

SERFF Tracking Number: USHG-126902075 State: Arkansas  
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 47300  
Company Tracking Number:  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: GACC-2010-C-AR-FLIC  
Project Name/Number: /

## Filing at a Glance

Company: Freedom Life Insurance Company of America

Product Name: GACC-2010-C-AR-FLIC SERFF Tr Num: USHG-126902075 State: Arkansas  
TOI: H02G Group Health - Accident Only SERFF Status: Closed-Approved- State Tr Num: 47300  
Closed

Sub-TOI: H02G.000 Health - Accident Only Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor  
Author: Shannon Morgan Cubby Disposition Date: 11/19/2010  
Date Submitted: 11/11/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name: Status of Filing in Domicile: Authorized  
Project Number: Date Approved in Domicile: 07/16/2010  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Large  
Overall Rate Impact: Group Market Type: Association  
Filing Status Changed: 11/19/2010 Explanation for Other Group Market Type:  
State Status Changed: 11/19/2010  
Deemer Date: Created By: Shannon Morgan Cubby  
Submitted By: Shannon Morgan Cubby Corresponding Filing Tracking Number:  
Filing Description:  
Please see the attached Cover Letter.

## Company and Contact

### Filing Contact Information

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801 Cherry Street, Unit 33 817-878-3310 [FAX]  
Fort Worth, TX 76102

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**Filing Company Information**

Freedom Life Insurance Company of America CoCode: 62324 State of Domicile: Texas  
 3100 Burnett Plaza Group Code: 839 Company Type: Accident, Life and Health  
 801 Cherry Street, Unit 33 Group Name: State ID Number:  
 Fort Worth, TX 76102 FEIN Number: 61-1096685  
 (817) 878-3328 ext. [Phone]

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**Filing Fees**

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Freedom Life Insurance Company of America	\$50.00	11/11/2010	41807636

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/19/2010	11/19/2010

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## Disposition

Disposition Date: 11/19/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:*      *USHG-126902075*                      *State:*                      *Arkansas*  
*Filing Company:*              *Freedom Life Insurance Company of America*      *State Tracking Number:*      *47300*  
*Company Tracking Number:*  
*TOI:*                      *H02G Group Health - Accident Only*              *Sub-TOI:*                      *H02G.000 Health - Accident Only*  
*Product Name:*              *GACC-2010-C-AR-FLIC*  
*Project Name/Number:*      /

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Form</b>	Accident Certificate	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number: GACC-2010-C-AR-FLIC**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/19/2010	GACC-2010-C-AR-FLIC	Certificate	Accident Certificate	Revised	Replaced Form #: GACC-2010-C-AR-FLIC Previous Filing #: USHG-126668525		GACC-2010-C-AR-FLIC.pdf

# FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102 • 1-800-387-9027]

## CERTIFICATE OF COVERAGE

### [ASSOCIATION GROUP[ ACCIDENT ][ AND][ HOSPITAL INDEMNITY] PLAN]

This is **Your Certificate** of coverage under an association **Group Policy** issued to the **Group Policyholder**.

The insurance coverage, **Benefits** and the principal provisions that apply to the **Insureds** are summarized in this **Certificate** which is merely evidence of insurance under the **Group Policy**. Insurance coverages are subject to the terms of the **Group Policy** and this **Certificate**, which alone constitutes the contract under which payment is made. The **Group Policy** is a contract between the **Group Policyholder** and **Us**. It may be changed or terminated only by those parties.

Please read this **Certificate** carefully. It contains DEFINITIONS, BENEFITS, EXCLUSIONS, and LIMITATIONS.

**Your Coverage** is conditionally renewable, subject to the **Company's** right to adjust **Renewal Premiums** in accordance with Section IV. B. RENEWAL PREMIUM, and otherwise discontinue or terminate **Your Coverage** as provided in Section III. C. TERMINATION OF COVERAGE. The **Initial Premium** for coverage of all **Insureds** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the Section IV. B. RENEWAL PREMIUM. **You** may renew coverage by timely payment of the proper amount of **Renewal Premium** when due.

Certain phrases and words have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS.

**IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION:** Please read the copy of **Your** application for coverage, which is attached to this **Certificate** and is a part of the **Group Policy**, to see if any medical history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or an **Insured's** coverage to be reformed or voided.

Your coverage under the **Group Policy** and this **Certificate** was issued in consideration of (i) the payment of the **Initial Premium**, (ii) upon **Our** reliance upon **Your** representation that the answers to all questions in the application are correct and complete, and (iii) upon **Our** reliance upon the representation from **You** and any other applicable **Insureds**, that the content of any supplemental information provided to **Us** in the underwriting process, including information provided during any telephone verification of the application or by, e-mails, facsimiles and correspondence is in each instance correct and complete.

### YOUR [10-30] DAY RIGHT TO RETURN THIS CERTIFICATE

If **You** are not satisfied with your coverage or this **Certificate**, **You** may return the **Certificate** to **Us** within [ten (10)-thirty (30)] days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. Your coverage will be voided as of the **Issue Date**, and **We** will refund any premium **We** have received prior to **Our** receipt of the returned **Certificate**.



SECRETARY



PRESIDENT

**NEITHER THE GROUP POLICY NOR ANY CERTIFICATE ISSUED THEREUNDER IS  
A POLICY OF WORKERS' COMPENSATION INSURANCE.**

# TABLE OF CONTENTS

Provision	Page
I. [CERTIFICATE SCHEDULE.....	3
II. DEFINITIONS.....	4-8
III. WHEN COVERAGE BEGINS AND ENDS.....	8-11
A. EFFECTIVE DATE.....	8
B. ELIGIBILITY AND ADDITIONS.....	8-9
C. TERMINATION OF COVERAGE.....	9-10
D. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION.....	10-11
IV. PREMIUM.....	11-12
A. INITIAL PREMIUM.....	11
B. RENEWAL PREMIUM.....	11-12
V. BENEFITS AND CLAIM PROCEDURES.....	13-14
A. [ACCIDENT ]BENEFITS.....	13
B. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT.....	13-14
VI. BENEFICIARY.....	15
VII. EXCLUSIONS .....	15-16
VIII. UNIFORM PROVISIONS.....	16-22
A. ENTIRE CONTRACT-CHANGES.....	16
B. TIME LIMIT ON CERTAIN DEFENSES.....	16
C. OTHER INSURANCE WITH US.....	21
D. CONFORMITY WITH STATE STATUTES.....	21
E. MISSTATEMENT OF AGE.....	21
F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION	21
G. LEGAL ACTION.....	21-22]

# I. Certificate Schedule

## A. GENERAL INFORMATION

Coverage is pursuant to a **Group Policy** form: [            ]

Issued to **Group Policyholder**: [            ]

**Certificate** form: [GACC-2010-C-FLIC]

**Primary Insured**: [            ] Age at Issue: [    ]

**Certificate Number**: [            ] **Issue Date**: [            ]

**Other Insureds on Issue Date**: [            ]

**Beneficiary**: [            ]

**Initial Premium**:

Amount	Mode Of Premium Payment	Method
[\$            ]	[Monthly, Quarterly, Semi-Annual, Annual]	[Credit Card, Check]

**First Renewal Date**: [            ]

First Renewal Premium	Mode Of Premium Payment	Method
[\$            ]	[Monthly, Quarterly, Semi-Annual, Annual]	[Bank Draft]

[**Premium Rate Guarantee Period**: [12 months]]

## B. COVERAGE SCHEDULES

### [ACCIDENT ]BENEFITS

#### [[1.] Accidental Death & Dismemberment (AD&D) Coverage

[**Accident Benefits** payable for all **Insureds** under this **Certificate** will be limited to a total of [\$500] during the first [0-90] days immediately following the **Issue Date** listed above.]

#### AD&D MAXIMUM BENEFIT

Your AD&D Maximum Benefit	[\$10,000-\$50,000]
Your Spouse's AD&D Maximum Benefit	[\$5,000-\$25,000]
Your Child's AD&D Maximum Benefit	[\$2,500-\$12,500] per child

The following chart shows the percentage of the **AD&D Maximum Benefit** amount payable in the event of **AD&D** loss:

AD&D Loss	Company Insurance Percentage of AD&D Maximum Benefit
Loss of life	[100%]
<b>Loss of Limbs</b> (two or more)	[100%]
<b>Loss of Speech</b> and <b>Loss of Hearing</b> (both ears)	[100%]
<b>Loss of Sight</b> (both eyes)	[100%]
<b>Loss of Limb</b> (one)	[50%]
<b>Loss of Speech</b>	[50%]

<b>Loss of Hearing</b> (both ears)	[50%]
<b>Loss of Sight</b> (one eye)	[50%]
<b>Loss of Hand</b> (one)	[50%]
<b>Loss of Foot</b> (one)	[50%]
<b>Loss of Hearing</b> (one ear)	[25%]
<b>Loss of Thumb and Index Finger</b> (same hand)	[25%]

**[[2.] EMERGENCY AIR AMBULANCE COVERAGE**

**Emergency Air Ambulance Coverage Maximum Benefit per Accident per Insured** [\$1,000-\$5,000]

**[[3.] HOSPITAL INDEMNITY COVERAGE**

<b>Daily Benefit</b>	[\$50-\$3,000]
<b>[Elimination Period]</b>	[[1-3] days]
<b>Hospital Indemnity Per Accident Benefit Maximum</b>	[2-25] days]

**[[4.] EXCESS MEDICAL EXPENSE COVERAGE**

**Excess Medical Expense Coverage Maximum Benefit, per Accident per Insured** [\$500-\$50,000]

**Excess Medical Expense Deductible, per Accident per Insured** [0-\$5,000]

[The **Excess Medical Expense Coverage Maximum Benefit** will be reduced by [fifty (50%)] [on the [sixty-fifth (65) birthday] of the **Primary Insured** and **Spouse of the Primary Insured.**]

[**Excess Medical Expense** coverage will be limited to [ten, twenty] [10-20] percent of the **Excess Medical Expense Coverage Maximum Benefit** shown above if the Insured does not have other valid insurance coverage at the time of the occurrence.]

## II. DEFINITIONS

“**Accident**”, “**Accidentally**” means an event or occurrence that was unplanned and unintended by the **Insured** that was the sole cause of **Injuries** sustained or suffered by such **Insured** and that takes place on or after the **Issue Date**.

[“**Accidental Death & Dismemberment**” or “**AD&D**” means with respect to each **Insured** (i) loss of life directly caused by an **Injury** or **Injuries** including the medical effects thereof, sustained in an **Accident** and independent from the medical effects of any **Sickness** and/or (ii) the **Loss of a Hand** or **Loss of Foot**, **Loss of Hearing**, **Loss of Limb**, **Loss of Sight**, **Loss of Speech**, and/or **Loss of a Thumb and Index Finger** directly caused by an **Injury** or **Injuries**, including the medical effects thereof, sustained in an **Accident** and independent from the medical effects of any **Sickness**.]

[“**AD&D Maximum Benefit**” means the maximum dollar amount payable for **Accidental Death & Dismemberment** per **Insured**, as set forth in the **Certificate Schedule** for the **Primary Insured**, **Spouse of Primary Insured** and **Children of Primary Insured**.]

“**Beneficiary**” means the individual or organization listed on the **Certificate Schedule** as the **Beneficiary**.

“**Benefit(s)**” means the coverage specifically set forth in the **Certificate Schedule**, and otherwise described in Section V A, [ACCIDENT ]BENEFITS.

“**Certificate**” means the general summary of the **Group Policy** prepared for the **Primary Insured**.

“**Certificate of Conversion Coverage**” means the documents prepared by **Us** in accordance with the provisions of Section III. D. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION, which on their effective date will replace the **Group Policy** and this **Certificate** as the contract of coverage between the applicable **Insured** and the **Company**, consisting of (i) an endorsement removing each applicable **Insured** from the **Group Policy** and this **Certificate**, and (ii) a new certificate of coverage for each applicable **Insured** with the same applicable provisions as the **Group Policy** and this **Certificate**, including any riders or amendments attached hereto, but bearing a new certificate number.

“**Certificate Schedule**” means the schedule of information that commences on page 3 of this **Certificate**.

“**Child/Children**” means an unmarried dependent child of the **Primary Insured** who is under the age of nineteen (19) years (twenty four (24) years if enrolled as a **Full-Time Student**) on the date of any **Accident** and who is either listed as an **Other Insured** on the **Certificate Schedule** or born after the applicable **Primary Insured’s Issue Date**, and for whom the **Primary Insured** (through written communication to the **Us**) has provided timely and proper notice of such **Child**.

“**Class**” means the classification by **Us** of (i) individuals to whom **We** have issued new coverage for the purposes of the calculation of their **Initial Premium** rates, and (ii) individuals to whom **We** have previously issued coverage for purposes of the calculation of their **Renewal Premium** rates.

“**Company**” means Freedom Life Insurance Company of America.

“**Confinement or Confined**” means **Inpatient** services received by an **Insured** for an **Injury** or **Injuries** as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

[“**Daily Benefit**” means the amount **We** will pay for each calendar day that an **Insured** has a **Medically Necessary Confinement** in a **Hospital** due to an **Injury** following the expiration of the number of calendar days contained in the **Elimination Period**. The maximum number of calendar days for which a **Daily Benefit** is payable shall not exceed the **Hospital Indemnity Per Accident Benefit Maximum** shown on the **Certificate Schedule**. The dollar amount of the **Daily Benefit** is also shown on the **Certificate Schedule**.]

["**Elimination Period**"] means the number of calendar days shown on the **Certificate Schedule** beginning with the first day of **Confinement** before a **Daily Benefit** is payable. The number of days of the **Elimination Period** for each **Confinement** is shown in the **Certificate Schedule**.]

"**Emergency**" means the sudden onset of acute symptoms directly caused by an **Injury** or **Injuries**, including severe pain, which symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the patient's health in severe jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

["**Emergency Air Ambulance**"] means **Medically Necessary** transportation by air, within 90 days from the date of an **Injury** sustained by an **Insured** in an **Accident**, to the nearest Hospital qualified to render treatment in an **Emergency**. "**Emergency Air Ambulance**" does not include (i) ground or water ambulance transportation or (ii) air ambulance transportation that is not on an **Emergency** basis.]

["**Emergency Air Ambulance Coverage Maximum Benefit**"] means the maximum dollar amount payable for each **Emergency Air Ambulance** transportation of an **Insured**, as set forth in the **Certificate Schedule**.]

["**Excess Medical Expense**"] means the remaining amount of medical expenses incurred per **Insured** per **Accident** for the charges incurred by an **Insured** for the medical care and treatment of **Injuries** sustained by such **Insured**, after reduction for any amounts that are (i) excluded or limited hereunder and (ii) covered under any other valid insurance coverage, accident medical expense benefits or health benefit plan coverage, including but not limited to coverage of benefit entitlement under or pursuant to any uninsured/underinsured motorist coverage, personal injury protection coverage under any automobile policy, comprehensive major medical insurance, hospital/medical surgical insurance, other indemnity health insurance, health coverage under a HMO or PPO plan, workers compensation medical expense benefits, Federal Employers Liability Act medical expense benefits, Jones Act medical expense benefits, Medicaid, Medicare, Medicare Supplement coverage, Medicare Advantage, and any other government provided benefits that cover the **Medically Necessary** treatment of bodily **Injuries** sustained in an **Accident**. Such excess amount, if any, is payable up to the amount of the **Maximum Allowable Charge** for each medical service after satisfaction by each applicable **Insured** of the **Excess Medical Expense Deductible** for all such services. The total **Excess Medical Expense** payment for all charges incurred by such **Insured** per **Accident** shall not exceed the amount of the **Excess Medical Expense Coverage Maximum Benefit**.]

["**Excess Medical Expense Coverage Maximum Benefit**"] means the maximum dollar amount (per **Accident**, per **Insured**) payable for **Excess Medical Expense**, as set forth in the **Certificate Schedule**.]

["**Excess Medical Expense Deductible**"] means the amount of expense an **Insured** must incur and pay per **Accident** for the **Medically Necessary** treatment of an **Injury** sustained by such **Insured** that is not (i) excluded or limited hereunder and/or (ii) covered under any other valid insurance coverage, accident medical expense benefits, health benefit plan, or group health plan coverage, including but not limited to coverage or benefit entitlement under or pursuant to any uninsured/underinsured motorist coverage, personal injury protection coverage under any automobile policy, comprehensive major medical insurance, hospital/medical surgical insurance, other indemnity health insurance, health coverage under a HMO or PPO plan, workers compensation medical expense benefits, Federal Employers Liability Act medical expense benefits, Jones Act medical expense benefits, Medicaid and Medicare, Medicare Supplement coverage, Medicare Advantage, and any other government provided benefits that cover **Medically Necessary** treatment of bodily **Injuries** sustained in an **Accident** before any **Excess Medical Expense** is payable under this **Certificate**. No amount is payable under this **Certificate** for any **Excess Medical Expense** until after such **Excess Medical Expense Deductible** is satisfied. The amount of the **Excess Medical Expense Deductible** is shown in the **Certificate Schedule**.]

"**Family**" means the spouse, son or daughter, brother or sister, parent, grandparent or grandchild of an **Insured**.

"**First Renewal Date**" means the first premium due date following payment of the **Initial Premium** which is shown on the **Certificate Schedule**.

"**First Renewal Premium**" means the amount of **Renewal Premium** due on the **First Renewal Date**. The amount of **First Renewal Premium**, if known on the **Issue Date**, is shown on the **Certificate Schedule**.

**“Full-Time Student”** means an individual, under the age of 24, who is enrolled in at least twelve (12) credit hours per semester at an accredited college or university.

**“Group Policy”** means the association group insurance contract issued to the **Group Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

**“Group Policyholder”** means the association shown on the **Certificate Schedule** to whom the **Group Policy** was issued.

**“Hospital”** means a place which:

1. is legally operated for the care and treatment of sick and injured persons at their expense;
2. is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to it on a formal pre-arranged basis);
3. has continuous twenty-four (24) hour nursing services by or under the supervision of a registered nurse (R.N.); and
4. has a staff of one or more **Providers** available at all times.

It also means a place that may not meet the above requirements, but is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

**“Hospital”** does not mean:

1. a convalescent home, nursing home, rest home or **Skilled Nursing Home**;
2. a place primarily operated for treatment of **Mental and Emotional Disorders**, drug addicts, alcoholics, or the aged;
3. a special unit or wing of a **Hospital** used by or for any of the above;
4. a long-term mental care facility; or
5. a facility primarily providing Custodial Care.

**“Hospital Indemnity”** means the amount payable on an indemnity basis by **Us** for a **Medically Necessary Hospital Confinement** of an **Insured** due to an **Injury** sustained in an **Accident**.]

**“Hospital Indemnity Per Accident Benefit Maximum”** means the maximum number of calendar days under Hospital Indemnity Coverage that **We** will pay the **Daily Benefit** per **Insured** per **Accident** due to **Confinement** in a **Hospital** as a result of an **Injury** sustained in an **Accident**. The amount of the **Hospital Indemnity Per Accident Benefit Maximum** is shown on the **Certificate Schedule**.]

**“Initial Premium”** means the amount charged for coverage under this **Certificate** for **You** and all **Other Insureds** for the period of time from the **Issue Date** through the day before the **First Renewal Date**. The amount of the **Initial Premium** is shown on the **Certificate Schedule**, and is payable in advance of the **Issue Date**.

**“Injury”** and **“Injuries”** means damage or harm **Accidentally** sustained to the physical structure of the body of an **Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause, which occurs on or after the **Issue Date** and while coverage is in force and effect for such **Insured**. A specific **Injury** from which disability continues or recurs shall be considered one and the same **Injury** or “any one **Injury**”, unless periods of **Confinement** to a **Hospital** or service, treatment, or medical expenses incurred resulting from such **Injury** are separated by an interval of at least ninety (90) consecutive days between the end of one such period and the beginning of a subsequent such period.

**“Inpatient”** means an **Insured** who receives **Medically Necessary** services for an **Injury** or **Injuries** from a **Provider** in a **Hospital** when such **Insured** is **Confined** and receives room and board from such **Hospital** for not less than eight (8) hours. Treatment or services rendered or provided in a **Hospital** emergency room for an **Injury** or **Injuries** is not an **Inpatient Confinement** for the purposes of this **Certificate**. A period of **Inpatient Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

“**Insured**” means the following:

1. the **Primary Insured** whose coverage is in force and effect,
2. any other individuals named as **Other Insureds** on the **Certificate Schedule** whose coverage is in force and effect, and
3. any individual who is added after the **Issue Date** by proper endorsement after proper application and payment of any additional premium and whose coverage is in force and effect.

“**Issue Date**” means the date on which coverage commences for **You** and **Other Insureds**. This date is shown on the **Certificate Schedule**.

[“**Loss of Hand**” or “**Loss of Foot**” means complete severance or amputation through or above the wrist or ankle joint or the **Total Loss of Use** of such hand below the wrist joint or such foot below the ankle joint.]

[“**Loss of Hearing**” means total and irrecoverable loss of the ability to hear.]

[“**Loss of Limb**” means complete severance or amputation of an arm at or above the elbow, complete severance or amputation of a leg at or above the knee, or the **Total Loss of Use** of such arm below the elbow or such leg below the knee.]

[“**Loss of Sight**” means total, permanent and medically irrecoverable loss of sight in the eye.]

[“**Loss of Speech**” means the total, permanent and medically irrecoverable loss of the ability to speak by use of the larynx without mechanical or electronic amplification.]

[“**Loss of Thumb and Index Finger**” means severance or amputation through or above the metacarpophalangeal joints (the joints between the fingers and the hand) of both the thumb and index finger on the same hand.]

“**Maximum Allowable Charge**” means the following:

1. For the **Emergency Air Ambulance** benefit, “**Maximum Allowable Charge**” is the actual expense incurred by an **Insured** for transportation to a hospital by **Emergency Air Ambulance**, after a reduction, adjustment, and/or discount pursuant to any discount agreements, network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the ambulance company:
  - a. agreed to accept as payment in full for such services, supplies, care or treatment, and
  - b. ultimately charged such **Insured**, regardless of any higher amount that may have been placed on the ambulance company’s billing statement of charges.

However, the amount of the “**Maximum Allowable Charge**” for **Emergency Air Ambulance** shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such service, (ii) the amount of the **Medicare** allowable or approved charge for the receipt of such service with respect to any **Insured** who is **Medicare** eligible, (iii) the amount of **Usual and Customary Expense** for the receipt of such service, or (iv) the **Emergency Air Ambulance Coverage Maximum Benefit** specified in the **Certificate Schedule**.

2. For the **Excess Medical Expense** benefit, “**Maximum Allowable Charge**” is the actual expense charged by each **Provider, Hospital** or other medical facility for each item of medical care, treatment services to an **Insured** due to an **Injury or Injuries**, after a reduction, adjustment, and/or network discount pursuant to any Participating **Provider** agreements, or other network agreements, negotiated rates, fee schedules or other arrangements that determine or prescribe the actual amount of charges or fees that such **Provider, Hospital** or other medical facility:
  - a. agreed to accept as payment in full for such applicable services, supplies, care, or treatment, and
  - b. ultimately charged such **Insured** for such applicable services, supplies, care, or treatment, regardless of any higher amount that may have been placed on the entity’s billing statement of charges.

However, the amount of the “**Maximum Allowable Charge**” for the **Excess Medical Expense** shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such applicable services, supplies, care, or treatment, (ii) the amount of the Medicare allowable or approved charge for the receipt of such applicable services, supplies, care, or treatment with respect to any **Insured** who is **Medicare** eligible, or (iii) the amount of **Usual and Customary expense** for the receipt of such applicable services, supplies, care, or treatment.

“**Medical Necessity**” and “**Medically Necessary**” means: any applicable **Confinement** of an **Insured**, as well as any service provided to an **Insured**:

- a. by or at the appropriate order, or upon the approval of a **Provider**;
- b. for the medically recognized diagnosis or care and treatment of an **Injury**;
- c. in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Injury**;
- d. according to and within generally accepted standards for medical practice;
- e. in the most cost effective setting and manner available to treat the **Injury**;
- f. not primarily for the convenience of an **Insured, Family**, or a **Provider**; and
- g. not investigational or experimental in nature.

The fact that a **Provider** prescribed, ordered, recommended or approved a service, supply, treatment or **Confinement** does not in and of itself make it **Medically Necessary** or a **Medical Necessity**.

“**Mental and Emotional Disorders**” means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

“**Mode of Premium Payment**” means the interval of time (monthly, quarterly, semi-annual or annual) that **You** have selected for payment of the **Initial Premium** and **Renewal Premium**. The premium payment interval selected by **You** as the **Mode Of Premium Payment** is shown on the **Certificate Schedule**. This **Mode of Premium Payment** is subject to change at **Our** discretion.

“**Other Insureds**” means those members of **Your Family** that are listed on the **Certificate Schedule** on the **Issue Date**.

“**Our**” means Freedom Life Insurance Company of America.

[“**Premium Rate Guarantee Period**” means the number of months immediately following the **Issue Date** that must expire before the amount of **Renewal Premium** charged by **Us** (with the same **Mode of Premium Payment** as the **Mode of Premium Payment** selected for payment of the **Initial Premium**) can be higher than the amount of the **Initial Premium** because of a change by **Us** in the table of premium rates used to calculate the **Initial Premium**. However, the amount of **Renewal Premium** may be increased by **Us**, even during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

- a. **You** change the amount of the **Excess Medical Expense Deductible** shown on the **Certificate Schedule**;
- b. **You** change any other coverage option;
- c. **You** change the **Mode Of Premium Payment**;
- d. **You** add optional coverage riders, if any; and/or
- e. a change occurs in [**Accident**] **Benefits** by amendatory endorsement pursuant to any federal or state law or regulation.

The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. ]

“**Primary Insured**” means the individual whose name is printed on the **Certificate Schedule** as the **Primary Insured**.

“**Provider**” means a person who has successfully completed the prescribed course of studies in medicine at a medical school officially recognized and accredited in the country in which it is located, and which person has been licensed by the state in which the medical services are rendered to practice medicine. The **Provider** must be acting within the scope of such license while rendering **Medically Necessary** professional service to an **Insured**, and cannot be a member of the **Insured’s Family**.

“**Renewal Premium**” means the amount charged for coverage of **Insureds** for the period of time from the **First Renewal Date** through the day before each subsequent renewal coverage renewal date. **Renewal Premium** for each renewal period is payable in advance for each applicable renewal period.

“**Sickness**” means illness or disease afflicting an **Insured**.

“**Skilled Nursing Home**” means a place which:

1. charges patients for their services;
2. is legally operated in the state (or similar jurisdiction) in which it is located;
3. has beds for patients who need medical and skilled care;
4. operates under a doctor's supervision;
5. has continuous twenty-four (24) hour nursing service supervised by a registered nurse (R.N.); and
6. keeps complete medical records on each patient.

“**Skilled Nursing Home**” also means a wing, area or floor of a **Hospital** specifically set aside to provide care similar to that of a **Skilled Nursing Home**, but it does not mean a **Hospital**.

“**Termination of Coverage**” means Section III. C. TERMINATION OF COVERAGE, that governs the conditions and circumstances under which coverage may be terminated for any or all **Insureds**.

“**Total Loss of Use**” means the complete, permanent and medically irreversible condition that renders utility or function of such bodily part useless for vocation, avocation and normal activities of daily living such that it is the functional equivalent of an amputation.

“**Us**” means Freedom Life Insurance Company of America.

“**Usual and Customary**” with respect to a **Provider**, means the actual expense charged by such **Provider** for service or treatment of an **Insured**, but not to exceed the [seventieth (70th)] percentile of the prevailing charges by all **Providers** in the same geographic area as such **Provider**, as determined by one of the current prevailing health care charges information systems in the insurance industry utilizing the applicable CPT Code for such services or treatment and the applicable ZIP code (first 3 or 5 digits) of such **Provider**. For services or treatments provided by other than **Providers**, **Usual and Customary** means the actual expense, but not to exceed the average charge made for similar services or supplies in the locality where the service or supply is furnished, taking into consideration the nature and the severity of the **Injury** suffered by the **Insured**.

“**We**” means Freedom Life Insurance Company of America.

“**You**”, “**Your**” and “**Yours**” means the individual listed on the **Certificate Schedule** as the **Primary Insured**.

“**Your Spouse**” means the spouse of the **Primary Insured** who (i) is either listed as an **Other Insured** on the **Certificate Schedule** or later added under Section III B, Eligibility and Additions, and (ii) is an **Insured** whose coverage has not ended by the date of such spouse's death.

### **III. WHEN COVERAGE BEGINS AND ENDS**

#### **A. EFFECTIVE DATE**

Your coverage and the coverage of **Other Insureds** under the **Group Policy** and this **Certificate** is effective at 12:01 A.M. local time where **You** live on the **Issue Date** shown on the **Certificate Schedule**.

#### **B. ELIGIBILITY AND ADDITIONS**

An individual will become eligible for coverage as a **Primary Insured** under the **Group Policy** and this **Certificate** upon becoming a member of the association to which the **Group Policy** is issued. The coverage for a **Primary Insured** will be effective under the **Group Policy** and this **Certificate** when **We** approve the written application for such coverage and accept payment of premium.

**Your Spouse; Your** unmarried, dependent children who are under the age of 19 (24 if a **Full-Time Student**); and grandchildren who are considered **Your** dependents for federal income tax purposes and who are under age 19 (24 if a **Full-Time Student**); any children which an **Insured** is required to insure under a medical support order; any child whom **You**, or **Your Spouse** (if listed as an **Other Insured** on the **Certificate Schedule**), intends to adopt and has become a party to a suit for that purpose; and any child who is in the custody of an **Insured** under a temporary court order that grants the **Insured** conservatorship of the child, are eligible for this coverage. The coverage of **Your Spouse** or **Children** (other than a newborn or adoptee) will be effective under the **Group Policy** and this **Certificate** when **We** approve the written application for such coverage, and accept payment of any necessary premium.

Newborn children born after the **Issue Date** to **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn child) will be automatically insured under this **Certificate** from and after the moment of birth for a period of ninety (90) days or before the next premium due date, whichever is later. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn child past the initial ninety (90) day period or beyond the next premium due date, **You** must notify **Us** of such birth and **Your** desire for such continued coverage under this **Certificate** within ninety (90) days or before the next premium due date after the date of such newborn child's birth. **You** must also pay any additional premium required for such additional coverage within such ninety (90) day period or before the next premium due date. If **You** do not notify **Us** of such birth and **Your** desire for continued coverage under this **Certificate** within such ninety (90) day period or before the next premium due date, and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn child will end after the expiration of ninety (90) days or the next premium due date, whichever is later, from the date of such newborn child's birth. **We** will notify **You** if more premium is needed.

Newborn children born after the **Issue Date** and immediately placed for adoption after birth with **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn adoptee) will be automatically insured under this **Certificate** from and after the date of the adoption placement of such newborn adoptee for a period of sixty (60) days. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn adoptee past the initial sixty (60) day period, **You** must notify **Us** of such birth, adoption placement and **Your** desire for continued coverage under this **Certificate** within sixty (60) days after the date of the adoption placement of such newborn adoptee. **You** must also pay any additional premium required for such additional coverage within such sixty (60) day period. If **You** do not notify **Us** within such sixty (60) day period of the birth, adoption placement and **Your** desire for continued coverage under this **Certificate** for such newborn adoptee and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn adoptee will end after the expiration of day from the date of such adoption placement of such newborn adoptee. **We** will notify **You** if more premium is needed.

If **You** wish to have automatic coverage after the **Issue Date** for any child not listed as an **Other Insured** on the **Certificate Schedule**, but for which adoption or custody of such child is sought by **You** or **Your Spouse** in a civil suit or other judicial custody proceeding filed or initiated after the **Issue Date**, **You** must notify **Us** within thirty-one (31) days after **You** or **Your Spouse**, as applicable: (i) become a party in such civil suit in which such adoption of the child is sought; or (ii) obtain custody of the child under the first court order (including temporary orders) that grants conservatorship and/or custody of the child. **You** must also pay any additional premium required for such additional coverage within such thirty-one (31) day period. If **You** do not notify **Us** within such applicable thirty-one (31) day period of **Your** desire for automatic coverage in the future for such child and timely pay any additional premium that may thereafter become due, then no automatic coverage will be afforded for such child. **We** will notify **You** if more premium is needed.

## **C. TERMINATION OF COVERAGE**

### **1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION**

Subject to the Section III. D. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION below, an applicable **Insured's** coverage ends on the earlier of the following:

- a. the premium due date in the month following the date the **Group Policy** is terminated by the **Group Policyholder**, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address;

- b. with respect to **Your Spouse**, the premium due date in the month following the effective date of **Your** divorce decree, annulment or court approved separation;
- c. with respect to **Your Child(ren)**, the premium due date in the month following such **Insured's** 19<sup>th</sup> birthday (24<sup>th</sup> if a **Full-Time Student**).

The coverage of **Your** child who is an **Insured** will not end if he or she is dependent upon **You** for support and maintenance and incapable of self-support because of a mental handicap or physical disability. Such dependent **Insured's** coverage will continue regardless of the dependent **Insured's** age, as long as **Renewal Premium** is timely and properly paid for **You** and the dependent **Insured** and such dependent **Insured** remains dependent upon **You** and incapable of self support because of such mental handicap or physical disability. Proof of such handicap or disability must be furnished to **Us** as soon as reasonably possible prior to the dependent **Insured** reaching the limiting age, and thereafter upon **Our** request, but not more frequently than annually after the two (2) year period following the attainment of the limiting age.

## 2. TERMINATIONS BY PRIMARY INSURED NOT SUBJECT TO RIGHT OF CONVERSION

Section III.D. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, the following described actions by either the **Primary Insured** or other applicable **Insured** will result in a termination of each applicable **Insured's** coverage with no right of conversion, in which event the coverage ends on the earlier of the following:

- a. the due date of any unpaid **Renewal Premium**, subject to the grace period; or
- b. the date **You** terminate coverage by notifying **Us** of the date **You** desire coverage to terminate and specify the **Insured** whose coverage is to terminate.

## 3. TERMINATIONS BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III. E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Insureds** with no right of conversion for the following reasons:

- a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Group Policy** or a **Class** under the **Group Policy**;
- b. **We** elect to discontinue offering accident coverage to all individuals in **Your** state who are covered under the same coverage form as this **Certificate**, in which case **You** will be given a minimum of thirty-one (31) days prior written notice of the termination, mailed to **Your** last known address;
- c. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in the application for **Your** coverage or the coverage of **Your Spouse** or **Children** under the **Group Policy** and this **Certificate**, or in a claim for **Benefits**.

Any termination of coverage will be effective at 11:59 P.M. local time where **You** live on the date(s) specified above.

If **You** die, **Your Spouse**, if then an **Insured** will become the **Primary Insured**. If **You** and **Your** spouse (if any) are not covered, the oldest **Insured** will become the **Primary Insured**.

**We** will not accept premium for any **Insured** whose coverage has terminated. Premiums, which are sent to **Us** and include an amount to cover the **Insured** whose coverage has terminated, will be returned. **We** will only accept the correct premium to cover those **Insureds** who are eligible for coverage. If premiums are accepted in error, **Our** liability is limited to coverage for the period of time for which premiums were accepted in error.

Except for claims involving fraud or intentional misrepresentation of material fact, any termination will be without prejudice to any claim for **Benefits** incurred prior to the date of termination. If coverage is terminated, unearned premium will be computed pro-rata and any unearned premium will be refunded to **You**.

## D. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION

A **Certificate of Conversion Coverage**, whereby the coverage then afforded under the **Group Policy** and this **Certificate** for an applicable **Insured** will continue under a **Certificate of Conversion Coverage** without a requirement of any additional evidence of the insurability of such **Insured**, is available only:

1. for **Your** spouse, if his or her coverage ceases due to divorce, annulment or court approved separation;
2. for **Your** unmarried child(ren), if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**), or
3. for each applicable **Insured**, if coverage terminates because the **Group Policyholder** has terminated coverage under the **Group Policy**, and does not replace coverage with another group policy, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address. Upon termination of the **Group Policy**, **You** may apply on behalf of all **Insureds** for a **Certificate of Conversion Coverage**. The **Certificate of Conversion Coverage** must be applied for and the first premium received by **Us** within thirty-one (31) days after the date that coverage under the **Group Policy** and this **Certificate** terminates. If a **Certificate of Conversion Coverage** is issued, it will take effect on the day after coverage under the **Group Policy** and this **Certificate** terminates.

A **Certificate of Conversion Coverage** is not available and will not be provided if:

1. an **Insured's** coverage under the **Group Policy** and this **Certificate** ceases because the **Group Policy** was terminated and was replaced by similar group coverage within thirty-one (31) days;
2. an **Insured's** coverage ceases because of failure to pay the required premiums in the time allowed;
3. an **Insured** was not covered under the **Group Policy** and this **Certificate** for the three (3) consecutive months immediately prior to the date the **Group Policy** terminates;
4. an **Insured** is covered by similar benefits furnished by any:
  - a. medical expense plan;
  - b. medical service subscriber contract;
  - c. medical pre-payment plan; or
  - d. medical plan provided in accordance with the requirements of any state or federal law;
5. an **Insured** is eligible to be covered by any group plan, insured or uninsured:
  - a. medical expense plan;
  - b. medical service subscriber contract;
  - c. medical pre-payment plan; or
  - d. medical plan provided in accordance with the requirements of any state or federal law;
6. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Group Policy** or a **Class** under the **Group Policy**;
7. **You** voluntarily terminated coverage for any **Insured** by notifying **Us** of the date **You** desired such coverage to terminate;
8. **We** elect to discontinue offering accident coverage to all individuals in **Your** state who are covered under the same coverage form as this **Certificate**, in which case **You** will be given a minimum of thirty (31) days prior written notice of the termination, mailed to **Your** last known address
9. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for coverage or in filing a claim for **Benefits**.

In order to be eligible for a **Certificate of Conversion Coverage**, a written election of conversion must be made by the applicable **Insured**, on a form furnished by **Us**, and the first premium must be paid, in advance, to **Us** on or before the date on which the applicable coverage under the **Group Policy** and this **Certificate** for such **Insured** would otherwise terminate. The amount of first premium required from the effective date through the end of the first renewal period of the **Certificate of Conversion Coverage** shall not be more than **Our** full group premium rate then applicable for the applicable **Insured** under the **Group Policy** and this **Certificate** with the same mode of payment. Applicable **Insureds** shall not be required to pay the **Renewal Premium** for a **Certificate of Conversion Coverage** less often than monthly.

## IV. PREMIUM

### A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep **Your** coverage in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** on a **Class** basis. **Your Class** for **Initial**

**Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) the plan of coverage, **Benefits**, limitations, and exclusions; (ii) **Mode Of Premium Payment** selected on the application; (iii) distribution channels; (iv) administrative costs; (v) taxes; (vi) other economic factors; and/or (vii) other coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar attained factors described above.

## B. RENEWAL PREMIUM

### 1. CALCULATION - PAYMENT

The current **Mode of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage will terminate.

**Renewal Premium** rates may be increased by **Us** for any renewal period after the **Issue Date**[.][,] [including during the **Premium Rate Guarantee Period**, if after the **Issue Date**]:

- a. **You** change the amount of the **Excess Medical Expense Deductible** shown on the **Certificate Schedule**;
- b. **You** change any other coverage option;
- c. **You** change the **Mode of Premium Payment**;
- d. **You** add optional coverage riders, if any; and/or
- e. a change occurs in [**Accident** ]**Benefits** by amendatory endorsement pursuant to any federal or state law or regulation.

[After expiration of the **Premium Rate Guarantee Period**,] [T][t]he amount of **Renewal Premium** may be increased for any renewal period based upon items a. through e. above as well as the following:

- a. change by **Us** in the table of premium rates used to calculate the **First Renewal Premium**, and
- b. change by **Us** in the table of premium rates used to calculate **Renewal Premium** for any prior renewal period.

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis for all members of **Your Renewal Premium Class**. **We** will tell **You** at least [thirty-one (31)] days in advance of the effective date of any **Renewal Premium** increase that occurs due to a change in the table of premium rates for **Renewal Premium**.

### 2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

### 3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew **Your** coverage under the **Group Policy** and this **Certificate** pursuant to the provisions of Section III. C. TERMINATION OF COVERAGE, a grace period of thirty-one (31) days from such due date is given for the late payment of the **Renewal Premium** due. If **You** make payment of the required **Renewal Premium** during such grace period, then coverage will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Insured's** coverage, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Insured** but for such cancellation.

### [4. PREMIUM RATE GUARANTEE PERIOD

[The amount of **Renewal Premium** with the same **Mode of Premium Payment** as the **Mode of Premium Payment** of the **Initial Premium** is guaranteed not to exceed the amount of the **Initial Premium** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of

any: (i) change in the table of premium rates used to calculate the **Initial Premium**; or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date** (i) **You** either add or change coverage or (ii) an amendatory endorsement is issued that changes any of the **Benefits** pursuant to any federal or state law or regulation.]]

## **V. BENEFITS AND CLAIM PROCEDURES**

### **A. [ACCIDENT ]BENEFITS**

Subject to all applicable definitions, exclusions, limitations, **Benefit** maximums[, **Elimination Periods** ]and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the following **Benefits** as a result of **Injuries** from an **Accident**.**[ Accident Benefits payable for all Insureds under this Certificate will be limited to a total of [\$500] during the first [0- 90] days immediately following the Issue Date.]**

#### **[1.][ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)]**

[The **Accidental Death & Dismemberment** amount specified in the **Certificate Schedule** will be paid to the applicable **Insured** or **Beneficiary** in the event of an **Accidental Death & Dismemberment** loss.

The maximum dollar amount recoverable by an **Insured** for an **Accidental Death & Dismemberment** loss is the applicable **AD&D Maximum Benefit**, regardless of the number of **Accidents** or **Injuries** sustained by an **Insured**.]

[Each **AD&D Maximum Benefit** amount specified in the **Certificate Schedule** automatically reduces by 50% on the [sixty-fifth (65) birthday] of the **Primary Insured** and **Spouse of the Primary Insured**.]

#### **[2.][EMERGENCY AIR AMBULANCE]**

[The amount of **Emergency Air Ambulance** expense incurred per **Insured** per **Emergency Air Ambulance** trip will be paid to the applicable **Insured** or **Beneficiary** up to the amount of the **Maximum Allowable Charge**.]

#### **[3.][HOSPITAL INPATIENT DAILY INDEMNITY]**

[After the expiration of the **Elimination Period**, the **Daily Benefit** will be paid to the applicable **Insured** or **Beneficiary** for each day of **Medically Necessary Inpatient** admission and **Confinement** of an **Insured** at a **Hospital** due to and for **Medically Necessary** treatment of an **Injury**.]

[The maximum number of days for which such **Daily Benefit** will be paid per **Insured** per **Accident** shall not exceed the **Hospital Indemnity Per Accident Benefit Maximum** shown on the **Certificate Schedule**.]

[The dollar amount of the **Daily Benefit** automatically reduces by 50% on the [sixty-fifth (65) birthday] of the **Primary Insured** and **Spouse of the Primary Insured**.]

#### **[4.][EXCESS MEDICAL EXPENSES]**

[After satisfaction of the **Excess Medical Expense Deductible**, the remaining amount of **Excess Medical Expense** incurred per **Insured** per **Accident** will be paid to the applicable **Insured** or **Beneficiary** up to the amount of the **Maximum Allowable Charge** for each item of service.**[ Excess Medical Expense coverage will be limited to [ten, twenty] [10-20] percent of the Excess Medical Expense Coverage Maximum Benefit shown above if the Insured does not have other valid insurance coverage at the time of the occurrence.]**

The total **Excess Medical Expense** payment for all charges incurred per **Insured** per **Accident** shall not exceed the amount of the **Excess Medical Expense Coverage Maximum Benefit.**]

[The **Excess Medical Expense Coverage Maximum Benefit** automatically reduces by 50% on the [sixty-fifth (65) birthday] of the **Primary Insured** and **Spouse of the Primary Insured.**]

## **B. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT**

### **1. NOTICE OF CLAIM**

Written notice of claim must be received by **Us** within thirty (30) days of the date of each **Accident** or the date the applicable expense is incurred. If it is not reasonably possible for the notice of claim to be transmitted to **Us** so that it is received within such thirty (30) day period, then written notice of claim must be received by **Us** as soon thereafter as reasonably possible. **Our** current address for providing a written notice of claim is shown on Page 1. A written notice of claim should include the applicable **Insured's** name, the **Primary Insured's** name and the **Certificate** number.

### **2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED**

When **We** receive timely written notice of claim, **We** will normally send **You** a claim form to be completed, signed and returned. The general purpose of the claim form is to provide **Us** with general background information about the nature of the claim, which information may be necessary in order to complete a proper proof of loss. If this claim form is not provided to **You** within fifteen (15) days, of **Our** timely receipt of written notice of the claim, then **You** will not be required to later complete, sign and return the written claim form, but may be required to provide other information, including a written authorization for the release of medical records and information, which in each event is necessary either for **Our** investigation of the claim or otherwise as part of the completion of a proper proof of loss. **We** must receive information requested within the time limit stated in the Section V. B. 3. PROOFS OF LOSS immediately below.

### **3. PROOFS OF LOSS**

Written proof of loss must be provided to **Us** within ninety (90) days after the date of **Accident** or the date the applicable expense is incurred. If it was not reasonably possible for **You** to give **Us** proof in the time required, **We** will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof of loss required must be provided no later than one (1) year from the date of **Accident** or the date the applicable expense is incurred unless **You** are legally incompetent or otherwise physically unable to act.

### **4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION**

As written notice of claims, completed claim forms, signed authorizations for release of medical authorizations, medical records, and other written information from **Insureds** and **Providers** are received and reviewed, additional investigation, requests for information and other matters may occur in connection with the completion of a proper proof of loss, adjustment and adjudication of the claim. At **Our** expense, **We** have the right to have the **Insured** examined by a **Provider** of **Our** choice as often as is reasonably necessary while a claim or other benefit determination is pending. Information received during the review and investigation of a claim will be considered, as applicable, in connection of whether a timely and proper proof of loss has been completed. After **Our** investigation has been completed, claims will be adjusted and adjudicated in accordance with the coverage that was in force on the date of the **Accident** or the date the applicable expense is incurred.

### **5. PAYMENT OF CLAIMS**

**Benefits** will be paid to the **Primary Insured** upon the death of the **Primary Insured**, the unpaid amount of any applicable **Benefits**, which are owed by the **Company** will be paid to the **Beneficiary**. Any claim payment made by **Us** in good faith will fully discharge **Our** liability for such claim to the extent of the amount of such good faith payment.

## 6. TIME OF PAYMENT OF CLAIMS

**We** will make payments due promptly once a decision has been made on a claim and this decision has been processed.

Payment shall be treated as being made on the date a draft or valid instrument was placed in the United States mail to the last known address of the applicable **Primary Insured** or **Beneficiary** in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

A **Benefit** payment owed by **Us**, but not paid within thirty (30) days after the date of **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim, will be considered past due. **We** will pay interest on any past due benefit payment amount at the rate of one and one-half percent per month commencing on the thirty-first (31<sup>st</sup>) day after the completion and **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim until the date such payment is tendered by **Us**.

## VI. BENEFICIARY

**Beneficiary** – The **Beneficiary** designation in **Your** application will remain in effect until changed by the **Primary Insured**. The **Beneficiary** will receive any **Benefit** payable at the death of the **Primary Insured**. If more than one person is named **Beneficiary**, they will share equally any **Benefit** payable unless otherwise specified in a written request. The **Primary Insured** will receive any **Benefit** payable upon the death of **Other Insureds**.

**Death of a Beneficiary** – If any **Beneficiary** dies before the **Primary Insured**, that person's interest will terminate. Any surviving **Beneficiaries** will be entitled to any **Benefit** payable thereafter upon the death of the **Primary Insured**, according to their respective interests. In the event the **Beneficiary** dies at the same time as or within thirty (30) days after the **Primary Insured**, the **Benefit** will be paid as if the **Beneficiary** had died before the **Insured**. If no **Beneficiary** survives the **Primary Insured**, the **Benefit** will be paid to **Your** estate.

**Change of Beneficiary** – You may change the **Beneficiary** at any time during **Your** lifetime. Any change must be by written request signed prior to the death of the **Insured**.

In the event there is no designated **Beneficiary**, as to all or any part of the **Benefit**, living at the death of an **Insured**, **We** may pay a part of such sum not exceeding [\$250] to any person appearing to **Us** to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the **Insured**.

Any payment the **Company** makes in good faith fully discharges the **Company's** liability to the extent of the payment made.

## VII. EXCLUSIONS

No **Benefits** shall be payable under the **Group Policy** and this **Certificate** for any loss caused by, in whole or in part, contributed to or resulting from, directly or indirectly, any of the following incidents, events, occurrences or activities involving any **Insured**:

1. **Injury** due to any act of war (whether declared or undeclared);
2. services provided by any state or Federal government agency, including the Veterans Administration unless, by law, an **Insured** must pay for such services;
3. intentionally self-inflicted **Injury**;
4. suicide or any suicide attempt while sane or insane;
5. serving in one of the branches of the armed forces of any foreign country or any international authority;
6. services provided by **You** or a **Provider** who is a member of an **Insured's Family**;
7. an **Injury** occurring outside the borders of the United States of America or its territories;
8. [any loss to which a contributing cause was the **Insured's** being engaged in an illegal occupation or attempting to commit assault or illegal activity;]
9. [participation in hang gliding, paragliding, hot air ballooning or any other form of aviation, except as a fare paying passenger traveling on a regularly scheduled commercial airline flight;]

10. participating, as driver or passenger, in any competition, race or speed contest, including sanctioned practice thereof, of any land or water vehicle;
11. **Mental and Emotional Disorders;**
12. for the purposes of the **Emergency Air Ambulance** benefit, the **Insured's** medical condition was not sufficiently acute or severe upon arrival at the **Hospital** to result in an **Inpatient** admission and **Confinement** in the Hospital immediately following the **Insured's** evaluation and treatment in the emergency room of such **Hospital**;
13. an **Insured** being intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a **Provider**, and taken in accordance with the limits of such advice. An **Insured** is conclusively determined to be intoxicated by drug or alcohol if (ii) a chemical test administered in the jurisdiction where either the **Accident** occurred or the **Insured** was medically treated is at or above the legal limit set by that jurisdiction or (ii) the level of alcohol was such that a person's coordination, ability to reason, was impaired, regardless of the legal limit set by that jurisdiction;
14. **Sickness;**
15. expenses Incurred for the diagnosis, care or treatment of **Mental and Emotional Disorders**, alcoholism, or drug addiction/abuse;
16. [the unintended or accidental results of any procedure, surgery or operation performed either for cosmetic purpose or in an attempt to surgically treat any **Sickness**, or any elective procedure not **Medically Necessary**, including but not limited to organ donation and elective sterilization;]
17. intentional inhalation or ingestion of any poison, gas or fumes;
18. services that are not **Medically Necessary**;
19. [all medical expenses incurred by an **Insured**, including but not limited to all professional fees and charges associated with **Hospital Confinement** including, but not limited to, **Provider** fees, lab fees, miscellaneous charges, intensive care unit charges, critical care unit charges, coronary care unit charges, **Hospital** room and board and medical expense charges;]
20. expenses incurred as the result of an **Injury** that are in excess of the **Usual and Customary** expenses incurred for **Medically Necessary** treatment of such **Injury**;
21. expenses incurred for the **Medically Necessary** treatment of an **Injury** for which the **Insured** has no legal liability and responsibility for payment;
22. expenses incurred for the **Medically Necessary** treatment of an **Injury** that are covered under any other valid insurance coverage, accident medical expense benefits or health benefit plan coverage (e.g. uninsured/underinsured motorist coverage, personal injury protection coverage under any automobile policy, comprehensive major medical insurance, hospital/medical surgical insurance, other indemnity health insurance, health coverage under a HMO or PPO plan, workers compensation medical expense benefits, Federal Employers Liability Act medical expense benefits, Jones Act medical expense benefits, Medicaid, Medicare, Medicare Supplement coverage, Medicare Advantage, and any other government provided benefits that cover the **Medically Necessary** treatment of bodily **Injuries** sustained in an **Accident.**);
23. the operation by an **Insured** of any motor vehicle without the permission/consent of the owner of such vehicle;
24. the operation by an **Insured** of any motor vehicle without a valid operators license/permit;
25. bacterial or viral infection, except such infection occurring with or through a cut or wound in the skin sustained in an **Accident** or the accidental ingestion of contaminated material;
26. participation in a riot, civil commotion or insurrection;
27. [actively serving in the armed forces, including the National Guard and Army reserves;
28. injury from being arrested or incarcerated or caused while incarcerated in penal institution or government detention facility;
29. [engaging in[ bungee jumping][, scuba diving][, parachuting][, rock climbing][, para-sailing para-kiting][, surfing][, mountaineering][, skateboarding][, or as driver or passenger on an off-road ATV vehicle][, or any other hazardous avocation];]
30. [injuries from raising, caring for, handling or working with dangerous animals;]
31. [participation in rodeo or equestrian events, semi-professional or professional sports or any other hazardous activity for wage, compensation, or profit;][ and]
32. [participating in intercollegiate sports or club sport activities];[ and]
33. [any **Benefit** amount exceeding [\$500] payable for all **Insureds** under this **Certificate** during the first [0-90] days immediately following the **Issue Date** of the **Certificate**].

## VIII. UNIFORM PROVISIONS

### A. ENTIRE CONTRACT- CHANGES

The entire contract between **You** and the **Company** consists of the **Group Policy** and this **Certificate**, **Your** application for coverage, which is attached to this **Certificate**, and any amendments, riders, or endorsements to the **Group Policy** and this **Certificate**. All statements made by **You** will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to contest the insurance or reduce the [**Accident**] **Benefits** unless contained in a written application, which is signed by the applicant. No agent may:

1. change, alter or modify the **Group Policy** and this **Certificate**, or any amendments, riders, or endorsements attached thereto;
2. waive any provisions of the **Group Policy** and this **Certificate**, or any amendments, riders, or endorsements attached thereto;
3. extend the time period for payment of premiums; or
4. waive any of the **Company's** rights or requirements.

No change in the **Group Policy** and this **Certificate** will be valid unless it is:

1. noted on or attached to the **Group Policy** and this **Certificate**;
2. signed by one of **Our** officers; and
3. notice of the change is delivered to the **Primary Insured**, as shown on the **Certificate Schedule**.

### B. TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the **Issue Date**, only fraudulent misstatements in **Your** application may be used to void **Your** coverage under the **Group Policy** and this **Certificate** or deny any claim for a loss occurring after the two (2) year period.

### C. OTHER INSURANCE WITH US

**You** may have coverage under only one policy providing accidental death and dismemberment coverage with **Us**. If through error, **We** issue coverage under more than one like policy to **You**, only one coverage chosen by **You** or **Your** estate, as the case may be, will stay in force. **We** will return the money **You** paid for the other coverage.

### D. CONFORMITY WITH STATE STATUTES

Any provision of the **Group Policy** and this **Certificate** which, on the **Issue Date** shown in the **Certificate Schedule**, is in conflict with the laws of the state in which **You** live on such **Issue Date**, is amended to conform to the minimum requirements of such laws.

### E. MISSTATEMENT OF AGE

If the age of an **Insured** has not been stated correctly, his or her correct age will be used to determine (i) the amount of insurance for which he or she is entitled, [and] (ii) the effective date of termination of insurance, [and (iii) any other rights or [**Accident**] **Benefits** under the **Group Policy** and this **Certificate**.]

Premiums will be adjusted if too much or too little was paid due to the misstatement.

## F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION

During the first two (2) years an **Insured's** coverage is in force, it may be modified as provided below if, within that time, **We** discover that a medical condition or other material information was mistakenly not disclosed to **Us**:

1. The **Insured's** coverage will stay in force with no change in [**Accident ]Benefits** or premiums if the disclosure of such condition would not have affected the way the **Insured's** coverage was issued.
2. If the disclosure would have resulted in coverage not being issued to an **Insured**, **We** will return all premium paid, less any **Benefits** paid for that person during the time the coverage was in force in error. The coverage for that person shall be void from the **Issue Date**.

This Section does not apply to any fraudulent misrepresentations that are made, which in all events can result in rescission of any coverage issued as a result of such fraudulent misrepresentations.

## G. LEGAL ACTION

No action at law or in equity will be brought to recover under the **Group Policy** and this **Certificate** prior to the expiration of sixty (60) days after proof of loss has been filed as required by the **Group Policy** and this **Certificate**; nor will any action be brought after three (3) years from the expiration of the time within which proof of loss is required by the **Group Policy** and this **Certificate**.

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**THIS CONCLUDES THIS CERTIFICATE**

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SERFF Tracking Number: USHG-126902075 State: Arkansas  
 Filing Company: Freedom Life Insurance Company of America State Tracking Number: 47300  
 Company Tracking Number:  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: GACC-2010-C-AR-FLIC  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> Please see the attached Flesch Certification. <b>Attachment:</b> AR FLESCH.flic.pdf	Approved-Closed	11/19/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Not a policy filing. <b>Comments:</b>	Approved-Closed	11/19/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Cover Letter <b>Comments:</b> Please see the attached Cover Letter. <b>Attachment:</b> AR Acc Ltr.pdf	Approved-Closed	11/19/2010

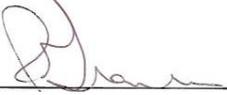
**FREEDOM LIFE INSURANCE COMPANY OF AMERICA**

**READABILITY CERTIFICATION**

I hereby certify that the forms, listed below, have been properly scored and have achieved the Flesch Score, as indicated.

Form Number  
GACC-2010-C-AR-FLIC

Flesch Score  
42.25

Signature:  \_\_\_\_\_

Name: Ranita Grauwiler

Title: Vice President – Product Development

Dated: June 9, 2010

# FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102 • 1-800-387-9027

November 11, 2010

Commissioner Jay Bradford  
Life and Health Division  
Department of Insurance  
1200 West 3<sup>rd</sup> Street  
Little Rock, AR 72201-1904

Attn: Ms. Rosalind Minor

RE: **Freedom Life Insurance Company of America**  
**NAIC 62324**                      **FEIN #61-1096685**  
**New Submission**

<b><u>Form</u></b>	<b><u>Description</u></b>
<b>GACC-2010-C-AR-FLIC</b>	<b>Association Group Accident and Hospital Indemnity Plan</b>

Dear Ms. Minor:

Enclosed please find the above-referenced form for your review and approval. *THIS FORM REPLACES AND IS AN EXACT DUPLICATE OF THE FORM YOU APPROVED ON AUGUST 6, 2010 (SERFF FILING # USHG-126668525), EXCEPT THAT THIS FORM HAS BRACKETS AROUND EXCLUSION #19 AND THE LAST FIVE EXCLUSIONS, WHICH WERE INADVERTENTLY NOT INCLUDED IN THE FIRST FILING.* I can assure you that this form has not yet been issued to Insureds in your state.

Again, this form will be marketed using application form APP-09-NOARB-FLIC, and/or APP-FI-FLIC, et al, previously approved by your Department. Previously filed optional riders and amendatory endorsements may be used with this certificate to provide additional benefits or meet regulatory requirements.

This product will be issued to any associations previously filed in your state or that will be filed in the future. The association and approval dates follow.

**Consumers Independent Association** – previously approved February 24, 2007  
**Heartland Alliance of America** – previously approved September 20, 2006  
**Small Business Association** – previously approved January 9, 2007

The group policy will be issued in Arizona, using previously approved forms GRP-P-06-FLIC and GRP-APP-FLIC. A certificate of insurance will be issued to members of the association to evidence coverage under the group policy. Please be advised this product is not employer/employee based, and it will be offered to individuals.

All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law. Paragraphs and Definitions may vary to the extent that such paragraphs and definitions may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions. Additionally, there will also be items that customarily vary according to the certificateholder's specific plan of insurance. The schedule pages of the certificate and selection page of the application are variable.

We also reserve the right to amend the referenced forms to correct any minor typographical errors we may have neglected to find prior to submitting for approval, and to amend the language in order to clarify the intent within the confines of the law.

The appropriate transmittal documents are enclosed.

Your consideration of this filing is greatly appreciated. Should you have any questions, please contact me via [cubbys@ushealthgroup.com](mailto:cubbys@ushealthgroup.com) by telephone at (800) 387-9027, ext.748, or fax (817) 878-3310.

Sincerely,

A handwritten signature in black ink that reads "Shannon Morgan Cubby". The signature is written in a cursive, flowing style.

Shannon Morgan Cubby  
Product Analyst  
Product Development