

SERFF Tracking Number: MCHX-126468971 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44685  
 Company Tracking Number: 8059.POL.AR  
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: 8059.POL.XX Individual Term Life - Time Insurance  
 Project Name/Number: 8059.POL.XX Individual Term Life - Time Insurance Company/8059.POL.XX Individual Term Life - Time Insurance Company

## Filing at a Glance

Company: Time Insurance Company

Product Name: 8059.POL.XX Individual Term Life - Time Insurance SERFF Tr Num: MCHX-126468971 State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved- Closed State Tr Num: 44685

Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Co Tr Num: 8059.POL.AR State Status: Approved-Closed

Filing Type: Form

Author: SPI McHughConsulting Reviewer(s): Linda Bird  
 Date Submitted: 01/22/2010 Disposition Date: 02/24/2010  
 Disposition Status: Approved-Closed

Implementation Date Requested: 02/22/2010  
State Filing Description:

Implementation Date:

## General Information

Project Name: 8059.POL.XX Individual Term Life - Time Insurance Company

Status of Filing in Domicile: Pending

Project Number: 8059.POL.XX Individual Term Life - Time Insurance Company

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: This program is being concurrently filed in the domicile state of Wisconsin.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 02/24/2010

Explanation for Other Group Market Type:

State Status Changed: 02/01/2010

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

Time Insurance Company

NAIC # 69477 FEIN # 39-0658730

SERFF Tracking Number: MCHX-126468971 State: Arkansas  
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Individual Term Life Policy  
8059.POL.AR, et al - Policy  
See Attached Form Listing

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned forms for your review seeking approval. The forms are new and not intended to replace any other forms currently in use.

This term life coverage will be marketed to individuals through agent/broker solicitation. This plan will be offered using the applications herewith submitted, applications previously filed for general use with individual ancillary coverages (see attached forms list), or as an integrated offer with health plans using previously filed application and enrollment forms. This program is being concurrently filed in the domicile state of Wisconsin. This policy provides term life benefits with an optional rider for accelerated benefits for critical illness.

Please note that the Policy is numbered using a matrix format, where each section of the document has a unique form number. For example, the Policy face page is numbered 8059.POL.AR, while the Exclusions section of the same document is numbered 8059.EXC.AR. The Company employs this form numbered style for administrative and tracking purposes. The Policy will always be issued in its entirety with all sections and form numbers included.

These forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Variable data or text is bracketed and a variability statement is attached herewith. Variable data will never exclude provisions required by applicable law.

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

## Company and Contact

### Filing Contact Information

Lauren Regnery, Compliance Assistant mcr@mchughconsulting.com  
McHugh Consulting Resources 215-230-7960 [Phone]  
350 South Main Street, Suite 103 215-230-7961 [FAX]  
Doylestown, PA 18901

### Filing Company Information

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(This filing was made by a third party - McHughConsulting)

Time Insurance Company	CoCode: 69477	State of Domicile: Wisconsin
501 West Michigan Avenue	Group Code: 19	Company Type:
Milwaukee, WI 53201-0624	Group Name:	State ID Number:
(414) 299-1140 ext. [Phone]	FEIN Number: 39-0658730	

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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 #
Time Insurance Company	\$50.00	01/22/2010	33722561

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/24/2010	02/24/2010
Approved-Closed	Linda Bird	02/01/2010	02/01/2010

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	01/28/2010	01/28/2010	SPI McHughConsulting	01/28/2010	01/28/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application Form for Life Insurance	SPI McHughConsulting	02/24/2010	02/24/2010

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to reopen	Note To Filer	Linda Bird	02/23/2010	02/23/2010

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## **Disposition**

Disposition Date: 02/24/2010

Implementation Date:

Status: Approved-Closed

Comment: Company has submitted revised Application Form 30186 (2/2010) to replace the original Application Form 30186 (12/2009) previously approved on 2/1/2010.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Forms List		Yes
Supporting Document	Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	01.22.10 Submission Letter		Yes
Form	Term Life Insurance Policy-Exclusions and Limitations		Yes
Form	Term Life Insurance Policy-Premium Provisions		Yes
Form	Term Life Insurance Policy-Other Provisions		Yes
Form	Term Life Insurance Policy- Table of Contents		Yes
Form	Term Life Insurance Policy-Definitions		Yes
Form	Term Life Insurance Policy-Term Life Insurance Benefits		Yes
Form	Term Life Insurance Policy-Claim Provisions		Yes
Form	Term Life Insurance Policy-Effective Date and Termination Date		Yes
Form	Term Life Insurance Policy		Yes
Form	Benefit Schedule-Term Life Insurance		Yes
Form	Critical Condition Accelerated Benefit Rider		Yes
Form (revised)	Application Form for Life Insurance		Yes
Form	Application Form for Life Insurance	Replaced	Yes
Form	Tele-App Part 2 Application		Yes
Form	Accelerated Benefit Disclosure		Yes

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## **Disposition**

Disposition Date: 02/01/2010

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		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Forms List		Yes
Supporting Document	Authorization Letter		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	01.22.10 Submission Letter		Yes
Form	Term Life Insurance Policy-Exclusions and Limitations		Yes
Form	Term Life Insurance Policy-Premium Provisions		Yes
Form	Term Life Insurance Policy-Other Provisions		Yes
Form	Term Life Insurance Policy- Table of Contents		Yes
Form	Term Life Insurance Policy-Definitions		Yes
Form	Term Life Insurance Policy-Term Life Insurance Benefits		Yes
Form	Term Life Insurance Policy-Claim Provisions		Yes
Form	Term Life Insurance Policy-Effective Date and Termination Date		Yes
Form	Term Life Insurance Policy		Yes
Form	Benefit Schedule-Term Life Insurance		Yes
Form	Critical Condition Accelerated Benefit Rider		Yes
Form (revised)	Application Form for Life Insurance		Yes
Form	Application Form for Life Insurance	Replaced	Yes
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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 01/28/2010  
Submitted Date 01/28/2010  
Respond By Date 03/01/2010

Dear Lauren Regnery,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Please be advised the first eight forms submitted did not have the attachments.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/28/2010  
Submitted Date 01/28/2010

Dear Linda Bird,

### Comments:

Please see the response below.

### Response 1

Comments: Dear Linda Bird,

Thank you for taking the time to speak with me today regarding this objection. This is a matrix policy and all of the form numbers are located within the main policy that is attached under policy number 8059.POL.AR.

I apologize for any inconvenience this may have caused.

### Related Objection 1

Comment:

Please be advised the first eight forms submitted did not have the attachments.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your continued assistance with this filing.

Sincerely,  
SPI McHughConsulting

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**Amendment Letter**

Submitted Date: 02/24/2010

**Comments:**

Dear Linda Bird,

Thank you for taking the time to speak with me yesterday and to reopen this filing. As we discussed, we have attached a revised Application Form 30186 (2/2010) for your review and approval. Please replace the application Form 30186 (12/2009) that was previously approved on February 1, 2010, with the attached, revised Application.

Below are the revisions that have been made....

Question 32 was revised to add Hodgkins Lymphoma to the list of conditions and question 34 was revised to add the first 3 bullet points.

Thank you for your continued assistance with this filing.

Sincerely,

Lauren Regnery  
 Compliance Project Specialist

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Form 30186 (2/2010)	Application/EApplication nrollment Form	Form for Life Insurance	Revised				49.000	Form 30186 (2_2010).PDF

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**Note To Filer**

**Created By:**

Linda Bird on 02/23/2010 01:10 PM

**Last Edited By:**

Linda Bird

**Submitted On:**

02/23/2010 01:10 PM

**Subject:**

Request to reopen

**Comments:**

Filing has been reopened in order for revision to be made.

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## Form Schedule

Lead Form Number: 8059.POL.AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	8059.EXC. AR	Matrix	Term Life Insurance Policy-Exclusions and Limitations	Initial		54.000	
	8059.PRM. AR	Matrix	Term Life Insurance Policy-Premium Provisions	Initial		54.000	
	8059.OTH. AR	Matrix	Term Life Insurance Policy-Other Provisions	Initial		54.000	
	8059.TOC. XX	Matrix	Term Life Insurance Policy- Table of Contents	Initial		54.000	
	8059.DEF. XX	Matrix	Term Life Insurance Policy-Definitions	Initial		54.000	
	8059.LIF.X X	Matrix	Term Life Insurance Policy-Term Life Insurance Benefits	Initial		54.000	
	8059.CLM. XX	Matrix	Term Life Insurance Policy-Claim Provisions	Initial		54.000	
	8059.EFF. XX	Matrix	Term Life Insurance Policy-Effective Date and Termination Date	Initial		54.000	
	8059.POL. AR	Policy/Contract/Fraternal Certificate	Term Life Insurance	Initial		54.000	8059_POL_AR.PDF
	8059.BNS. AR	Schedule Pages	Benefit Schedule- Term Life Insurance	Initial		58.000	8059_BNS_AR.PDF

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B590.AR	Policy/Cont Critical Condition	Initial		50.200	B590_AR.PDF
	ract/Fratern Accelerated Benefit				F
	al Rider				
	Certificate:				
	Amendmen				
	t, Insert				
	Page,				
	Endorseme				
	nt or Rider				
Form	Application/ Application Form for	Revised	Replaced Form #:	49.000	Form 30186
30186	Enrollment Life Insurance		Previous Filing #:		(2_2010).PDF
(2/2010)	Form				
Form	Application/ Tele-App Part 2	Initial		46.000	Form 30187
30187	Enrollment Application				(12_2009).PDF
(12/2009)	Form				F
B592.XX	Other Accelerated Benefit	Initial		40.000	B592_XX.PDF
	Disclosure				F

Time Insurance Company  
[501 West Michigan  
Milwaukee, WI 53203]

### TERM LIFE INSURANCE POLICY

The insurance described in this Policy is effective on the date shown in the Benefit Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this Policy. This Policy is evidence of Your coverage. This Policy is issued and delivered in the State of Arkansas.

This Policy is issued based on the statements and agreements in the application form and during the enrollment process, any exam that may be required, any other amendments or supplements and payment of the required premium. This Policy may be changed. If that happens, You will be notified of any such changes.

### RIGHT TO EXAMINE POLICY FOR [10-30] DAYS

If You are not satisfied, return the Policy to Us or Our agent within [10-30] days after You have received it. All premiums will be refunded and Your coverage will be void from the Effective Date.

### IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION FORM FOR INSURANCE

Please read the copy of the application form included with this Policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the application form. [If a material omission or misstatement is made in the application form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount.] Carefully check the application form and, if any information shown in the application form is not correct and complete, write to Us at the address above, within [10-30] days.

[Secretary's Signature]  
Secretary

[President's Signature]  
President

[This Policy is guaranteed renewable until age [65-85] years.] [This Policy contains a Pre-Existing Conditions limitation.] This Policy automatically renews except for as stated in the Effective Date and Termination Date section. Read Your Policy carefully to understand coverage limitations and termination provisions.

## GUIDE TO YOUR POLICY

The sections of the Policy appear in the following order:

- [I] Definitions
- [II] Life Insurance Benefits
- [III] Exclusions and Limitations
- [IV] Claim Provisions
- [V] Premium Provisions
- [VI] Effective Date and Termination Date
- [VII] Other Provisions

## [I.] DEFINITIONS

When reading this Policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this Policy are defined below. Just because a term is defined does not mean it is covered. Please read the Policy carefully.

### Accident or Accidental

Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.
2. It results from an external agent or trauma.
3. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
4. It is definite as to time and place.
5. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness or a stroke. Accident does not include any overdose of controlled substance, drug, or narcotic.

### [Accelerated Benefit

The benefit providing payment for a portion of the Face Amount prior to the Covered Person's death as identified on the Benefit Schedule.

### Accidental Death

Death caused by an Injury independent and exclusive of all other causes that occurs:

1. on or after the Effective Date
2. while this Policy is in effect and
3. within 90 days after such Injury and which is not excluded under Section III

### Accidental Death Benefit

An amount equal to the Face Amount as indicated on the Benefit Schedule.

### Beneficiary

The person or entity to whom a Death Benefit is payable in the event of a Covered Person's death. The Beneficiary is named by the [Covered Person]. [The Policyholder is the Beneficiary of any dependent child Death Benefit.]

### Calendar Year

The period beginning on January 1 of any year and ending on December 31 of the same year.

### Covered Dependent

A person who meets the definition of a Dependent and is eligible to receive benefits under this Policy.

### Covered Person

A person who is eligible to receive benefits under this Policy as shown on the Benefit Schedule [or added by rider].

### Death Benefit

An amount equal to the Face Amount [reduced by the amount of any Accelerated Benefit payments].

[Dependent

A Dependent is:

1. The Policyholder's lawful spouse[, including the Policyholder's Domestic Partner if recognized under applicable law]; or
2. The Policyholder's naturally born child, legally adopted child, a child that is placed for adoption with the Policyholder, a stepchild or a child for whom the Policyholder is the legal guardian:
  - [a.] [Who is unmarried; and]
  - [b.] [Who is age [18] or younger; and]
  - [c.] [Who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student; and]
  - [d.] [Whose legal address is the same as the Policyholder's legal address.]

If the child's legal address is different than the Policyholder, the child will be considered a Dependent if You submit proof that:

- [a.] [You are required by a qualified medical child support order to provide medical insurance; or]
- [b.] [The child was claimed as an exemption on Your most recent federal income tax return.]

If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

- [a.] [The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
- [b.] [The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Policyholder for financial support and be claimed as an exemption on Your most recent federal income tax return. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this Policy or within [31 days] after the child reaches the normal age for termination. Additional proof may be requested periodically but not more often than annually after the [2-year] period following the date the child reaches the normal age for termination.]

A child will no longer be a Dependent on the earliest of the date that he or she:

- [a.] [Is no longer a full-time student; or]
- [b.] [Ceases to be claimed as an exemption on the Policyholder's federal income tax return, except for a Dependent child who is a full-time student; or]
- [c.] [Attains age [24]; or]
- [d.] [Marries; or]
- [e.] [Is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.]

[Domestic Partner

[A person of the same or opposite gender who resides with the Policyholder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

[1.] [Be at least [18] years of age.]

[2.] [Be competent to enter into a contract.]

[3.] [Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides. ]

A Domestic Partner must provide Us with an affidavit attesting that the domestic partnership has existed for a minimum period of [24 months] at the time of enrollment under this Policy. Proof that the Domestic Partner relationship continues to exist will be requested by Us periodically.]

#### Effective Date

The date coverage under this Policy begins for a Covered Person as stated on the Benefit Schedule. The Covered Person's coverage begins at 12:01 a.m. local time at the Policyholder's state of residence. In addition to the original Policy Effective Date, the Benefit Schedule may indicate a subsequent endorsement Effective Date if re-issued to include changes to coverage effected after the original Policy Effective Date.

#### Expiration Date

The date insurance coverage under this Policy expires. The Expiration Date is shown on the Benefit Schedule.

#### Face Amount

The Face Amount[s] as shown on the Benefit Schedule.

#### Health Care Practitioner

A person licensed by the state or other geographic area in which the medical services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

#### Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

#### Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

#### Policy

The contract issued by Us to the Policyholder for benefit of Covered Persons.

#### Policyholder

The person to whom this Policy is issued as shown on the Benefit Schedule.

#### [Pre-Existing Condition

A Sickness or an Injury and related complication:

1. For which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or prescription drugs were prescribed during the [6-24]-month period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. That produced signs or symptoms during the [6-24]-month period immediately prior to the Policyholder's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
- b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.]

[Sickness

A disease or illness of a Policyholder. [Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness. ]]

[Total Disability/Totally Disabled

A disability resulting from bodily injury or physical or mental disease. The disability must wholly prevent the [Covered Person][Policyholder] from engaging in any gainful occupation or employment for which the person is or becomes reasonably fitted by education, training or experience. [Retired individuals and homemakers will not be considered unable to perform an occupation solely because they are unemployed.]]

[We, Us, Our, Our Company

[Time Insurance Company] or its administrator.]

You, Your, Yours

The person listed on the Benefit Summary as the Policyholder.

## II. LIFE INSURANCE BENEFITS

### [Death Benefit

[We will pay the Death Benefit shown on the Benefit Schedule to the Beneficiary if We receive proof of the Covered Person's death that occurs while this Policy is in effect] [We reserve the right to have an autopsy performed at Our expense where it is not prohibited by law before benefits are considered.]

[[At age [65-85], the Term Life Insurance Policy [terminates] [is reduced to [50-75%] of the original amount of the Death Benefit that the Covered Person had on the Effective Date].] [On the date the Term Life Insurance Policy ends for the Policyholder, coverage will also end for any Covered Dependents.]]

[[Payment will be made to the designated Beneficiary.] If there is no surviving Beneficiary, payment will be made to the Covered Person's estate. The Beneficiary designation should be kept up-to-date so that benefits will be paid as the Covered Person wants them to be paid. The Beneficiary may be changed by sending Us written notice. No change is effective until We receive written notice.]

[Once an amount equal to the Face Amount has been paid for a Covered Person, no other benefits are available for that Covered Person under this provision.]

In the event of death by suicide within the first two years of Your Effective Date under this Policy, benefits will be limited to the premium paid for this Life Insurance.

[If a Covered Person dies during the Grace Period, We will deduct any premium due Us from the Death Benefit We pay.]

### [Accidental Death Benefit

[We will pay an Accidental Death Benefit to the Beneficiary if all of the following requirements are met:

- [1.] [We receive proof of the Covered Person's death; and]
- [2.] [The proof shows that death resulted directly from bodily Injury caused solely as a result of an Accident and independent of disease, physical condition, bodily infirmity or any other cause; and]
- [3.] [Death occurred within the first [90 days] after the Accident[, unless at the end of the [90 day] period a Covered Person is comatose or is being kept clinically alive by an artificial life support system, the [90 day] limit will not apply to death resulting from that Accident]; and]
- [4.] [Death occurred while this Policy is in effect; and]
- [5.] [Death occurred prior to the date the Covered Person attains age [65-75]; and]

The maximum Accidental Death Benefit amount is in addition to the Death Benefit amount. [We reserve the right to have an autopsy performed at Our expense where it is not prohibited by law before benefits are considered.]

The Accidental Death Benefit terminates on the earliest of the date as determined in accordance with the Expiration Date of this Policy or the date a Covered Person attains age [65-75] or the date of the death of a Covered Person or if a Covered Dependent spouse [or Domestic Partner] the date on which the Policyholder and Covered Dependent spouse become legally divorced.

[Waiver of Premium

[This Waiver of Premium provision becomes effective only after [the][a] [Policyholder][Covered Person] has been continuously insured under this Policy for [[15-365] days][[2-18] months]. [After such waiting period, i][I]n the event [the][a] [Policyholder] [Covered Person] is continuously Totally Disabled for at least [1-12] months and the Total Disability began prior to age [65], We will waive [monthly] premium payments due for [the][that][Policyholder][Covered Person] for the remainder of the period of continuous Total Disability. If [the] [a] [Policyholder's][Covered Person's] Total Disability begins after age [55], the maximum benefit period will be 60 months, not to exceed the date on which [the] [that] [Policyholder][Covered Person] attains age 60.

During the first [2] years that Waiver of Premium is being provided, [the][a] [Policyholder][Covered Person] is required to provide a monthly Health Care Practitioner's statement documenting their continued Total Disability. Thereafter, We will not require a Health Care Practitioner's statement more often than once a year. Under no circumstances will Waiver of Premium extend beyond the period during which [the][a] [Policyholder][Covered Person] is Totally Disabled. [We will not waive premium for any disability related to pregnancy or childbirth[, including complications of pregnancy,] regardless of the duration of the disability.] [The Waiver of Premium benefit is only available once every [2-10] years [from the date that the Total Disability][Waiver of Premium] [began][ended].]]

The Waiver of Premium provision terminates on the earliest of the date as determined in accordance with the Expiration Date of this Policy or the date a Covered Person attains age [65-75] or the date of the death of a Covered Person or if a Covered Dependent spouse [or Domestic Partner] the date on which the Policyholder and Covered Dependent spouse become legally divorced.

### [III.] EXCLUSIONS AND LIMITATIONS

#### Exclusions

[We will not pay benefits for loss caused by any of the following:

- [1.] [War or any act of war[, whether declared or undeclared].]
- [2.] [Participation in the armed forces of any country, combination of countries or international organization, whether or not it is at war, unless such loss is due to Injury sustained while the Covered Person is off duty.]
- [3.] [[Suicide,] attempted suicide or self-inflicted Sickness or Injury[, while sane or insane,] [even if the Covered Person did not intend to cause the harm which resulted in death from the action which led to the self-inflicted Sickness or Injury,] within two (2) years from the date of issue of the Policy or within two (2) years of the Effective Date of any increase in the face amount of the Policy.]
- [4.] [Taking part in a riot or insurrection or any act incident to riot or insurrection when the Covered Person takes part in such riot or insurrection.]
- [5.] [Resisting or fleeing from arrest.]
- [6.] [Participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]
- [7.] [Voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]
- [8.] [Voluntarily taking, absorbing, or inhaling any gas, poison or drugs.]
- [9.] [Intoxication that includes, but is not limited to, operating a motor vehicle while intoxicated. Intoxication and intoxicated mean that the Covered Person's blood alcohol level at the time of the incident exceeded the blood alcohol level otherwise permitted by law or violates legal standards [for a person operating a motor vehicle] in the state where death occurs.]
- [10.] [Air travel, in any type of vehicle, except as a fare-paying passenger traveling on a regularly scheduled flight by an airline.]

[Additional Exclusions specific to Accidental Death Benefit:

- [11.] [Disease, other than bacterial infection, occurring through an Accidental Injury, or medical or surgical treatment of disease or infirmity.]
- [12.] [Air travel, in any type of vehicle, except as a fare-paying passenger traveling on a regularly scheduled flight by an airline.]]

[Additional Exclusions specific to Waiver of Premium:

- [13.] [Foreign or domestic acts of terrorism [that result in a nationwide epidemic].]

- [14.] [Disability caused by or related to: [mental illness; anxiety or nervous disorders]. [Mental illness and anxiety or nervous disorders include all disorders listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.]]
- [15.] [Disability caused by or related to Injury received while engaging in any hazardous occupation or other activity including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity. ]
- [16.] [Disability caused by or related to Injury received while engaging in any hazardous occupation or other activity for which compensation is received including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports], [extreme sports], [parachute jumping], [hot-air ballooning], [hang-gliding], [bungee jumping], [scuba diving], [sail gliding], [parasailing], [parakiting], [rock or mountain climbing], [parkour], [free running], [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle], [skiing], [horse riding] [, hunting] [, or] [rodeo activities] [, or similar hazardous activities]. Also excluded is disability due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity. ]]

#### [Limitations

We will not pay Waiver of Premium Benefits for Total Disability that is related to or caused by a Pre-Existing Condition until the Policyholder has been continuously covered under this Policy for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]

## [IV.] CLAIM PROVISIONS

### Notice of Claim

We must be notified of the claim within [30-90] [calendar][business] days after the covered loss occurs, or as soon as reasonably possible[, by calling Our Home Office]. When providing notice of the claim, include the Covered Person's name, address, and Policy number.

### Claim Forms

Within [15-30] [calendar][business] days after We receive the notice of claim, We will provide claim forms to be used when submitting proof of loss. The forms must be completed and sent to Us or Our designee. If You do not receive the claim forms within [15-30] [calendar][business] days, We will accept a written description of the exact nature and extent of the loss as proof of loss provided it meets the requirements, including timeframes, for submitting proof of loss stated below.

### Proof of Loss

We must receive written or electronic proof of loss for the covered loss for which the claim is made. Proof of loss must be provided to Us within [90-180] [calendar][business] days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date the proof of loss is otherwise required, except for absence of legal capacity.

The proof of loss must include all of the following:

1. Covered Person's name, address and Policy number.
2. Due proof of loss

[3.] [The details and supporting medical documentation of the loss for which claim in made.]

When We receive written or electronic proof of loss, We may require additional information. All items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section must be furnished to Us. We will not pay benefits if the required information or authorization for its release is not furnished to Us.

### Right to Collect Information

To determine Our liability, We may request additional information from a Covered Person, Health Care Practitioner, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within [30-90] [calendar][business] days of Our request. Benefits will be denied if We are unable to determine Our liability because a Covered Person, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records and death records to Us and other information We requested.
2. Provide Us with information We requested about pending claims or other insurance coverage.
3. Provide Us with information as required by any contract with Us.
4. Provide Us with information that is accurate and complete.
5. Have any examination or autopsy completed as requested by Us.
6. Provide reasonable cooperation to any requests made by Us.

Upon receipt of information allowing the determination of Our liability, We will reopen any claim for benefits. No claim for benefits can be reopened after [180-540] [calendar][business] days.

#### Physical Examination Medical Review

We have the right to have a Health Care Practitioner of Our choice conduct a review of medical records and/or examine a Covered Person at any time regarding a claim for benefits to verify any claim of death. Health Care Practitioner charges for these reviews and/or exams will be paid by Us. We also have the right, in case of death, to have an autopsy done, at Our expense, where it is not prohibited by law.

#### Payment of Benefits

When We receive due written proof of loss [,] and determine Our liability, benefits will be paid to the Beneficiary of record. Any benefits unpaid at Your death will be paid to Your Beneficiary. [Benefits may not be assigned.]

Any amount We pay will release Us from further liability for that amount. Any benefit paid in error may be recovered from You or the person or entity receiving the incorrect payment. We may offset the overpayment against future benefit payments.

#### Rights of Administration

We maintain Our ability to determine Our rights and obligations under this Policy including, without limitation, the eligibility for and amount of any benefits payable.

#### Claims Involving Fraud or Misrepresentation

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this Policy and it is later shown the claims for these benefits involved misrepresentation or fraud, We will be entitled to a refund from You, the Beneficiary or the person or entity receiving the payment.

If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the claimant may be subject to civil and/or criminal penalties.

#### Claim Appeal

You or Your Beneficiary have the right to request a review of all adverse claim decisions. A review must be requested by writing to Us at Our Home Office within 180 days following the claimant's receipt of the notice that the claim was denied or reduced.

## [V.] PREMIUM PROVISIONS

### Consideration

This Policy is issued based on the statements and agreements in the Covered Person's application form, any exam of a Covered Person that is required, any other amendments or supplements to the application form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

### Premium Payment

The initial premium must be paid [on or before the due date for this coverage to be in effect. Subsequent premiums are due] as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received [by] [Us][or][Our designee][in cash or check][or][by credit card or automatic charge to a bank account][at Our office] on [or before] the date due. [We may agree to accept premium payment in alternative forms[, such as credit card or automatic charge to a bank account].] If We tried to obtain payment for the amount due but were unsuccessful, We reserve the right to require an alternative form of payment during the grace period.

[Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] age, [smoking status,] and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage. [The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.]

### Grace Period

There is a grace period of 31 calendar days for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the grace period ends.

Coverage will continue during the grace period unless You call Our office or give Us written notice to cancel the coverage. If a claim is payable during the grace period, any unpaid premiums due will be deducted from the claim payment.

### Reinstatement

If any premium is not paid within the required time period, coverage for You and any Covered Dependents will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than three years;
2. You submit a supplemental application form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us;
3. We approve Your application form for reinstatement; and
4. the eligible term period of this Policy has not expired.

The coverage will be reinstated on the date We approve Your application form for reinstatement together with all premium owed to Us since the date of lapse with interest on such premium amount at a rate of 6%

per annum compounded annually. [Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid.]

[If the coverage is reinstated, the Policy is subject to a new Pre-Existing Condition period that begins on the date that We approve Your application form for reinstatement.

A reinstated Policy will only cover loss resulting from a death [or Injury] [or Sickness] [or Total Disability] occurring after the date of reinstatement. No benefits will be paid for death resulting from any such condition and related complications if prior to the reinstatement date:

1. Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or prescription drugs were prescribed regardless of whether the condition was diagnosed or not diagnosed; or
2. The condition produced signs or symptoms that were significant enough to establish manifestation or onset by one of the following tests:
  - a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
  - b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

This limitation will apply until coverage has been in effect for [12-24] months after the reinstatement date. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]

In all other respects, You and Our company will have the same rights as existed under this Policy before the coverage lapsed, subject to any provisions included with or attached to this Policy in connection with the reinstatement.

## [VI.] EFFECTIVE DATE AND TERMINATION DATE

### Eligibility and Effective Date of Covered Person

A person who is eligible may elect to be covered under this Policy by completing and signing an application form and submitting any required premium. [You must be a resident of or employed in Your primary occupation in the state where this Policy is issued on the Effective Date.] [Evidence of insurability must also be provided.] Your coverage will take effect at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

### Eligibility and Effective Date of Dependents

The following information explains how You can obtain coverage for any Dependents that You want to add to Your Policy. A Dependent can be added after the Policyholder's Effective Date. To be covered under this Policy, a person must meet the Dependent definition in this Policy and is subject to the additional requirements below:

a. Adding a Newborn Child: A newborn child can be added on the date the child was born. You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within [31] days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is born.

b. Adding an Adopted Child: A newly adopted child can be added on the date the child is placed with the Policyholder in anticipation of legal adoption and the Policyholder assumes a legal obligation for support of the child. You must call Our office or send Us written notice of the placement for adoption of the child and We must receive any required additional premium within [31] days of the placement for adoption. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is placed for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.

c. Adding Any Other Dependent: To add any other Dependents, an application form must be completed and sent to Us along with any required premium. [Evidence of insurability must also be provided.] The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date We approve coverage under Our coverage criteria.

### Termination Date of Coverage

The Policyholder's Term Life Insurance Policy terminates on the earliest of the date as determined in accordance with the Expiration Date of this Policy or the date of renewal occurring on or after his or her [65-85th] birthday. Dependent life insurance coverage terminates on the earliest of the date as determined in accordance with the Expiration Date of this Policy or the date a Covered Dependent no longer meets the Dependent definition in this Policy or the date the Policyholder's life insurance coverage ceases or, if a Covered Dependent spouse [or Domestic Partner], the date of renewal occurring on or after his or her [65-85th] birthday or the date on which the Policyholder and Covered Dependent spouse become legally divorced.

The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws of the state in which the Policy is issued minus any claims that were incurred after the Expiration Date and paid by Us.

This Policy will terminate at 12:01 a.m. local time in the state of issue on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this Policy or on a later date that is requested by the Policyholder for termination.
2. The date this Policy lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
3. The date of death of the Policyholder.
4. The [10<sup>th</sup>-30<sup>th</sup>] annual anniversary date following the Effective Date.
- [5.] [The date the Policyholder attains [65-85] years of age.]
- [6.] [The date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
- [7.] [On] [T][t]he date the Policyholder moves to a state where We do not provide individual life insurance coverage.]

## [VII.] OTHER PROVISIONS

### Assignment [Prohibited]

A Covered Person's right to benefits under this Term Life Insurance Policy is [not] assignable. [A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment. We are not responsible for the validity or effect of any assignment of life insurance benefits.]

### Change of Beneficiary

The right to change a beneficiary is reserved for the Policyholder, and the consent of the beneficiary or beneficiaries is not required for any change of beneficiary or beneficiaries or for any other changes in this Policy.

### Policy Changes

No change in the Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any Policy provision or waive any other applicable application or application requirements.

### Modification of Your Coverage

We may modify the insurance coverage for You under this Policy at any time. This modification will be consistent with state law and will apply uniformly to all policies with Your plan of coverage. You will be notified of any change.

### Clerical Error

If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled.

Delay or failure to report termination of any insurance will not continue the insurance in effect beyond the date it would have terminated according to this Policy.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within [60] days of Our notifying You of the error.

### Conformity with State Statutes

If this Policy, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this Policy, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the Policy to the contrary. If payment of the benefits under this Policy would violate any U.S. economic or trade sanctions, such coverage will be null and void.

### Enforcement of Policy Provisions

Failure by Us to enforce or require compliance with any provision within this Policy will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

### Entire Contract

This Policy is issued to the Policyholder. The entire contract of insurance includes the Policy, the benefit schedule, a Covered Person's application form, and any riders and endorsements to this Policy.

#### [Incentives, Rebates and Contributions

We may elect to furnish or participate in programs with other organizations that furnish individual applicants for coverage or Policyholders that meet common criteria or requirements determined by Us with "premium holidays" or programs where premiums, fees, Policy benefit limits will be discounted, credited, refunded, waived or otherwise adjusted or where other gifts or items of value may be offered or provided to You at no charge or a discount at a time or times or for a period determined by Us.]

#### Misstatements

If a Covered Person's material information, including but not limited to occupation, age or income, has been misstated and the premium or benefit amount would have been different had the correct information been disclosed, an adjustment in premiums or benefit level will be made based on the corrected information. In addition to adjusting future premiums, We will require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age, occupation or other information furnished by the Covered Person is misstated and coverage would not have been issued based on had such information been accurately provided, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.

#### Representations Made on Application

A copy of the application form will be included when the Policy is issued. All statements made on the application form will be deemed representations and not warranties. No statement made in the application form will be used in any suit or action at law or equity unless a copy of the application form is furnished to the Policyholder, or in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's Beneficiary or personal representative.

#### Rescission of Insurance and/or Denial of Claim and Time Limit on Certain Defenses

[Within the first two years after the Effective Date of coverage,] We have the right to rescind or modify Your Policy of insurance coverage and/or deny a claim for a Covered Person if the application form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a Policy of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.

#### Incontestability

This Policy shall be incontestable, except for nonpayment of premium, after it has been in effect for a period of two years from the Effective Date, or if reinstated, the reinstatement date.

#### Legal Action

No suit or action at law or in equity may be brought to recover benefits under this Policy until the exhaustion of administrative remedies. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review process. No suit or action at law or in equity can be brought later than [2-4] years from the date proof of loss was required.

#### Forum

Any lawsuits or disputes arising under the terms of the Policy must be brought in the United States District Court for the Eastern District of Wisconsin.

**TERM LIFE INSURANCE**  
**BENEFIT SCHEDULE**

POLICYHOLDER: [Jane Doe] INITIAL ANNUAL PREMIUM: [\$XXX.XX]  
 POLICY NUMBER: [00000001] MAXIMUM GUARANTEED  
 ANNUAL PREMIUM: [\$XXX.XX]  
 [TERM PERIOD:] [5 - 30 YEARS] [PAYMENT MODE:] [MONTHLY]  
 EXPIRATION DATE: [MM/DD/YYYY] [[MODAL] PREMIUM:] [\$XXX.XX]  
 Effective Date: [MM/DD/YYYY]  
 [Effective Date of this endorsement:] [MM/DD/YYYY]

Subject to the Policy Effective Date and Termination Date section, coverage may terminate prior to the Expiration Date shown above. Read Your Policy carefully.

[Death Benefit:	
	<u>Face Amount</u>
[Policyholder	\$[1,000-750,000]]
[Covered Dependent Spouse	\$[1,000-750,000]]
[Covered Dependent Child(ren)	\$[1,000-100,000]]
[This Amount of Life Insurance will be subject to the Age Reduction Percentages listed below:]	
[Age Reduction Percentages:]	
[Reduction Age:]	[Reduction Percentage:]
[[55]	Reduces to [70]% of the amount in force upon attainment of age [55]]
[[65]	Reduces to [60]% of the amount in force upon attainment of age [65]]
[[70]	Reduces to [60]% of the amount in force upon attainment of age [70]]

[[Accidental Death Benefit:]	
[[The Accidental Death Benefit will be] [[an amount equal to] [and in addition to]] the amount of Death Benefit [(including any applicable adjustment or reduction)] in effect on the date of loss.]	
[Policyholder	\$[1,000-750,000]]
[Covered Dependent Spouse	\$[1,000-750,000]]
[Covered Dependent Child(ren)	\$[1,000-100,000]]

[[Critical Condition Accelerated Benefit [Rider]

[Waiting Period:

- [Cancer Type A or Cancer Type B first Diagnosed within the [10-60] days after the Covered Person's rider effective date will not be eligible for benefits.]
- [For all other Critical Conditions,] [L][I]oss due to Sickness that occurs within the first [10-60] days after the Covered Person's rider Effective Date will not be eligible for benefits. Loss due to Injury is eligible for benefits from the Effective Date of the Critical Condition Accelerated Benefit rider.]

Up to 100% of the Critical Condition Benefit Lifetime Maximum will be paid.

	[Policyholder]	[Covered Dependent Spouse]
[Critical Condition Benefit Lifetime Maximum:]	[\$1,000 – 750,000]	[\$1,000 – 750,000]
[Critical Condition Benefit Lifetime Maximum remaining:]	[\$1,000 – 750,000]	[\$1,000 – 750,000]

Critical Condition	Benefit as percent of Critical Condition Benefit Lifetime Maximum
Advanced Alzheimer's Disease	[10% - 100%]
[Blindness]	[10% - 100%]
[Cancer Type A]	[10% - 100%]
[Cancer Type B]	[10% - 100%]
[Coma]	[10% - 100%]
[Coronary Artery Bypass Graft]	[10% - 100%]
[Deafness]	[10% - 100%]
[End Stage Renal Disease (Kidney Failure)]	[10% - 100%]
[Heart Attack]	[10% - 100%]
[Heart Valve Surgery]	[10% - 100%]
[Loss of Limbs]	[10% - 100%]
[Major Burns]	[10% - 100%]
[Major Organ Transplant]	[10% - 100%]
[Paralysis]	[10% - 100%]
[Stroke]	[10% - 100%]

- Benefits are payable only once for each condition.]
- Only one Critical Condition Benefit will be payable for multiple procedures performed in the same surgical session. The benefit payable will be the highest applicable benefit shown on the Benefit Schedule.]
- Benefits payable for all Critical Conditions combined are limited to the Critical Condition Benefit Lifetime Maximum.]

- The Policy [Death Benefit] Face Amount, up to the full amount, will be reduced by Critical Condition Benefit amounts paid.]
- Critical Condition Benefits are reduced by [50%] as of the Covered Person's [60-70]th birthday.]
- Critical Condition Benefits terminate the earlier of age [65] or at the end of the Policy Term.]]

[[Waiver of Premium for Total Disability Benefit:]

[Policyholder]:

[Jane Doe]

**[AGENT INFORMATION]**

[Name]

Address & Telephone Number]

## CRITICAL CONDITION ACCELERATED BENEFIT RIDER

The provisions of this CRITICAL CONDITION ACCELERATED BENEFIT RIDER are made a part of the Policy and are subject to all Policy provisions and definitions unless modified herein. This rider is only applicable to the Covered Person(s) as of the given Effective Date for this rider as shown in the Benefit Schedule. Any Waiting Periods or contestability periods applicable to this rider will be based on this rider's Effective Date.

Benefits paid under this rider will reduce the benefits payable under the Policy.

Benefits payable under this rider may be taxable. You or Your Beneficiary may incur a tax obligation. A tax advisor should be consulted to determine the impact of benefits paid under this rider.

### DEFINITIONS

#### [Activities of Daily Living (ADLs)]

Activities used in measuring your levels of personal functioning capacity. Normally, these activities are performed without assistance, allowing you personal independence in everyday living.

The ADLs are:

1. Maintaining continence: controlling urination and bowel movements, including ability to use ostomy supplies or other devices such as catheters;
2. Transferring: moving between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing;
4. Toileting: getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene; and
5. Eating: performing all major tasks of getting food into your body.]

#### [Advanced Alzheimer's Disease]

Diagnosis of Advanced Alzheimer's disease [before age [x]] by a board certified neurologist or board qualified geriatrician. Diagnosis must include documented medical evidence that the Covered Person has experienced permanent loss of the ability to: remember, reason; understand and express ideas. The Covered Person must permanently require daily supervision and assistance for at least three Activities of Daily Living. No other types of dementia are covered.]

#### [Blindness]

Diagnosis of an irreversible reduction in sight[ as a result of Sickness or Injury][, lasting at least 180 days,] that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together.]

#### [Cancer Type A]

1. A malignant neoplasm (including hematologic malignancy), which is characterized by the uncontrolled growth & spread of malignant cells such as:
  - a. Leukemia & Lymphomas.
  - b. All N0M0 cancers of stage T1 or higher not listed under Cancer Type B
  - c. Skin cancers with nodal or metastatic involvement (N1, M1).

2. It does not include:
  - a. Anything not listed above.
  - b. Any carcinoma-in-situ growth regardless of origin, classified as TisN0M0.
  - c. Anything in Cancer Type B.]

[Cancer Type B

1. In-Situ cancer that affects only the area of the body in which it began, has not spread and, is classified by pathology as TisN0M0. Cancer Type B includes:
  - a. In-situ cancers classified as TisN0M0.
  - b. Bowen's disease.
  - c. Ductal carcinoma in situ (DCIS)
  - d. Lobular carcinoma in situ (LCIS).
  - e. Other specific localized cancers including:
    - i) Prostate cancer in early stage (T1N0M0).
    - ii) Gastrointestinal (GI) cancers staged T1N0M0 treated solely with endoscopy.
    - iii) Melanoma (T1N0M0) - All other stages of melanoma are Cancer Type A.
2. It does not include:
  - a. Anything in Cancer Type A.
  - b. Benign and pre-malignant tissue diagnosed by clinical or laboratory studies. Condition(s) include, but are not limited to:
    - i) Intraepithelial neoplasia (ie. prostate intraepithelial neoplasia (PIN)) and other such lesions.
    - ii) Abnormal pap smear results – cervical dysplasia known as LGSIL, HGSIL or ASCUS.
    - iii) Benign tumors or polyps.
    - iv) Actinic Keratosis.
    - v) Leukoplakia or Erythroplakia.
    - vi) All skin cancers not listed in Cancer Type A or Cancer Type B.]

[Coma/Comatose

A state of unconsciousness, characterized by the absence of any voluntary, purposeful movement, from which the Covered Person cannot be aroused for a period of at least [96 hours].

For the purpose of this rider, Coma does not include any medically induced coma.]

[Coronary Artery Bypass

A procedure which uses a saphenous vein or internal mammary artery graft to surgically bypass obstructions in a native coronary artery or arteries to treat coronary artery atherosclerosis. For the purpose of this rider, Coronary Artery Bypass does not include: balloon angioplasty, laser relief of obstruction or any other intra-arterial procedures.]

[Cosmetic Services

A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem, or body image and/or to relieve or prevent social, emotional or psychological distress.]

Critical Condition

Any Condition for which this rider pays benefits, consisting only of those identified as Critical Conditions on the Benefit Schedule. Conditions for which the Covered Person has received a Diagnosis or

procedures that the Covered Person has undergone, anytime prior to his or her Effective Date under the rider, are not considered Critical Conditions for the purpose of this rider.

[Deafness

An irreversible loss of hearing[,as a result of Sickness or Injury,] for all sounds in both ears. Diagnosis must be on the basis of audiometric and auditory threshold tests indicating an auditory threshold of 90 decibels or less while using a hearing aid.]

Diagnosis

A Diagnosis made during the Covered Person's life by a Health Care Practitioner that is supported by diagnostic evaluations, clinical tests, observations, and laboratories, documented in the Covered Person's medical records.

[End Stage Renal Disease (Kidney Failure)

A Diagnosis of chronic and irreversible failure of both kidneys which requires treatment by regular dialysis for at least 90 days or kidney transplant.]

[Heart Attack

A new myocardial infarction resulting in the death of an area of the heart muscle due to insufficient blood supply to that area. The basis of the Diagnosis must include: typical clinical presentation; serial measurements of cardiac biomarkers showing a pattern and level consistent with a Heart Attack; and new electrocardiographic changes consistent with acute myocardial infarction.]

[Heart Valve Surgery

Having undergone a median sternotomy (surgery to divide the breastbone) in order to replace or repair one or more heart valves.]

[Loss of Limbs

Severance of two or more limbs at or proximal to the wrist or ankle joints.]

[Major Burns

Acute full thickness or third degree burns covering at least 20% of a Covered Person's body surface area.]

[Major Organ Transplant

Having undergone surgery as a recipient of a transplant as follows:

1. Human bone marrow using hematopoietic stem cells preceded by ablative therapy (Platelet/blood infusions excluded) [for any of the following specified diseases]:
  - [a.] [Aplastic Anemia including Acquired secondary to Ablative chemotherapy.]
  - [b.] [Leukemia/Lymphoma/Myeloproliferative Disorders.]
  - [c.] [Inherited disorders of metabolism.]
  - [d.] [Severe Combined Immunodeficiency Disease.]

[e.] [Multiple myeloma.]

2. Human organ because of the irreversible end stage failure of such organ, limited to[ the following organs and specified diseases]:
  - [a.] [Heart [- due to any of the following specified diseases: Tumors, cardiomyopathy, congenital heart disease, heart failure, inoperable coronary artery disease].]
  - [b.] [Lung[- due to any of the following specified diseases: Fibrotic lung disease, obstructive lung disease, primary pulmonary hypertension].]
  - [c.] [Liver[ - due to any of the following specified diseases: Cirrhosis, end stage liver disease, hepatic failure, metabolic & inherited diseases, unresectable hepatic tumor].]
  - [d.] [Kidney[-due to end stage renal disease].]
  - [e.] [Kidney/Pancreas[- due to diabetes mellitus].]
  - [f.] [Small Intestine[ - due to any of the following specified diseases: Short Gut Syndrome, diseases causing life-threatening malabsorption such as Hirschsprung's disease and Other life-threatening Motility disorders].]

#### [Paralysis

A total and irreversible loss of use of two or more Limbs. "Limbs" means the entire arm or entire leg. The Paralysis must be due to neurological Injury or Sickness of associated nerves that is expected to last continuously for 12 months or longer [and continuously present for a period of at least [180 days]]. Paralysis, for the purposes of this rider does not include any Paralysis caused by a Stroke.]

#### [Special Exception Rider

A form that is included with this rider which identifies a body part, system, disease, Sickness, Injury or other condition for a Covered Person in which all claims related to that body part, system, disease, Sickness, Injury or other condition are excluded from coverage for a specified period of time as shown in the Special Exception Rider.]

#### [Stroke

Brain tissue infarction due to acute cerebrovascular incident, embolism, thrombosis or hemorrhage. The basis of the Diagnosis must include evidence of:

1. Neurological damage persisting for at least [30 days] and the damage is expected to be permanent; and
2. Magnetic Resonance Imaging, computerized tomography or other neuroimaging studies consistent with Diagnosis of a new Stroke.

For the purposes of this Policy Stroke does not include:

1. Transient Ischemic Attacks (TIAs).
2. Transient Global Amnesia (TGA).
3. External trauma causing Injury to the brain.
4. Brain damage due to infection, vasculitis, encephalopathy and inflammatory disease.
5. Ischemic disorders of the vestibular system.]

#### [Waiting Period

The period of time after the Effective Date of this rider, during which loss due to [Injury or] Sickness will not be eligible for benefits.]

## BENEFITS

### Benefits Provided

If, after any applicable Waiting Period, a Covered Person has a Diagnosis or procedure qualifying as a Critical Condition while insured under this rider We will pay the benefits shown in the Benefit Schedule.

We will not pay benefits for any condition or procedure if the Covered Person has received that Diagnosis or procedure at any time prior to the Covered Person's Effective Date of coverage under this rider.

Only one Critical Condition Benefit will be payable for multiple procedures performed in the same surgical session. The benefit payable will be the highest applicable benefit shown on the Benefit Schedule.

### Amount of Benefit

Benefits are payable according to the amount shown for each specific Critical Condition on the Benefit Schedule.

Benefits are payable no more than one time for each specific Critical Condition listed on the Benefit Schedule for a Covered Person.

The total amount payable for all Critical Conditions combined for a Covered Person is limited to the Critical Condition Benefit lifetime maximum.

[At age [60-70] the Critical Condition Benefits are reduced to [50%] of the original amount of Critical Conditions Benefit that the Covered Person has on the rider Effective Date.]

### Payment of Benefits

Benefits under this rider will be payable to the Policyholder or, if the Policyholder is not living at the time benefits are payable to the Beneficiary according to the terms of the Policy to which this rider is attached.

### [Effect of Critical Condition Benefit Payment

The Policy [Death Benefit] Face Amount, up to the full amount, will be reduced by Critical Condition Benefit amounts paid. [Payment of an accelerated benefit will not reduce any Accidental Death Benefits available to You under the Policy.]]

## EXCLUSIONS AND LIMITATIONS

In addition to the Limitations and Exclusions of the Policy to which this rider is attached, We will not pay benefits under this rider for:

- [1.] Any Critical Condition if the Covered Person was previously Diagnosed with or underwent the procedure qualifying that Critical Condition anytime prior to his or her Effective Date under this Policy.
  - [2.] [[Cancer Type A or Cancer Type B first Diagnosed within the [10-90 day] Waiting Period immediately following the rider Effective date; or] [any [other] Critical Condition [due to Sickness] first occurring within the [10 – 90] day Waiting Period immediately following the rider Effective Date. [In such event, We will terminate this rider and refund the portion of the premium paid for this rider.]
  - [3.] Any Critical Condition that is related to or caused by a Pre-Existing Condition until the Covered Person has been continuously covered under this rider for [12-24] months. [A condition that has been specifically excluded from coverage will continue to be excluded after [12-24] months of continuous coverage.]]
  - [4.] Any loss for which Our liability cannot be determined because a Covered Person, Health Care Practitioner, facility, or other individual or entity within 30 calendar days of Our request, failed to:
    - a. Authorize the release of all medical records to Us and other information We requested.
    - b. Provide Us with information We requested about pending claims or other insurance coverage.
    - c. Provide Us with information as required by any contract with Us.
    - d. Provide Us with information that is accurate and complete.
    - e. Have any examination completed as We requested.
    - f. Provide reasonable cooperation to any requests made by Us.
- Upon receipt of information allowing the determination of Our liability, We will reopen any claim for benefits. No claim for benefits can be reopened after [180-540] [calendar][business] days.
- [5.] [Conditions or procedures related to or a complication of a Pre-Existing Condition.]
  - [6.] [Conditions or procedures caused by or contributed to by:
    - a. War or any act of war, whether declared or undeclared.
    - b. Participation in the military service of any country or international organization, including non-military units supporting such forces.
    - c. Foreign or domestic acts of terrorism[ that result in a nationwide epidemic].]
  - [7.] [Conditions or procedures caused by or related to: [mental illness; anxiety or nervous disorders;] [substance abuse, including alcohol abuse and use of depressants, narcotics, hallucinogens, excitants, or other chemical substances, except when taken under the medical advice of a Health Care Practitioner;] [behavior modification or behavioral (conduct) problems;] or [learning disabilities]. [Mental illness and anxiety or nervous disorders include all disorders listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.]]

- [8.] [Conditions or procedures caused by or related to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was [.08 or higher][over the legal limit]. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the accident.]
- [9.] [Conditions or procedures related to or caused by the Covered Person's voluntary attempt to commit, participation in or commission of a felony, misdemeanor, or illegal act.]
- [10.] Conditions or procedures related to or caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, including voluntary ingestion, inhalation or injection of poisons, toxins or gaseous substances, even if the Covered Person did not intend to cause the harm which resulted from the action. This exclusion applies regardless of whether the Covered Person was sane or insane at the time the event occurred.
- [11.] [Conditions or procedures due to an Injury received while engaging in any hazardous occupation or other activity including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports,] [extreme sports,] [parachute jumping,] [hot-air ballooning,] [hang-gliding,] [bungee jumping,] [scuba diving,] [sail gliding,] [parasailing,] [parakiting,] [mountain climbing,] [parkour,] [free running,] [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle,] [horse riding] [ or] [rodeo activities,] [ or similar hazardous activities]. Also excluded is any condition or procedure due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]
- [12.] [Conditions or procedures due to an Injury received while engaging in any hazardous occupation or other activity for which compensation is received including the following: Participating, instructing, demonstrating, guiding or accompanying others in [professional or semi-professional sports,] [extreme sports,] [parachute jumping,] [hot-air ballooning,] [hang-gliding,] [bungee jumping,] [scuba diving,] [sail gliding,] [parasailing,] [parakiting,] [mountain climbing,] [parkour,] [free running,] [racing [including stunt show or speed test] of any motorized [or non-motorized] vehicle,] [skiing,] [horse riding,] [ hunting] [ or] [rodeo activities,] [ or similar hazardous activities]. Also excluded is condition or procedure due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity. ]
- [13.] [Any condition, treatment, body part, or system specifically excluded by a Special Exception Rider.]
- [14.] [Conditions or procedures that are caused by, or complications of Cosmetic Services.]
- [15.] [Conditions or procedures caused by or related to a complication of a Sickness, Injury, or medical treatment or services that are not covered under this rider.]
- [16.] [Procedures performed outside of the United States or its territories.]

TERMINATION

Coverage for a Covered Person under this rider will terminate at 12:01 a.m. local time in the state of issue on the earliest of the following dates:

- [1.] The date this rider or Policy to which this rider is attached terminates.
- [2.] The date the Covered Person no longer meets this Policy's definition of a Dependent or Policyholder.
- [3.] [The date the Covered Person attains age [65-75] years.][The anniversary date of this Policy following the Covered Person's [65th – 75th] birthday.]
- [4.] The date We receive a request in writing or by telephone to terminate coverage under this rider or on a later date that is requested by the Policyholder for termination.

Nothing contained in this rider will be held to vary, alter, waive or extend any of the terms, conditions, agreements, exclusions or limitations of the Policy other than as stated above. The provisions of this rider supersede any provisions of the Policy with which they may be in conflict.

[Secretary's Signature]  
Secretary

[President's Signature]  
President

# Application Form for [Term Life Insurance] [with] [Optional Coverage[s]]

## AGENT/AGENCY INFORMATION

PLEASE PRINT IN BLACK INK

Agent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Agent Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Key Agency Contact: \_\_\_\_\_ Agency Name: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_ Agency Number: \_\_\_\_\_

[Policy should be mailed to:]       Agent       Agency       Policyholder

## TYPE OF ACTIVITY (Please check appropriate box.)

NEW [If not a new applicant, check appropriate box and list affected policy number.]

<input type="checkbox"/> CHANGE/ADDITION TO AN EXISTING POLICY. POLICY # _____ ]	
<input type="checkbox"/> Internal Replacement <input type="checkbox"/> Adding Dependent <input type="checkbox"/> Removal of Tobacco Rates <input type="checkbox"/> Applying for Preferred Rates <input type="checkbox"/> Removal of [Condition Specific Deductible] [or] [Special Exception Rider]]	<input type="checkbox"/> Removal/Reduction of Special Class Premium <input type="checkbox"/> Conversion (over age dependent/divorce) <input type="checkbox"/> Policy/Benefit Change to an Existing Policy [List Type if Change Requested: _____] <input type="checkbox"/> Reinstatement of Coverage

## REQUESTED EFFECTIVE DATE

Requested effective date \_\_\_\_\_

[A policy may not have an effective date of the 29th, 30th, or 31st.] [Your effective date is based on the date [you sign] [we receive] your application form.] [If [you sign] [we receive] it on the [1st] through the [15th] of the month, your effective date will be the [1st] of the [following] month. If [you sign] [we receive] the application form on the [16th] through the [31st] of the month, your effective date will be the [15th] of the [following] month.] [Check with your agent for more details.]

## PERSON[S] TO BE INSURED

	Last	Name First	M.I.	Sex	Age	Birthdate (MM/DD/YY)	State of Birth	Height	Weight	Social Security Number
1. [PRIMARY] [PROPOSED] [INSURED]										
2. [SPOUSE] [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S) (list relationship)	Last	Name First	M.I.	Sex	Age	Birthdate (MM/DD/YY)	Full-time Student?	Height	Weight	Social Security Number

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4a. Resident Address: \_\_\_\_\_  
(Street) (City) (State) (ZIP)

4b. E-mail Address: \_\_\_\_\_

[5.] [Does any proposed insured live outside the above household?.....  Yes  No]  
[If "Yes," explain. \_\_\_\_\_]

[6.] Phone Number: (\_\_\_\_\_) \_\_\_\_\_ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (\_\_\_\_\_) \_\_\_\_\_]

[7.] [Are any proposed insureds NOT a U.S. citizen or lawful permanent resident/Green Card Holder? \_\_\_  Yes  No]  
[If "Yes," indicate who: \_\_\_\_\_]  
(Last) (First) (MI)

[8a.] [Primary Insured Occupation: \_\_\_\_\_][Industry: \_\_\_\_\_]  
[Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_]  
[Duties: \_\_\_\_\_][Annual Income: \_\_\_\_\_]  
[Is the Primary Insured [self-employed] [or] [a sole proprietor]?.....  Yes  No]

[8b.] [Spouse[/Domestic Partner][/Civil Union] Occupation: \_\_\_\_\_][Industry: \_\_\_\_\_]  
[Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_]  
[Duties: \_\_\_\_\_][Annual Income: \_\_\_\_\_]  
[Is the Spouse[/Domestic Partner][/Civil Union] [self-employed] [or] [a sole proprietor]?.....  Yes  No]

[ **OTHER COVERAGE IN FORCE OR APPLIED FOR** ]

[9.] [[Are any of] [Is] the [primary] [proposed] [insured][s] covered by, or has application been made for any type of [life][or][critical illness] [or] [medical] insurance? .....  Yes  No]  
[If "Yes," complete the section below.]

Proposed Insured Name	Insurance Company Name	Type of Coverage	Benefit Amount	Effective Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

[10.] [Were all] [Was the] proposed insured[s] covered under the prior plan listed above?  Yes  No  
[If "No," list those not covered. \_\_\_\_\_]

[11.] [[Have any of] [Has] the [primary] [proposed] [insured][s] [within the last [1-10] years] been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance?.....  Yes  No]  
[If "Yes," give details. \_\_\_\_\_]  
\_\_\_\_\_ ]]

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**HAZARDOUS ACTIVITIES AND DRIVING**

[12.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] participated in any motorized [or non-motorized] vehicle racing (includes [stunt show or speed test,] drivers, pit crew, owners or mechanics) or any of the following activities: [cave exploration,] [boxing,] [bungee jumping,] [hot-air ballooning,] [professional or semi-professional sports,] [parkour,] [free running,] [extreme sports,] [skydiving,] [ultra light flying,] [parachute jumping,] [parakiting,] [parasailing,] [sail gliding,] [scuba diving,] [hang gliding,] [rock or mountain climbing,] [horse riding,] [or] [rodeo participation]?.....  Yes  No]

[If "Yes," was it a one-time event with no current or future participation?.....  Yes  No]

[13.] [In the last [3] years, has any proposed insured [ever] flown as a pilot, crew member or student, or planning such activity in the next 12 months? .....  Yes  No]

[14.] [Does the [primary] [proposed] [insured] have a valid driver's license?.....  Yes  No]

[If "Yes" list state of issue and number: \_\_\_\_\_]

[15.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] been cited for operating a motor vehicle under the influence of alcohol or drugs, [had more than [1-5] moving violations] [or] [had their driver's license suspended or revoked]? .....  Yes  No]

[If "Yes," indicate who: \_\_\_\_\_]

(Last) (First) (MI)

[16.] [In the last [10] years, has any proposed insured been convicted of a felony or are felony charges now pending? .....  Yes  No]

[If "Yes," indicate who: \_\_\_\_\_]

(Last) (First) (MI)

**HEALTH STATEMENT**

**[IMPORTANT! IF ANY OF QUESTIONS [17]-[39] ARE ANSWERED "YES," PLEASE GIVE DETAIL ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.]**

**[Complete questions [17]-[29] if you are applying for a Time Insurance Company medical policy at the same time you are applying for a [critical illness] [or] [life insurance] policy.]**

**For Questions [17-27], WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:**

[Note: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be disclosed.]

[17.] [Had surgery [in a hospital or outpatient facility]? .....  Yes  No]

[18.] [Had medical treatment [in a hospital or outpatient facility] [other than already disclosed]? ...  Yes  No]

[19.] [Had any urgent care or emergency room visits [not disclosed in Questions [17] & [18]]? .....  Yes  No]

[20.] [Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider [other than already disclosed]? [Do NOT include annual physical exams.]....  Yes  No]

[21.] [Had any testing [with abnormal findings] or tests for which you have not received results [other than already disclosed]? .....  Yes  No]

[22.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed?.....  Yes  No]

[23.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? .....  Yes  No]

[24.] [Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use? ..  Yes  No]

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[32.] [[In the last [10] years,] [H][h]as any proposed insured [ever] received any abnormal test results, medical or surgical treatment, consulted a health care professional, or taken medication for any of the following conditions? .....  Yes  No]

- [• Heart disorders]
- [• Stroke (cerebral vascular accident)]
- [• TIA (Transient Ischemic Attack)]
- [• Peripheral Vascular Disease (PVD), Peripheral Arterial Disease (PAD)]
- [• Crohn's Disease or Ulcerative Colitis]
- [• Liver disorders, excluding fully recovered Hepatitis A]
- [• Kidney disorders, excluding kidney stones]
- [• Emphysema or Chronic Obstructive Pulmonary Disease (COPD)]
- [• Pulmonary Fibrosis, Cystic Fibrosis]
- [• Alzheimer's Disease]
- [• Dementia]
- [• Blood Disorders]
- [• Systemic Lupus Erythematosus]
- [• Tuberculosis (TB)]
- [• Diabetes]
- [• Cancer or Tumor]
- [• Leukemia]
- [• Melanoma]
- [• Skin Cancer (2 or more occurrences)]
- [• Hodgkin lymphoma or non-Hodgkin lymphoma (NHL)]
- [• Alcoholism, Alcohol or Chemical Dependency, or Drug or Alcohol Abuse]
- [• Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)]
- [• Multiple Sclerosis (MS)]
- [• ALS (Amyotrophic Lateral Sclerosis)]
- [• Paralysis]
- [• Organ or stem cell transplant]
- [• Bipolar, Schizophrenia, or Chronic Depression]]

[33.] [[In the last [12] months,] [H][h]as any proposed insured [ever]:

- [• Required assistance from another person for eating, bathing, toileting, getting in and out of a chair or bed, dressing, or taking their own medication? .....  Yes  No]
- [• Been bedridden, confined to a hospital, nursing home, mental facility, inpatient rehabilitation, subacute facility or hospice? .....  Yes  No]
- [• Applied for, received, or been refused disability benefits due to their sickness or injury? [Do not include [pregnancy,] [fractures,] [spinal] [or] [back disorders]] .....  Yes  No]]

[34.] [In the last [12] months, has any proposed insured: .....  Yes  No]

- [• been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed?]
- [• had any testing with abnormal findings?]
- [• had tests for which you have not received results?]
- [• had any unexplained: weight loss, anemia, chronic fatigue, chest pain, shortness of breath, palpitations, chronic cough, gastrointestinal bleeding, lumps in the breast, dizziness or loss of consciousness?]

[35.] [In the last [12] months, has any proposed insured been diagnosed or treated for high blood pressure (systolic blood pressure [140] or greater and/or a diastolic blood pressure of [90] or greater? .....  Yes  No]

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**COMPLETE IF APPLYING FOR THE DISABILITY WAIVER OF PREMIUM OPTIONAL COVERAGE**

[40.] [Does the [primary] [proposed] insured work less than [1-40] hours per week at their primary occupation? .....  Yes  No]

[41.] [In the last [[5] years] [[12] months], has the [primary] [proposed] insured missed [1-10] consecutive days or [1-10] total days of work because of [their] sickness or injury for which symptoms existed? [Do NOT include routine childbirth] .....  Yes  No]

[42.] [[In the last [10] years,][H][h]as the [primary] [proposed] [insured] [ever] been diagnosed with or [ever] treated for any of the following? .....  Yes  No]

- |                                              |                                |                                     |                          |
|----------------------------------------------|--------------------------------|-------------------------------------|--------------------------|
| [• Chronic Epstein-Barr]                     | [• Fibromyalgia]               | [• Mental or Nervous Disorder]      | [• Rheumatoid arthritis] |
| [• Chronic Fatigue Syndrome]                 | [• Grand mal epilepsy]         | [• Mixed Connective Tissue Disease] | [• Ulcerative colitis]   |
| [• Crohn’s disease]                          | [• Inflammatory arthritis]     | [• Psoriatic arthritis]             |                          |
| [• Diabetes, excluding Gestational Diabetes] | [• Inflammatory bowel disease] |                                     |                          |

[43.] [In the last [[10] years] [[12] months], has the [primary] [proposed] insured experienced symptoms, been diagnosed as having or been treated for a disease or disorder of the back or neck, including acute and chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back? .....  Yes  No]

[If you answered “Yes” to any of questions [40] through [43], you are not eligible for the Waiver of Premium Optional Coverage.]

**OTHER PHYSICIANS**

[Physician or Healthcare Provider seen in the last [1-10] years [for] [each] [primary] [proposed] [insured] [other than disclosed above]. Attach a separate sheet if additional space is needed. Sign and date any additional sheets.]

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_ ]

**FAX ALL PAGES TO [866.387.0486]**

[Assurant Health 501 West Michigan Milwaukee, WI 53203] [Fax 414.299.6020]

**[ ADDITIONAL [MEDICAL] DETAILS**

**IMPORTANT! IF ANY OF QUESTIONS [17] - [39] ARE ANSWERED "YES," PLEASE GIVE COMPLETE DETAILS BELOW.**

*Attach a separate sheet if additional space is needed. Sign and date any additional sheets.*

	Last	Name First	MI	Provide Dates, Type of Treatment, Diagnosis or Condition, Results	Full Recovery?	Name of Doctor or Hospital, and Complete Address and Phone Number
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	

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[Assurant Health 501 West Michigan Milwaukee, WI 53203] [Fax 414.299.6020]

**[ADDITIONAL [MEDICAL] DETAILS]**

[Empty space for additional medical details]

**FAX ALL PAGES TO [866.387.0486]**

[Assurant Health 501 West Michigan Milwaukee, WI 53203] [Fax 414.299.6020]

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

**HIPAA ELIGIBILITY**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the below statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
  - Your most recent coverage was under a group plan, a governmental plan or a church plan.
  - You are not covered under another group health plan.
  - Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
  - You are not currently eligible for Medicare or Medicaid.
  - You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.
- No, I or anyone to be insured do not meet any of the above requirements.
- Yes, I or anyone to be insured meet all of the above requirements.]

**EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for [individual] [supplemental] [critical illness] [or] [life] insurance for you [(and your family)]. [You further understand that this application for [supplemental] [critical illness] [or] [life] insurance [will] [may] [be] [fully] [medically] [underwritten] [,] [and] [is subject to eligibility requirements] [and that coverage is not guaranteed].] You are personally paying the entire premium for this [supplemental] [critical illness] [or] [life] insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [2]-[50] full-time employees,] I agree that I will not use [employer contributions] [or] [funds from a [Health Reimbursement Arrangement] [(HRA)] [or a Cafeteria Plan]] to pay the premium for my individual coverage.]

Do you agree with this statement? .....  Yes  No]

**FAX ALL PAGES TO [866.387.0486]**

[Assurant Health 501 West Michigan Milwaukee, WI 53203] [Fax 414.299.6020]



## IMPORTANT NOTICES - LEAVE WITH CUSTOMER

### [NOTIFICATION REGARDING MIB, Inc.

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at [www.mib.com](http://www.mib.com).]

### [ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

### [FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.]

### [PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]]

## CONDITIONAL RECEIPT

This Conditional Receipt is received from \_\_\_\_\_,

this \_\_\_\_\_ day of \_\_\_\_\_ (month) \_\_\_\_\_ (year).

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company received the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided. ]

LEAVE THIS PAGE WITH THE CUSTOMER — DO NOT FAX

Assurant Health 501 West Michigan Milwaukee, WI 53203

# Part 2 Application Form for [Term Life Insurance] [with] [Optional Coverage[s]]

## AGENT/AGENCY INFORMATION PLEASE PRINT IN BLACK INK

Agent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Agent Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Key Agency Contact: \_\_\_\_\_ Agency Name: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_ Agency Number: \_\_\_\_\_

[Policy should be mailed to:]       Agent       Agency       Policyholder]

## TYPE OF ACTIVITY *(Please check appropriate box.)*

NEW [If not a new applicant, check appropriate box and list affected policy number.]

CHANGE/ADDITION TO AN EXISTING POLICY. POLICY # \_\_\_\_\_ ]

<input type="checkbox"/> Internal Replacement <input type="checkbox"/> Adding Dependent <input type="checkbox"/> Removal of Tobacco Rates <input type="checkbox"/> Applying for Preferred Rates <input type="checkbox"/> Removal of [Condition Specific Deductible] [or] [Special Exception Rider]]	<input type="checkbox"/> Removal/Reduction of Special Class Premium <input type="checkbox"/> Conversion (over age dependent/divorce) <input type="checkbox"/> Policy/Benefit Change To An Existing Policy [List Type if Change Requested: _____] <input type="checkbox"/> Reinstatement of Coverage]
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

## PERSON[S] TO BE INSURED

	Last	Name First	M.I.	Sex	Age	Birthdate (MM/DD/YY)	State of Birth	Height	Weight	Social Security Number
1. [PRIMARY] [PROPOSED] [INSURED]										
2. [SPOUSE] [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S) <i>(list relationship)</i>	Last	Name First	M.I.	Sex	Age	Birthdate (MM/DD/YY)	Full-time Student?	Height	Weight	Social Security Number

4a. Resident Address: \_\_\_\_\_  
*(Street)* *(City)* *(State)* *(ZIP)*

4b. E-mail Address: \_\_\_\_\_

[5.] [Does any proposed insured live outside the above household?.....  Yes  No]  
 [If "Yes," explain. \_\_\_\_\_ ]

[6.] Phone Number: (\_\_\_\_\_) \_\_\_\_\_ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (\_\_\_\_\_) \_\_\_\_\_ ]

- [7a.] [Primary Insured Occupation: \_\_\_\_\_ ]  
 [Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_ ]  
 [Duties: \_\_\_\_\_ ]  
 [Is the Primary Insured [self-employed] [or] [a sole proprietor]?.....  Yes  No]
- [7b.] [Spouse[/Domestic Partner] [/Civil Union] Occupation: \_\_\_\_\_ ]  
 [Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_ ]  
 [Duties: \_\_\_\_\_ ]  
 [Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]?.....  Yes  No]

**OTHER COVERAGE IN FORCE**

- [8.] [[Are any of] [Is] the [primary] [proposed] [insured][s] covered by, or has application been made for any type of [life][critical illness] [or] [health-related] insurance?.....  Yes  No]  
 [If "Yes," complete the section below.]

Proposed Insured Name	Insurance Company Name	Type of Coverage	Benefit Amount	Effective Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

- [9.] [Were all] [Was the] proposed insured[s] covered under the prior plan listed above? .....  Yes  No]  
 [If "No," list those not covered. \_\_\_\_\_ ]
- [10.] [[Have any of] [Has] the [primary] [proposed] [insured][s] [within the last [1-10] years] been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or health related insurance? .....  Yes  No]  
 [If "Yes," give details. \_\_\_\_\_ ]  
 \_\_\_\_\_ ]]

**HAZARDOUS ACTIVITIES AND DRIVING**

- [11.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] participated in any motorized [or non-motorized] vehicle racing (includes [stunt show or speed test,] drivers, pit crew, owners or mechanics) or any of the following activities: [cave exploration,] [boxing,] [bungee jumping,] [hot-air ballooning,] [professional or semi-professional sports,] [parkour,] [free running,] [extreme sports,] [skydiving,] [ultra light flying,] [parachute jumping,] [hang-gliding,] [parakiting,] [parasailing,] [sail gliding,] [scuba diving,] [hang gliding,] [rock or mountain climbing,] [horse riding,] [or] [rodeo participation]? .....  Yes  No]
- [12.] [In the last [3] years, has any proposed insured [ever] flown as a pilot, crew member or student, or planning such activity in the next 12 months? .....  Yes  No]
- [13.] [Does the [primary] [proposed] [insured] have a valid driver's license?.....  Yes  No]  
 [If "Yes" list state of issue and number: \_\_\_\_\_ ]
- [14.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] been cited for operating a motor vehicle under the influence of alcohol or drugs, [had more than [1-5] moving violations] [or] [had their driver's license suspended or revoked]? .....  Yes  No]

[15.] [In the last 10 years, has any proposed insured been convicted of a felony or are felony charges now pending? .....  Yes  No]

## HEALTH STATEMENT

[Complete questions [16]-[27] if you are applying for a Time Insurance Company medical policy at the same time you are applying for a [critical illness][life insurance] policy]

**For Questions [16]-[27], WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:**

[Note: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be disclosed.]

[16.] [Had surgery [in a hospital or outpatient facility]? .....  Yes  No]

[17.] [Had medical treatment [in a hospital or outpatient facility] [other than already disclosed]? .....  Yes  No]

[18.] [Had any urgent care or emergency room visits [not disclosed in Questions [16] & [17]]? .....  Yes  No]

[19.] [Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider [other than already disclosed]? [Do NOT include annual physical exams.] .....  Yes  No]

[20.] [Had any testing [with abnormal findings] or tests for which you have not received results [other than already disclosed]? .....  Yes  No]

[21.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed? .....  Yes  No]

[22.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? .....  Yes  No]

[23.] [Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use? .....  Yes  No]

### Additional Questions

[24.] [Has any proposed insured taken or been advised to take any prescription medication in the last [[10] years] [[12] months]? .....  Yes  No]

[25.] [Has any proposed adult [ever] used tobacco products in any form or nicotine substitutes [within the last [10] years] [after the age of [21]]? .....  Yes  No]

[26.] [Has any proposed insured had a diagnosis, [[or] treatment] [or follow-up] for cancer in the last [10] years? .....  Yes  No]

[27.] [Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? [This includes a surrogate mother or any person that she is contracted with.] .....  Yes  No]

[28.] [Have you fully disclosed all medical conditions for you and your family within the last [10] years? .....  Yes  No]

[Complete questions [29]-[39] [if you are NOT applying for a Time Insurance Company medical policy at the same time you are applying for a [life insurance][critical illness] policy][for all face amounts].]

[29.] [Has [the] [any] [primary] [proposed] [adult] [insured] [ever] used tobacco products in any form or nicotine substitutes [within the last [[1-10] years] [[1-12] [months]]] [after the age of [21]]? .....  Yes  No]

[30.] [Has any proposed insured been advised by a physician that their life expectancy is less than [24] months? .....  Yes  No]

- [31.] [[In the last [6] months,] [H][h]as any proposed insured [ever] been bedridden, confined to a hospital, nursing home, mental facility, inpatient rehabilitation, subacute facility or hospice? .....  Yes  No]
- [32.] [Has any proposed insured ever had a diagnosis[,] [or] [treatment] [or follow-up] for cancer[,] [or] heart disorders including heart attack, coronary bypass or angioplasty?.....  Yes  No]
- [33.] [[In the last [10] years,] [H][h]as any proposed insured [ever] received any abnormal test results, medical or surgical treatment, consulted a health care professional, or taken medication for any of the following conditions?
- [• Heart disorders .....  Yes  No]
  - [• Stroke (cerebral vascular accident) .....  Yes  No]
  - [• TIA (Transient Ischemic Attack) .....  Yes  No]
  - [• Peripheral Vascular Disease (PVD), Peripheral Arterial Disease (PAD) .....  Yes  No]
  - [• Crohn's Disease or Ulcerative Colitis .....  Yes  No]
  - [• Liver disorders, excluding fully recovered Hepatitis A.....  Yes  No]
  - [• Kidney disorders, excluding kidney stones .....  Yes  No]
  - [• Emphysema or Chronic Obstructive Pulmonary Disease (COPD) .....  Yes  No]
  - [• Pulmonary Fibrosis, Cystic Fibrosis.....  Yes  No]
  - [• Alzheimer's Disease .....  Yes  No]
  - [• Dementia.....  Yes  No]
  - [• Blood Disorders .....  Yes  No]
  - [• Systemic Lupus Erythematosus.....  Yes  No]
  - [• Tuberculosis (TB) .....  Yes  No]
  - [• Diabetes.....  Yes  No]
  - [• Cancer or Tumor .....  Yes  No]
  - [• Leukemia.....  Yes  No]
  - [• Melanoma .....  Yes  No]
  - [• Skin Cancer (2 or more occurrences) .....  Yes  No]
  - [• Non-Hodgkins Lymphoma .....  Yes  No]
  - [• Alcoholism, Alcohol or Chemical Dependency, or Drug or Alcohol Abuse .....  Yes  No]
  - [• Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV) .....  Yes  No]
  - [• Multiple Sclerosis (MS) .....  Yes  No]
  - [• ALS (Amyotrophic Lateral Sclerosis).....  Yes  No]
  - [• Paralysis.....  Yes  No]
  - [• Organ or stem cell transplant .....  Yes  No]
  - [• Bipolar, Schizophrenia, or Chronic Depression.....  Yes  No]
- [34.] [[In the last [2] years,] [H][h]as any proposed insured [ever]:
- [• Required oxygen use?.....  Yes  No]
  - [• Required assistance from another person for eating, bathing, toileting, getting in and out of a chair or bed, dressing, or taking their own medication? .....  Yes  No]
  - [• Received or been prescribed dialysis? .....  Yes  No]
  - [• Been hospitalized 2 or more times?.....  Yes  No]
  - [• Applied for, received, or been refused disability benefits due to their sickness or injury? [Do not include [pregnancy,] [fractures,] [spinal] [or] [back disorders]] .....  Yes  No]
  - [• Had or now awaiting a stem cell, organ or bone marrow transplant .....  Yes  No]
- [35.] [In the last [12] months, has any proposed insured been seen by, or been referred to, or have a pending appointment to see any of the following specialists?
- [• Cardiology / Cardio vascular surgeon (heart and vascular specialist) .....  Yes  No]
  - [• Hematology (blood, blood forming organs and lymph nodes specialist) .....  Yes  No]
  - [• Neurology / Neurosurgeon (nervous system specialist) .....  Yes  No]
  - [• Endocrinology (endocrine organs / hormonal disorder specialist).....  Yes  No]
  - [• Oncology (cancer specialists).....  Yes  No]
  - [• Rheumatology (arthritis/vasculitis specialist) .....  Yes  No]
  - [• Pulmonology (lung/respiratory specialist).....  Yes  No]
  - [• Nephrology (kidney specialist) .....  Yes  No]

- [36.] [In the last [12] months, has any proposed insured had any unexplained: weight loss, chronic fatigue, chest pain, shortness of breath, palpitations, chronic cough, gastrointestinal bleeding, lumps in the breast, dizziness or loss of consciousness?..... Yes  No]
- [37.] [In the last [12] months, has any proposed insured been diagnosed or treated for high blood pressure (systolic blood pressure [140] or greater and/or a diastolic blood pressure of [90] or greater?..... Yes  No]
- [38.] [Has any proposed insured taken or been advised to take any prescription medication in the last [[10 years]][[12] months]? .....  Yes  No]
- [39.] [Has any proposed insured's natural parents, brothers or sisters, either living or deceased, been diagnosed prior to age [60] with any of the following conditions: [Aneurysm,] [Cancer,] [Diabetes,] [Heart Disease,] [Huntington's Disease] [or] [Stroke]? .....  Yes  No]

[If you answered "Yes" to any of questions [29]-[39], or if you are applying for more than a [\$50,000] face amount, complete questions [40]-[43].]

- [40.] [Has any proposed adult insured ever used tobacco products in any form or nicotine substitutes? ....  Yes  No]

Proposed Insured's First Name	Form of Tobacco or Substitute	Number per day or number of packs per day	How many years	Date quit
		_____ per day or _____ packs per day		
		_____ per day or _____ packs per day		

- [41.] [If any proposed insured has Diabetes, was it diagnosed before the age of [50] or do they currently have any related complications (cardiac, kidney or vascular)? [Do not include gestational diabetes.].....  Yes  No]

**BENEFICIARY DESIGNATION**

The Policyowner may designate one or more Beneficiaries. Any benefits payable to Beneficiaries will be divided equally among all surviving named Beneficiaries unless a percentage is specified or otherwise required by law.

Beneficiary Name (Last, First, M.I.)	Relationship	Address	Percent

Must total to 100%

**COMPLETE IF APPLYING FOR THE DISABILITY WAIVER OF PREMIUM OPTIONAL COVERAGE**

- [42.] [Does the [primary] [proposed] insured work less than [1-40] hours per week at their primary occupation? .....  Yes  No]
- [43.] [In the last [[1-5] years] [[1-12] months], has the [primary] [proposed] insured missed [1-10] consecutive days or [1-10] total days of work because of [their] sickness or injury for which symptoms existed? [Do NOT include routine childbirth] ..... Yes  No]
- [44.] [Has the [primary] [proposed] [insured] ever been diagnosed with or ever treated for any of the following?

..... Yes  No]

- [• Chronic Epstein-Barr]                      [• Fibromyalgia]                                      [• Mental or Nervous Disorder]
- [• Chronic Fatigue Syndrome]              [• Grand mal epilepsy]                                      [• Rheumatoid arthritis]
- [• Crohn’s disease]                              [• Inflammatory arthritis]                                      [• Ulcerative colitis]
- [• Diabetes, excluding Gestational Diabetes]
- [• Inflammatory bowel disease]                                      [• Mixed Connective Tissue Disease]
- [• Psoriatic arthritis]

[45.] [In the last [[1-5] years] [[1-12] months], has the [primary] [proposed] insured experienced symptoms, been diagnosed as having or been treated for a disease or disorder of the back or neck, including acute and chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back? ..... Yes  No]

[If you answered “Yes” to any of questions [41] through [45], you are not eligible for the Waiver of Premium Optional Coverage.]

**REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE**

[46.] [Has there been any medical treatment or medication use for, or have you consulted with a physician or healthcare provider concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person’s effective date? ..... Yes  No]]

**OTHER PHYSICIANS**

[Physician or Healthcare Provider seen in the last [1-10] years [for] [each] [primary] [proposed] [insured] [other than disclosed above]. Attach a separate sheet if additional space is needed. Sign and date any additional sheets.

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_ ]

**[ ADDITIONAL [MEDICAL] DETAILS**

Attach a separate sheet if additional space is needed. Sign and date any additional sheets.

	Last	Name First	MI	Provide Dates, Type of Treatment, Diagnosis or Condition, Results	Full Recovery?	Name of Doctor or Hospital, and Complete Address and Phone Number
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	

**ADDITIONAL NOTES**

[Empty space for additional notes]

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- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

No, I or anyone to be insured do not meet any of the above requirements.

Yes, I or anyone to be insured meet all of the above requirements.]

**EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for [individual] [supplemental] [life] insurance for you [(and your family)]. [You further understand that this application for [supplemental] [life] insurance [will] [may] [be] [fully] [medically] [underwritten] [,] [and] [is subject to eligibility requirements] [and that coverage is not guaranteed].] You are personally paying the entire premium for this [supplemental] [health] [life] [vision] insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [2]-[50] full-time employees,] I agree that I will not use [employer contributions] [or] [funds from a [Health Reimbursement Arrangement] [(HRA)] [or a Cafeteria Plan]] to pay the premium for my individual coverage.]

Do you agree with this statement? .....  Yes  No]



## **[ ADDITIONAL NOTICES**

### **[NOTIFICATION REGARDING ("MIB") formerly known as the MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).]

### **[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

### **[FRAUD NOTICE**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.]

### **[PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]]

**LEAVE THIS PAGE WITH THE CUSTOMER — DO NOT FAX**

Assurant Health 501 West Michigan Milwaukee, WI 53203

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

Time Insurance Company  
[501 West Michigan  
Milwaukee, WI 53203]

CRITICAL CONDITION ACCELERATED BENEFIT RIDER  
ACCELERATED BENEFIT DISCLOSURE

The following is a brief description of the accelerated benefit and definitions of conditions triggering payment of the benefits, applicable if the optional rider is purchased. Refer to the policy and rider for complete details.

Benefits payable under the rider may be taxable. You or Your Beneficiary may incur a tax obligation. A tax advisor should be consulted to determine the impact of benefits paid under this rider.

Benefits payable under the rider may also adversely affect Your eligibility for Medicaid or other government benefits or entitlement.

Effect of Critical Condition Benefit Payment

The Policy [Death Benefit] Face Amount, up to the full amount, will be reduced by Critical Condition Benefit amounts paid.

For Example: A policy is purchased with a Death Benefit Face Amount of \$150,000 and a Critical Condition Benefit lifetime maximum of amount of \$100,000.

If a Critical Condition Benefit of \$25,000 is paid, then the Policy's Death Benefit Face Amount would be reduced to \$125,000 and the available Critical Condition Benefit would be \$75,000.

Premiums due following the Critical Condition Benefit payment would be reduced to reflect the resulting Death Benefit Face Amount of \$125,000 and the remaining Critical Condition Benefit of \$75,000. Applicable policy fees will apply according to the resulting Face Amounts. There are no other administrative expenses under the rider.

(Actual amounts will depend on the face amounts purchased on your policy.)

CRITICAL CONDITION DEFINITIONS

[Advanced Alzheimer's Disease

Diagnosis of Advanced Alzheimer's disease [before age [x]] by a board certified neurologist or board qualified geriatrician. Diagnosis must include documented medical evidence that the Covered Person has experienced permanent loss of the ability to: remember, reason; understand and express ideas. The Covered Person must permanently require daily supervision and assistance for at least three Activities of Daily Living. No other types of dementia are covered.]

[Blindness

Diagnosis of an irreversible reduction in sight[ as a result of Sickness or Injury][, lasting at least 180 days,] that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together.]

[Cancer Type A

1. A malignant neoplasm (including hematologic malignancy), which is characterized by the uncontrolled growth & spread of malignant cells such as:
  - a. Leukemia & Lymphomas.
  - b. All N0M0 cancers of stage T1 or higher not listed under Cancer Type B
  - c. Skin cancers with nodal or metastatic involvement (N1, M1).
2. It does not include:
  - a. Anything not listed above.
  - b. Any carcinoma-in-situ growth regardless of origin, classified as TisN0M0.
  - c. Anything in Cancer Type B.]

[Cancer Type B

1. In-Situ cancer that affects only the area of the body in which it began, has not spread and, is classified by pathology as TisN0M0. Cancer Type B includes:
  - a. In-situ cancers classified as TisN0M0.
  - b. Bowen's disease.
  - c. Ductal carcinoma in situ (DCIS)
  - d. Lobular carcinoma in situ (LCIS).
  - e. Other specific localized cancers including:
    - i) Prostate cancer in early stage (T1N0M0).
    - ii) Gastrointestinal (GI) cancers staged T1N0M0 treated solely with endoscopy.
    - iii) Melanoma (T1N0M0) - All other stages of melanoma are Cancer Type A.
2. It does not include:
  - a. Anything in Cancer Type A.
  - b. Benign and pre-malignant tissue diagnosed by clinical or laboratory studies. Condition(s) include, but are not limited to:
    - i) Intraepithelial neoplasia (ie. prostate intraepithelial neoplasia (PIN)) and other such lesions.
    - ii) Abnormal pap smear results – cervical dysplasia known as LGSIL, HGSIL or ASCUS.
    - iii) Benign tumors or polyps.
    - iv) Actinic Keratosis.
    - v) Leukoplakia or Erythroplakia.
    - vi) All skin cancers not listed in Cancer Type A or Cancer Type B.]

[Coma/Comatose

A state of unconsciousness, characterized by the absence of any voluntary, purposeful movement, from which the Covered Person cannot be aroused for a period of at least [96 hours].

For the purpose of this rider, Coma does not include any medically induced coma.]

[Coronary Artery Bypass

A procedure which uses a saphenous vein or internal mammary artery graft to surgically bypass obstructions in a native coronary artery or arteries to treat coronary artery atherosclerosis. For the purpose of this rider, Coronary Artery Bypass does not include: balloon angioplasty, laser relief of obstruction or any other intra-arterial procedures.]

[Deafness

An irreversible loss of hearing[,as a result of Sickness or Injury,] for all sounds in both ears. Diagnosis must be on the basis of audiometric and auditory threshold tests indicating an auditory threshold of 90 decibels or less while using a hearing aid.]

[End Stage Renal Disease (Kidney Failure)

A Diagnosis of chronic and irreversible failure of both kidneys which requires treatment by regular dialysis for at least 90 days or kidney transplant.]

[Heart Attack

A new myocardial infarction resulting in the death of an area of the heart muscle due to insufficient blood supply to that area. The basis of the Diagnosis must include: typical clinical presentation; serial measurements of cardiac biomarkers showing a pattern and level consistent with a Heart Attack; and new electrocardiographic changes consistent with acute myocardial infarction.]

[Heart Valve Surgery

Having undergone a median sternotomy (surgery to divide the breastbone) in order to replace or repair one or more heart valves.]

[Loss of Limbs

Severance of two or more limbs at or proximal to the wrist or ankle joints.]

[Major Burns

Acute full thickness or third degree burns covering at least 20% of a Covered Person's body surface area.]

[Major Organ Transplant

Having undergone surgery as a recipient of a transplant as follows:

1. Human bone marrow using hematopoietic stem cells preceded by ablative therapy (Platelet/blood infusions excluded) [for any of the following specified diseases]:
  - [a.] [Aplastic Anemia including Acquired secondary to Ablative chemotherapy.]
  - [b.] [Leukemia/Lymphoma/Myeloproliferative Disorders.]
  - [c.] [Inherited disorders of metabolism.]
  - [d.] [Severe Combined Immunodeficiency Disease.]
  - [e.] [Multiple myeloma.]
2. Human organ because of the irreversible end stage failure of such organ, limited to[ the following organs and specified diseases]:
  - [a. [Heart [- due to any of the following specified diseases: Tumors, cardiomyopathy, congenital heart disease, heart failure, inoperable coronary artery disease].]
  - [b. [Lung[- due to any of the following specified diseases: Fibrotic lung disease, obstructive lung disease, primary pulmonary hypertension].]
  - [c. [Liver[ - due to any of the following specified diseases: Cirrhosis, end stage liver disease, hepatic failure, metabolic & inherited diseases, unresectable hepatic tumor].]
  - [d. [Kidney[-due to end stage renal disease].]
  - [e. [Kidney/Pancreas[- due to diabetes mellitus].]
  - [f. [Small Intestine[ - due to any of the following specified diseases: Short Gut Syndrome, diseases causing life-threatening malabsorption such as Hirschsprung's disease and Other life-threatening Motility disorders].]]

[Paralysis

A total and irreversible loss of use of two or more Limbs. "Limbs" means the entire arm or entire leg. The Paralysis must be due to neurological Injury or Sickness of associated nerves that is expected to last continuously for 12 months or longer [and continuously present for a period of at least [180 days]]. Paralysis, for the purposes of this rider does not include any Paralysis caused by a Stroke.]

[Stroke

Brain tissue infarction due to acute cerebrovascular incident, embolism, thrombosis or hemorrhage. The basis of the Diagnosis must include evidence of:

1. Neurological damage persisting for at least [30 days] and the damage is expected to be permanent; and
2. Magnetic Resonance Imaging, computerized tomography or other neuroimaging studies consistent with Diagnosis of a new Stroke.

For the purposes of this Policy Stroke does not include:

1. Transient Ischemic Attacks (TIAs).
2. Transient Global Amnesia (TGA).
3. External trauma causing Injury to the brain.
4. Brain damage due to infection, vasculitis, encephalopathy and inflammatory disease.
5. Ischemic disorders of the vestibular system.]

[\_\_\_\_\_  
[Applicant's Signature]

[\_\_\_\_\_  
[Date]

[\_\_\_\_\_  
[Licensed Agent's Signature]

SERFF Tracking Number: MCHX-126468971 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44685  
 Company Tracking Number: 8059.POL.AR  
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life - Fixed/Indeterminate Premium  
 Product Name: 8059.POL.XX Individual Term Life - Time Insurance  
 Project Name/Number: 8059.POL.XX Individual Term Life - Time Insurance Company/8059.POL.XX Individual Term Life - Time Insurance Company

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification		
<b>Comments:</b>		
<b>Attachments:</b>		
AR - READABILITY CERTIFICATION.PDF		
AR Certification R&R 49.PDF		
Certification of Compliance.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application		
<b>Comments:</b>		
Please see forms schedule tab		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Forms List		
<b>Comments:</b>		
<b>Attachment:</b>		
Forms List.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Authorization Letter		
<b>Comments:</b>		
<b>Attachment:</b>		
Authorization Letter.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>

SERFF Tracking Number: MCHX-126468971 State: Arkansas  
Filing Company: Time Insurance Company State Tracking Number: 44685  
Company Tracking Number: 8059.POL.AR  
TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -  
Fixed/Indeterminate Premium  
Product Name: 8059.POL.XX Individual Term Life - Time Insurance  
Project Name/Number: 8059.POL.XX Individual Term Life - Time Insurance Company/8059.POL.XX Individual Term Life - Time Insurance Company  
**Satisfied - Item:** Statement of Variability  
**Comments:**  
**Attachment:**  
Statement of Variability.PDF

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** 01.22.10 Submission Letter  
**Comments:**  
**Attachment:**  
01\_22\_10 Submission Letter.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

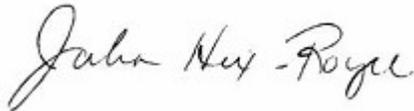
**COMPANY NAME:** Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
8059.POL.AR	54
8059.TOC.XX	54
8059.DEF.XX	54
8059.LIF.XX	54
8059.EXC.AR	54
8059.CLM.XX	54
8059.PRM.AR	54
8059.EFF.XX	54
8059.OTH.AR	54
8059.BNS.AR	58
B590.AR	50.2
Form 30186 (12/2009)	49
Form 30187 (12/2009)	46
B592.XX	40

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

Form Number	Score
-------------	-------

Signed:   
Name: Julia Hix-Royer  
Title: Vice President, Compliance  
Date: January 22, 2010

## CERTIFICATE OF COMPLIANCE

Insurer: Time Insurance Company

Form Numbers:

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



---

Signature of Company Officer

Julia Hix-Royer

---

Name

Vice President, Product Compliance

---

Title

January 22, 2010

---

Date

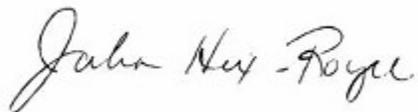
## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Time Insurance Company

Form Number(s):

8059.POL.AR  
8059.TOC.XX  
8059.DEF.XX  
8059.LIF.XX  
8059.EXC.AR  
8059.CLM.XX  
8059.PRM.AR  
8059.EFF.XX  
8059.OTH.AR  
8059.BNS.AR  
B590.AR  
Form 30186 (12/2009)  
Form 30187 (12/2009)  
B592.XX

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



---

Signature of Company Officer

Julia Hix-Royer

---

Name

Vice President, Product Compliance

---

Title

January 22, 2010

---

Date

Term Life Insurance  
w/ Critical Illness Accelerated Benefit Rider  
Forms Listing

<b><u>Form Number</u></b>	<b><u>Form Description</u></b>
8059.POL.AR	Term Life Insurance Policy
8059.TOC.XX	Matrix Insert Section: Table of Contents
8059.DEF.XX	Matrix Insert Section: Definitions
8059.LIF.XX	Matrix Insert Section: Term Life Insurance Benefits
8059.EXC.AR	Matrix Insert Section: Exclusions and Limitations
8059.CLM.XX	Matrix Insert Section: Claim Provisions
8059.PRM.AR	Matrix Insert Section: Premium Provisions
8059.EFF.XX	Matrix Insert Section: Effective Date and Termination Date
8059.OTH.AR	Matrix Insert Section: Other Provisions
8059.BNS.AR	Benefit Schedule – Term Life Insurance
B590.AR	Critical Condition Accelerated Benefit Rider
Form 30186 (12/2009)	Application Form for Life Insurance
Form 30187 (12/2009)	Tele-App Part 2 Application
B592.XX	Accelerated Benefit Disclosure

Previously filed forms to be used with this product; filed separately:

Form 30054 (10/2009)	Acceptance of Offer and Attestation	Approved 11/19/09
Form 30064 (10/2009)	Tele-App Part 1 Application	Approved 11/19/09



**ASSURANT**  
Health

501 West Michigan  
P.O. Box 3050  
Milwaukee, WI 53201-3050  
T 800.800.1212

[www.assurant.com](http://www.assurant.com)

January 2010

Re: Time Insurance Company-NAIC 69477; FEIN 39-0658730

Dear Sir or Madam,

This letter acts as authorization for McHugh Consulting Resources and its representative analysts to file any or all policy forms on behalf of the above referenced company and to serve as the primary contact on behalf of the company regarding such filings while under review. Please contact McHugh Consulting Resources with questions or comments regarding the enclosed filing.

Best Regards,

Daniel Ziebell, MHP  
Director Product Compliance  
Worksite, Voluntary and Ancillary Products  
[daniel.ziebell@assurant.com](mailto:daniel.ziebell@assurant.com)  
T 414.299.6045  
F 414.299.6168

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

### **Statement of Variability**

- 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 vary to the extent that such paragraphs 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.
- Definitions may vary to the extent that such definition 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.
- Items which customarily vary according to the policyholder's specific plan of insurance.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval and amend the language to clarify the intent within the confines of the law.

.....  
**McHugh Consulting Resources, Inc.**

January 22, 2010

Jay Bradford  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

Sent via SERFF

**RE: Time Insurance Company**  
NAIC # 69477 FEIN # 39-0658730

**Individual Term Life Policy**  
**8059.POL.AR, et al - Policy**  
*See Attached Form Listing*

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned forms for your review seeking approval. The forms are new and not intended to replace any other forms currently in use.

This term life coverage will be marketed to individuals through agent/broker solicitation. This plan will be offered using the applications herewith submitted, applications previously filed for general use with individual ancillary coverages (see attached forms list), or as an integrated offer with health plans using previously filed application and enrollment forms. This program is being concurrently filed in the domicile state of Wisconsin. This policy provides term life benefits with an optional rider for accelerated benefits for critical illness.

Please note that the Policy is numbered using a matrix format, where each section of the document has a unique form number. For example, the Policy face page is numbered 8059.POL.AR, while the Exclusions section of the same document is numbered 8059.EXC.AR. The Company employs this form numbered style for administrative and tracking purposes. The Policy will always be issued in its entirety with all sections and form numbers included.

These forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Variable data or text is bracketed and a variability statement is attached herewith. Variable data will never exclude provisions required by applicable law.

*Commissioner of Insurance  
Time Insurance Company  
Page 2 of 2*

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

Sincerely,

A handwritten signature in black ink that reads "Linda Boyce". The signature is written in a cursive, slightly slanted style.

Linda Boyce  
Consultant

Attachments



# Application Form for [Term Life Insurance] [with] [Optional Coverage[s]]

## AGENT/AGENCY INFORMATION

PLEASE PRINT IN BLACK INK

Agent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Agent Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Key Agency Contact: \_\_\_\_\_ Agency Name: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_ Agency Number: \_\_\_\_\_  
 [Policy should be mailed to:]       Agent       Agency       Policyholder

## TYPE OF ACTIVITY (Please check appropriate box.)

NEW [If not a new applicant, check appropriate box and list affected policy number.]

<input type="checkbox"/> CHANGE/ADDITION TO AN EXISTING POLICY. POLICY # _____ ]	
<input type="checkbox"/> Internal Replacement <input type="checkbox"/> Adding Dependent <input type="checkbox"/> Removal of Tobacco Rates <input type="checkbox"/> Applying for Preferred Rates <input type="checkbox"/> Removal of [Condition Specific Deductible] [or] [Special Exception Rider]]	<input type="checkbox"/> Removal/Reduction of Special Class Premium <input type="checkbox"/> Conversion (over age dependent/divorce) <input type="checkbox"/> Policy/Benefit Change To An Existing Policy [List Type if Change Requested: _____] <input type="checkbox"/> Reinstatement of Coverage

## REQUESTED EFFECTIVE DATE

Requested effective date \_\_\_\_\_

[A policy may not have an effective date of the 29th, 30th, or 31st.] [Your effective date is based on the date [you sign] [we receive] your application form.] [If [you sign] [we receive] it on the [1st] through the [15th] of the month, your effective date will be the [1st] of the [following] month. If [you sign] [we receive] the application form on the [16th] through the [31st] of the month, your effective date will be the [15th] of the [following] month.] [Check with your agent for more details.]

## PERSON[S] TO BE INSURED

	Last	Name First	M.I.	Sex	Age	Birthdate (MM/DD/YY)	State of Birth	Height	Weight	Social Security Number
1. [PRIMARY] [PROPOSED] [INSURED]										
2. [SPOUSE] [/DOMESTIC PARTNER] [/CIVIL UNION]										
3. DEPENDENT(S) (list relationship)	Last	Name First	M.I.	Sex	Age	Birthdate (MM/DD/YY)	Full-time Student?	Height	Weight	Social Security Number

FAX ALL PAGES TO [866.387.0486]

[Assurant Health 501 West Michigan Milwaukee, WI 53203] [Fax 414.299.6020]

4a. Resident Address: \_\_\_\_\_  
(Street) (City) (State) (ZIP)

4b. E-mail Address: \_\_\_\_\_

[5.] [Does any proposed insured live outside the above household?.....  Yes  No]  
 [If "Yes," explain. \_\_\_\_\_ ]

[6.] Phone Number: (\_\_\_\_\_) \_\_\_\_\_ [Please list the phone number that would be the best to reach you during the day to inquire about medical history. (\_\_\_\_\_) \_\_\_\_\_ ]

[7.] [Are any proposed insureds NOT a U.S. citizen or lawful permanent resident/Green Card Holder? \_\_\_\_  Yes  No]  
 [If "Yes" indicate who: \_\_\_\_\_ ]  
(Last) (First) (MI)

[8a.] [Primary Insured Occupation: \_\_\_\_\_ ]  
 [Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_ ]  
 [Duties: \_\_\_\_\_ ]  
 [Is the Primary Insured [self-employed] [or] [a sole proprietor]?.....  Yes  No]

[8b.] [Spouse[/Domestic Partner] [/Civil Union] Occupation: \_\_\_\_\_ ]  
 [Company Name: \_\_\_\_\_ Work Number: (\_\_\_\_\_) \_\_\_\_\_ ]  
 [Duties: \_\_\_\_\_ ]  
 [Is the Spouse[/Domestic Partner] [/Civil Union] [self-employed] [or] [a sole proprietor]?.....  Yes  No]

**[ OTHER COVERAGE IN FORCE**

[9.] [[Are any of] [Is] the [primary] [proposed] [insured][s] covered by, or has application been made for any type of [life][critical illness] [or] [health-related] insurance?.....  Yes  No]  
 [If "Yes," complete the section below.

Proposed Insured Name	Insurance Company Name	Type of Coverage	Benefit Amount	Effective Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

[10.] [Were all] [Was the] proposed insured[s] covered under the prior plan listed above? .....  Yes  No]  
 [If "No," list those not covered. \_\_\_\_\_ ]

[11.] [[Have any of] [Has] the [primary] [proposed] [insured][s] [within the last [1-10] years] been declined, postponed, rescinded, reformed, charged an extra premium or had a portion of coverage excluded for life, disability, or health related insurance? .....  Yes  No]  
 [If "Yes," give details. \_\_\_\_\_ ]  
 \_\_\_\_\_ ]]

**HAZARDOUS ACTIVITIES AND DRIVING**

[12.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] participated in any motorized [or non-motorized] vehicle racing (includes [stunt show or speed test,] drivers, pit crew, owners or mechanics) or any of the following activities: [cave exploration,] [boxing,] [bungee jumping,] [hot-air ballooning,] [professional or semi-professional sports,] [parkour,] [free running,] [extreme sports,] [skydiving,] [ultra light flying,]

**FAX ALL PAGES TO [866.387.0486]**

[Assurant Health 501 West Michigan Milwaukee, WI 53203] [Fax 414.299.6020]

[parachute jumping,] [hang-gliding,] [parakiting,] [parasailing,] [sail gliding,] [scuba diving,] [hang gliding,] [rock or mountain climbing,] [horse riding,] [or] [rodeo participation]? .....  Yes  No]

[If "Yes," was it a one-time event with no current or future participation? .....  Yes  No]

[13.] [In the last [3] years, has any proposed insured [ever] flown as a pilot, crew member or student, or planning such activity in the next 12 months? .....  Yes  No]

[14.] [Does the [primary] [proposed] [insured] have a valid driver's license?.....  Yes  No]

[If "Yes" list state of issue and number: \_\_\_\_\_]

[15.] [In the last [1-10] years, [have any of] [has] the [primary] [proposed] [insured][s] been cited for operating a motor vehicle under the influence of alcohol or drugs, [had more than [1-5] moving violations] [or] [had their driver's license suspended or revoked]? .....  Yes  No]

[16.] [In the last 10 years, has any proposed insured been convicted of a felony or are felony charges now pending? .....  Yes  No]

**HEALTH STATEMENT**

**[IMPORTANT! IF ANY OF QUESTIONS [17]-[42] ARE ANSWERED "YES," PLEASE GIVE DETAIL ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.]**

**[Complete questions [17]-[29] if you are applying for a Time Insurance Company medical policy at the same time you are applying for a [critical illness][life insurance] policy]**

**For Questions [17-27], WITHIN THE LAST [10] YEARS, HAS ANY PROPOSED INSURED:**

[Note: any follow-up visits in the last [10] years as a result of a diagnosis over [10] years ago must be disclosed.]

[17.] [Had surgery [in a hospital or outpatient facility]? .....  Yes  No]

[18.] [Had medical treatment [in a hospital or outpatient facility] [other than already disclosed]? .....  Yes  No]

[19.] [Had any urgent care or emergency room visits [not disclosed in Questions [16] & [17]]? .....  Yes  No]

[20.] [Received treatment, testing, consulted with or received a diagnosis from a physician or healthcare provider [other than already disclosed]? [Do NOT include annual physical exams.] .....  Yes  No]

[21.] [Had any testing [with abnormal findings] or tests for which you have not received results [other than already disclosed]? .....  Yes  No]

[22.] [Been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up or surgery that has not been completed? .....  Yes  No]

[23.] [Received or recommended to have any treatment for alcoholism, alcohol or drug abuse or addiction, including but not limited to, counseling or attendance at support groups? .....  Yes  No]

[24.] [Used illegal drugs or prescription medication other than as prescribed or been advised by a physician or health care provider to discontinue or decrease alcohol consumption or drug use? .....  Yes  No]

**Additional Questions**

[25.] [Has any proposed insured taken or been advised to take any prescription medication in the last [[10] years] [[12] months]? .....  Yes  No]

[26.] [Has any proposed adult [ever] used tobacco products in any form or nicotine substitutes [within the last [10] years] [after the age of [21]]? .....  Yes  No]

[27.] [Has any proposed insured had a diagnosis, [[or] treatment] [or follow-up] for cancer in the last [10] years? .....  Yes  No]

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[28.] [Is any proposed insured currently pregnant, an expectant parent or in the process of adoption or surrogate pregnancy? [This includes a surrogate mother or any person that she is contracted with.] .....  Yes  No]

[29.] [Have you fully disclosed all medical conditions for you and your family within the last [10] years? .....  Yes  No]

[Complete the questions [30]-[40] [if you are NOT applying for a Time Insurance Company medical policy at the same time you are applying for a [life insurance][critical illness] policy][for all face amounts].]

[30.] [Has [the] [any] [primary] [proposed] [adult] [insured] [ever] used tobacco products in any form or nicotine substitutes [within the last [[1-10] years] [[1-12 [months]] [after the age of [21]]]? .....  Yes  No]

[31.] [Has any proposed insured been advised by a physician that their life expectancy is less than [24] months? .....  Yes  No]

[32.] [In the last [6] months [H][h]as any proposed insured [ever] been bedridden, confined to a hospital, nursing home, mental facility, inpatient rehabilitation, subacute facility or hospice? .....  Yes  No]

[33.] [Has any proposed insured ever had a diagnosis[,] [or] [treatment] [or follow-up] for cancer[,] [or] heart disorders including heart attack, coronary bypass or angioplasty?.....  Yes  No]

[34.] [[In the last [10] years,] [H][h]as any proposed insured [ever] received any abnormal test results, medical or surgical treatment, consulted a health care professional, or taken medication for any of the following conditions?

- [• Heart disorders .....  Yes  No]
- [• Stroke (cerebral vascular accident) .....  Yes  No]
- [• TIA (Transient Ischemic Attack) .....  Yes  No]
- [• Peripheral Vascular Disease (PVD), Peripheral Arterial Disease (PAD) .....  Yes  No]
- [• Crohn's Disease or Ulcerative Colitis .....  Yes  No]
- [• Liver disorders, excluding fully recovered Hepatitis A.....  Yes  No]
- [• Kidney disorders, excluding kidney stones .....  Yes  No]
- [• Emphysema or Chronic Obstructive Pulmonary Disease (COPD) .....  Yes  No]
- [• Pulmonary Fibrosis, Cystic Fibrosis.....  Yes  No]
- [• Alzheimer's Disease .....  Yes  No]
- [• Dementia.....  Yes  No]
- [• Blood Disorders .....  Yes  No]
- [• Systemic Lupus Erythematosus.....  Yes  No]
- [• Tuberculosis (TB) .....  Yes  No]
- [• Diabetes.....  Yes  No]
- [• Cancer or Tumor .....  Yes  No]
- [• Leukemia.....  Yes  No]
- [• Melanoma .....  Yes  No]
- [• Skin Cancer (2 or more occurrences) .....  Yes  No]
- [• Non-Hodgkins Lymphoma .....  Yes  No]
- [• Alcoholism, Alcohol or Chemical Dependency, or Drug or Alcohol Abuse .....  Yes  No]
- [• Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV) .....  Yes  No]
- [• Multiple Sclerosis (MS) .....  Yes  No]
- [• ALS (Amyotrophic Lateral Sclerosis).....  Yes  No]
- [• Paralysis.....  Yes  No]
- [• Organ or stem cell transplant .....  Yes  No]
- [• Bipolar, Schizophrenia, or Chronic Depression.....  Yes  No]

[35.] [[In the last [2] years,] [H][h]as any proposed insured [ever]:

- [• Required oxygen use?.....  Yes  No]
- [• Required assistance from another person for eating, bathing, toileting, getting in and out of a chair or bed, dressing, or taking their own medication? .....  Yes  No]
- [• Received or been prescribed dialysis? .....  Yes  No]
- [• Been hospitalized 2 or more times? .....  Yes  No]

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[41.] [Has any proposed adult insured ever used tobacco products in any form or nicotine substitutes? ....  Yes  No]

Proposed Insured's First Name	Form of Tobacco or Substitute	Number per day or number of packs per day	How many years	Date quit
		_____ per day or _____ packs per day		
		_____ per day or _____ packs per day		

[42.] [If any proposed insured has Diabetes, was it diagnosed before the age of [50] or do they currently have any related complications (cardiac, kidney or vascular)? [Do not include gestational diabetes.].....  Yes  No]

**BENEFICIARY DESIGNATION**

The Policyowner may designate one or more Beneficiaries. Any benefits payable to Beneficiaries will be divided equally among all surviving named Beneficiaries unless a percentage is specified or otherwise required by law.

Beneficiary Name (Last, First, M.I.)	Relationship	Address	Percent

Must total to 100%

**COMPLETE IF APPLYING FOR THE DISABILITY WAIVER OF PREMIUM OPTIONAL COVERAGE**

[43.] [Does the [primary] [proposed] insured work less than [1-40] hours per week at their primary occupation? .....  Yes  No]

[44.] [In the last [[1-5] years] [[1-12] months], has the [primary] [proposed] insured missed [1-10] consecutive days or [1-10] total days of work because of [their] sickness or injury for which symptoms existed? [Do NOT include routine childbirth] .....  Yes  No]

[45.] [Has the [primary] [proposed] [insured] ever been diagnosed with or ever treated for any of the following? .....  Yes  No]

- [• Chronic Epstein-Barr]      [• Fibromyalgia]      [• Mental or Nervous Disorder]      [• Rheumatoid arthritis]
- [• Chronic Fatigue Syndrome]      [• Grand mal epilepsy]      [• Ulcerative colitis]
- [• Crohn's disease]      [• Inflammatory arthritis]      [• Mixed Connective Tissue Disease]
- [• Diabetes, excluding Gestational Diabetes]      [• Inflammatory bowel disease]      [• Psoriatic arthritis]

[46.] [In the last [[1-5] years] [[1-12] months], has the [primary] [proposed] insured experienced symptoms, been diagnosed as having or been treated for a disease or disorder of the back or neck, including acute and chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back? .....  Yes  No]

[If you answered "Yes" to any of questions [43] through [46], you are not eligible for the Waiver of Premium Optional Coverage.]

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**OTHER PHYSICIANS**

[Physician or Healthcare Provider seen in the last [1-10] years [for] [each] [primary] [proposed] [insured] [other than disclosed above].  
Attach a separate sheet if additional space is needed. Sign and date any additional sheets.

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_

Person \_\_\_\_\_ Physician \_\_\_\_\_ Specialty \_\_\_\_\_

Address or Phone Number \_\_\_\_\_

Date Last Seen \_\_\_\_\_ Reason & Results \_\_\_\_\_ Follow-up visit:  Yes  No Date \_\_\_\_\_ ]

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**[ ADDITIONAL [MEDICAL] DETAILS**

**IMPORTANT! IF ANY OF QUESTIONS [16] - [41] ARE ANSWERED "YES," PLEASE GIVE COMPLETE DETAILS BELOW.**

*Attach a separate sheet if additional space is needed. Sign and date any additional sheets.*

	Last	Name First	MI	Provide Dates, Type of Treatment, Diagnosis or Condition, Results	Full Recovery?	Name of Doctor or Hospital, and Complete Address and Phone Number
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Question #:					<input type="checkbox"/> Yes <input type="checkbox"/> No	

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**HIPAA ELIGIBILITY**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the below statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

No, I or anyone to be insured do not meet any of the above requirements.

Yes, I or anyone to be insured meet all of the above requirements.]

**EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for [individual] [supplemental] [life] insurance for you [(and your family)]. [You further understand that this application for [supplemental] [life] insurance [will] [may] [be] [fully] [medically] [underwritten] [,] [and] [is subject to eligibility requirements] [and that coverage is not guaranteed].] You are personally paying the entire premium for this [supplemental] [health] [life] [vision] insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [2]-[50] full-time employees,] I agree that I will not use [employer contributions] [or] [funds from a [Health Reimbursement Arrangement] [(HRA)] [or a Cafeteria Plan]] to pay the premium for my individual coverage.]

Do you agree with this statement? .....  Yes  No]

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## IMPORTANT NOTICES - LEAVE WITH CUSTOMER

### [NOTIFICATION REGARDING ("MIB") formerly known as the MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).]

### [ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

### [FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.]

### [PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]

## CONDITIONAL RECEIPT

This Conditional Receipt is received from \_\_\_\_\_,

this \_\_\_\_\_ day of \_\_\_\_\_ (month) \_\_\_\_\_ (year).

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which the Personal Health History call is completed.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned. If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company received the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided. ]

LEAVE THIS PAGE WITH THE CUSTOMER — DO NOT FAX

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