (Continued)

7. Blood: Fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the Out-of-Pocket Limit is met as described in Number 10.
8. Part B Cost Sharing: Except for coverage provided for Part B Preventive Services as described in Number 9, fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after You pay the Part B Deductible until the Out-of-Pocket Limit is met as described in Number 10.
9. Part B Preventive Services: One hundred percent (100%) of the cost sharing for Medicare Part B preventive services after You pay the Part B deductible.
10. Cost Sharing After Out-of-Pocket Limits: One hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year after You have reached the Out-of-Pocket Limit on annual expenditures under Medicare Parts A and B, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services. The Out-of-Pocket Limit for the current Calendar Year is shown in the Schedule.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

UNIFORM PROVISIONS (Continued)

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181
Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032
(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80L POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY- PLAN L

We, **Colonial Penn Life Insurance Company**, promise to pay You the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

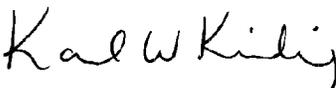
This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary  President 

POLICY GUIDE

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APPLICATION NO.CPL-GR-A80L

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80L	POLICY FORM

OUT-OF-POCKET LIMIT PER CALENDAR YEAR: AS OF [2009], \$[2310.00].

INSURED:	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80L	\$ XXX.XX

TOTAL ANNUAL PREMIUM \$XXXX.XX

EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

DEFINITIONS (Continued)

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily Injury to You caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Inpatient Reserve Days" means the extra 60 Hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Hospital Coinsurance" means the fixed amount per day Medicare does not pay from the 61st through the 90th day and the 91st through 150th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part A Inpatient Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Out-of-Pocket Limit" means the maximum amount You may pay in a Calendar Year for cost sharing of Medicare Part A and Part B covered expenses defined in the policy.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease which results in Your loss covered by this policy. The loss must begin while the policy is in force.

DEFINITIONS (Continued)

"Skilled Nursing Copayment Amount" means the fixed amount per day Medicare does not pay during the 21st through 100th day of Skilled Nursing Facility confinement. This amount is set each year by Medicare.

"Skilled Nursing Facility" means a place, which is defined, recognized and approved for payment by Medicare.

"We", **"Us"**, and **"Our"** refer to the Colonial Penn Life Insurance Company.

"You", **"Your,"** and **"Yours"** refer to the Insured named on Page 1 of this policy.

BENEFITS

We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

We will pay as follows:

1. Part A Hospital Coinsurance, 61st through 90th days: One hundred percent (100%) of the Part A Hospital Coinsurance amount for each day used from the 61st through the 90th day in any Medicare Benefit Period.
2. Part A Hospital Coinsurance, 91st through 150th days: One hundred percent (100%) of the Part A Hospital Coinsurance amount for each Medicare Lifetime Inpatient Reserve Day used from the 91st through the 150th day in any Medicare Benefit Period.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days: One hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. Medicare Part A Deductible: Seventy-five percent (75%) of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period until the Out-of-Pocket Limit is met as described in Number 10.
5. Skilled Nursing Facility Care: Seventy-five percent (75%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility Care eligible under Medicare Part A until the Out-of-Pocket Limit is met as described in Number 10.

BENEFITS (Continued)

6. Hospice Care: Seventy-five percent (75%) of cost sharing for all Part A Medicare eligible expenses and Respite Care until the Out-of-Pocket Limit is met as described in Number 10.
7. Blood: Seventy-five percent (75%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the Out-of-Pocket Limit is met as described in Number 10.
8. Part B Cost Sharing: Except for coverage provided for Part B Preventive Services as described in Number 9, seventy-five percent (75%) of the cost sharing otherwise applicable under Medicare Part B after You pay the Part B Deductible until the Out-of-Pocket Limit is met as described in Number 10.
9. Part B Preventive Services: One hundred percent (100%) of the cost sharing for Medicare Part B preventive services after You pay the Part B deductible.
10. Cost Sharing After Out-of-Pocket Limits: One hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the Calendar Year after You have reached the Out-of-Pocket Limit on annual expenditures under Medicare Parts A and B, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services. The Out-of-Pocket Limit for the current Calendar Year is shown in the Schedule.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached signed application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

UNIFORM PROVISIONS (Continued)

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181

Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80M POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY- PLAN M

We, **Colonial Penn Life Insurance Company**, promise to pay You the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary



President



POLICY GUIDE

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APPLICATION NO.CPL-GR-A80M

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80M	POLICY FORM

INSURED:	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80M	\$ XXX.XX

TOTAL ANNUAL PREMIUM \$XXXX.XX

EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

DEFINITIONS(Continued)

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily Injury to You caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" meant the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Reserve Days" means the extra 60 hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Copayment Amount" means the fixed amount per day Medicare does not pay from the 61st through the 90th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part A Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease of an Insured Person which results in loss covered by this policy. The loss must begin while the policy is in force.

"Skilled Nursing Copayment Amount" means the fixed amount per day Medicare does not pay during the 21st through 100th day of Skilled Nursing Facility confinement. This amount is set each year by Medicare.

DEFINITIONS(Continued)

"**Skilled Nursing Facility**" means a place, which is defined, recognized and approved for payment by Medicare.

"**We**", "**Us**", and "**Our**" refer to the Colonial Penn Life Insurance Company.

"**You**", "**Your**," and "**Yours**" refer to the Insured named on Page 1 of this policy.

BENEFITS

We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

BASIC COVERAGE

We will pay as follows:

1. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days, one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. The reasonable cost under Medicare Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

BENEFITS (Continued)

ADDITIONAL COVERAGE

We will pay as follows:

1. Medicare Part A Deductible: Fifty percent (50%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: The actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility Care eligible under Medicare Part A.
3. Medically Necessary Emergency Care in a Foreign Country: Expenses to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "Emergency Care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached signed application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

UNIFORM PROVISIONS (Continued)

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

A Stock Company • Home Office: 399 Market Street • Philadelphia, PA 19181

Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

(800) 800-2254

NAME OF INSURED	POLICY NUMBER
FIRST PREMIUM	ISSUE DATE
FIRST RENEWAL DATE	CPL-GR-A80N POLICY FORM

MEDICARE SUPPLEMENT INSURANCE POLICY- PLAN N

We, **Colonial Penn Life Insurance Company**, promise to pay You the benefits provided by this policy. All benefits are subject to its definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE FOR LIFE

You may renew this policy on any renewal date as long as You live. To renew, pay the renewal premium when it is due. You must pay it by its due date or during the 31 days that follow. Unless there is a material misrepresentation, We cannot refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING MEDICAL CONDITIONS

This policy will pay benefits for pre-existing medical conditions incurred after the policy Issue Date.

RENEWAL PREMIUM

PREMIUM RATES ARE EXPECTED TO INCREASE EACH YEAR

Since Your benefits are tied to Medicare's deductible amounts, coinsurance amounts, co-payment amounts and limits, premium and benefit changes are expected to occur each January. The change may also be due to a new table of rates, or a change in Medicare's benefit structure that changes the nature of the risk We assume. We can change the premium rates for this policy only if We change it for all policies like Yours based on the state in which Your policy was issued on a class basis. We will provide You with the written notice of any change in the premium within the time required by the state of issue.

30 DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this policy will be void.

READ YOUR POLICY VERY CAREFULLY

This policy is a legal contract between You and Us. See the "POLICY GUIDE" on Page 1A.

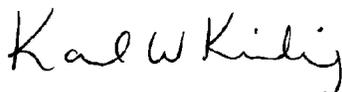
IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Please read the copy of the application which is a part of this policy. Write Us if any information shown is not right or complete. We issued this policy on the basis that the answers to all questions are correct and complete. If applicable, check to see if any medical history requested has been left out or was misstated. Any wrong or left out statements could cause an otherwise valid claim to be denied.

NOTICE TO BUYER: THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Signed by Our President and Secretary on its Issue Date.

Secretary



President



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APPLICATION NO.CPL-GR-A80N

COLONIAL PENN LIFE INSURANCE COMPANY
HOME OFFICE: 399 MARKET STREET • PHILADELPHIA, PA 19181
ADMINISTRATIVE OFFICE: 11825 NORTH PENNSYLVANIA STREET • CARMEL, IN 46032
TELEPHONE: 1-800-800-2254

SCHEDULE

NAME OF INSURED	DOE, JOHN J.	999,999,999	POLICY NUMBER
FIRST PREMIUM	\$XXXX.XX	JUNE 1, 2010	ISSUE DATE
FIRST RENEWAL DATE	JUNE 1, 2011	CPL-GR-A80N	POLICY FORM

POLICY COPAYMENT AMOUNTS:

HOSPITAL EMERGENCY ROOM VISITS: \$[50]

OTHER PROVIDER PART B VISITS: \$[20]

INSURED:	PLAN NO.	ANNUAL PREMIUM
DOE, JOHN J. MALE		
BIRTHDATE 1/1/29 AGE 65	A80N	\$ XXX.XX

TOTAL ANNUAL PREMIUM \$XXXX.XX

EFFECTIVE DATE

This policy begins at 12:01 A.M. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the Grace Period, at 12:01 A.M. on the date any renewal premium is due.

CONSIDERATION

We issued this policy in consideration of Your application and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Renewal Date and First Premium are shown in the Schedule.

PREMIUM REFUND AT DEATH

We will refund that part of any premium paid covering the period beyond Your date of death.

SUSPENSION OF COVERAGE

Coverage may be suspended under the following circumstances:

- (1) If You have applied for and are entitled to benefits under Medicaid, You have the right to suspend coverage of Your policy for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If You suspend coverage, the benefits and premiums will be suspended during Your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date You lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to You that portion of the premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If You are an under age 65 disabled insured, You may request that the benefits and premiums under this policy be suspended for the period provided for under federal regulation if You are entitled to benefits under 42 U.S.C. section 426(b) and You are covered under a group health plan (as defined in 42 U.S.C. section 1395y(b)(1)(A)(v)). If this policy is suspended and You lose coverage under the group health plan, this policy will be automatically reinstated as of the date of the loss of Your coverage under the group health plan. However, You must notify Us of the loss of coverage within 90 days after the date of the loss and pay Us the premium for this policy attributable to the period from the date of the loss of coverage.

Reinstatement of coverage pursuant to (1) and (2) above:

- (a) will not be subject to any waiting period for pre-existing conditions;
- (b) will provide coverage that is substantially equivalent to the coverage in effect before the date of suspension; and
- (c) will provide for premium class terms that are at least as favorable as the premium class terms that would have applied had coverage not been suspended.

DEFINITIONS

"Benefit Period" or "Medicare Benefit Period" is the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A of Medicare. It begins after the policy effective date of coverage with the first day You are confined in a Hospital. The date it ends is determined by Medicare.

"Calendar Year" is the unit of time used to measure Medicare Part B benefits. It begins on the Issue Date and ends December 31 of that year. Then it is the period from January 1 through December 31 of each following year.

"Doctor" means any licensed practitioner of the healing arts recognized and approved for payment by Medicare. It does not include You or a member of Your family.

"Explanation of Medicare Benefits Form" or "EOMB" means the form sent by Medicare's Benefit Department. It shows the incurred Hospital or medical expenses and how each was serviced by Medicare.

DEFINITIONS (Continued)

"Hospice Care" means a program of palliative care approved for payment by Medicare that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare.

"Injury" means bodily Injury caused by an accident which results in loss covered by this policy. The loss must begin while the policy is in force.

"Medicaid" means the "Health Insurance for the Aged Act," Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Eligible Expenses" means expenses of the kinds covered by Medicare Part A and Part B, to the extent recognized as reasonable and medically necessary by Medicare.

"Medicare Lifetime Reserve Copayment Amount" means the fixed amount per day Medicare does not pay during the 60 Medicare Lifetime Reserve Days Medicare allows. It is set each year by Medicare.

"Medicare Lifetime Reserve Days" means the extra 60 Hospital days Medicare allows. You can use Medicare Lifetime Reserve Days if You have a long illness and have to stay in the Hospital for more than 90 days. Medicare Lifetime Reserve Days are not renewable and may be used only once.

"Medicare Part A Copayment Amount" means the fixed amount per day Medicare does not pay from the 61st through the 90th day of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part A Deductible" means the fixed amount Medicare does not pay during the first 60 days of Hospital confinement during a Benefit Period. It is set each year by Medicare.

"Medicare Part B Coinsurance Amount" means the amount after the Part B Deductible amount has been met, which Medicare does not pay for Medicare Part B expenses. It is set each year by Medicare.

"Medicare Part B Deductible" is the amount You must pay each Calendar Year before benefits can be paid under Part B of Your policy. It includes the Medicare Part B annual deductible which is not paid by Medicare. It is set each year by Medicare.

"Policy Copayment Amount" means a fixed amount that the policy may not pay for specified Medicare Part B expenses after the Medicare Part B Deductible has been met. The policy copayment amounts are shown in the Schedule. These amounts have been determined by laws and regulations applicable to the Medicare Supplement plan. These amounts may change in accordance with applicable law and regulation. See the "Renewal Provision" on Page 1.

"Respite Care" means Hospice Care services provided by the Hospice Care program to give temporary relief to a Hospice patient's family or other care givers.

"Sickness" means illness or disease which results in Your loss covered by this policy. The loss must begin while the policy is in force.

"Skilled Nursing Copayment Amount" means the fixed amount per day Medicare does not pay during the 21st through 100th day of Skilled Nursing Facility confinement. This amount is set each year by Medicare.

"Skilled Nursing Facility" means a place, which is defined, recognized and approved for payment by Medicare.

DEFINITIONS (Continued)

"We", "Us", and "Our" refer to the Colonial Penn Life Insurance Company.

"You", "Your," and "Yours" refer to the Insured named on Page 1 of this policy.

BENEFITS

We will pay benefits for covered expenses incurred by You due to Injury or Sickness. Covered expenses and policy benefits and limits are explained below. To be covered, the expense must be incurred while coverage under this policy is in force. We will not duplicate benefits paid by Medicare.

IF YOU ARE NOT COVERED UNDER EITHER PART A OR PART B OF MEDICARE, We will pay policy benefits for covered expenses as though You had coverage under both Medicare Part A and Part B and as though Medicare had paid its share of the covered expenses. We will not impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

EXTENSION OF BENEFITS

Any claim for a continuous loss that begins while this policy is in force will not be affected by the ending of this policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability and are limited to the duration of the Calendar Year, Medicare Benefit Period, if any, or the maximum benefits payable.

FOR INPATIENT CARE (Medicare Part A) and MEDICAL CARE (Medicare Part B):

BASIC COVERAGE

We will pay as follows:

1. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Reserve Days, one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill You for any balance.
4. The reasonable cost under Medicare Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible and Policy Copayment Amounts as described below.

You are responsible to pay the lesser of: (a) the Policy Copayment Amount shown in the Schedule for each covered health care provider office visit (including visits to medical specialists), or (b) the Medicare Part B coinsurance or copayment; and the lesser of: (a) the Policy Copayment Amount shown in the Schedule for each covered emergency room visit, or (b) the Medicare Part B coinsurance or copayment. The emergency room copayment will be waived if You are admitted to any Hospital and the emergency room visit is subsequently covered as a Medicare Part A expense.

6. Hospice Care: Cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

BENEFITS (Continued)

ADDITIONAL COVERAGE

We will pay as follows:

1. Medicare Part A Deductible: One hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: The actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility Care eligible under Medicare Part A.
3. Medically Necessary Emergency Care in a Foreign Country: Expenses to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "Emergency Care" shall mean care needed immediately because of an Injury or an Illness of sudden and unexpected onset.

EXPLANATION OF MEDICARE BENEFITS FORM "HOW WE PAY BENEFITS"

We do not require a claim form for Medicare Eligible Expenses. Before We can pay any benefits for expenses covered under Medicare, You or a health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits Form, also commonly referred to as an "EOMB." This is the form that is sent by Medicare. It shows the Medicare Eligible Expenses and how they were serviced under Medicare. Upon receipt of the EOMB We will pay any benefits that are due based on Medicare's determination. If You are submitting a claim directly to Us rather than assigning benefits to a provider, clearly write Your policy number on the EOMB and send it to Us. You received a Health Insurance Identification Card which lists the policy name, number and central mailing address to which notices from a Medicare Carrier may be sent.

We will pay the user fees for claim notices that are transmitted electronically or otherwise. We will provide to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare Carriers.

AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE

The risk We assume on this policy's Issue Date is based on Medicare's benefit structure then in effect. Medicare benefits change from time to time. When Medicare changes deductible amounts or co-payment amounts or limits under its benefit structure in effect on the Effective Date, We will change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this policy's coverage. We will make such a change by adding: (a) an endorsement or rider to the policy; (b) a new Schedule; or (c) both (a) and (b). Before making any such change, We will get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk We assume on this policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after You are given the advance notice that the state where Your policy was issued requires.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: The entire contract of insurance is: (a) the policy; (b) the attached signed application; (c) any supplemental application made a part of the policy; and (d) any endorsements or riders attached to the policy. No change in this policy will be effective until approved by one of Our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Issue Date of this policy no misstatements, except fraudulent misstatements, made by You in the application for the policy shall be used to void the policy or to deny a claim for loss incurred (as defined in the policy) commencing after the expiration of the two year period.

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

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring an application for reinstatement, shall reinstate this policy.

If We require an application for reinstatement it must be submitted to Us. Reinstatement of the policy is subject to approval by Us.

A reinstated policy will cover only loss which results from an Injury sustained after the date of reinstatement or Sickness that starts after such date. In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: We must receive written notice of a claim within 60 days after it starts or as soon as reasonably possible. You must give the notice or You may have someone do it for You. The notice should give Your name and policy number as shown on the Schedule. The notice can be given to Us at Our Administrative Office address shown on Page 1 or to any one of Our agents. Also see "How We Pay Benefits."

CLAIM FORMS: When We get notice of claim, We will send any forms needed for filing Proof Of Loss. If these forms are not given within 15 days, You will meet the Proof Of Loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof Of Loss section. Also see "How We Pay Benefits."

PROOF OF LOSS: Written proof of loss must be given to Us within 90 days after such loss. If it was not reasonably possible for You to give Us proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written Proof of Loss.

PAYMENT OF CLAIMS: All benefits will be paid to You or, if dually assigned, to the health care provider. If the provider accepts assignment, We will notify You and Your provider of the payment determination. We will pay benefits directly to the provider accepting Your assignment.

Any unassigned benefits due and unpaid at Your death will be paid to Your estate. We may also pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

UNIFORM PROVISIONS (Continued)

PHYSICAL EXAMINATION: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after three (3) years from the time written Proof of Loss is required to be given.

OTHER INSURANCE WITH US: You may have coverage under only one of Our Medicare Supplement policies at any one time. If through error, We issue more than one such policy to You, You can select the one policy that is to remain in effect. In the event of death, this selection will be made by Your estate. We will return the money You paid, less any claim benefits that We paid, for any policy that does not remain in effect.

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

CHOICE OF LAW: This insurance policy and claims arising under it are governed by the laws of the state where You signed the initial application for this policy, exclusive of such state's choice of laws provisions.

MEDICARE SUPPLEMENT POLICY

Colonial Penn Life Insurance Company

Home Office: 399 Market Street • Philadelphia, PA 19181

Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates On or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A●	B●	C	D	F●	F*●	G●	K●	L●	M●	N●
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$[20] copayment for office visit, and up to \$[50] copayment for ER						
		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance				
	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible					
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)	Part B Excess (100%)					
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency				Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit \$[4620]; paid at 100% after limit reached	Out-of-pocket limit \$[2310]; paid at 100% after limit reached			

● Plans currently available for sale

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

2010 STATE OF ARKANSAS
PREMIUMS

	Issue Age	ANNUAL
CPL-GR-A80A	65 & Older	1517.44
CPL-GR-A80B	65 & Older	1873.40
CPL-GR-A80F	65 & Older	2094.96
CPL-GR-A80FH	65 & Older	502.80
CPL-GR-A80G	65 & Older	1926.20
CPL-GR-A80K	65 & Older	708.76
CPL-GR-A80L	65 & Older	1240.46
CPL-GR-A80M	65 & Older	1667.55
CPL-GR-A80N	65 & Older	1215.15

PREMIUM INFORMATION

We, Colonial Penn Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. A change may be due to a new table of rates, increase in age of an insured person, or a change in Medicare's benefit structure that changes the nature of the risk we assumed. We'll tell you in advance of any change in premium.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it by mail to the Administrative Office: 11825 North Pennsylvania Street, Carmel, IN 46032. Or you may return the policy to the agent who sold it to you. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither Colonial Penn Life Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Please note if you are in an open enrollment period or otherwise qualify for a guaranteed issue policy, this paragraph does not apply to you.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$0	\$[1068] (Part A deductible)
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	\$0	Up to \$[133.50] a day
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A (Continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	\$0	Up to \$[133.50] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B (Continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
 ** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2000] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B deductible)	\$0
- Remainder of Medicare Approved Amounts	80%	20%	\$0
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G (Continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4620] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[534] (50% of Part A deductible)	\$[534] (50% of Part A deductible)◆
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[66.75] a day	Up to \$[66.75] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	50%	50%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	50% of Medicare copayment/coinsurance	50% of Medicare copayment/coinsurance ◆

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K (Continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4620] per year. However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	\$[135] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 10%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[4620])*
BLOOD First 3 pints Next \$[135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%◆ \$[135] (Part B deductible)****◆ Generally 10%◆
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare Approved Amounts***** - Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$[135] (Part B deductible)◆ 10%◆

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[801] (75% of Part A deductible)	\$[267] (25% of Part A deductible)◆
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[100.13] a day	Up to \$[33.37] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	75%	25%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	75% of Medicare copayment/coinsurance	25% of Medicare copayment/coinsurance◆

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L (Continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2310] per year. However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	\$[135] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 5%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[2310])*
BLOOD First 3 pints Next \$[135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ \$[135] (Part B deductible)◆ Generally 5%
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare Approved Amounts***** - Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$[135] (Part B deductible)◆ 5%◆

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[534] (50% of Part A deductible)	\$[534] (50% of Part A deductible)
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M (Continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN N

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1068]	\$[1068] (Part A deductible)	\$0
61st thru 90th day	All but \$[267] a day	\$[267] a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[534] a day	\$[534] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed \$[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$[135] (Part B deductible) Up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[135] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[135] of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[135] (Part B deductible) \$0
OTHER BENEFITS - NOT COVERED BY MEDICARE			
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

APPLICATION FOR INSURANCE TO

Colonial Penn Life Insurance Company ("The Company")

Home Office: 399 Market Street • Philadelphia, PA 19181

Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

1. Policy Information (PLEASE CLEARLY PRINT ALL INFORMATION)

A. I apply for NEW COVERAGE ON FORM CPL-GR-A80:

PLAN A PLAN B PLAN F PLAN HIGH DEDUCTIBLE F PLAN G PLAN K PLAN L

PLAN M PLAN N OTHER _____

Open Enrollment - Indicate the date below if applicable.

____ - ____ - 20 ____
Date first enrolled in Medicare Part B

B. I apply for EXISTING POLICY NUMBER _____ TO BE CHANGED.

EXCHANGE REINSTATEMENT OTHER _____

C. List any other existing policy number(s) to be ended or changed.

 End Change End Change End Change

Describe any change(s): _____

D. Do you believe you are eligible for guaranteed issue coverage because other coverage is terminating? If "Yes", please indicate the type of coverage and provide the end date below.

Employee Welfare Benefit Plan Medicare Advantage Private Fee For Service (PFFS)

Medicare Select Plan, Medicare Risk or Cost Plan, or a Medicare HMO Plan Medicare Supplement Plan

Other Guaranteed Issue Qualified Plan? _____

End Date ____ - ____ - 20 ____

E. Request for Special Issue ____ - ____ - 20 ____

2. Personal Information of Applicant:

First Name M.I. Last Name Suffix

Gender: M F Marital Status: Married Single Widowed Divorced

____ - ____ - ____
Date of Birth (mm-dd-yyyy) Age Medicare I.D Number _____

Social Security Number _____
(Show only if no Medicare I.D. Number)

Railroad Retiree Number _____

3. Association/Organization Verification (complete this section only if applicable)

The Applicant is an employee/member in good standing of:

Association/Organization

Account Number

4. Contact Information

A. Home Address

City/Town State Zip Code

_____ - _____ - _____
Home Phone Work Phone

E-mail Address

B. Billing Address (if different than home address)

City/Town State Zip Code

5. Qualifying Information

Questions 5A. through 5C. must always be answered.

- A. Are you insured under Part A and Part B of Medicare? YES NO
B. Is the state paying your Medicare Part B premium? YES NO
C. Do you receive federal, state or local government financial assistance in any form, such as Supplemental Security Income? YES NO

6. Other Health Coverage

A. Statements to Proposed Insured:

- 1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan.
6. Counseling services may be available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

6. Other Health Coverage (Continued)

B. Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. (Please mark YES or NO below with an "X", as applicable)

To the best of your knowledge:

	YES	NO
1. (a) Did you turn age 65 in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Did you enroll in Medicare Part B in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
(c) If yes, what is the effective date?		
	_____ - _____ - 20 _____	
	Date (mm-dd-yy)	

	YES	NO
2. Are you covered for medical assistance through the state Medicaid program?	<input type="checkbox"/>	<input type="checkbox"/>

NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

	YES	NO
If yes,		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	<input type="checkbox"/>	<input type="checkbox"/>

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (e.g. Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. If you are still covered under this plan, leave "End" blank.	Start:	_____ - _____ - 20 _____
		Date (mm-dd-yy)
	End:	_____ - _____ - 20 _____
		Date (mm-dd-yy)

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Was this your first time in this type of Medicare plan?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?	<input type="checkbox"/>	<input type="checkbox"/>
4. (a) Do you have another Medicare supplement policy in force?	<input type="checkbox"/>	<input type="checkbox"/>
(b) If so, with what company and what plan do you have?		

Company: _____

Plan: _____

	YES	NO
(c) If so, do you intend to replace your current Medicare supplement policy with this policy?	<input type="checkbox"/>	<input type="checkbox"/>

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)	<input type="checkbox"/>	<input type="checkbox"/>
(a) If so, with what Company and what kind of policy?		

Company: _____

Policy: _____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)	Start:	_____ - _____ - 20 _____
		Date (mm-dd-yy)
	End:	_____ - _____ - 20 _____
		Date (mm-dd-yy)

6. Other Health Coverage (Continued)

C. The agent shall list any other health insurance coverage they have sold to the applicant.

(a) List policies sold which are still in force. _____

(b) List policies sold in the past five (5) years which are no longer in force. _____

7. Replacement of Existing Coverage

A. Will any existing Medicare Supplement, Accident or Sickness, Specified Disease, Hospital Indemnity, Accident/Travel Accident or Nursing Home, Long Term Care, Short Term Care or Home Health Care Plan be replaced or changed if this proposed policy is issued? If "Yes," give details below: **YES NO**

Company	Policy Number	End Date (mm-dd-yy)
_____	_____	____ - ____ - 20 ____
_____	_____	____ - ____ - 20 ____
_____	_____	____ - ____ - 20 ____
_____	_____	____ - ____ - 20 ____

B. If you are replacing a Medicare Supplement policy, please indicate the reason below:

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. _____
- Other, please specify _____

8. Premium Payment Service Plan (PPSP). I want my policy to be paid each month by Electronic Funds Transfer (EFT) from my bank account. If "YES" please provide the information requested below. **YES NO**

Note: To help ensure encoding accuracy of bank information, please include a specimen check marked "VOID."

_____ Bank Routing/Transit Identification Numbers (first set of numbers in the lower left hand bottom of check - 9 digits)

_____ Checking or Savings Account Number _____ Account Name

_____ Bank Name

_____ City/Town _____ State _____ Zip Code

Please charge my account on the ____ day of the month.

I also want these policy numbers billed on the PPSP plan (EFT):

DO NOT ANSWER MEDICAL QUESTIONS #9 AND #10 IF YOU ARE IN AN OPEN ENROLLMENT OR OTHER GUARANTEED ISSUE QUALIFIED PERIOD. CONTINUE ON THE NEXT PAGE WITH #11.

9. Questions 9A. through 9E.

A. Please list your height and weight below.

 "	 "
Height (Feet and Inches)	Weight (Pounds)

- | | YES | NO |
|---|--------------------------|--------------------------|
| B. Are you now confined in a hospital or nursing home, or, within the past 60 days, have you been advised by a doctor to seek medical care or treatment in a hospital or in a nursing home? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Are you bedridden? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Do you require the use of a wheelchair? (if "Yes," please give details in #14 Remarks) | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Are you receiving kidney dialysis? | <input type="checkbox"/> | <input type="checkbox"/> |

10. Questions 10A. through 10E.

- | | YES | NO |
|---|--------------------------|--------------------------|
| A. Have you, due to mental or physical disability, authorized any person or institution to legally act in your behalf and take over your personal transactions? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. In the past 12 months, have you been advised to have surgery but it has not yet been done? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. In the past 12 months, have you been hospitalized three or more times? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Do you routinely visit the same medical provider more than monthly for medical advice or treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Do you now have any of the following conditions or have you received medical advice or treatment for the following conditions within the past 12 months? | | |
| 1. Cancer (except skin) or Leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Chronic Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Cirrhosis of the Liver | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Diabetes (insulin dependent) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Angina Pectoris, Heart Attack, Congestive Heart Failure, or Valvular Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Alzheimer's Disease, memory loss or impairment, dementia or cognitive impairment | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Parkinson's Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Chronic Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Any form of Arthritis or Degenerative Bone Disease causing crippling, fractures, limitation of motion, or requiring joint replacement | <input type="checkbox"/> | <input type="checkbox"/> |

11. Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof in order to underwrite and administer any policy issued and offer financial products and services. This authorization will be valid for a period of 2 years and 6 months from the date signed.

12. Acknowledgments

THE APPLICANT REPRESENTS AND AGREES AS FOLLOWS:

- A. I have read, or had read to me, the completed application and realize that any false statements or misrepresentation in this application may result in loss of coverage under the policy.
- B. No agent is authorized to waive or modify any terms of this application.
- C. No agent, medical examiner or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.
- D. If premium was paid with this application, I have read the receipt for same and fully understand the conditions and limitations stated in the receipt, and that no agent can waive or change such conditions and limitations.
- E. Any insurance issued as a result of this application will either: (i) not take effect for insurance unless and until the full first premium is paid and the policy is delivered during my lifetime and while I am in the condition of health set forth in this application; or (ii) take effect as may be specified in the receipt, if any, completed with this application.
- F. For an exchange, the new coverage will be treated as a renewal of any current coverage.

13. Applicant's Acknowledgment of Notices

I have received and acknowledge receipt of the following:

- "Guide to Health Insurance for People with Medicare"
- Applicable Outline of Coverage
- Notice Regarding Replacement, if applicable
- Conditional Receipt, if applicable
- Privacy Notice

14. Remarks:

15. Third Party Countersignature

Note: If the Applicant is age 85 or older, a third party presence is required and the following statement completed by a trusted relative, friend or financial advisor who was present at the time of this sale.

Third Party First Name	M.I.	Last Name	Suffix
------------------------	------	-----------	--------

Relationship to Applicant _____ number of years I have known the Applicant.

Home Address _____

City/Town	State	Zip Code
-----------	-------	----------

Home Phone _____ - _____ - _____

Signature of Third Party X

16. Signatures

I certify that the statements contained in the application are complete, true and correct. I understand that the agent represents, provides services on behalf of and is compensated by Colonial Penn Life Insurance Company. If my answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind my coverage.

_____ Dated at City/Town _____ State _____ Zip Code

This ____ Day of _____ 20 ____

Signature of Applicant X

I have witnessed the signature of the Applicant. I certify that I asked all the applicable questions and truly and accurately recorded the answers contained herein. I certify that the Applicant has read the completed application or had it read to him or her. To the best of my knowledge and belief, except as may be stated by the responses to Questions 6 and 7, the insurance applied for is not or is not likely to replace or change any existing policy(ies) or contract(s).

Signature of Licensed Resident Agent X Agent No. _____ %

Branch Office Number _____

Signature of Licensed Resident Agent X Agent No. _____ %

Branch Office Number _____

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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.

MAKE ALL CHECKS PAYABLE ONLY TO Colonial Penn Life Insurance Company

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

Colonial Penn Life Insurance Company
Home Office: 399 Market Street • Philadelphia, PA 19181
Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Colonial Penn Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the reason shown on your application.

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

[Signature box]

Signature of Agent

Typed Name and Address of Issuer, Agent or Broker

[Signature box]

Applicant's Signature

____ - ____ - 20 ____
Date (mm-dd-yy)

AMENDMENT RIDER

EFFECTIVE DATE: This rider is part of the Policy to which it is attached and is effective on the Date of Issue of the Policy. It will terminate when the coverage terminates. Except as stated below, this rider is subject to all of the terms of the Policy.

APPEAL OF DECISION

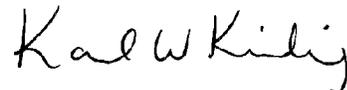
Any dispute arising out of or related in any manner to the Policy is subject to certain administrative procedures that must be exhausted by the party claiming rights under the policy, such as the insured, policy owner, authorized representative, or beneficiary(ies) (collectively, "Policyholder") prior to the Policyholder pursuing any other remedy that may be available in law or equity.

- (1) If Colonial Penn Life Insurance Company ("the Company") makes a decision which the Policyholder wishes to appeal, a written request must be sent within sixty (60) days of the date of the Company's written notice of that decision. The appeal should be addressed to Colonial Penn Life Insurance Company, Attn: V.P., Claims, at the Administrative Office address shown on Page 1 of your policy.
- (2) The Policyholder's written request must provide:
 - (a) The policy number, name of the insured person, and a written statement of the reasons for the appeal and the facts of the matter; and
 - (b) copies of any evidence or other supporting documentation.
- (3)
 - (a) Within forty-five (45) days after the date of receipt of a timely filed request for reconsideration, the Company must provide written notice to the Policyholder that:
 - (i) the decision has been reversed or modified;
 - (ii) the decision has been reaffirmed; or
 - (iii) additional information is being requested from the Policyholder (which shall include any information from third parties, such as health care providers).
 - (b) Within thirty (30) days after the additional requested information is received, the Company must notify the Policyholder as provided in (3)(a)(i) and (ii) above.
 - (c) If the Policyholder does not provide the additional information requested within sixty (60) days of the requesting date, the Company will reconsider the decision based on the information in the file.

MEDIATION

After exhaustion of the Appeal of Decision procedures, the parties will, in good faith, attempt to settle any dispute arising out of or related in any manner to the policy that remains by mediation in accordance with the Insurance Dispute Resolution Program, as amended, and as administered by the American Arbitration Association.

Colonial Penn Life Insurance Company



Secretary

CHANGE FORM

Colonial Penn Life Insurance Company
Home Office: 399 Market Street • Philadelphia, PA 19181
Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

POLICY NUMBER:

POLICY FORM(S):

THIS INSURANCE WAS ISSUED SUBJECT TO THE FOLLOWING:

I CERTIFY THAT THE MEDICAL HISTORY AND HEALTH OF THE INSURED HAS NOT CHANGED AND IS THE SAME AS THAT SHOWN ON THE APPLICATION COPY INCLUDED WITH THIS POLICY.

I HAVE READ, OR HAD READ AND EXPLAINED TO ME THE ABOVE CHANGE(S). I UNDERSTAND AND AGREE THAT THE CHANGE(S) ARE PART OF THIS POLICY.

DATED AT _____ THIS ____ DAY OF _____, 20 ____

SIGNED _____
(APPLICANT)

WITNESS _____
(LICENSED RESIDENT AGENT)

CPL-5451

CHANGE FORM

Colonial Penn Life Insurance Company
Home Office: 399 Market Street • Philadelphia, PA 19181
Administrative Office: 11825 North Pennsylvania Street • Carmel, IN 46032

POLICY NUMBER:

POLICY FORM(S):

THIS INSURANCE WAS ISSUED SUBJECT TO THE FOLLOWING:

I HAVE READ, OR HAD READ AND EXPLAINED TO ME THE ABOVE CHANGE(S). I UNDERSTAND AND AGREE THAT THE CHANGE(S) ARE A PART OF THIS POLICY.

DATED AT _____ THIS _____ DAY OF _____, 20 _____

SIGNED _____
(APPLICANT)

WITNESS _____

(LICENSED RESIDENT AGENT)

CHANGE APPLICATION

To: Colonial Penn Life Insurance Company
Administrative Office:
11825 North Pennsylvania Street
Carmel, IN 46032

Please change Policy _____ as follows:

I understand and agree that: (1) the above change(s) will not take effect unless this application is accepted by you and any additional premium has been paid; and (2) except as may be provided above, the effective date of such change(s) will be the later of the policy's Issue Date or the date you approve this application.

Date _____, 20_____

X _____
Applicant's Signature

AGENT'S SIGNATURE NOT NEEDED WHEN DEALING DIRECTLY WITH ADMINISTRATIVE OFFICE.

Agent's Signature

Number

Colonial Penn Life Insurance Company
Administrative Office:
11825 North Pennsylvania Street
Carmel, IN 46032

IMPORTANT:
PLEASE ATTACH THIS FORM
TO YOUR POLICY.

JOHN DOE
123 ANY STREET
ANY CITY, USA 12345

POLICY NUMBER:

MONTHLY PREMIUM:
BEFORE CHANGE: \$
AFTER CHANGE: \$

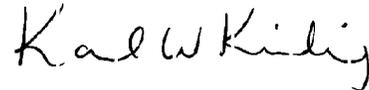
PREMIUM NOW
PAID TO:

POLICY CHANGE FORM

Attached to and made a part of this policy effective on the date shown below. This will be the date of issue for determining the effective date of any additional benefits (if any) provided by this form.

EFFECTIVE DATE:

Colonial Penn Life Insurance Company



Secretary

Colonial Penn Life Insurance Company
Administrative Office:
11825 North Pennsylvania Street
Carmel, IN 46032

**ATTACH
ONE COPY TO YOUR POLICY
DATE, SIGN AND RETURN
SECOND COPY**

JOHN DOE
123 ANY STREET
ANY CITY, USA 12345

POLICY NUMBER:
MONTHLY PREMIUM-
BEFORE CHANGE:
AFTER CHANGE:
PREMIUM NOW
PAID TO:

POLICY CHANGE FORM

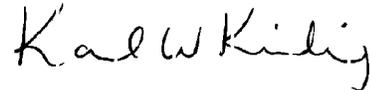
Attached to and made a part of this policy effective on the date shown below. This will be the date of issue for determining the effective date of any added benefits provided by this form.

EFFECTIVE DATE:

Accepted
Date: _____

Colonial Penn Life Insurance Company

Insured: _____
Not valid unless signed
by the Insured



Karl W. Kindig
Secretary

<p>DESCRIPTION OF INSURANCE Policy Number</p> <p>_____</p>	<p>Colonial Penn Life Insurance Company Administrative Office: 11825 North Pennsylvania Street, Carmel, IN 46032</p> <p>FILL OUT AND RETURN THIS FORM. SEND NO MONEY NOW.</p> <p>WE WILL BILL YOU FOR THE AMOUNT DUE AFTER WE APPROVE YOUR REINSTATEMENT. ANY PAYMENT SENT BEFORE THEN WILL BE RETURNED TO YOU.</p>
---	--

APPLICATION FOR REINSTATEMENT

To: Colonial Penn Life Insurance Company

I apply to reinstate my insurance under the policy number shown above. To the best of my knowledge and belief:

(1) I am now in good health; and (2) have not in the past five (5) years had any illness, or any medical or surgical treatment, consultations or check-ups, except as follows: (If "none," so state).

Name	Conditions and Complications	Date of						Days in Hospital	Names and Addresses of Physicians
		Onset		Operations		Recovery			
		MO	YR	MO	YR	MO	YR		

My exact duties of Employment _____

I agree the insurance will not be reinstated until this application is approved by the Company at its Home Office.

I further agree the insurance, if reinstated, will insure against:

- A. Covered loss due to accident, if the accident happens after reinstatement.
- B. Covered loss due to sickness, if it begins after reinstatement.

Upon reinstatement, one (1) month's premium will be used to revive the policy. Another month's premium will be due on the reinstatement date. I understand I have a 31 day Grace Period to pay cash premium after reinstatement. I am to send no money now. I will be billed for the amount due after my reinstatement is approved.

Dated at _____ this _____ day of _____ 20 _____

Signature of Applicant

Street Address

City State Zip Code

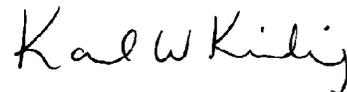
ATTACH TO YOUR POLICY

POLICY CHANGE FORM

POLICY NUMBER _____ to which this form is attached is changed as follows:

ATTACHED TO and made a part of said policy this ____ day of _____, 20____.

Colonial Penn Life Insurance Company



Secretary

SERFF Tracking Number: BNLA-126219064 State: Arkansas
 Filing Company: Colonial Penn Life Insurance Company State Tracking Number: 43127
 Company Tracking Number: CPL-GR-A80A ET AL
 TOI: MS071 Individual Medicare Supplement - Sub-TOI: MS071.001 Plan A 2010
 Medicare Select 2010
 Product Name: 2008 MIPAA Medicare Supplement Plans
 Project Name/Number: 2008 MIPAA Medicare Supplement Plans/CPL-GR-A80A et al

Rate/Rule Schedule

Schedule	Document Name:	Affected Form	Rate	Rate Action Information:	Attachments
Item		Numbers:	Action:*		
Status:		(Separated with commas)			
Approved	Policy Rates	CPL-GR-A80A Et New			AR - Rate
09/18/2009		AI			Sheet.pdf

Colonial Penn Life Insurance Company

Standardized Medicare Supplement
Policy Form Series CPL-GR-A80

Annual Premium Rates* Male or Female

<u>Issue Age</u>	<u>Plan A</u>	<u>Plan B</u>	<u>Plan F</u>	<u>Plan FH</u>	<u>Plan G</u>	<u>Plan K</u>	<u>Plan L</u>	<u>Plan M</u>	<u>Plan N</u>
Ages 65 & Over	\$1,517.44	\$1,873.40	\$2,094.96	\$502.80	\$1,926.20	\$708.76	\$1,240.46	\$1,667.55	\$1,215.15

*To determine the Bank Draft (P.P.S.P.) or Payroll Deduction (P.R.D.), Semi-Annual, Quarterly or Renewal Direct Bill rates multiply the Annual Rates, as given above, by the appropriate factor shown below and add \$1.00:

0.08583 for Monthly Bank Draft/Payroll Deduction; 0.515 for Semi-Annual; 0.2625 for Quarterly; 0.09167 for Renewal Direct Bill

SERFF Tracking Number: BNLA-126219064 State: Arkansas
 Filing Company: Colonial Penn Life Insurance Company State Tracking Number: 43127
 Company Tracking Number: CPL-GR-A80A ET AL
 TOI: MS071 Individual Medicare Supplement - Sub-TOI: MS071.001 Plan A 2010
 Medicare Select 2010
 Product Name: 2008 MIPAA Medicare Supplement Plans
 Project Name/Number: 2008 MIPAA Medicare Supplement Plans/CPL-GR-A80A et al

Supporting Document Schedules

		Item Status:	Status
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	Date: 09/18/2009

Comments:

Attachments:

AR Certif of Compliance.pdf

AR Certif of Flesch Compliance.pdf

		Item Status:	Status
Satisfied - Item:	Application	Approved	Date: 09/18/2009

Comments:

The application is attached to the Forms Schedule tab.

		Item Status:	Status
Satisfied - Item:	Outline of Coverage	Approved	Date: 09/18/2009

Comments:

The Outline of Coverage is attached to the Forms Schedule tab.

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: **Colonial Penn Life Insurance Company**

Form Number(s): CPL-GR-A80A ET AL

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19; Rule and Regulation 49 and the Consumer Information Notice.

Mariann Dobbs

Signature of Company Officer

Mariann Dobbs

Name

Assistant Secretary

Title

08/05/2009

Date

ARKANSAS

CERTIFICATION

<u>Form Number</u>	<u>Score</u>	<u>Form Number</u>	<u>Score</u>
CPL-GR-A80A	47.72	CPL-28301	46.94
CPL-GR-A80B	48.02	CPL-4043-SUP	46.66
CPL-GR-A80F	46.53	CPL-16150	48.68
CPL-GR-A80FH	45.63	CPL-5451	61.45
CPL-GR-A80G	46.39	CPL-5453	57.58
CPL-GR-A80K	48.36	CPL-405	45.44
CPL-GR-A80L	48.69	CPL-424	46.00
CPL-GR-A80M	46.15	CPL-424CCA	49.80
CPL-GR-A80N	46.59	CPL-1364	54.84
CPL-28300-AR	45.16	CPL-7146	46.30

I hereby certify that to the best of my knowledge and belief, the above form(s) meets the minimum reading ease requirements of your Department. The Flesch Test Reading Ease score is listed above.

Colonial Penn Life Insurance Company



Assistant Secretary

Date: August 05, 2009