

SERFF Tracking Number: NELLI-126856553 State: Arkansas
Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 47029
Company Tracking Number: H-0184
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: H-0184
Project Name/Number: H-0184/H-0184

Filing at a Glance

Company: Philadelphia American Life Insurance Company

Product Name: H-0184 SERFF Tr Num: NELLI-126856553 State: Arkansas
TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved-
Closed State Tr Num: 47029

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: H-0184 State Status: Approved-Closed
Filing Type: Form/Rate Reviewer(s): Rosalind Minor
Author: Brian Hull Disposition Date: 10/25/2010
Date Submitted: 10/12/2010 Disposition Status: Approved-
Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: H-0184
Project Number: H-0184
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/25/2010

Status of Filing in Domicile:
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: 10/25/2010
Created By: Brian Hull
Corresponding Filing Tracking Number:

Deemer Date:
Submitted By: Brian Hull
Filing Description:
NEW FORMS FILING – INDIVIDUAL HOSPITAL INDEMNITY POLICY
PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY
NAIC # 67784 / FEIN # 74-1952955

Form Number / Description
H-0184.AR / Hospital Indemnity Policy
H-0184.OC / Outline of Coverage
CMB.AP / Application
CMB.AP.SUP / Application Supplement

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DIS.NT / Application Disclosure
 CRT.IL.RD / Critical Illness Rider
 TRM.LF.RD / Term Life Rider

We are submitting the captioned forms for review and approval. The forms are new and not intended to replace any previously approved forms. These forms will be marketed through independent agents. We also would like to be able to use the above application forms and riders with policy form H-0180.AR previously approved on 8/13/10 and the application forms with policy form H-0089.AR approved on 8/12/10.

Company and Contact

Filing Contact Information

Brian Hull, bhull@neweralife.com
 200 Westlake Blvd. Ste. #1200 281-368-7278 [Phone]
 Houston, TX 77079

Filing Company Information

Philadelphia American Life Insurance Company CoCode: 67784 State of Domicile: Texas
 200 Westlake Park #1200 Group Code: 520 Company Type:
 Houston, TX 77079 Group Name: State ID Number:
 (281) 368-7200 ext. [Phone] FEIN Number: 74-1952955

Filing Fees

Fee Required? Yes
 Fee Amount: \$400.00
 Retaliatory? Yes
 Fee Explanation: Our domicilliary state of Texas filing fees are less so we are paying the Arkansas fee.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Philadelphia American Life Insurance Company	\$400.00	10/12/2010	40599967

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/25/2010	10/25/2010

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Disposition

Disposition Date: 10/25/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application Supplement	Approved-Closed	Yes
Form	Application Disclosure	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

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Form Schedule

Lead Form Number: H-0184

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/25/2010	H-0184.AR	Policy/Cont ract/Fratern al Certificate	Policy	Initial		43.400	H-0184.AR.pdf
Approved-Closed 10/25/2010	H-0184.OC	Outline of Coverage	Outline of Coverage	Initial		45.500	H-0184.OC.pdf
Approved-Closed 10/25/2010	CMB.AP	Application/ Enrollment Form	Application	Initial		51.100	CMB.AP.pdf
Approved-Closed 10/25/2010	CMB.AP.S UP	Application/ Enrollment Form	Application Supplement	Initial		51.200	CMB.AP.SUP.pdf
Approved-Closed 10/25/2010	DIS.NT	Application/ Enrollment Form	Application Disclosure	Initial		50.100	DIS.NT.pdf
Approved-Closed 10/25/2010	CRT.IL.RD	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Rider	Initial		50.100	CRT.IL.RD.pdf
Approved-Closed 10/25/2010	TRM.LF.R D	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert	Rider	Initial		50.200	TRM.LF.RD.pdf

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Page,
Endorseme
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P.O. Box 4884, Houston, Texas 77210-4884

HOSPITAL INDEMNITY POLICY

THIS POLICY IS GUARANTEED RENEWABLE TO AGE 65. THE COMPANY RESERVES THE RIGHT TO CHANGE PREMIUM RATES ON A CLASS BASIS.

You have the right to renew this policy until the first premium due date on or after Your 65th birthday.

We reserve the right, subject to 45 days prior written notice to You at Your last known address, to establish a new schedule of premium rates; such schedule of rates will be effective on the following Premium Due Date for all or any class of insured's covered by the policy. Premiums may also change due to attained age. Please read the Premium Rate Change provision carefully that is contained within.

TEN DAY FREE LOOK

You may cancel the insurance described in this policy at any time during the 10 day period after You receive this policy. Mail this policy with Your written request for cancellation to Us at Our Home Office. We will promptly refund the premium paid and the insurance will be void.

Philadelphia American Life Insurance Company, a stock company, certifies that the Covered Person(s) named in the Schedule of Benefits, are insured for the benefits described in this policy.

Your insurance is effective at 12:01 a.m. Standard Time at the legal address of the Insured on the policy Effective Date shown in the Schedule of Benefits. All time periods referenced herein begin and end at 12:01a.m. Standard Time at the Insured's legal address of record.

Signed for: **PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY**

Secretary

President

PLEASE READ YOUR POLICY CAREFULLY

NON-PARTICIPATING

**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE.
THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

	<u>Page</u>
Section 1 DEFINITIONS	5
Section 2 EFFECTIVE DATES	8
Section 3 BENEFIT PROVISIONS	9
Section 4 EXCLUSIONS AND LIMITATIONS	10
Section 5 TERMINATION OF INSURANCE	11
Section 6 PREMIUMS	12
Section 7 POLICY PROVISIONS	12

AMENDMENT RIDERS, IF ANY

SCHEDULE OF BENEFITS

POLICY NUMBER: [0000000001]

EFFECTIVE DATE: [08/01/2010]

INITIAL PREMIUM: [\$XX.XX]

PREMIUM MODE: Monthly

INSURED: [JOHN DOE]

FIRST POLICY RENEWAL DATE: [09/01/2010]

COVERED PERSON(S): [JOHN DOE], Insured

[, Spouse]

[, Dependent Child]

[, Dependent Child]

Limiting Age: 65 years of age

Limiting Age for Dependents: The age stated in the definition of Dependent shown in Section 1 hereof

Calendar Year Policy Deductible (per Covered Person with a maximum of three deductibles per policy)(Additional Outpatient Benefits Calendar Year Deductible does not apply to satisfaction of Calendar Year Policy Deductible)	[\$1,000][\$2,500][\$5,000]
Lifetime Maximum (per policy)	[\$5,000,000]

Maximum Covered Benefits per Covered Person per Calendar Year	[\$100,000][\$250,000] [\$1,000,000]
Daily Indemnity Benefits as described below are limited to the Maximum Number of Days Per Covered Person Per Calendar Year indicated (for all benefits combined)	[30][60][180]

HOSPITAL INDEMNITY BENEFITS

Facility Fees	
Daily Indemnity Benefit during Confinement in a Hospital (including Observation Unit stay for 24 hours or more) as a result of a covered Injury or Sickness	[\$1,500][\$3,000][\$4,500]
Daily Indemnity Benefit during Confinement in a Hospital for Mental Illness, Alcohol and/or Substance Abuse Dependency	[\$750][\$1,500][\$2,250]
Daily Indemnity Benefit during Confinement in a Hospital's Intensive Care Unit (ICU) up to 20 days per Calendar Year	[\$2,250][\$4,500][\$6,750]
Daily Indemnity Benefit during Confinement in a Rehabilitation Facility or a Skilled Nursing Facility	[\$750][\$1,500][\$2,250]
Daily Indemnity Benefit for Outpatient Hospital or ambulatory surgical center services when surgery is performed	[\$1,500][\$3,000][\$4,500]
Daily Indemnity Benefit for Outpatient Radiation Therapy or Chemotherapy	[\$750][\$1,500][\$2,250]
Professional Services	
Other Inpatient Benefits: Physician Hospital Visit per visit	[\$50][\$100][\$150]
Surgical Indemnity Benefit for covered services when performed in a Hospital or in an ambulatory surgical center	[1X][2X][3X] of current RBRVS per procedure for your provider location
Inpatient Pathologist/Radiologist Benefits for covered services	[1X][2X][3X] of current RBRVS per procedure for your provider location
Anesthesia Indemnity Benefit for covered services	25% of surgical benefits payable
Emergency Ambulance Indemnity Benefit	\$250 per trip

Hospital, Rehabilitation Facility & Skilled Nursing Facility Benefits for covered persons confined in such medical facilities for 24 or more consecutive hours are as shown in the above schedule.

ADDITIONAL OUTPATIENT BENEFITS (these benefits are payable for services performed on an outpatient basis only)

Calendar Year Deductible (Per Covered Person)(Calendar Year Policy Deductible does not apply towards satisfaction of Calendar Year Deductible)	\$500
Aggregate Calendar Year Maximum (Per Covered Person)	\$2,000
Outpatient Office Visit (fees per visit for office, outpatient clinic or emergency room)	[\$25][\$50][\$75]
Other Outpatient Services (per test)	
MRI, CAT Scan or Nuclear testing	[\$175][\$350][\$525]
Other diagnostic testing or X-rays	[\$40][\$80][\$120]
Laboratory testing	[\$10][\$20][\$30]
Injections	[\$5][\$10][\$15]
Generic Prescription (per prescription filled)	[\$5][\$10][\$15]
Brand Name Prescription (per prescription filled)	[\$10][\$20][\$30]
Well Care Maximum:	\$50 per visit up to \$150 per calendar year

Base Policy Modal Premium: \$[000.00]

[Term Life Insurance Rider Premium (TRM.LIF.RDR):]
 [Term Life Coverage Type:][Insured Only][Insured and Child(ren)][Insured and Spouse or Family]
 [Number of Units:]

[Critical Illness Rider Premium (CRT.ILL.RDR):]
 [Critical Illness Coverage Type:][Insured Only][Insured Spouse][Insured Dependent Children]
 [Maximum Critical Illness Benefit:]

Section 1 - DEFINITIONS

As used in this policy, the following definitions apply:

Calendar Year

The period from January 1 through December 31 of the same year.

Complications of Pregnancy

Any condition that requires medical treatment or Hospital confinement prior to or subsequent to the termination of the pregnancy whose diagnosis is distinct from, but is adversely affected by the pregnancy. Such conditions include, but are not limited to: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) missed abortion; and, (5) similar conditions of comparable severity. Complications of Pregnancy will also include non-elective caesarean section or spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible. Complications of Pregnancy will not include: (1) false labor; (2) occasional spotting; (3) prescribed bed rest; (4) morning Sickness; or, (5) similar conditions that are common to the care of a difficult pregnancy.

Confinement or Confined

Confinement for 24 or more consecutive hours in a Hospital, Rehabilitation Facility or Skilled Nursing Facility as a resident bed patient, upon the advice of a Physician, for other than custodial care. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, a freestanding surgical facility, a custodial care facility or an outpatient facility.

Covered Benefits

Those services and/or supplies if included in this policy, that:

- (a) are for Medically Necessary treatment and recommended by a Physician;
- (b) are received while a Covered Person is insured under the policy, subject to any Extension of Benefits; and
- (c) are not excluded under Section 4 of the policy.

Covered Person(s)

You and Your Dependents, if any who are insured under the policy.

Deductible

The amount of benefit incurred during a Calendar Year that the Covered Person must pay before any benefits are payable.

Dependent

Your:

- (a) spouse under age 65; or
- (b) natural child, step child, adopted child or a child during the pendency of adoption who is not eligible for insurance under this policy and who;
 - (i) is less than 25 years old; and/or
 - (ii) is required by a court order to be provided medical support coverage.
- (c) grandchild less than 25 years of age on the date the Insured makes written request for coverage of such grandchild;
- (d) child or grandchild who becomes incapable of self-support because of mental retardation or physical disability while insured under the policy and prior to reaching 25 years of age. We must receive proof of incapacity. Then, coverage will continue for as long as Your insurance stays in force and such child or grandchild remains incapacitated. Additional proof may be required from time to time but not more often than once a year.

Effective Date

Effective date is the policy Effective Date shown on the Schedule of Benefits page. If a Dependent is added to a policy after the original policy Effective Date, that Dependents Effective Date will be shown on an endorsement.

Hospital

A licensed institution that has on its premises:

- (a) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
- (b) 24-hour-a-day nursing service by graduate registered nurses; and
- (c) the patient's written history and medical records.

It shall also have (or have available on a pre-arranged basis) laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians, or be accredited by the Joint Commission on Accreditation of Hospitals.

Hospital shall not include any institution or portion thereof used as a place for rehabilitation, rest, the aged, education or training; or a nursing or convalescent home or an extended care facility for the care of convalescent patients.

Immediate Family

The parents, spouse, children, or siblings of a Covered Person.

Injury

Accidental bodily Injury sustained on or after the Covered Person's Effective Date that causes a loss independent of any other cause. Such Injury must occur while this policy is in force. All Injuries to the same Covered Person sustained in any one accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

Intensive Care Unit

A specifically designed facility of the Hospital that provides the highest level of medical care and which is restricted to those patients who are critically ill or injured.

Such facility must be separate and apart from the Hospital's emergency room, surgical recovery room and from rooms, beds and wards customarily used for patient confinement. Such facility must be permanently equipped with special life-saving equipment for the care of the critically ill or injured; and under constant and continuous observation 24 hours a day by nursing staff assigned exclusively to such facility.

Intensive Care Unit does not mean any of these step-down units: progressive care, intermediate intensive care or intermediate care units, private monitored rooms, recovery rooms, areas primarily for post-operative or post-anesthesia care, Observation Units; or other facilities which do not meet the standards for intensive care.

Medically Necessary

The services or supplies provided by a Hospital or Physician that are required to identify or treat an Injury or Sickness and which, as determined by Us, are:

- (a) consistent with the symptom or diagnosis and treatment of a Covered Person's condition, Sickness or Injury;
- (b) appropriate with regard to standards of good medical practice;
- (c) not solely for the convenience of a Covered Person, a Physician or other provider; and
- (d) the most appropriate supply or level of service that can be safely provided to the Covered Person.

Mental Illness

Any Sickness, disease or disorder, which is:

- (a) listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association; and
- (b) usually treated by a mental health provider or other qualified provider, using psychotherapy, psychotropic drugs or other similar methods of Treatment.

Mental Illness includes any such conditions whether or not related to an underlying physical, genetic, chemical, organic or biological cause, although it may be associated with physical symptoms, manifestations or expressions. Specific conditions include, but are not limited to: bipolar disorder; depression and depressive disorders; psychoses; mood disorders; manic-depressive illness; anxiety disorders; stress disorders including post-traumatic stress disorders; somatoform disorders; factitious disorders; eating disorders; adjustment disorders; and personality disorders. However, for purposes of the policy, Mental Illness does not include mental retardation or Alzheimer's disease and other forms of dementia with an objective organic basis.

Observation Unit

An area in a hospital or outpatient facility providing outpatient observation for the purpose of monitoring a patient prior to or following an emergency treatment, outpatient surgery or major diagnostic test(s).

Outpatient

Services provided by a Physician to a Covered Person for treatment either outside a Hospital or Skilled Nursing Facility or from an outpatient department of a Hospital or Skilled Nursing Facility or licensed ambulatory surgical center.

Physician

A practitioner of the healing arts who:

- (a) is practicing within the scope of his or her license in the state where so licensed; and
- (b) is not a member of a Covered Person's Immediate Family; and
- (c) provides treatment or service covered under the policy.

Pre-Existing Condition

A condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a Covered Person's Effective Date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under this policy for 12 consecutive months.

Premium Due Date

The Effective Date of the policy and the first day of each calendar month thereafter.

Resource Based Relative Value System, referred to as RBRVS.

The methodology used by the federal government to determine benefits payable under Medicare. Medicare assigns a "Relative Value Unit" or RVU to thousands of procedure codes used to bill physician and other services. The total RVU is the sum of three component RVUs including the Work RVU, the Practice Expense RVU and the Malpractice RVU. The Work RVU takes into account factors such as the amount of time required to perform the service and the degree of skill required to perform it. The Practice Expense RVU takes into account the location of the service, e.g., office setting, outpatient setting, etc. The Malpractice RVU takes into account the malpractice cost associated with a particular practice. We will base benefits payable on RBRVS.

Rehabilitation Facility

A facility providing therapy and training to restore functions of motion, speech or vision lost as a result of an Injury or Sickness.

Schedule of Benefits

The benefit schedule set forth in this policy.

Sickness

Sickness or disease that is diagnosed or treated while a Covered Person's insurance is in force, whose Sickness is the basis of a claim, and which results in loss covered by this policy. The term "Sickness" includes Complications of Pregnancy of a Covered Person.

Skilled Nursing Facility

- (a) a special unit or ward of a Hospital used primarily as a nursing or convalescent home; or
- (b) an institution that has a transfer agreement with one or more Hospitals and meets fully all of the requirements of Title XVIII of the Social Security Act of 1965, as now or hereafter amended, commonly known as "Medicare".

Substance Abuse

Alcoholism, or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician.

Total Disability or (Totally Disabled)

You are disabled and prevented from performing the material and substantial duties of Your occupation. For Dependents, Totally Disabled means the inability to perform a majority of the normal activities of a person of like age in good health.

You, Your and Yours

The Insured named in the policy Schedule of Benefits.

We, Our and Us

Philadelphia American Life Insurance Company.

Section 2 - EFFECTIVE DATES

DATE YOU ARE ELIGIBLE FOR INSURANCE

You are eligible to be insured under the policy if at that time You:

- (a) have paid the first premium; and
- (b) have completed an application acceptable to Us.

DATE INSURANCE TAKES EFFECT

When We have approved the application for You and have received the initial premium, coverage for You and Your eligible Dependents, if any, will be insured on the policy Effective Date shown on the Schedule of Benefits.

DEPENDENTS

DATE PERSON'S ARE ELIGIBLE FOR INSURANCE

If Dependent coverage is available under the policy, each Dependent will be eligible for such coverage on the latest of the following dates:

- (a) the day You become eligible for insurance;
- (b) the day You acquire Your first Dependent; or
- (c) the day Your Dependent becomes eligible for insurance under the policy.

You may elect Dependent coverage by completing and signing an application within 31 days of the date the Dependent becomes eligible.

The Effective Date of coverage for each eligible Dependent for whom You have met the above requirements will be the first day of the month following Our:

- (a) acceptance of the application; and
- (b) receipt of the first premium.

A newborn child will become insured for the benefits under this policy automatically on the day he or she is born as long as Your coverage was in force on that date. Coverage includes prematurity, congenital defects and birth abnormalities. The newborn child's coverage will not continue past the 90-day period following birth unless:

- (a) We are notified by the end of that 90-day period of the addition of such newborn child; and
- (b) any applicable additional premium is paid and received by Us.

An adopted child, or a child that You are a party to a suit in which You seek to adopt the child, will become insured for benefits under this policy on the date of the filing of the petition to adopt as long as Your insurance is in force. For newborn adopted children, coverage will begin from the moment of birth, if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the child. Coverage for an adopted child will not continue past the 90-day period following adoption or placement unless:

- (a) We are notified by the end of the 90-day period of the addition of such adopted child; and
- (b) any applicable additional premium is paid and received by Us.

In all other instances if a Dependent is Totally Disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage of the Dependent will be deferred until the first of the month following the Dependent's cessation of Total Disability.

DEFERRED EFFECTIVE DATE

If an eligible person, except for a newborn child, is hospitalized on the date Your insurance under this policy is otherwise to take effect, such insurance will take effect on the day after such person is discharged from the hospital.

SECTION 3 – BENEFIT PROVISIONS

HOSPITAL INDEMNITY INSURANCE

Hospital and Skilled Nursing Facility Benefits

Subject to all of the terms and provisions of the policy, including any Calendar Year Policy Deductible, Lifetime Maximum and Calendar Year Maximum shown in the Schedule of Benefits, We will pay Covered Benefits for one or more of the following:

Maximum Number of Days Per Calendar Year

The Maximum Number of Days per Calendar Year for which Covered Benefits will be paid is shown in the Schedule of Benefits. No further Indemnity Benefits will be paid in a calendar year after one, or any combination, of the above-described Indemnity Benefits has been paid for the Maximum Number of Days Per Calendar Year shown in the Schedule of Benefits.

Daily Indemnity Benefit During Confinement in a Hospital

We will pay the Daily Indemnity Benefit shown in the Schedule of Benefits for each day a Covered Person is Confined in a Hospital as a result of a covered Injury or Sickness. Benefits are payable for the period such person is so confined and receiving medical care and regular attendance of a Physician.

Daily Indemnity Benefit During Confinement in a Hospital's Intensive Care Unit

We will pay the Daily Indemnity Benefit shown in the Schedule of Benefits for each day a Covered Person is Confined in a Hospital's Intensive Care Unit (ICU) as a result of a covered Injury or Sickness. Benefits are payable for the period such person is so confined and receiving medical care and regular attendance of a Physician.

Daily Indemnity Benefit During Confinement in a Rehabilitation Facility or a Skilled Nursing Facility

We will pay the Daily Indemnity Benefit shown in the Schedule of Benefits for each day a Covered Person is Confined in a Rehabilitation Facility or a Skilled Nursing Facility as a result of a covered Injury or Sickness. Benefits are payable for the period such person is so confined and receiving medical care and regular attendance of a Physician.

Daily Indemnity Benefit for Outpatient Hospital or Ambulatory Surgical Center Services

We will pay the Indemnity Benefit shown in the Schedule of Benefits for Outpatient Hospital or ambulatory surgical center services when surgery is performed for each outpatient visit as a result of a covered Injury or Sickness. Benefits are payable for the period such person is receiving medical care and regular attendance of a Physician.

Daily Indemnity Benefit for Outpatient Radiation Therapy or Chemotherapy

We will pay the Daily Indemnity Benefit shown in the Schedule of Benefits for each day a Covered Person is being treated with Outpatient Radiation Therapy or Chemotherapy as a result of a covered Sickness. Benefits are payable for the actual day of treatment. Treatment in this benefit is defined as receiving actual treatment by X-ray, radium or radioactive isotopes, or by chemical or biological antineoplastic agents.

Other Inpatient Benefits: Indemnity for Physician Hospital Visits

We will pay the Indemnity Benefit shown in the Schedule of Benefits for each visit a Covered Person receives from a Physician while confined.

Surgical Indemnity Benefit and Inpatient Pathologist/Radiologist Benefit

We will pay the multiple of RBRVS shown in the Schedule of Benefits for covered Surgical Benefits per procedure as a result of Injury or Sickness when performed in a Hospital or in an ambulatory surgical center. We will pay 20% of the multiple of RBRVS shown in the Schedule of Benefits for covered assistant surgical services. We will pay the multiple of RBRVS shown in the Schedule of Benefits for covered Inpatient Pathologist/Radiologist Benefits per procedure as a result of Injury or Sickness.

Anesthesia Indemnity Benefit

We will pay the Anesthesia Indemnity Benefit for covered anesthesia services as shown in the Schedule of Benefits for a Covered Person who receives treatment as a result of Injury or Sickness.

Emergency Ambulance Indemnity Benefit

We will pay the Emergency Ambulance Benefit shown in the Schedule of Benefits to a Covered Person for each trip due to an Injury or Sickness. The ambulance service must be to or from a Hospital if immediately confined.

Additional Outpatient Benefits

Subject to all of the terms and provisions of the policy, including any Calendar Year Deductible and Aggregate Calendar Year Maximum shown in the Schedule of Benefits, We will pay Covered Benefits for one or more of the following:

Outpatient Office Visits

Benefit amount shown in the Schedule of Benefits for physician visits, surgery or treatment of any kind in the office, outpatient clinic or emergency room.

Other Outpatient Expense

Benefit amount shown in the Schedule of Benefits for MRI, CAT Scan or Nuclear testing per test; other diagnostic testing or X-rays (including professional and facility fee; excluding lab tests); laboratory testing (including facility and professional fee if any); injections at the amount shown in the Schedule of Benefits per injection.

Prescriptions

Benefit amount shown in the Schedule of Benefits for prescriptions.

Well Care

Benefit amount shown in the Schedule of Benefits for Well Care. This benefit is subject to a Calendar Year Maximum of \$150 allowable per Calendar Year.

SECTION 4 - EXCLUSIONS AND LIMITATIONS

With respect to all of the benefits provided under the policy, no benefits will be payable as the result of:

- (a) any service, supplies or treatment that is not a Covered Service described in Section 3 hereof;
- (b) suicide or any attempt thereat, while sane or insane;
- (c) any intentionally self-inflicted Injury or Sickness;
- (d) rest care;
- (e) cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery resulting from an Injury if initial treatment of the Covered Person is begun within 12 months of the date of the Injury;
- (f) immunization shots and routine examinations such as: health exams; periodic check-ups; pre-marital exams; and routine physicals, except as otherwise covered under the policy;
- (g) routine newborn care, including routine nursery charges;
- (h) voluntary abortion, except with respect to You or Your covered Dependent spouse where such person's life would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion;
- (i) pregnancy of a Dependent child, unless required by law;
- (j) a Covered Person's participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
- (k) a Covered Person committing, attempting to commit, or taking part in a felony, or engaging in an illegal occupation;
- (l) a Covered Person's participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee-jumping, or hang gliding;
- (m) air travel, except:
 - (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
 - (2) as a passenger for transportation only and not as a pilot or crew member;
- (n) any Injury occurring directly or indirectly as a result of the voluntary use of intoxicants, narcotics or hallucinogens unless taken on the written advice of a Physician except for treatment of Alcohol and/or Substance Abuse Dependency as provided in the Schedule of Benefits;
- (o) sex changes;

- (p) any dental care, treatment or service to the teeth, gums or mouth;
- (q) experimental treatments or surgery;
- (r) the reversal of tubal ligation and vasectomies;
- (s) artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or Physician's services, unless required by law;
- (t) treatment of exogenous obesity or weight control;
- (u) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Injury sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered;
- (v) Injury or Sickness arising out of and in the course of any occupation for compensation, wage or profit. Expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made;
- (w) any service, supplies or treatment that is not Medically Necessary;
- (x) any facility charges for treatment at a Hospital in excess of the indemnity amount specified in the Schedule of Benefits;
- (y) pregnancy, childbirth or voluntary abortion, except for complications of pregnancy as defined;
- (z) Pre-Existing Conditions; and
- (aa) any service or treatment rendered outside the territorial limits of the United States of America.

SECTION 5 – TERMINATION OF INSURANCE

TERMINATION OF A COVERED PERSON'S INSURANCE: Your insurance will cease on the earliest of:

- (a) the date of lapse at the end of the Grace Period for non-payment of premium;
- (b) the later of the date a written request to terminate the policy is received by Us or the date specified in the written request;
- (c) the premium due date following the date the Covered Person attains the Limiting Age shown in the Schedule of Benefits; or
- (d) the date the policy terminates.

The insurance on a Dependent will cease on the earliest of:

- (a) the date Your coverage terminates;
- (b) the premium due date following the date the Covered Person attains the limiting age for Dependents;
- (c) the end of the last period for which premium payment has been made to Us, subject to the Grace Period;
- (d) the premium due date following the date the Dependent no longer meets the definition of Dependent, as defined in the policy;
- (e) the date the policy is modified so as to exclude Dependent coverage; or
- (f) the date the policy terminates.

We shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the policy.

If We accept a premium for coverage for a Covered Person after the date on which the policy provides that a Covered Person will cease to be covered, the coverage for that Covered Person will continue in force until the end of the period for which such premium has been accepted.

EXTENSION OF BENEFITS: Whenever termination of coverage under this section occurs because of termination of Your eligibility, such termination shall be without prejudice to:

- (a) any Hospital Confinement which commenced while the policy was in force, with respect to In-Hospital Indemnity Benefits; or
- (b) any covered treatment or service for which benefits would be provided under the Hospital Indemnity Benefits of the policy and which commenced while the policy was in force; provided; however, that the Covered Person is and continues to be Hospital Confined or Totally Disabled. Such Extension of Benefits shall continue for up to 90 days.

SECTION 6 – PREMIUMS

All premiums are payable on or before the date they are due. The premiums are shown in the policy Schedule of Benefits.

PREMIUM RATE CHANGE: After the first 12 months of coverage, We have the right to change premium rates as of any Premium Due Date. We will notify You in writing at least 45 days prior to the change in rates. The rates may change prior to this time however, for reasons that affect the insured risk, which include:

- (a) a change in benefits; or
- (b) a new law or a change in any existing law is enacted which applies to the policy.

The premiums for this coverage are based upon the attained age of each Covered Person. They are scheduled to change based upon the Covered Person's attained age at a predetermined interval. Attained age means the age of the Covered Person on the policy Effective Date of coverage and any subsequent policy anniversary.

GRACE PERIOD: If Your premium is not paid on or before its Premium Due Date, it can still be paid during the 31-day grace period that starts on the Premium Due Date. During the grace period the insurance will stay in force and claims will be continued payable. No Grace Period is provided when, prior to the end of the grace period, the policyholder has given Us written notice of its intent to terminate the policy.

REINSTATEMENT: If the premium is not paid before the Grace Period ends, this policy will lapse. Later acceptance of premium by Us (or by agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy. If We or Our agent require an application you will be given a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously notified you, in writing, of our disapproval.

The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than 10 days 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.

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid may be deducted therefrom.

UNEARNED PREMIUM: If coverage of this policy terminates because of the Insured's death, the unearned premiums paid for any period beyond the end of the policy month, if any, in which the death occurred will be returned to the beneficiary of the Insured's estate. The unearned premiums, if any, will be paid in a lump sum on a date no later than 30 days after proof of the Insured's death has been furnished to Us.

SECTION 7 – POLICY PROVISIONS

ENTIRE CONTRACT: CHANGES: This policy, including the application and any attachments, constitute the entire contract. No change under the contract shall be valid unless approved in writing by one of our executive officers and unless such approval has been forwarded to you for attachment to the policy. All statements by the Insured in the application shall, in the absence of fraud, be deemed representations and not warranties. No agent has authority to change the terms under the contract or to waive any of the provisions.

TIME LIMIT ON CERTAIN DEFENSES: If You made a written material misstatement on the written application or written evidence of insurability form signed by the Insured, We may not use it to void insurance under this policy or to deny a claim for loss incurred after 2 years from the Covered Person's effective date. However, if the misstatement was fraudulent, there is no time limit. If You request an increase in benefits, a new 2 year time limit period will apply to the increase in benefits only.

NOTICE OF CLAIM: Written notice of claim must be given to Us at Our home office or to Our authorized Agent. Such notice should be made within 30 days after any loss covered by the policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay. Notice given by or on behalf of the claimant to Us or to any authorized Agent with information sufficient to identify the Covered Person shall be deemed notice to Us.

CLAIM FORMS: We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

CLAIMS: Claims must be submitted to Us within 91 days from date of loss. Within 15 days of Our receipt of notice of claim, We will:

1. acknowledge receipt of the claim;
2. commence any investigation of the claim; and
3. request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant. Additional requests may be made if during the investigation of the claim such additional requests are necessary.

If the acknowledgement of the claim is not made in writing, We shall make a record of the date, means and content of the acknowledgement.

We shall notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date We receive all items, statements, and forms required by Us, in order to secure final proof of loss. If We reject the claim, We will provide you with the reasons for rejection. If We cannot accept or reject the claim within the 15 day period, We shall notify the claimant within the 15 day period and give the reasons that We require the additional time. We must accept the claim within 45 days of such notice of delay.

PROOFS OF LOSS: Written proof of loss must be furnished to Us at Our said office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid within 30 days after the date on which We receive due written proof of such loss. If We pay the claim after the end of that time period, We will also pay interest on the amount payable at the rate of interest and period of time required by applicable State law, unless We were unable to pay the claim on time because of cause beyond Our control.

PAYMENT OF BENEFITS: All benefits payable by Us will be paid to You, unless assigned by You or other Covered Person to the provider(s) of the services for which such benefits are payable. Any accrued benefits unpaid on Your date of death will be paid to Your estate, unless assigned by You or other Covered Person to the provider(s) of the services for which such benefits are payable. If benefits are payable to Your estate or to a beneficiary who cannot execute a valid release, We may pay benefits up to \$1,000 to You or whom We at our exclusive discretion deem to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

ASSIGNMENT, CHANGE OF BENEFICIARY: Benefits payable under the policy may be assigned to the provider(s) of the services for which such benefits are payable. The assignment will not be effective until We receive the written notice. We assume no responsibility for the validity of any assignment.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have a Covered Person examined by a Physician of Our choice as often as reasonably necessary while a claim is pending. We will pay for such examination. In case of death, We may request an autopsy where it is not forbidden by law. These will be done at Our expense.

DISPUTE AND APPEAL PROCEDURE: We will provide You with a written explanation of any denial by Us of benefits regarding You or Your Dependents. You, or Your duly authorized representative, may dispute and appeal the denial by sending Us a letter within 60 days after the date of such denial by Us. The letter must state the reason for the appeal and any additional information that might support the appeal. To assist Us in identifying and processing the appeal, You should include a photocopy of Our original denial letter or Explanation of Benefits form.

We will notify You, or Your duly authorized representative, by mail of Our final decision and the specific reason for Our decision within 30 days after We receive the written appeal. This time period may be extended for an additional 30 days if We are unable to complete Our review of the appeal within the 30-day time period. In that event, We will notify You, or Your duly authorized representative, in writing of Our reasons for extending the time period.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

MISSTATEMENT OF AGE: If the age of any Covered Person is incorrectly stated, the amount of benefits payable will be the amount shown on the Schedule of Benefits. The premium will be adjusted so that We will be paid any amount due based on such Covered Person's true age.

CONFORMITY WITH STATE STATUTES: Any provision of the policy which is in conflict with the statutes of the state in which you reside is hereby amended to conform to the minimum requirements of such statutes.



**HOSPITAL INDEMNITY INSURANCE
OUTLINE OF COVERAGE
FORM H-0184**

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

Hospital confinement indemnity coverage is designed to provide you with a fixed daily benefit during periods of hospital confinement resulting from a covered injury or sickness. Coverage is provided for the benefits outlined in the table below, subject to the limitations and exclusions described below.

Calendar Year Policy Deductible (per covered person with a maximum of 3 deductibles per policy)(Additional Outpatient Benefits Calendar Year Deductible does not apply to satisfaction of Calendar Year Policy Deductible)	\$1,000 / \$2,500 / \$5,000
Lifetime Maximum (per policy)	\$5,000,000

Maximum Covered Benefits per Covered Person per Calendar Year	\$100,000	\$250,000	\$1,000,000
Daily Indemnity Benefits as described below are limited to the Maximum Number of Days Per Covered Person Per Calendar Year indicated (for all benefits combined)	30	60	180

HOSPITAL INDEMNITY BENEFITS	UNITS		
	1	2	3
Facility Fees			
Daily Indemnity Benefit during Confinement in a Hospital (including Observation Unit stay for 24 hours or more) as a result of a covered Injury or Sickness	\$1,500	\$3,000	\$4,500
Daily Indemnity Benefit during Confinement in a Hospital for Mental Illness, Alcohol and/or Substance Abuse Dependency	\$750	\$1,500	\$2,250
Daily Indemnity Benefit during Confinement in a Hospital's Intensive Care Unit (ICU) up to 20 days per Calendar Year	\$2,250	\$4,500	\$6,750
Daily Indemnity Benefit during Confinement in a Rehabilitation Facility or a Skilled Nursing Facility	\$750	\$1,500	\$2,250
Daily Indemnity Benefit for Outpatient Hospital or ambulatory surgical center services when surgery is performed	\$1,500	\$3,000	\$4,500
Daily Indemnity Benefit for Outpatient Radiation Therapy or Chemotherapy	\$750	\$1,500	\$2,250

	Units		
	1	2	3
Professional Services			
Other Inpatient Benefits: Physician Hospital Visit per visit	\$50	\$100	\$150
Surgical Indemnity Benefit for covered services when performed in a Hospital or in an ambulatory surgical center (RBRVS is the allowable charges schedule used by Medicare)	1X, 2X or 3X of current RBRVS per procedure for your provider location		
Inpatient Pathologist/Radiologist Benefits for covered services (RBRVS is the allowable charges schedule used by Medicare)	1X, 2X or 3X of current RBRVS per procedure for your provider location		
Anesthesia Indemnity Benefit for covered services	25% of surgical benefits payable		
Emergency Ambulance Indemnity Benefit	\$250 per trip		

Hospital, Rehabilitation Facility & Skilled Nursing Facility Benefits for covered persons confined in such medical facilities for 24 or more consecutive hours are as shown in the above schedule.

ADDITIONAL OUTPATIENT BENEFITS (these benefits are payable for services performed on an outpatient basis only)

Calendar Year Deductible (per covered person)(Calendar Year Policy Deductible does not apply towards satisfaction of Calendar Year Deductible)	\$500 per insured		
Aggregate Calendar Year Maximum (per covered person)	\$2,000		
	Units		
	1	2	3
Outpatient Office Visit (fees per visit for office, outpatient clinic or emergency room)	\$25	\$50	\$75
Other Outpatient Services (per test)			
MRI, CAT Scan or Nuclear testing	\$175	\$350	\$525
Other diagnostic testing or X-rays	\$40	\$80	\$120
Laboratory testing	\$10	\$20	\$30
Injections	\$5	\$10	\$15
Generic Prescription (per prescription filled)	\$5	\$10	\$15
Brand Name Prescription (per prescription filled)	\$10	\$20	\$30
Well Care Maximum:	\$50 per visit up to \$150 per calendar year		

OPTIONAL BENEFITS

Optional Critical Illness Benefit Rider (CRT.IL.RD)	Pays up to the maximum critical illness benefit for covered illnesses.
Optional Term Life Insurance Rider (TRM.LF.RD)	Decreasing Term Life Insurance that covers the entire family.

GUARANTEED RENEWABLE TO AGE 65. THE COMPANY RESERVES THE RIGHT TO CHANGE PREMIUM RATES ON A CLASS BASIS.

You have the right to renew the policy until the first premium due date on or after your 65th birthday.

We reserve the right, subject to 45 days prior written notice to You at Your last known address, to establish a new schedule of premium rates; such schedule of rates will be effective on the following premium due date for all or any class of insured's covered by the policy. Premiums may also change due to attained age. Please read the Premium Rate Change provision carefully that is contained in the policy.

EXCLUSIONS AND LIMITATIONS

With respect to all of the benefits provided under the policy, no benefits will be payable as the result of: any service, supplies or treatment that is not a covered service described in the policy; suicide or any attempt thereat, while sane or insane; any intentionally self-inflicted injury or sickness; rest care; cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery resulting from an injury if initial treatment of the covered person is begun within 12 months of the date of the injury; immunization shots and routine examinations such as: health exams; periodic check-ups; pre-marital exams; and routine physicals, except as otherwise covered under the policy; routine newborn care, including routine nursery charges; voluntary abortion, except with respect to the insured or covered dependent spouse where such person's life would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion; pregnancy of a dependent child, unless required by law; a covered person's participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority; a covered person committing, attempting to commit, or taking part in a felony, or engaging in an illegal occupation; a covered person's participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee-jumping, or hang gliding; air travel, except: (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or (2) as a passenger for transportation only and not as a pilot or crew member; any injury occurring directly or indirectly as a result of the voluntary use of intoxicants, narcotics or hallucinogens unless taken on the written advice of a physician except for treatment of alcohol and/or substance abuse dependency as provided in the policy Schedule of Benefits; sex changes; any dental care, treatment or service to the teeth, gums or mouth; experimental treatments or surgery; the reversal of tubal ligation and vasectomies; artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or physician's services, unless required by law; treatment of exogenous obesity or weight control; an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes injury sustained or sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the covered person is not covered; injury or sickness arising out of and in the course of any occupation for compensation, wage or profit. Expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made; any service, supplies or treatment that is not medically necessary; any facility charges for treatment at a hospital in excess of the indemnity amount specified in the policy Schedule of Benefits; pregnancy, childbirth or voluntary abortion, except for complications of pregnancy as defined in the policy; Pre-Existing Conditions; and any service or treatment rendered outside the territorial limits of the United States of America.

Pre-Existing Condition means a condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a covered person's effective date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under the policy for 12 consecutive months.

TERMINATION OF A COVERED PERSON'S INSURANCE

An insured persons insurance will cease on the earliest of: (a) the date of lapse at the end of the grace period for non-payment of premium; (b) the later of the date a written request to terminate the policy is received by the company or the date specified in the written request; (c) the premium due date following the date the covered person attains the limiting age; or (d) the date the policy terminates.

The insurance on a dependent will cease on the earliest of: (a) the date the Insured's coverage terminates; (b) the premium due date following the date the dependent attains the limiting age for dependents; (c) the end of the last period for which premium payment has been made to the company, subject to the grace period; (d) the first day of the month following the date the dependent no longer meets the definition of dependent, as defined in the policy; (e) the date the policy is modified so as to exclude dependent coverage; or (f) the date the policy terminates.

The company shall have the right to terminate the coverage of any covered person who submits a fraudulent claim under the policy.

If the company accepts a premium for coverage for a covered person after the date on which the policy provides that a covered person will cease to be covered, the coverage for that covered person will continue in force until the end of the period for which such premium has been accepted.

TEN DAY FREE LOOK

You have 10 days after receiving the policy, and if you are not satisfied for any reason, you may return it to the company for a full refund of all premiums paid. Mail the policy with your written request for cancellation to us at our Home Office. We will promptly refund the premium paid and the insurance will be void.

Received \$ _____ for ____ month's premium with application for:
If for any reason policy is not issued, payment is to be refunded. Insurance is not effective until policy applied for has been issued. If you do not receive the policy in 30 days, please call or write the company.
Authorized Representative _____ Date _____

Important Notice: This Outline of Coverage provides general information about the policy. It is not a contract. Only the actual policy provisions issued by the company will control.





**PHILADELPHIA
AMERICAN**
LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

APPLICATION

HOSPITAL INDEMNITY INSURANCE (Form H-0180 / H-0184)
ACCIDENT EXPENSE INSURANCE (Form H-0089)

REQUESTED EFFECTIVE DATE: _____

ELECTRONIC APPLICATION YES NO

PAYMENT MODE: Monthly Quarterly
 Semi-Annual Annual

PAYMENT TYPE: Monthly Bank Draft Direct Bill
 List Bill

HOSPITAL INDEMNITY POLICY		
Calendar Year Maximum Benefit	<input type="radio"/> \$100,000	<input type="radio"/> \$250,000 <input type="radio"/> \$1,000,000
Number of Units Per Policy	<input type="radio"/> 1 Unit	<input type="radio"/> 2 Units <input type="radio"/> 3 Units
Calendar Year Deductible	<input type="radio"/> \$1,000	<input type="radio"/> \$2,500 <input type="radio"/> \$5,000
Tobacco User-Applicant:	<input type="radio"/> Yes <input type="radio"/> No	Tobacco User-Spouse: <input type="radio"/> Yes <input type="radio"/> No
Hospital Indemnity Optional Benefits:		
Term Life Rider:	<input type="radio"/> Yes <input type="radio"/> No	If Yes, Plan Type: <input type="radio"/> Insured Only <input type="radio"/> Insured & Children <input type="radio"/> Family
Critical Illness Rider:	<input type="radio"/> Yes <input type="radio"/> No	
If Yes, Plan Type: <input type="radio"/> Insured Only <input type="radio"/> Insured Spouse <input type="radio"/> Dependent Children - how many? ____		
Benefit Amount: Insured Only _____ Insured Spouse _____ Dependent Children _____		
ACCIDENT EXPENSE POLICY		
Benefit Amount	<input type="radio"/> 1 Unit	<input type="radio"/> 2 Units
Plan Type:	<input type="radio"/> Individual <input type="radio"/> Individual & Spouse <input type="radio"/> Single Parent <input type="radio"/> Family <input type="radio"/> Child Only (per Child)	
Accident Expense Optional Benefits:		
Disability Income Benefit Rider:	<input type="radio"/> Occ. Type 1 <input type="radio"/> Occ. Type 2	
Number of Units	<input type="radio"/> 1 Unit	<input type="radio"/> 2 Units
Benefit Period	<input type="radio"/> 12 Months <input type="radio"/> 24 Months	

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HEIGHT	WEIGHT	PREMIUM
1.										
2.			SPOUSE							
3.			DEP. 1							
4.			DEP. 2							
5.			DEP. 3							
6.			DEP. 4							
7.			DEP. 5							
8.			DEP. 6							

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (If different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:		
APPLICANT: _____		
SPOUSE: _____		
HOSPITAL INDEMNITY INSURANCE PREMIUM		\$ _____
TERM LIFE RIDER PREMIUM		\$ _____
CRITICAL ILLNESS RIDER PREMIUM		\$ _____
ACCIDENT EXPENSE INSURANCE PREMIUM.....		\$ _____
ACCIDENT DISABILITY RIDER PREMIUM		\$ _____
APPLICATION FEE (non-refundable)		\$ _____
TOTAL PAYMENT DUE		\$ _____

HOSPITAL INDEMNITY INSURANCE STATEMENT OF ELIGIBILITY AND OTHER INSURANCE

	APPLICANT YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO	CHILD 4 YES/NO	CHILD 5 YES/NO	CHILD 6 YES/NO
IF THE ANSWER TO QUESTION 1-7 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.								
1. Within the past 10 years, has any Applicant been diagnosed with or received treatment, tested positive or taken medication for any of the following conditions? Liver cirrhosis, Hepatitis B or C, insulin-diabetes including neuropathy, ulcerative colitis or Crohn's, Down's syndrome, mental retardation, Autism, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Alzheimer's, Parkinson's, Dementia, cystic fibrosis, heart attack, coronary bypass, cerebral palsy, sickle cell or aplastic anemia, leukemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure, or been hospitalized more than 3 times in the past year?	<input type="radio"/> <input type="radio"/>							
2. In the past 10 years, has any Applicant tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="radio"/> <input type="radio"/>							
3. Is any household member-whether applying for coverage or not currently pregnant or have a pending adoption?	<input type="radio"/> <input type="radio"/>							
4. Within the past 5 years has any applicant been diagnosed with, taken medication or been treated for internal cancer, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	<input type="radio"/> <input type="radio"/>							
5. Within the past 4 years has any applicant been diagnosed with or received any medical treatment, taken medication for or been advised to have medical test for alcohol or drug abuse?	<input type="radio"/> <input type="radio"/>							
6. In the past 6 months, has any family member been confined to a nursing facility (except for short term rehabilitation), bedridden, or been told they are disabled?	<input type="radio"/> <input type="radio"/>							
7. Does any proposed insured intend to reside outside the U.S?	<input type="radio"/> <input type="radio"/>							
<u>THE FOLLOWING QUESTIONS APPLY TO THOSE FAMILY MEMBERS THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.</u>								
8. Has anyone to be insured used any form of tobacco (including cigars, pipe or chewing tobacco) within the past 24 months?	<input type="radio"/> <input type="radio"/>							

9. In the last 12 months has any proposed insured been treated, tested or taken medication for any of the following conditions and has seen a physician more than twice for any of these conditions? Please add one (1) point for each condition and underline the condition(s).

- a. kidney stones, kidney/bladder or urinary infections, hepatitis A,
- b. asthma or bronchitis, sleep apnea, unoperated hernia, pituitary, thyroid, stomach, disc or back,
- c. (TMJ) temporomandibular joint, carpal tunnel syndrome, pelvic inflammatory disease,
- d. depression, obsessive-compulsive disorder, psychosis, schizophrenia,
- e. migraines, endometriosis, uterine fibroids or uterine cyst.

10. If any proposed insured had a cesarean section, more than one miscarriage or seen a physician for infertility treatment and has not had a tubal-ligation or hysterectomy and is still of childbearing age, add two (2) points.

11. In the last 12 months has any proposed insured been treated, tested or taken medication for any of the following conditions? Please add two (2) points for each condition(s) and underline the condition(s).

- a. Emphysema and not smoking, non-insulin Diabetes, glaucoma,
- b. Osteoarthritis, bariatric surgery (weight loss)-bypass, stapling, or lap band
- c. cataracts or glaucoma, macular degeneration,
- d. cardiac ablation, epilepsy-seizures, hip or knee replacement,
- e. mitral valve prolapse, tachycardia-bradycardia or arrhythmia.

12. In the last 12 months, other than conditions mentioned above, has any applicant had any medical or surgical advice including treatment, prescriptions, operations or been advised to have medical test (excluding HIV and AIDS) or surgery that has not yet been performed, or is awaiting medical test (excluding HIV and AIDS)?

13. Is there any other condition that will require a rate up? Please put the appropriate amount of point(s) in the box and provide details in the next section.

Add total points including height and weight.

	APPLICANT	SPOUSE	CHILD 1	CHILD 2	CHILD 3	CHILD 4	CHILD 5	CHILD 6
a. kidney stones, kidney/bladder or urinary infections, hepatitis A,	<input type="checkbox"/>							
b. asthma or bronchitis, sleep apnea, unoperated hernia, pituitary, thyroid, stomach, disc or back,	<input type="checkbox"/>							
c. (TMJ) temporomandibular joint, carpal tunnel syndrome, pelvic inflammatory disease,	<input type="checkbox"/>							
d. depression, obsessive-compulsive disorder, psychosis, schizophrenia,	<input type="checkbox"/>							
e. migraines, endometriosis, uterine fibroids or uterine cyst.	<input type="checkbox"/>							
10. If any proposed insured had a cesarean section, more than one miscarriage or seen a physician for infertility treatment and has not had a tubal-ligation or hysterectomy and is still of childbearing age, add two (2) points.	<input type="checkbox"/>							
11. In the last 12 months has any proposed insured been treated, tested or taken medication for any of the following conditions? <u>Please add two (2) points for each condition(s) and underline the condition(s).</u>								
a. Emphysema and not smoking, non-insulin Diabetes, glaucoma,	<input type="checkbox"/>							
b. Osteoarthritis, bariatric surgery (weight loss)-bypass, stapling, or lap band	<input type="checkbox"/>							
c. cataracts or glaucoma, macular degeneration,	<input type="checkbox"/>							
d. cardiac ablation, epilepsy-seizures, hip or knee replacement,	<input type="checkbox"/>							
e. mitral valve prolapse, tachycardia-bradycardia or arrhythmia.	<input type="checkbox"/>							
12. In the last 12 months, other than conditions mentioned above, has any applicant had any medical or surgical advice including treatment, prescriptions, operations or been advised to have medical test (excluding HIV and AIDS) or surgery that has not yet been performed, or is awaiting medical test (excluding HIV and AIDS)?	<input type="checkbox"/>							
13. Is there any other condition that will require a rate up? <u>Please put the appropriate amount of point(s) in the box and provide details in the next section.</u>	<input type="checkbox"/>							
<u>Add total points including height and weight.</u>	<input type="checkbox"/>							

IF ANY ANSWER TO ANY PART OF QUESTION 9, 10, 11, 12 or 13 IS "YES" FOR ANY APPLICANT, PROVIDE DETAILS BELOW

Applicant #	Nature of illness or Accident Include Diagnosis, Operations and Medications	Date Started	Date Ended	Surgery Y/N	Hospitalized From / To	Physician's Name, Address and Provide Number

APPLICANT #1'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP

ACCIDENT EXPENSE INSURANCE STATEMENT OF ELIGIBILITY AND OTHER INSURANCE

	APPLICANT YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO	CHILD 4 YES/NO	CHILD 5 YES/NO	CHILD 6 YES/NO
IF THE ANSWER TO QUESTION 1-7 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.								
1. In the past 12 months, has any person to be insured engaged in any hazardous sports or activities including racing, parachuting, rodeo riding, motorcycling, mountain climbing or scuba diving?	<input type="radio"/> <input type="radio"/>							
2. Is any person to be insured currently under treatment or has any person to be insured been under treatment for excessive drug or alcohol abuse in the past 3 years?	<input type="radio"/> <input type="radio"/>							
3. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of Insurance:	<input type="radio"/> <input type="radio"/>							
4. Is there any other health, accident or disability insurance in force on the proposed insured? If YES, give name of Company and type of insurance:	<input type="radio"/> <input type="radio"/>							

BENEFICIARY

Primary: _____

Relationship: _____

Secondary: _____

Relationship: _____

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

_____ X _____
Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____
Name Name of Employer
to deduct from my salary and pay to Philadelphia American Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____, \$ _____ each month.

_____ Date _____ Signature of Employee

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Philadelphia American Life Insurance Company, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

- 1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
- 2. If after due consideration, you still wish to terminate your present insurance 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 or correct information regarding the tobacco use of any applicant may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
- 3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
- 4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Philadelphia American Life Insurance Company.

APPLICANT'S STATEMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I understand the if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income. I acknowledge receipt of the Outline of Coverage and Disclosure Notice and have read the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance if this is a replacement.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and which may subject such person to criminal and/or civil penalties.

Dated at _____ on _____ 20_____.
City, State & Zip Month & Day

Signature of Applicant: _____ Signature of Spouse: _____

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: YES NO

2. Did you personally meet with each Applicant? (If No, explain) YES NO

3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members. YES NO

4. I have left or made available an Outline of Coverage and a Disclosure Notice. YES NO

5. Was the application solicited by: PAPER ELECTRONIC

6. Mail Policy to: AGENT INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT *	AGENT NUMBER	MONTH	DAY	YEAR
SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %		
1.				
2.				
3.				

Agent Notes



APPLICATION SUPPLEMENT

 APPLICANT NAME (PRINT)

 APPLICANT SIGNATURE

 DATE

 AGENT NAME (PRINT)

 AGENT SIGNATURE

 DATE

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HEIGHT	WEIGHT	PREMIUM
9.			DEP. 7							
10.			DEP. 8							
11.			DEP. 9							
12.			DEP. 10							
13.			DEP. 11							
14.			DEP. 12							

HOSPITAL INDEMNITY INSURANCE STATEMENT OF ELIGIBILITY

IF THE ANSWER TO QUESTION 1-7 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.	CHILD 7 YES/NO	CHILD 8 YES/NO	CHILD 9 YES/NO	CHILD 10 YES/NO	CHILD 11 YES/NO	CHILD 12 YES/NO
1. Within the past 10 years, has any Applicant been diagnosed with or received treatment, tested positive or taken medication for any of the following conditions? Liver cirrhosis, Hepatitis B or C, insulin-diabetes including neuropathy, ulcerative colitis or Crohn's, Down's syndrome, mental retardation, Autism, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Alzheimer's, Parkinson's, Dementia, cystic fibrosis, heart attack, coronary bypass, cerebral palsy, sickle cell or aplastic anemia, leukemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure, or been hospitalized more than 3 times in the past year?	<input type="radio"/> <input type="radio"/>					
2. In the past 10 years, has any Applicant tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="radio"/> <input type="radio"/>					
3. Is any household member-whether applying for coverage or not currently pregnant or have a pending adoption?	<input type="radio"/> <input type="radio"/>					
4. Within the past 5 years has any applicant been diagnosed with, taken medication or been treated for internal cancer, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	<input type="radio"/> <input type="radio"/>					
5. Within the past 4 years has any applicant been diagnosed with or received any medical treatment, taken medication for or been advised to have medical test for alcohol or drug abuse?	<input type="radio"/> <input type="radio"/>					
6. In the past 6 months, has any family member been confined to a nursing facility (except for short term rehabilitation), bedridden, or been told they are disabled?	<input type="radio"/> <input type="radio"/>					
7. Does any proposed insured intend to reside outside the U.S.?	<input type="radio"/> <input type="radio"/>					

THE FOLLOWING QUESTIONS APPLY TO THOSE FAMILY MEMBERS THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.

8. Has anyone to be insured used any form of tobacco (including cigars, pipe or chewing tobacco) within the past 24 months?

9. In the last 12 months has any proposed insured been treated, tested or taken medication for any of the following conditions and **has seen a physician more than twice for any of these conditions? Please add one (1) point for each condition and underline the condition(s).**

a. kidney stones, kidney/bladder or urinary infections, hepatitis A,

b. asthma or bronchitis, sleep apnea, unoperated hernia, pituitary, thyroid, stomach, disc or back,

c.(TMJ) temporomandibular joint, carpal tunnel syndrome, pelvic inflammatory disease,

d. depression, obsessive-compulsive disorder, psychosis, schizophrenia,

e. migraines, endometriosis, uterine fibroids or uterine cyst.

10. If any proposed insured had a cesarean section, more than one miscarriage or seen a physician for infertility treatment and has not had a tubal-ligation or hysterectomy and is still of childbearing age, add two (2) points.

11. In the last 12 months has any proposed insured been treated, tested or taken medication for any of the following conditions? **Please add two (2) points for each condition(s) and underline the condition(s).**

a. Emphysema and not smoking, non-insulin Diabetes, glaucoma,

b. Osteoarthritis, bariatric surgery (weight loss)-bypass, stapling, or lap band

c. cataracts or glaucoma, macular degeneration,

d. cardiac ablation, epilepsy-seizures, hip or knee replacement,

e. mitral valve prolapse, tachycardia-bradycardia or arrhythmia.

12. In the last 12 months, other than conditions mentioned above, has any applicant had any medical or surgical advice or treatment including prescriptions or operations or been advised to have medical test (excluding HIV and AIDS) or surgery that has not yet been performed, or is awaiting medical test (excluding HIV and AIDS)?

13. Is there any other condition that will require a rate up? **Please put the appropriate amount of point(s) in the box and provide details in the next section.**

Add total points including height and weight.

IF ANY ANSWER TO ANY PART OF QUESTION 9, 10, 11, 12 or 13 IS "YES" FOR ANY APPLICANT, PROVIDE DETAILS BELOW

Applicant #	Nature of illness or Accident Include Diagnosis, Operations and Medications	Date Started	Date Ended	Surgery Y/N	Hospitalized From / To	Physician's Name, Address and Provide Number

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS. (Attach extra page if more space is needed)

CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP

ACCIDENT EXPENSE INSURANCE STATEMENT OF ELIGIBILITY

	CHILD 7 YES/NO	CHILD 8 YES/NO	CHILD 9 YES/NO	CHILD 10 YES/NO	CHILD 11 YES/NO	CHILD 12 YES/NO
IF THE ANSWER TO QUESTION 1-7 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.						
1. In the past 12 months, has any person to be insured engaged in any hazardous sports or activities including racing, parachuting, rodeo riding, motorcycling, mountain climbing or scuba diving?	<input type="radio"/> <input type="radio"/>					
2. Is any person to be insured currently under treatment or has any person to be insured been under treatment for excessive drug or alcohol abuse in the past 3 years?	<input type="radio"/> <input type="radio"/>					
3. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of Insurance: _____	<input type="radio"/> <input type="radio"/>					
4. Is there any other health, accident or disability insurance in force on the proposed insured? If YES, give name of Company and type of insurance: _____	<input type="radio"/> <input type="radio"/>					



DISCLOSURE NOTICE

HOSPITAL INDEMNITY INSURANCE POLICY

By my signature affixed hereto, I verify that I have been provided an Outline of Coverage describing the Policy for which I have applied on this date. I verify that the agent representing Philadelphia American Life Insurance Company discussed, in detail, the coverage as explained in the Outline of Coverage. In addition, the agent explained and I understand the following provisions:

1. The coverage for which I have applied will become effective only when the application is approved by the Home Office and only on the Effective Date assigned by the Company.
2. If I am approved and my Policy is issued, my coverage will begin immediately on the assigned Effective Date.
3. No benefits will be payable for any sickness or injury due to a Pre-Existing Condition. Pre-existing Condition means a condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a Covered Person's Effective Date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under this policy for 12 consecutive months.
4. I understand that a claim for benefits may not be payable under the new Policy due to the above-mentioned Pre-existing Condition waiting period; whereas, the same claim might have been payable under my present coverage, if any, had it remained in force.
5. I understand that until the coverage has been approved and issued, Philadelphia American Life Insurance Company has absolutely no liability to me other than to refund my initial premium if my Application is not approved. Any injury or sickness which may develop between now (today) and the date my coverage is effective will be a Pre-existing Condition, and depending on extent and severity, such injury or sickness may render me (or a dependent) ineligible for coverage.
6. I have read or have been read to me and answered the questions on my Application on behalf of myself and my dependents. I also understand that disclosure of health information is important and any omission may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed. My Policy, if issued, will contain a photocopy of this document along with the Application for Coverage.

DATE: _____

APPLICANT'S SIGNATURE: _____

DATE: _____

AGENT'S SIGNATURE: _____

ADDITIONAL DEFINITIONS

Carcinoma In-Situ - Diagnosis of Cancer wherein the tumor cells lie within the tissue of the site of origin without having invaded the neighboring tissue.

Critical Illness Covered Condition - One of the medical conditions or diseases listed in paragraphs A. through H. below.

A. Cancer (Internal Cancer)

A disease that is identified by the uncontrolled and abnormal growth of malignant cells. This includes Hodgkin's Disease, leukemia, lymphoma, carcinoma, sarcoma, and malignant tumors. For purposes of this rider, the following are not considered Cancer (Internal Cancer):

1. pre-malignant conditions or conditions with malignant potential;
2. cervical intraepithelial neoplasia (CIN) stages I and II;
3. Carcinoma in Situ; and
4. Skin Cancer.

B. Non-Invasive Carcinoma In-Situ

A localized malignant tumor, which contains one or several cells that have the potential to invade or metastasize but have not yet done so. This excludes skin cancer.

C. Heart Attack

The death (infarction) of a portion of the heart muscle as a result of inadequate blood supply. The following are not considered as a Heart Attack: an EKG change consistent with transient ischemic change, angina, or chance finding of EKG changes suggestive of a previous Heart Attack, or death of the heart muscle coincident with death of a Covered Person from other causes. Diagnosis of a Heart Attack must be based on all of the following criteria:

1. associated new EKG changes consistent with injury;
2. elevation of cardiac enzymes above generally accepted laboratory levels of normal (a diagnostic elevation of Troponin.i or in the case of CPK, a CPK-MB measurement must be used); and
3. confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

In the event of death, an autopsy confirmation and death certificate identifying Heart Attack as the cause of death will be accepted.

D. Stroke

A cerebrovascular event resulting in permanent neurological damage, including infarction of, hemorrhage of, or embolization to brain tissue from an extracranial source. Stroke does not mean a cerebrovascular event resulting from a head injury, transient ischemic attack or chronic cerebrovascular insufficiency. Diagnosis of a Stroke must be based on the following criteria:

1. documented neurological impairment or deficits; and
2. confirming neuroimaging studies.

E. Coronary Artery Bypass Surgery (surgical treatment)

The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a Legally Qualified Physician who is a board certified cardiothoracic surgeon.

F. Angioplasty

The actual undergoing of angioplasty, arthrectomy or laser treatment for coronary artery disease, which cannot be adequately controlled by medical therapy, following a recommendation by a cardiologist. Angiographic evidence of the underlying disease must be provided.

G. End Stage Renal Failure

End Stage Renal disease which:

1. results in chronic irreversible failure of both kidneys to function; and
2. requires a Covered Person to undergo regular renal dialysis at least weekly.

H. Major Organ Transplant (of heart, lung, liver, pancreas, kidney)

Clinical evidence of failure of these organs, which requires the malfunctioning organ(s) of a Covered Person to be replaced with the organ(s) from a suitable donor under generally accepted medical procedures. Date of Diagnosis of a transplant means the date the transplant surgery is performed on a Covered Person.

Date of Diagnosis - means the date the clinical or pathological Diagnosis is made. The Date of Diagnosis is established by a Legally Qualified Physician as supported by the Covered Person's medical records.

Diagnosis or Diagnosed - means a written diagnosis by a Legally Qualified Physician of the Insured's Critical Illness Covered Condition.

First Diagnosis – The first time a Physician diagnoses a Covered Person as having a Critical Illness Covered Condition, which is first manifested after the Waiting Period and while this rider, is in force.

Immediate Family - means the Spouse, father, mother, sons, daughters, brothers or sisters of any Covered Person.

Legally Qualified Physician - A practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat sickness or injuries. Such person must not be the Covered Person, a Covered Person's Immediate Family member or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required by this rider. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Legally Qualified Physicians.

Skin Cancer - Any of the following:

1. basal cell carcinoma and squamous cell carcinoma of the skin;
2. Kaposi's Sarcoma; or
3. melanoma that is Diagnosed as Clark's Level I or II or Breslow less than .75mm.

RIDER PROVISIONS

Termination of Rider: This rider will terminate without notice when the first of these occurs:

1. The attached policy is surrendered, or lapsed or expires.
2. You do not pay the premium for the attached policy or for this rider when due or within the grace period.
3. You ask Us in writing to cancel this rider and send the policy for endorsement. You must make the request within 31 days after a premium due date.

Effective Date: This rider is effective from the Effective Date of the attached policy unless stated otherwise above.

Philadelphia American Life Insurance Company


President & CEO



TERM LIFE INSURANCE RIDER

This rider amends and is made a part of the policy to which it is attached. It is subject to all provisions, conditions, exclusions, and limitations of the policy, which are not in conflict with those of this rider.

“Covered Person” as used in this rider means the Insured if “Insured Only” coverage option is elected. It means the Insured and Dependent Child(ren) if “Insured & Child(ren)” coverage option is elected. It means the Insured, Insured’s Spouse and/or Dependent Child(ren) if “Insured & Spouse Or Family” coverage option is elected. The coverage option is shown in the Schedule of Benefits.

Subject to all the terms and conditions of the policy, we will pay to the Beneficiary the amount of insurance in force on the Covered Person’s life upon receipt of due proof of the death of the Covered Person on a form acceptable to us. The amount provided will be the applicable amount shown below. The amount shown below is for one unit of coverage. The number of covered units is shown in the Schedule of Benefits. The amount of insurance decreases with the increase in age for the Covered Person except for the Insured Child(ren).

RIDER SCHEDULE

Covered Person [John Doe]	Policy Number [12345678]	Effective Date [00/00/0000]
-------------------------------------	------------------------------------	---------------------------------------

ONE UNIT DECREASING TERM TO AGE 65

<u>Attained Age</u>	<u>Insured</u>	<u>Spouse (If Applicable)</u>
18-29	\$50,000	\$10,000
30-34	\$40,000	\$10,000
35-39	\$30,000	\$10,000
40-44	\$20,000	\$10,000
45-49	\$15,000	\$7,500
50-54	\$10,000	\$5,000
55-59	\$7,500	\$3,750
60-64	\$5,000	\$2,500

(If Applicable)	
<u>Child’s Attained Age at Death</u>	<u>Benefit</u>
0 - 14 days	\$0
15 days – 5 months	\$500
6 months – 17 years	\$3,000

SUICIDE

If the Covered Person, whether sane or insane, dies by suicide within two years from the effective date of coverage, the Company’s liability will be limited to an amount equal to the premiums paid for the Covered Person’s life insurance coverage.

BENEFICIARY

The Insured will designate a beneficiary. The beneficiary may be changed by filing a written request on a form provided by us. No beneficiary change will be valid until it is recorded by us. Once recorded, the change will be effective on the date the written request was signed. However, if an Insured dies before the request has been recorded, the request will not be effective as to those proceeds paid before the request was recorded.

If a beneficiary dies before you, that beneficiary's interest in the proceeds ends with that beneficiary's death. Only those beneficiaries who survive the Insured will be eligible to share in the proceeds. If no beneficiary survives the Insured, the proceeds will be paid to the estate of the Insured.

If there is no sufficient evidence that the beneficiary and Insured have died other than simultaneously the proceeds of the plan shall be distributed as if the Insured had survived the beneficiary.

PAYMENT OF BENEFITS

Payment of all death benefits will normally be made in one lump sum. However, prior to the Insured's death, you may choose to have your death benefits paid in any way approved by us. If you do not make an election for payment other than a lump sum, the beneficiary may elect the benefits to be paid in any other way approved by us.

RESERVE BASIS

The reserve under this benefit shall be computed on the Commissioner's 2001 Standard Ordinary Smoker and Nonsmoker Mortality Tables and 4% interest per year.

RIDER PROVISIONS

Termination of Rider: This rider will terminate without notice when the first of these occurs:

1. The attached policy is surrendered, or lapsed or expires.
2. You do not pay the premium for the attached policy or for this rider when due or within the grace period.
3. You ask Us in writing to cancel this rider and send the policy for endorsement. You must make the request within 31 days after a premium due date.

Payment of Premiums: The Premium for this rider is included in the Schedule of Benefits. The consideration for this rider is the attached application, if any, and the first premium.

Effective Date: This rider is effective from the Effective Date of the attached policy unless stated otherwise above.

Philadelphia American Life Insurance Company



President & CEO

SERFF Tracking Number: NELL-126856553 State: Arkansas
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 47029
 Company Tracking Number: H-0184
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: H-0184
 Project Name/Number: H-0184/H-0184

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 10/25/2010	Rates	H-0184.AR, CRT.IL.RD, TRM.LF.RD	New		Rates.pdf

Philadelphia American Life Insurance Company

**Hospital Indemnity Policy (H-0184)
Attained Age Monthly Rate for One Unit with CY Deductible of \$1,000**

Age	PLAN 1*				PLAN 2*				PLAN 3*			
	NTU		STD		NTU		STD		NTU		STD	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Dependent Child (0-25)	35.64	35.64	35.64	35.64	39.60	39.60	39.60	39.60	45.54	45.54	45.54	45.54
25 and under	56.13	50.79	62.37	56.43	62.37	56.43	69.30	62.70	71.73	64.90	79.70	72.11
26	57.07	51.63	63.42	57.38	63.42	57.38	70.46	63.75	72.92	65.98	81.03	73.30
27	58.00	52.48	64.46	58.32	64.46	58.32	71.61	64.79	74.12	67.07	82.36	74.50
28	58.94	53.33	65.51	59.27	65.51	59.27	72.77	65.84	75.32	68.16	83.69	75.70
29	59.87	54.18	66.55	60.21	66.55	60.21	73.92	66.88	76.52	69.25	85.02	76.90
30	60.81	55.02	67.57	61.14	67.57	61.14	75.08	67.93	77.70	70.31	86.34	78.11
31	61.74	55.87	68.61	62.07	68.61	62.07	76.23	68.97	78.90	71.39	87.67	79.32
32	62.68	56.72	69.65	63.02	69.65	63.02	77.39	70.02	80.10	72.47	89.00	80.53
33	63.61	57.56	70.70	63.97	70.70	63.97	78.54	71.06	81.30	73.55	90.33	81.74
34	64.55	58.41	71.74	64.91	71.74	64.91	79.70	72.11	82.50	74.62	91.66	82.95
35	65.49	59.26	72.77	65.84	72.77	65.84	80.85	73.15	83.68	75.71	92.98	84.13
36	67.55	61.12	75.05	67.90	75.05	67.90	83.39	75.45	86.31	78.09	95.90	86.77
37	69.62	62.99	77.34	69.97	77.34	69.97	85.93	77.75	88.94	80.47	98.82	89.42
38	71.69	64.86	79.63	72.04	79.63	72.04	88.47	80.05	91.56	82.84	101.75	92.07
39	73.76	66.73	81.92	74.11	81.92	74.11	91.01	82.35	94.19	85.22	104.68	94.72
40	75.78	68.56	84.21	76.19	84.21	76.19	93.56	84.65	96.83	87.62	107.59	97.34
41	78.57	71.08	87.30	78.99	87.30	78.99	97.00	87.76	100.40	90.83	111.55	100.92
42	81.37	73.63	90.42	81.82	90.42	81.82	100.47	90.90	104.00	94.07	115.54	104.53
43	84.20	76.19	93.57	84.67	93.57	84.67	103.96	94.06	107.62	97.34	119.56	108.17
44	87.06	78.77	96.75	87.55	96.75	87.55	107.49	97.25	111.27	100.63	123.61	111.83
45	89.94	81.37	99.93	90.42	99.93	90.42	111.04	100.46	114.92	103.98	127.70	115.54
46	93.67	85.73	104.07	95.26	104.07	95.26	115.63	105.85	119.68	109.55	132.98	121.72
47	97.42	90.13	108.24	100.14	108.24	100.14	120.26	111.28	124.48	115.17	138.31	127.97
48	101.20	94.56	112.45	105.06	112.45	105.06	124.93	116.75	129.31	120.83	143.69	134.27
49	105.01	99.03	116.69	110.02	116.69	110.02	129.64	122.26	134.18	126.53	149.10	140.62
50	108.85	103.53	120.95	115.05	120.95	115.05	134.38	127.82	139.08	132.30	154.54	146.99
51	112.90	108.64	125.44	120.71	125.44	120.71	139.39	134.12	144.26	138.81	160.29	154.24
52	116.99	113.78	129.99	126.43	129.99	126.43	144.43	140.46	149.48	145.37	166.09	161.54
53	121.10	118.97	134.57	132.19	134.57	132.19	149.52	146.86	154.74	151.99	171.93	168.90
54	125.25	124.20	139.18	138.00	139.18	138.00	154.64	153.31	160.03	158.65	177.82	176.32
55	129.44	129.44	143.82	143.82	143.82	143.82	159.80	159.80	165.39	165.39	183.77	183.77
56	134.56	136.12	149.51	151.25	149.51	151.25	166.12	168.06	171.94	173.93	191.04	193.26
57	139.71	142.86	155.24	158.74	155.24	158.74	172.49	176.38	178.53	182.54	198.37	202.82
58	144.91	149.65	161.01	166.29	161.01	166.29	178.90	184.76	185.18	191.21	205.75	212.46
59	150.14	156.50	166.82	173.90	166.82	173.90	185.37	193.21	191.87	199.95	213.19	222.17
60	155.42	163.39	172.69	181.55	172.69	181.55	191.88	201.72	198.60	208.78	220.67	231.98
61	160.16	170.32	177.96	189.24	177.96	189.24	197.74	210.26	204.66	217.62	227.40	241.80
62	164.90	177.24	183.23	196.93	183.23	196.93	203.59	218.81	210.72	226.46	234.14	251.63
63	169.64	184.16	188.50	204.62	188.50	204.62	209.45	227.35	216.78	235.31	240.89	261.46
64	174.38	191.09	193.76	212.32	193.76	212.32	215.30	235.90	222.84	244.15	247.63	271.28

*Plan 1 Max calendar year benefit limit of \$100,000
 Plan 2 Max calendar year benefit limit of \$250,000
 Plan 3 Max calendar year benefit limit of \$1,000,000

NTU - Non Tobacco User Rates, STD - Tobacco User Rates

Please add one time non-refundable and non-commissionable application fee of \$30.00

Factors to convert from \$1,000 deductible to \$2,500 deductible and \$5,000 deductible

\$2,500 Deductible \$5,000 Deductible

Factor 0.73 0.57

CRITICAL ILLNESS RIDER (CRT.IL.RD)			
NTU		STD	
Issue Age	Per \$1,000 Benefit	Issue Age	Per \$1,000 Benefit
30-39	\$0.68	30-39	\$1.19
40-49	\$1.40	40-49	\$2.58
50-59	\$2.60	50-59	\$5.03
60-64	\$4.20	60-64	\$8.47
Per \$1,000 Benefit Amount			
Per Dependent Child \$.16			

FAMILY TERM LIFE RIDER (TRM.LF.RD)		1 UNIT
Applicant Only:		\$10.00
Applicant and Children:		\$12.50
Applicant and Spouse or Family:		\$15.00

SERFF Tracking Number: NELL-126856553 State: Arkansas
 Filing Company: Philadelphia American Life Insurance Company State Tracking Number: 47029
 Company Tracking Number: H-0184
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: H-0184
 Project Name/Number: H-0184/H-0184

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Readability Certification.pdf	Approved-Closed	10/25/2010

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Please see Form Schedule Comments:	Approved-Closed	10/25/2010

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: Please see Form Schedule Comments:	Approved-Closed	10/25/2010

READABILITY CERTIFICATION

I hereby certify that the forms listed below meet the minimum reading ease score on a Flesch test basis:

<u>New Form Number</u>	<u>Readability Score</u>
H-0184.AR.....	43.4
H-0184.OC	45.5
CMB.AP	51.1
CMB.AP.SUP	51.2
DIS.NT	50.1
CRT.IL.RD	50.1
TRM.LF.RD	50.2



James B. Hobelman, FSA, MAAA
Second Vice-President & Actuary