

SERFF Tracking Number: ALST-126529305 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
 Company Tracking Number: GVCIP2 AND GCIP3
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: GVCIP2 and GCIP3/

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Group Critical Illness SERFF Tr Num: ALST-126529305 State: Arkansas
 TOI: H07G Group Health - Specified Disease - SERFF Status: Closed-Approved- State Tr Num: 45128
 Limited Benefit Closed
 Sub-TOI: H07G.001 Critical Illness Co Tr Num: GVCIP2 AND GCIP3 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Angie Redden, Jennifer Disposition Date: 03/29/2010
 Aiello, Lynn Bautista, Patti Hicks,
 Leslie Blandford, Juli Clausen
 Date Submitted: 03/09/2010 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: GVCIP2 and GCIP3 Status of Filing in Domicile: Pending
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Overall Rate Impact: Group Market Type: Employer, Association,
 Trust, Other
 Filing Status Changed: 03/29/2010 Explanation for Other Group Market Type:
 Union
 State Status Changed: 03/29/2010
 Deemer Date: Created By: Angie Redden
 Submitted By: Angie Redden Corresponding Filing Tracking Number:
 Filing Description:
 The above referenced forms are being submitted for your review and approval. These forms are new and do not replace any forms previously approved by your department. They will be solicited by agents licensed to do business within your state. Forms GVCIP2; GVCIC2AR; GCIP3; GCIC3AR; GCIAPPAR; G-AMD; and AWD4530AR will be used to issue and enroll in Group Critical Illness Insurance.

SERFF Tracking Number: ALST-126529305 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
 Company Tracking Number: GVCIP2 AND GCIP3
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: GVCIP2 and GCIP3/

Form ERAPPAR is a multi-product employer application that may be used with this Group Critical Illness Insurance as well as any other group products that are approved for use in your state.

Material may vary, but will always be in accordance with your state laws. The bracketing on the enrollment forms will allow us the ability to customize the form for particular groups by removing products the employer has chosen to not offer to their employees.

The enrollment may be taken through electronic enrollment procedures by our licensed agents using a pen-based signature pad, PIN numbers, and any other valid electronic signature method. You have our assurance that appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it.

A Statement of Variability is enclosed, which outlines the variables for the submitted forms. Any logo, officer signature, or Home Office address and telephone number that appears on these forms is subject to change.

Company and Contact

Filing Contact Information

Angie Redden, Compliance Analyst, Group Insurance ARedden@allstate.com
 ATTN: Legal/Compliance 800-521-3535 [Phone] 3045 [Ext]
 1776 American Heritage Life Drive 904-992-2975 [FAX]
 Jacksonville, FL 32224-9983

Filing Company Information

American Heritage Life Insurance Company CoCode: 60534 State of Domicile: Florida
 ATTN: Legal/Compliance Group Code: 8 Company Type: Life and Health
 1776 American Heritage Life Drive Group Name: Allstate State ID Number:
 Jacksonville, FL 32224-9983 FEIN Number: 59-0781901
 (904) 992-1776 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No

SERFF Tracking Number: ALST-126529305 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
Company Tracking Number: GVCIP2 AND GCIP3
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
Limited Benefit
Product Name: Group Critical Illness
Project Name/Number: GVCIP2 and GCIP3/
Fee Explanation: Fee is \$50.00 per filing.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Heritage Life Insurance Company	\$50.00	03/09/2010	34712979

SERFF Tracking Number: ALST-126529305 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
 Company Tracking Number: GVCIP2 AND GCIP3
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: GVCIP2 and GCIP3/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/29/2010	03/29/2010

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	Rosalind Minor	03/10/2010	03/10/2010	Jennifer Aiello	03/22/2010	03/22/2010

SERFF Tracking Number: ALST-126529305 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
 Company Tracking Number: GVCIP2 AND GCIP3
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: GVCIP2 and GCIP3/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Forms List	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Group Critical Illness Policy	Approved-Closed	Yes
Form (revised)	Group Critical Illness Certificate	Approved-Closed	Yes
Form	Group Critical Illness Certificate	Replaced	Yes
Form	Group Critical Illness Policy	Approved-Closed	Yes
Form (revised)	Group Critical Illness Certificate	Approved-Closed	Yes
Form	Group Critical Illness Certificate	Replaced	Yes
Form	Employer Application	Approved-Closed	Yes
Form	Employer Application	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes

SERFF Tracking Number: ALST-126529305 State: Arkansas
Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
Company Tracking Number: GVCIP2 AND GCIP3
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
Limited Benefit
Product Name: Group Critical Illness
Project Name/Number: GVCIP2 and GCIP3/

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/10/2010
Submitted Date 03/10/2010

Respond By Date

Dear Angie Redden,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Critical Illness Certificate , GVCIC2AR (Form)
- Group Critical Illness Certificate , GCIC3AR (Form)

Comment: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/22/2010
Submitted Date 03/22/2010

Dear Rosalind Minor,

Comments:

We are in receipt of your objection letter dated March 10, 2010. Please allow this to be our response.

Response 1

Comments: We have revised the Termination of Coverage language in both certificates to be in compliance with ACA 23-86-108(4) and Bulletin 14-81.

Related Objection 1

Applies To:

- Group Critical Illness Certificate , GVCIC2AR (Form)

SERFF Tracking Number: ALST-126529305 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
 Company Tracking Number: GVCIP2 AND GCIP3
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: GVCIP2 and GCIP3/

- Group Critical Illness Certificate , GCIC3AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Critical Illness Certificate	GVCIC2A	R	Certificate	Initial			GVCIC2A R.pdf
Previous Version							
Group Critical Illness Certificate	GVCIC2A	R	Certificate	Initial			GVCIC2A R.pdf
Group Critical Illness Certificate	GCIC3AR		Certificate	Initial			GCIC3AR Certificate.pdf
Previous Version							
Group Critical Illness Certificate	GCIC3AR		Certificate	Initial			GCIC3AR.pdf

No Rate/Rule Schedule items changed.

We hope that you will now find our filing acceptable for approval. If you should have any additional questions or concerns, please contact me. Thank you for your continued consideration.

Sincerely,

Angie Redden, Jennifer Aiello, Juli Clausen, Leslie Blandford, Lynn Bautista, Patti Hicks

SERFF Tracking Number: ALST-126529305 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
 Company Tracking Number: GVCIP2 AND GCIP3
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: GVCIP2 and GCIP3/

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/29/2010	GVCIP2	Policy/Contract/Fraternal Certificate	Group Critical Illness Policy	Initial			GVCIP2 Policy.pdf
Approved-Closed 03/29/2010	GVCIC2AR	Certificate	Group Critical Illness Certificate	Initial			GVCIC2AR.pdf
Approved-Closed 03/29/2010	GCIP3	Policy/Contract/Fraternal Certificate	Group Critical Illness Policy	Initial			GCIP3 Policy.pdf
Approved-Closed 03/29/2010	GCIC3AR	Certificate	Group Critical Illness Certificate	Initial			GCIC3AR Certificate.pdf
Approved-Closed 03/29/2010	GCIAPPAR	Application/Enrollment Form	Employer Application	Initial			GCIAPPAR.pdf
Approved-Closed 03/29/2010	ERAPPAR	Application/Enrollment Form	Employer Application	Initial			ERAPPAR.pdf
Approved-Closed 03/29/2010	G-AMD	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy Amendment	Initial			G-AMD Generic Amendment.pdf

1



AMERICAN HERITAGE LIFE INSURANCE COMPANY
 HOME OFFICE:
 [1776 AMERICAN HERITAGE LIFE DRIVE
 JACKSONVILLE, FLORIDA 32224-6687]
 (904) 992-1776
 A Stock Company

**GROUP CRITICAL ILLNESS INSURANCE POLICY
 NON-PARTICIPATING**

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholders' signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

2

[*Cam Stewart*]

Secretary

[*David A. Beard*]

President

THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

TABLE OF CONTENTS

3

POLICY SPECIFICATIONS..... 3

POLICYHOLDER PROVISIONS [4-5]

GLOSSARY..... [6-7]

CERTIFICATE PROVISIONS MADE PART OF GROUP POLICY..... [7]

POLICY SPECIFICATIONS

4

POLICYHOLDER: [XYZ COMPANY, INC.] [XYZ LOCAL UNION NO. XXX]
POLICY NUMBER: [GROUP106]
POLICY EFFECTIVE DATE: [APRIL 1, 2010]
POLICY ANNIVERSARY DATE: [April 1, 2011] and the [first] day of [April] each calendar year thereafter.
GOVERNING JURISDICTION: the [state of Florida] and subject to the laws of that jurisdiction.

5

ELIGIBLE CLASS(ES):

[All full-time active employees or members working at least [30] hours per week excluding those who are insured under any other critical illness policy issued by American Heritage Life Insurance Company]

6

ELIGIBILITY WAITING PERIOD:

[Three Months]

7

BASIC BENEFIT AMOUNT:

[\$50,000 for Insured Employee or Member
\$25,000 for Insured Spouse
\$25,000 for Insured Child(ren)]

8

[GUARANTEED ISSUE LIMIT:

We may ask for evidence of insurability if a person proposed for insurance applies for a basic benefit amount over [\$15,000].]

9

[OPTIONAL BENEFITS:

[Second Event Critical Illness Benefit]
[Cancer Critical Illness Benefit – Same as Basic Benefit Amount]
[Second Event Cancer Critical Illness Benefit]
[Supplemental Critical Illness Benefit [I] [II] – Same as Basic Benefit Amount]
[Wellness Benefit - \$25.00 per test per covered person]
[Increasing Critical Illness Benefit - \$250/Per Coverage Year for the insured employee*
\$125/ Per Coverage Year for the insured spouse*
\$125/ Per Coverage Year for the insured child*
*For Coverage Years 2-5]]

10

INITIAL RATE:

The following are the initial rates for all available coverage types:
[Monthly rate of [\$XX.XX] per insured employee or member for Individual Coverage; or
[\$XX.XX] per insured employee or member for Individual and Spouse coverage; or
[\$XX.XX] per insured employee or member for Individual and Child(ren) coverage; or
[\$XX.XX] per insured employee or member for Family Coverage]

11

RATE GUARANTEE DATE:

[04/01/2011]

POLICY SPECIFICATIONS (Continued)

12

PREMIUM DUE:

[04/01/2010] and the [first day] of each [calendar month] thereafter.

The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

13

COST OF COVERAGE:

[The policyholder pays the cost of the insured employee or member's coverage.]

[The insured employee or member pays the cost of the dependent's coverage.]

[The insured employee or member and the policyholder share the cost of coverage.]

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

14

NAME

[NONE]

LOCATION (CITY AND STATE)

(This space intentionally left blank.)

POLICYHOLDER PROVISIONS

15

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members changes by [25%] or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than [25%] of those eligible for coverage are participating.

We will notify the policyholder in writing at least [30 days] before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
 - a. who are eligible to become insured; and
 - b. whose coverage changes; and
 - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

16

[WHEN EVIDENCE OF INSURABILITY IS REQUIRED

[Evidence of insurability is required at the time of enrollment.

Evidence of insurability is also required if:

1. the employee or member:
 - a. voluntarily canceled coverage and is reapplying; or
 - b. is applying for an amount of coverage over the Guaranteed Issue Limit; or
 - c. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.]

[Evidence of insurability is required if:

1. the employee or member:
 - a. voluntarily canceled coverage and is reapplying; or
 - b. is applying for an amount of coverage over the Guaranteed Issue Limit; or
 - c. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.]]

POLICYHOLDER PROVISIONS (Continued)

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

17

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least [31 days] written notice to the policyholder, if:

1. [less than [25%] of those eligible for coverage are participating; or]
2. this policy has been in effect more than [12] months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than [5] employees or members are insured; or
6. the policyholder fails to pay any premium within the [31] day grace period.

If the premium is not paid during the grace period, this policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must pay us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least [31] days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

CERTIFICATES OF INSURANCE

We will issue certificates of insurance for each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the benefits provided; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under this policy.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

GLOSSARY

18

Active Employment. Means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. For the purposes of this policy:

1. the employee or member must be working at least the minimum number of hours as described under Eligible Class(es); and
2. the employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. [Temporary and seasonal workers are excluded from coverage].

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Eligibility Waiting Period. Means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible for coverage.

Employee. Means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

Employer. Means the individual, company or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

19

[Evidence of Insurability. Means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.]

Family Coverage. Means coverage that includes the insured employee or member as defined, his or her eligible spouse and children as described in the certificate.

20

Grace Period. Means a period of [31] days following the premium due date during which premium payment may be made.

21

[Individual and Child(ren) Coverage. Means coverage that includes only the insured employee or member, as defined and eligible children as described in the certificate.]

[Individual and Spouse Coverage. Means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse as described in the certificate.]

Individual Coverage. Means coverage that includes only the insured employee or member, as defined.

22

Initial Enrollment Period. Means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending [31] days after the date he or she is first eligible to apply for coverage.

GLOSSARY (Continued)

23

Insured Employee or Member. Means the employee or member accepted for coverage by us who has completed and signed the enrollment form [or evidence of insurability] and whose name appears on the [certificate specification] [benefit statement] page.

24

Member. Means a member in good standing in an labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States; and (b) is [(1)] engaged in [, or (2) able to engage in and currently seeking,] active employment.

Policyholder. Means the legal entity to whom this policy is issued.

We, Us, and Our. Means American Heritage Life Insurance Company.

25

CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any optional riders or endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members [and their dependents, if applicable].

(This space intentionally left blank.)



Allstate[®]

Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

[1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687]
(904) 992-1776

A Stock Company

THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

1



Allstate

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

2

In this certificate, the words:

"You" and "your" mean the named insured [employee][or][member] shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"This policy" and "the policy" mean the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

3

Secretary

President

THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

TABLE OF CONTENTS

[CERTIFICATE SPECIFICATIONS..... 3]

GENERAL PROVISIONS [4 – 7]

[CONTINUATION OF INSURANCE (COBRA) 8 – 9]

[PORTABILITY 10]

LIMITATIONS AND EXCLUSIONS..... [11]

BENEFITS.....[12-15]

CLAIM INFORMATION [16-17]

GLOSSARY [18 – 20]

[AMERICAN HERITAGE LIFE INSURANCE COMPANY
 1776 American Heritage Life Drive, Jacksonville, Florida 32224

5

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	ANNUAL PREMIUM AMOUNT	
6	GVCIC2AR INITIAL CRITICAL ILLNESS		
	INSURED EMPLOYEE	BASIC BENEFIT AMOUNT \$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	SECOND EVENT INITIAL CRITICAL ILLNESS	SAME AMOUNT AS INITIAL CRITICAL ILLNESS	\$00.00
	CANCER CRITICAL ILLNESS	BASIC BENEFIT AMOUNT	\$00.00
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	SECOND EVENT CANCER CRITICAL ILLNESS	SAME AMOUNT AS CANCER CRITICAL ILLNESS	\$00.00
	SUPPLEMENTAL CRITICAL ILLNESS [I][II]	BASIC BENEFIT AMOUNT	\$00.00
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	INCREASING CRITICAL ILLNESS BENEFIT		
INSURED EMPLOYEE	\$250/PER COVERAGE YEAR*	\$00.00	
INSURED SPOUSE	\$125.00/PER COVERAGE YEAR*		
INSURED CHILD(REN)	\$125.00/PER COVERAGE YEAR*		
	*FOR COVERAGE YEARS 2-5		
WELLNESS BENEFIT	\$25/TEST	\$00.00	
FAMILY COVERAGE			

The effective date of each benefit is the Effective Date unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
\$000.00	\$000.00	\$00.00	\$00.00	\$00.00

Premium Payment Method **PAYROLL – MONTHLY** Premium Class **TOBACCO/NON-TOBACCO**

INSURED: JOHN DOE ISSUE AGE: 35
 EFFECTIVE DATE: MAY 01, 2010 CERTIFICATE NUMBER: 123456
 POLICY NUMBER: GROUP106
 BENEFICIARY: AS NAMED AT ENROLLMENT OR LATER CHANGED

GROUP CRITICAL ILLNESS COVERAGE

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

7 Your coverage will be effective at 12:01 a.m. on the effective date shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] provided you are actively employed on that date.

If you are not actively employed on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage [that is subject to evidence of insurability], the change in coverage is effective on the date we approve such change.

[For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.]

8 WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
 - a. the initial enrollment period; or
 - b. [at any other time] [at the next re-enrollment period] [, subject to evidence of insurability].
2. You may increase coverage [at any time] [at the next re-enrollment period] [, subject to evidence of insurability].
3. You may discontinue coverage at any time.

9 [WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. you:
 - a. voluntarily canceled coverage and are reapplying; or
 - b. are applying for an amount of coverage over the guaranteed issue limit; or
 - c. are applying for the coverage, or an increase in the amount of coverage, at any time after your initial enrollment period; or
2. an eligible dependent did not enroll within 31 days of eligibility.]

(This space intentionally left blank.)

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. your legal spouse [or domestic partner]; and
2. your unmarried children including adopted children from the moment of placement in the residence, stepchildren, [children of a domestic partner] or legal ward who are [under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school]. Your children must be dependent on you for support or reside with you over 50% of the time in a regular parent-child relationship and be named on the enrollment [or evidence of insurability] form.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to the certificate if we are notified within 31 days after they become eligible.

If you have Individual Coverage [or Individual and Child(ren) Coverage], then marry and desire coverage for your spouse, we must be notified within 31 days of the marriage. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.]

[If you have Individual Coverage [or Individual and Child(ren) Coverage], then establish a domestic partnership and desire coverage for your domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the date a domestic partnership was formed, then evidence of insurability will be required.]]

A child born to you or your spouse [or domestic partner], while [Individual and Child(ren) Coverage] [or] [Family Coverage] is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under the certificate. No additional premium will be required for newborns added if [Individual and Child(ren) Coverage or] Family Coverage is in force at the time the newborn is added.

If you have Individual Coverage [or Individual and Spouse Coverage,] newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for a newborn child, you must notify us within 31 days of that child's birth. Upon notification, we will convert your Individual Coverage [to Individual and Child(ren) Coverage] [or Individual and Spouse Coverage] to Family Coverage and provide notification of the additional premium due. If you do not notify us within 31 days of the birth of the child, the temporary automatic coverage ends.

An adopted child or child pending adoption will be covered as follows, as long as [Individual and Child(ren) Coverage or] Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 60 days after the date of birth.
2. If adoption proceedings have been instituted by you 60 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

GENERAL PROVISIONS (Continued)

11

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day you are [actively employed with your employer] [or] [a member in good standing in the labor union, association or other entity] that is the policyholder, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. the date you have received the maximum total percentage of the basic benefit amount for each critical illness; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

We will provide coverage for a payable claim that occurs while a covered person is covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

[If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death.]

Coverage for a dependent child ends on your death or [the certificate anniversary next following the date the child is no longer eligible] [the end of month in which the dependent child is no longer eligible]. This is the earlier of when the child: (a) marries; or (b) reaches age [22 (26 if a full-time student attending an educational institution of higher learning beyond high school)]; or (c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as the certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us, at our expense, when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if you have Individual and Children Coverage or Family Coverage and there are other eligible dependents insured under the policy.

Coverage may be eligible for continuation as outlined in [the CONTINUATION OF INSURANCE (COBRA) provision] [or] [the PORTABILITY PRIVILEGE provision].

12

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease [active employment] [or] [membership in the union or association] because of a temporary layoff or leave of absence while coverage is in force, we will continue your coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved your leave in writing. Coverage will be continued for [3 months] following the date you ceased [active employment] [or] [membership in the union or association].

If your coverage ends while on a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active status.

We will not:

1. apply a new pre-existing condition exclusion[]; or
2. require evidence of insurability[].

GENERAL PROVISIONS (Continued)

13

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] GROUP INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior group policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior group policy when it terminated; and
3. the covered person making the claim:
 - a. has been continuously insured under this policy since the policy date; and
 - b. was insured under the prior group policy when it terminated; and
4. the prior group policy:
 - a. [was issued by us; and]
 - b. had the same policyholder as this policy; and
 - c. provided coverage substantially similar to this policy; and
 - d. was issued before the policy date of this policy; and
 - e. terminated within 60 days of the policy date of this policy.]

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] INDIVIDUAL INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior individual policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior individual policy when it terminated; and
3. the covered person making the claim:
 - a. has been continuously insured under this policy since the policy date; and
 - b. was insured under the prior individual policy when it terminated; and
4. the prior individual policy:
 - a. [was issued by us; and]
 - b. provided coverage substantially similar to this policy; and
 - c. was issued before the policy date of this policy; and
 - d. terminated within 60 days of the policy date of this policy.]

14

[DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

GENERAL PROVISIONS (Continued)

INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder documenting any clerical errors.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

(This space intentionally left blank.)

[CONTINUATION OF INSURANCE (COBRA)]

15

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if your insurance would otherwise end due to one of the following events, called a qualifying event:

1. Termination of employment (other than by reason of gross misconduct), or of your eligibility due to reduction in your hours. Insurance may be continued for you and any dependents[, except for domestic partners and their covered dependents].
2. Your death. Insurance may be continued for any covered person[, except for domestic partners and their covered dependents].
3. Divorce or legal separation. Insurance may be continued for any dependent whose insurance would otherwise end. [However, COBRA does not extend continuation of coverage to domestic partners and their dependents.]
4. Your becoming eligible for Medicare. Insurance may be continued for any insured's dependents who are not entitled to Medicare[, except for domestic partners and their covered dependents]
5. A child ceasing to be an eligible dependent as defined in the policy. Insurance may be continued for that child.
6. Your employer files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of critical illness insurance, you must be insured under the policy on the day before the qualifying event. In the case of bankruptcy, you must also be: (a) an employee who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

You will not be denied continuation solely because you are covered under another group critical illness plan or eligible for Medicare on the date the qualifying event occurs.

COVERAGE CONTINUED

The insurance being continued by this section is subject to all terms and provisions of the policy that do not conflict with this section. The insurance will be the same as if the qualifying event had not occurred. The continued insurance will be subject to any changes to the policy affecting the benefits of your class following the qualifying event.

NOTIFICATION AND PAYMENT REQUIREMENTS

You have the responsibility to inform your employer of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

Your employer has the responsibility of notifying the plan administrator of: (a) your death, termination of employment, or reduction in hours; or (b) your employer's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify you of the right to continue within 14 days of the notice described above. You will then have 60 days to elect to continue your insurance. Failure to elect to continue insurance within 60 days after you are notified by the plan administrator will result in loss of the right to continue such insurance.

You will be required to pay a premium for the continued insurance to the policyholder. You will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

CONTINUATION OF INSURANCE (COBRA) – (Continued)

15

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

TERMINATION

Insurance being continued by this section will terminate on the first of the following dates that apply:

1. The date the policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverages have been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date you become covered under any other group critical illness policy, whether as an insured employee or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date you become entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees of employers under Chapter 11 Bankruptcy and their dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
 - a. If you are totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, you must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
 1. within 60 days of the Social Security determination of total disability; and
 2. within the initial 18 months of continuation coverage.
 - b. If you have a qualifying event (termination or reduction in hours worked) and you had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
 1. 36 months from the date you first became entitled to Medicare; or
 2. 18 months from your termination or reduction in hours.
 - c. For a qualifying event involving retired employees of employers under Chapter 11 Bankruptcy and their dependents, the maximum period of continuation coverage is:
 1. the lifetime of the retiree; or
 2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
 3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.]

[PORTABILITY PRIVILEGE

16

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

1. coverage under the policy terminates under the TERMINATION OF COVERAGE provision; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after you are insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured [employees][or][members] and may change on any premium due date. If you are on portability coverage, we will give you written notice at least [31] days before a change is to take effect.

GRACE PERIOD

The grace period, as defined in the policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
 - a. the date your insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.]

[PRE-EXISTING CONDITION LIMITATION

17

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from, a pre-existing condition when the date of diagnosis for the critical illness is within [12] months after the effective date of coverage.

A pre-existing condition is a sickness, injury or other condition, whether diagnosed or not, for which, during the [12] months just prior to the effective date of coverage, either:

1. symptoms existed; or
2. medical advice or treatment was recommended by or received from a physician or other member of the medical profession, acting within the scope of their license.]

EXCLUSIONS

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from:

1. War, declared or undeclared, participation in a riot, insurrection or rebellion.
2. Intentionally self-inflicted injury or action.
3. Illegal activities or participation in an illegal occupation.
4. Suicide while sane, or self-destruction while insane, or any attempt at either.
5. Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.

(This space intentionally left blank.)

CRITICAL ILLNESS BENEFIT

GENERAL

Subject to the conditions, limitations and exclusions of this coverage, we will pay a benefit when a covered person is diagnosed with a critical illness described in this coverage if:

1. the date of diagnosis for the critical illness is while the covered person is insured under the policy; and
2. the critical illness is not excluded by name or specific description.

A covered person can receive a benefit for each critical illness only once, unless the Second Event Critical Illness Benefit for that critical illness is included in the coverage.

A covered person can receive benefits for different critical illnesses described in the policy if the dates of diagnosis for each critical illness are separated by at least 90 days.

Coverage for a covered person terminates when the covered person is not eligible for any further benefits.

Each critical illness must be diagnosed by a physician in the United States. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

We do not pay any benefit for any condition or loss not described below.

18

INITIAL CRITICAL ILLNESS BENEFIT

- A. BENEFIT AMOUNT.** The benefit amount for each initial critical illness is the percentage shown below for that initial critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Initial Critical Illness	Percentage of Basic Benefit Amount
Heart Attack	[100%]
Stroke	[100%]
Coronary Artery By-Pass Surgery	[25%]
Major Organ Transplant	[100%]
End Stage Renal Failure	[100%]

- B. BENEFIT DESCRIPTION.** The initial critical illnesses are:

1. **Heart Attack.** The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis must be based on both:

- a. new electrocardiographic changes; and
- b. elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

Heart attack does not include an established (old) myocardial infarction.

The date of diagnosis for Heart Attack is the date of death (infarction) of a portion of the heart muscle.

2. **Stroke.** The death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke does not include: transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits.

The date of diagnosis for Stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.

CRITICAL ILLNESS BENEFIT (Continued)

B. BENEFITS DESCRIPTION. (Continued)

3. **Coronary Artery By-Pass Surgery.** The surgical operation to correct narrowing or blockage of one or more coronary arteries with by-pass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required.

Coronary artery by-pass surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

The date of diagnosis for Coronary Artery By-Pass Surgery is the date the actual coronary artery by-pass surgery occurs.

4. **Major Organ Transplant.** The surgical transplantation of a heart, lung, liver, pancreas, or kidney. The transplanted organ must come from a human donor.

The date of diagnosis for Major Organ Transplant is the date the actual surgery occurs for the covered transplant.

5. **End Stage Renal Failure.** The irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis.

End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas.

The date of diagnosis for End Stage Renal Failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.

19

[INSERT AS APPLICABLE OPTIONAL BENEFITS:

[SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT]

[CANCER CRITICAL ILLNESS BENEFIT]

[SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT]

[SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT]

[SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT]

[INCREASING CRITICAL ILLNESS BENEFIT]

[WELLNESS BENEFIT]]

[OPTIONAL BENEFITS

20 SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT

We will pay a Second Event Initial Critical Illness Benefit if a covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the INITIAL CRITICAL ILLNESS BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the initial critical illness; and
2. the second date of diagnosis is while the covered person is insured under the policy.

The benefit amount is equal to the benefit amount previously paid for that initial critical illness. A covered person can receive a Second Event Initial Critical Illness Benefit only once for each initial critical illness.

(This space intentionally left blank.)

[OPTIONAL BENEFITS

21 **CANCER CRITICAL ILLNESS BENEFIT**

A. BENEFIT AMOUNT. The benefit amount for each cancer critical illness is the percentage shown below for that cancer critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Cancer Critical Illness	Percentage of Basic Benefit Amount
Carcinoma in situ	[25%]
Invasive Cancer	[100%]

B. BENEFIT DESCRIPTION. The cancer critical illnesses are:

1. **Carcinoma In Situ.** A cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

Carcinoma in situ includes:

- a. early prostate cancer diagnosed as stages A, I or II or equivalent staging; and
- b. melanoma not invading the dermis.

Carcinoma in situ does not include:

- a. other skin malignancies; or
- b. pre-malignant lesions (such as intraepithelial neoplasia); or
- c. benign tumors or polyps.

2. **Invasive Cancer.** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Invasive Cancer includes Leukemia and Lymphoma.

Invasive cancer does not include:

- a. carcinoma in situ; or
- b. tumors in the presence of any human immuno-deficiency virus; or
- c. skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or
- d. early prostate (stages A, I or II) cancer.

C. DIAGNOSIS REQUIREMENTS. A cancer critical illness must be diagnosed in one of two ways:

1. **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology.

2. **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis only if:

- a. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- b. there is medical evidence to support the diagnosis.

The date of diagnosis for cancer critical illness is the day the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based.

The “first diagnosis of cancer” includes a diagnosis of a recurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the recurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter.

For purposes of this benefit, “treatment” does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

“Maintenance drug therapy” means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

[OPTIONAL BENEFITS

22

SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT

We will pay Second Event Cancer Critical Illness Benefit if a covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the CANCER CRITICAL ILLNESS BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the cancer critical illness; and
2. the covered person did not receive treatment during that 12 month period; and
3. the second date of diagnosis is while the covered person is insured under the policy.

For purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

The benefit amount is equal to the benefit amount previously paid for that cancer critical illness. A covered person can receive a Second Event Cancer Critical Illness Benefit only once for each cancer critical illness.

(This space intentionally left blank.)

[OPTIONAL BENEFITS

23

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each supplemental critical illness is the percentage shown below for that supplemental critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Supplemental Critical Illness	Percentage of Basic Benefit Amount
Advanced Alzheimer's Disease	[25%]
Advanced Parkinson's Disease	[25%]
Benign Brain Tumor	[100%]
Coma	[100%]
Complete Blindness	[100%]
Complete Loss of Hearing	[100%]
Paralysis	[100%]
Occupational HIV	[100%]

B. BENEFITS DESCRIPTION. The supplemental critical illnesses are:

1. **Advanced Alzheimer's Disease.** Alzheimer's disease that causes the covered person to be incapacitated.

"Alzheimer's disease" is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease.

"Incapacitated" means that, due to Alzheimer's disease, the covered person:

- a. exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
- b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease.

2. **Advanced Parkinson's Disease.** Parkinson's disease that causes the covered person to be incapacitated.

"Parkinson's disease" is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease.

"Incapacitated" means that, due to Parkinson's disease, the covered person:

- a. exhibits 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); and
- b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

3. **Benign Brain Tumor.** A non-cancerous brain tumor:
- a. confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
 - b. resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- a. tumors of the skull; or
- b. pituitary adenomas; or
- c. meningiomas.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

4. **Coma.** A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

5. **Complete Blindness.** A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:
- a. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
 - b. visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

6. **Complete Loss of Hearing.** The total and irreversible loss of hearing in both ears.

Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

7. **Paralysis.** The total and permanent voluntary loss of movement or motor function of 2 or more limbs.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

8. **Occupational HIV.** An accidental occupational exposure to HIV-contaminated body fluids due to a needle stick or splash from which the covered person is infected with HIV. The accidental exposure must occur during the normal course of duties of the occupation in which the covered person is regularly engaged and for which remuneration is earned. The covered person must have never previously tested HIV positive.

For a benefit to be paid under Occupational HIV, the following additional requirements must be met:

- a. an incident report (notice of exposure) which describes the nature of the exposure to HIV is filed with the employer within 48 hours of the exposure and sent to us as soon as reasonably possible; and
- b. a preliminary screening test, such as an enzyme-linked immunoabsorbent assay (ELISA) or other approved test by the Food and Drug Administration (FDA), other than saliva or urine testing, is performed within 14 days of the accidental exposure; and
- c. a subsequent screening test is performed within 26 weeks of the accidental exposure and we receive notification of the HIV positive test results as soon as reasonably possible.

"HIV positive" means the presence of HIV antibodies in the blood of a covered person as substantiated through both a positive screening test such as ELISA, and a positive supplemental test such as the Western Blot. All such tests must be approved by the FDA with the interpretation of positive results as specified by the manufacturer(s). If the Western blot is negative and remains so for 6 months, HIV infection is not present.

The date of diagnosis for Occupational HIV is the date a physician determines the covered person is HIV positive as supported by the ELISA test, Western Blot test or another FDA approved test.

C. ACTIVITIES OF DAILY LIVING. As used in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision, "activities of daily living" are:

1. Bathing — to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing — to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting — to get on and off the toilet and maintain personal hygiene.
4. Bladder and Bowel Continence — to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
6. Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

[OPTIONAL BENEFITS

23

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each supplemental critical illness is the percentage shown below for that supplemental critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Table with 2 columns: Supplemental Critical Illness, Percentage of Basic Benefit Amount. Rows include: Advanced Alzheimer's Disease (25%), Advanced Parkinson's Disease (25%), Benign Brain Tumor (100%), Coma (100%), Complete Blindness (100%), Complete Loss of Hearing (100%), Paralysis (100%).

B. BENEFITS DESCRIPTION. The supplemental critical illnesses are:

1. Advanced Alzheimer's Disease. Alzheimer's disease that causes the covered person to be incapacitated.

"Alzheimer's disease" is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease.

"Incapacitated" means that, due to Alzheimer's disease, the covered person:

- a. exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease.

2. Advanced Parkinson's Disease. Parkinson's disease that causes the covered person to be incapacitated.

"Parkinson's disease" is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease.

"Incapacitated" means that, due to Parkinson's disease, the covered person:

- a. exhibits 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

3. **Benign Brain Tumor.** A non-cancerous brain tumor:
 - a. confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
 - b. resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- a. tumors of the skull; or
- b. pituitary adenomas; or
- c. meningiomas.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

4. **Coma.** A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

5. **Complete Blindness.** A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:
 - c. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
 - d. visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

6. **Complete Loss of Hearing.** The total and irreversible loss of hearing in both ears.

Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

7. **Paralysis.** The total and permanent voluntary loss of movement or motor function of 2 or more limbs.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

C. ACTIVITIES OF DAILY LIVING. As used in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision, "activities of daily living" are:

1. Bathing — to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing — to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting — to get on and off the toilet and maintain personal hygiene.
4. Bladder and Bowel Continence — to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
6. Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.]

[OPTIONAL BENEFITS

24

INCREASING CRITICAL ILLNESS BENEFIT

We will increase the basic benefit amounts shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] on each of the first 5 coverage year anniversaries. This increase will be the specified amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] and will increase the basic benefit amount for each covered person. This increase only applies to the basic benefit amount. It does not apply to any other benefit included with this certificate. Each increase in the basic benefit amount will be automatically processed by us.

“Coverage year anniversary” means the same day and month each year as the effective date of the certificate for each succeeding year the certificate remains in force.

(This space intentionally left blank.)

[OPTIONAL BENEFITS**WELLNESS BENEFIT**

We pay the amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] per calendar year per covered person for any one of the below. Each covered person is covered for no more than the amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] per calendar year. The eligible Wellness Benefits are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

(This space intentionally left blank.)

WAIVER OF PREMIUM BENEFIT

We will waive your premiums for this coverage if, while covered under the policy, you:

1. become disabled due to a critical illness for which a benefit is paid; and
2. remain disabled for at least 90 consecutive days.

After the 90th day, we will waive the premiums due for the first 90 days and each consecutive day thereafter you are disabled, until the earliest of:

1. the date you are no longer disabled; or
- 26 2. [2 years from the first day of disability; or]
3. [upon your reaching age 65 or 2 years from the first day of disability, whichever occurs last; or]
4. the date coverage ends according to the TERMINATION OF COVERAGE provision.

“Disabled” means you are:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

“Unable to work” means:

1. During the first 365 days of disability, you are unable to work at the occupation you were performing when your disability began.
2. [During the second 365 days of disability] [After the first 365 days of disability], you are unable to work at any gainful occupation for which you are suited by education, training or experience.

This benefit is payable only for the disability of the insured [employee] [or] [member]. It does not apply to any other covered person. You must provide sufficient proof of disability at least once every 6 months.

(This space intentionally left blank.)

CLAIM INFORMATION

NOTICE OF CLAIM

27 We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any benefit covered by the policy, or as soon as is reasonably possible. Notice given to us by, or on behalf of, you or the beneficiary at [1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687], or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the form is not received from us within 15 days of the request, written proof of claim may be sent to us without waiting for the form.

FILING A CLAIM

You must complete all applicable sections of the claim form and then give it to your attending physician. The physician should complete his or her section statement of the form and send it directly to us.

PROOF OF CLAIM

Written proof must be furnished to us within 90 days of each critical illness or payable loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have you examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under this certificate and we will make payment to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid you.

UNPAID PREMIUM

Upon the payment of a claim under the policy, any unpaid premium may be deducted.

CLAIM INFORMATION (Continued)

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. your right to submit any additional information that might allow us to change our decision.

You may, upon written request, have any reports that are not confidential. For a fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

(This space intentionally left blank.)

GLOSSARY

Active Employment or **Actively Employed** means that the covered person is working for his/her employer for earnings that are paid regularly and that the covered person is performing the material and substantial duties of his/her regular occupation. When used in connection with you:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not one of your employer's scheduled work days only if you were actively employed on the preceding scheduled work day.

The covered person's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the covered person's job requires travel.

28

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. [Temporary and seasonal workers are excluded from coverage.]

Calendar Year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

29

Covered Person means any of the following:

1. any eligible family member (including you) named on the enrollment [or evidence of insurability] and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

Critical Illness means one of the critical illnesses described in the CRITICAL ILLNESS BENEFIT provision for which a benefit may be paid.

[Domestic Partner means your same-sex or opposite-sex partner who is eligible for coverage provided that:

30

1. Both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. If your state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, you must satisfy the definition of domestic partner as defined by the policyholder; or
3. If your state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both you and your same-sex or opposite-sex partner must:
 - a. have resided together in the same permanent residence; and
 - b. be at least 18 years of age; and
 - c. intend to remain each other's sole domestic partner indefinitely; and
 - d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon you for care and financial assistance; and
 - e. not be legally married to or the legal domestic partner of anyone else; and
 - f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.]

Employer means the individual, company or corporation where the covered person is in active employment, and includes any division, subsidiary, or affiliated company of the employer.

GLOSSARY (Continued)

31 **[Evidence of Insurability]** means a statement of your or your dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.]

32 **Family Coverage** means coverage that includes you, your spouse [or domestic partner] and eligible children.

33 **Grace Period** means a period of [31] days following the premium due date during which premium payment may be made.

Individual Coverage means coverage that includes only you, as defined.

34 **[Individual and Children Coverage]** means coverage that includes only you, as defined, and eligible children.]

[Individual and Spouse Coverage] means coverage that includes only you, as defined, and your eligible spouse [or domestic partner.]

Initial Enrollment Period means one of the following periods during which you may first apply, in writing, for coverage under the policy:

1. a period before the policy effective date as set by us and the policyholder if you are eligible for coverage on the policy effective date; or
2. the period ending 31 days after the date you are first eligible to apply for coverage if you become eligible for coverage after the policy effective date.

Injury means accidental bodily injury.

Material and Substantial Duties means duties that:

1. are normally required for the performance of the covered person's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the covered person is required to work on average in excess of 40 hours per week. We will consider the covered person able to perform that requirement if he/she is working or has the capacity to work 40 hours per week.

Payable Claim means a claim for which we are liable under the terms of the policy.

35 **Physician** means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize you, or your [domestic partner,] spouse, children, parents, or siblings as a physician for a claim.

Policy means the policy of insurance issued by us to the policyholder.

Policy Date means the effective date of the policy.

Policyholder means the legal entity to whom the policy is issued.

Re-enrollment Period means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if you are currently enrolled.

Sickness means an illness or disease.

GLOSSARY (Continued)

Symptoms mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

We, Us and **Our** mean American Heritage Life Insurance Company.

36 **You** and **Your** mean the named insured [employee][or][member] shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

(This space intentionally left blank.)



Allstate[®]

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

**THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS
ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED.
THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**

1



AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
[1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687]
(904) 992-1776

A Stock Company

**GROUP CRITICAL ILLNESS INSURANCE POLICY
NON-PARTICIPATING**

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholders' signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

2

[*Cam Stewart*]

Secretary

[*David A. Beard*]

President

THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

TABLE OF CONTENTS

3

POLICY SPECIFICATIONS..... 3

POLICYHOLDER PROVISIONS [4-5]

GLOSSARY..... [6-7]

CERTIFICATE PROVISIONS MADE PART OF GROUP POLICY..... [7]

POLICY SPECIFICATIONS

4

POLICYHOLDER: [XYZ COMPANY, INC.] [XYZ LOCAL UNION NO. XXX]
POLICY NUMBER: [GROUP106]
POLICY EFFECTIVE DATE: [APRIL 1, 2010]
POLICY ANNIVERSARY DATE: [April 1, 2011] and the [first] day of [April] each calendar year thereafter.
GOVERNING JURISDICTION: the [state of Florida] and subject to the laws of that jurisdiction.

5

ELIGIBLE CLASS(ES):

[All full-time active employees or members working at least [30] hours per week excluding those who are insured under any other critical illness policy issued by American Heritage Life Insurance Company]

6

ELIGIBILITY WAITING PERIOD:

[Three Months]

7

BASIC BENEFIT AMOUNT:

[\$50,000 for Insured Employee or Member
\$25,000 for Insured Spouse
\$25,000 for Insured Child(ren)]

8

[GUARANTEED ISSUE LIMIT:

We may ask for evidence of insurability if a person proposed for insurance applies for a basic benefit amount over [\$50,000].]

9

[OPTIONAL BENEFITS:

[Second Event Critical Illness Benefit]
[Cancer Critical Illness Benefit – Same as Basic Benefit Amount]
[Second Event Cancer Critical Illness Benefit]
[Supplemental Critical Illness Benefit [I] [II] – Same as Basic Benefit Amount]
[Wellness Benefit - \$25.00 per test per covered person]

10

INITIAL RATE:

The following are the initial rates for all available coverage types:
[Monthly rate of [\$XX.XX] per insured employee or member for Individual Coverage; or
[\$XX.XX] per insured employee or member for Individual and Spouse coverage; or
[\$XX.XX] per insured employee or member for Individual and Child(ren) coverage; or
[\$XX.XX] per insured employee or member for Family Coverage]

11

RATE GUARANTEE DATE:

[04/01/2011]

POLICY SPECIFICATIONS (Continued)

12

PREMIUM DUE:

[04/01/2010] and the [first day] of each [calendar month] thereafter.

The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

13

COST OF COVERAGE:

[The policyholder pays the cost of the insured employee or member's coverage.]

[The insured employee or member pays the cost of the dependent's coverage.]

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

14

NAME

[NONE]

LOCATION (CITY AND STATE)

(This space intentionally left blank.)

POLICYHOLDER PROVISIONS

15

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members changes by [25%] or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than [25%] of those eligible for coverage are participating.

We will notify the policyholder in writing at least [30 days] before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

Premium increases or decreases may take effect any time subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
 - a. who are eligible to become insured; and
 - b. whose coverage changes; and
 - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

16

[WHEN EVIDENCE OF INSURABILITY IS REQUIRED

[Evidence of insurability is required at the time of enrollment.

Evidence of insurability is also required if:

1. the employee or member:
 - a. voluntarily canceled coverage and is reapplying; or
 - b. is applying for an amount of coverage over the Guaranteed Issue Limit; or
 - c. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.]

[Evidence of insurability is required if:

1. the employee or member:
 - a. voluntarily canceled coverage and is reapplying; or
 - b. is applying for an amount of coverage over the Guaranteed Issue Limit; or
 - c. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.]]

POLICYHOLDER PROVISIONS (Continued)

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

17

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least [31 days] written notice to the policyholder, if:

1. [less than [25%] of those eligible for coverage are participating; or]
2. this policy has been in effect more than [12] months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than [5] employees or members are insured; or
6. the policyholder fails to pay any premium within the [31] day grace period.

If the premium is not paid during the grace period, this policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must pay us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least [31] days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

CERTIFICATES OF INSURANCE

We will issue certificates of insurance for each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the benefits provided; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under this policy.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

GLOSSARY

18

Active Employment. Means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. For the purposes of this policy:

1. the employee or member must be working at least the minimum number of hours as described under Eligible Class(es); and
2. the employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. [Temporary and seasonal workers are excluded from coverage].

Calendar Year. Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Eligibility Waiting Period. Means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible for coverage.

Employee. Means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

Employer. Means the individual, company or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

19

[Evidence of Insurability. Means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.]

Family Coverage. Means coverage that includes the insured employee or member as defined, his or her eligible spouse and children as described in the certificate.

20

Grace Period. Means a period of [31] days following the premium due date during which premium payment may be made.

21

[Individual and Child(ren) Coverage. Means coverage that includes only the insured employee or member, as defined and eligible children as described in the certificate.]

[Individual and Spouse Coverage. Means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse as described in the certificate.]

Individual Coverage. Means coverage that includes only the insured employee or member, as defined.

22

Initial Enrollment Period. Means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending [31] days after the date he or she is first eligible to apply for coverage.

GLOSSARY (Continued)

23

Insured Employee or Member. Means the employee or member accepted for coverage by us who has completed and signed the enrollment form [or evidence of insurability] and whose name appears on the [certificate specification] [benefit statement] page.

24

Member. Means a member in good standing in an labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States; and (b) is [(1)] engaged in [, or (2) able to engage in and currently seeking,] active employment.

Policyholder. Means the legal entity to whom this policy is issued.

We, Us, and Our. Means American Heritage Life Insurance Company.

25

CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any optional riders or endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members [and their dependents, if applicable].

(This space intentionally left blank.)



Allstate[®]

Workplace Division]

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

[1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687]
(904) 992-1776

A Stock Company

THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

1



Allstate

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

2

In this certificate, the words:

"You" and "your" mean the named insured [employee][or][member] shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"This policy" and "the policy" mean the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

3

Secretary

President

THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

TABLE OF CONTENTS

[CERTIFICATE SPECIFICATIONS..... 3]

GENERAL PROVISIONS [4 – 7]

[CONTINUATION OF INSURANCE (COBRA) 8 – 9]

[PORTABILITY 10]

LIMITATIONS AND EXCLUSIONS..... [11]

BENEFITS.....[12-15]

CLAIM INFORMATION [16-17]

GLOSSARY [18 – 20]

[AMERICAN HERITAGE LIFE INSURANCE COMPANY
 1776 American Heritage Life Drive, Jacksonville, Florida 32224

5

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	ANNUAL PREMIUM AMOUNT	
6	GCIC3AR INITIAL CRITICAL ILLNESS		
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	SECOND EVENT INITIAL CRITICAL ILLNESS	SAME AMOUNT AS INITIAL CRITICAL ILLNESS	\$00.00
	CANCER CRITICAL ILLNESS		
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	SECOND EVENT CANCER CRITICAL ILLNESS	SAME AMOUNT AS CANCER CRITICAL ILLNESS	\$00.00
SUPPLEMENTAL CRITICAL ILLNESS [I][II]			
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	WELLNESS BENEFIT	\$25/TEST	\$00.00

FAMILY COVERAGE

The effective date of each benefit is the Effective Date unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
\$000.00	\$000.00	\$00.00	\$00.00	\$00.00

Premium Payment Method PAYROLL – MONTHLY Premium Class TOBACCO/NON-TOBACCO

INSURED: JOHN DOE ISSUE AGE: 35
 EFFECTIVE DATE: MAY 01, 2010 CERTIFICATE NUMBER: 123456
 POLICY NUMBER: GROUP106
 BENEFICIARY: AS NAMED AT ENROLLMENT OR LATER CHANGED

GROUP CRITICAL ILLNESS COVERAGE

GCIC3AR

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

7 Your coverage will be effective at 12:01 a.m. on the effective date shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] provided you are actively employed on that date.

If you are not actively employed on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage [that is subject to evidence of insurability], the change in coverage is effective on the date we approve such change.

[For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.]

8 WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
 - a. the initial enrollment period; or
 - b. [at any other time] [at the next re-enrollment period] [, subject to evidence of insurability].
2. You may increase coverage [at any time] [at the next re-enrollment period] [, subject to evidence of insurability].
3. You may discontinue coverage at any time.

9 [WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. you:
 - a. voluntarily canceled coverage and are reapplying; or
 - b. are applying for an amount of coverage over the guaranteed issue limit; or
 - c. are applying for the coverage, or an increase in the amount of coverage, at any time after your initial enrollment period; or
2. an eligible dependent did not enroll within 31 days of eligibility.]

(This space intentionally left blank.)

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. your legal spouse [or domestic partner]; and
2. your unmarried children including adopted children from the moment of placement in the residence, stepchildren, [children of a domestic partner] or legal ward who are [under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school]. Your children must be dependent on you for support or reside with you over 50% of the time in a regular parent-child relationship and be named on the enrollment [or evidence of insurability] form.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to the certificate if we are notified within 31 days after they become eligible.

If you have Individual Coverage [or Individual and Child(ren) Coverage], then marry and desire coverage for your spouse, we must be notified within 31 days of the marriage. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.]

[If you have Individual Coverage [or Individual and Child(ren) Coverage], then establish a domestic partnership and desire coverage for your domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the date a domestic partnership was formed, then evidence of insurability will be required.]]

A child born to you or your spouse [or domestic partner], while [Individual and Child(ren) Coverage] [or] [Family Coverage] is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under the certificate. No additional premium will be required for newborns added if [Individual and Child(ren) Coverage or] Family Coverage is in force at the time the newborn is added.

If you have Individual Coverage [or Individual and Spouse Coverage,] newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for a newborn child, you must notify us within 31 days of that child's birth. Upon notification, we will convert your Individual Coverage [to Individual and Child(ren) Coverage] [or Individual and Spouse Coverage] to Family Coverage and provide notification of the additional premium due. If you do not notify us within 31 days of the birth of the child, the temporary automatic coverage ends.

An adopted child or child pending adoption will be covered as follows, as long as [Individual and Child(ren) Coverage or] Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 60 days after the date of birth.
2. If adoption proceedings have been instituted by you within 60 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

GENERAL PROVISIONS (Continued)

11

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day you are [actively employed with your employer] [or] [a member in good standing in the labor union, association or other entity] that is the policyholder, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. the date you have received the maximum total percentage of the basic benefit amount for each critical illness; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

We will provide coverage for a payable claim that occurs while a covered person is covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

[If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death.]

Coverage for a dependent child ends on your death or [the certificate anniversary next following the date the child is no longer eligible] [the end of month in which the dependent child is no longer eligible]. This is the earlier of when the child: (a) marries; or (b) reaches age [22 (26 if a full-time student attending an educational institution of higher learning beyond high school)]; or (c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as the certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished to us, at our expense, when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if you have Individual and Children Coverage or Family Coverage and there are other eligible dependents insured under the policy.

Coverage may be eligible for continuation as outlined in [the CONTINUATION OF INSURANCE (COBRA) provision] [or] [the PORTABILITY PRIVILEGE provision].

12

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease [active employment] [or] [membership in the union or association] because of a temporary layoff or leave of absence while coverage is in force, we will continue your coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved your leave in writing. Coverage will be continued for [3 months] following the date you ceased [active employment] [or] [membership in the union or association].

If your coverage ends while on a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active status.

We will not:

1. apply a new pre-existing condition exclusion[]; or
2. require evidence of insurability[].

GENERAL PROVISIONS (Continued)

13

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] GROUP INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior group policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior group policy when it terminated; and
3. the covered person making the claim:
 - a. has been continuously insured under this policy since the policy date; and
 - b. was insured under the prior group policy when it terminated; and
4. the prior group policy:
 - a. [was issued by us; and]
 - b. had the same policyholder as this policy; and
 - c. provided coverage substantially similar to this policy; and
 - d. was issued before the policy date of this policy; and
 - e. terminated within 60 days of the policy date of this policy.]

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] INDIVIDUAL INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior individual policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior individual policy when it terminated; and
3. the covered person making the claim:
 - a. has been continuously insured under this policy since the policy date; and
 - b. was insured under the prior individual policy when it terminated; and
4. the prior individual policy:
 - a. [was issued by us; and]
 - b. provided coverage substantially similar to this policy; and
 - c. was issued before the policy date of this policy; and
 - d. terminated within 60 days of the policy date of this policy.]

14

[DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

GENERAL PROVISIONS (Continued)

INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder documenting any clerical errors.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

(This space intentionally left blank.)

[CONTINUATION OF INSURANCE (COBRA)]

15

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if your insurance would otherwise end due to one of the following events, called a qualifying event:

1. Termination of employment (other than by reason of gross misconduct), or of your eligibility due to reduction in your hours. Insurance may be continued for you and any dependents[, except for domestic partners and their covered dependents].
2. Your death. Insurance may be continued for any covered person[, except for domestic partners and their covered dependents].
3. Divorce or legal separation. Insurance may be continued for any dependent whose insurance would otherwise end. [However, COBRA does not extend continuation of coverage to domestic partners and their dependents.]
4. Your becoming eligible for Medicare. Insurance may be continued for any insured's dependents who are not entitled to Medicare[, except for domestic partners and their covered dependents]
5. A child ceasing to be an eligible dependent as defined in the policy. Insurance may be continued for that child.
6. Your employer files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of critical illness insurance, you must be insured under the policy on the day before the qualifying event. In the case of bankruptcy, you must also be: (a) an employee who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

You will not be denied continuation solely because you are covered under another group critical illness plan or eligible for Medicare on the date the qualifying event occurs.

COVERAGE CONTINUED

The insurance being continued by this section is subject to all terms and provisions of the policy that do not conflict with this section. The insurance will be the same as if the qualifying event had not occurred. The continued insurance will be subject to any changes to the policy affecting the benefits of your class following the qualifying event.

NOTIFICATION AND PAYMENT REQUIREMENTS

You have the responsibility to inform your employer of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

Your employer has the responsibility of notifying the plan administrator of: (a) your death, termination of employment, or reduction in hours; or (b) your employer's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify you of the right to continue within 14 days of the notice described above. You will then have 60 days to elect to continue your insurance. Failure to elect to continue insurance within 60 days after you are notified by the plan administrator will result in loss of the right to continue such insurance.

You will be required to pay a premium for the continued insurance to the policyholder. You will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

CONTINUATION OF INSURANCE (COBRA) – (Continued)

15

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

TERMINATION

Insurance being continued by this section will terminate on the first of the following dates that apply:

1. The date the policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverages have been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date you become covered under any other group critical illness policy, whether as an insured employee or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date you become entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees of employers under Chapter 11 Bankruptcy and their dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
 - a. If you are totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, you must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
 1. within 60 days of the Social Security determination of total disability; and
 2. within the initial 18 months of continuation coverage.
 - b. If you have a qualifying event (termination or reduction in hours worked) and you had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
 1. 36 months from the date you first became entitled to Medicare; or
 2. 18 months from your termination or reduction in hours.
 - c. For a qualifying event involving retired employees of employers under Chapter 11 Bankruptcy and their dependents, the maximum period of continuation coverage is:
 1. the lifetime of the retiree; or
 2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
 3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.]

[PORTABILITY PRIVILEGE

16

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

1. coverage under the policy terminates under the TERMINATION OF COVERAGE provision; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after you are insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured [employees][or][members] and may change on any premium due date. If you are on portability coverage, we will give you written notice at least [31] days before a change is to take effect.

GRACE PERIOD

The grace period, as defined in the policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
 - a. the date your insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.]

[PRE-EXISTING CONDITION LIMITATION

17

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from, a pre-existing condition when the date of diagnosis for the critical illness is within [12] months after the effective date of coverage.

A pre-existing condition is a sickness, injury or other condition, whether diagnosed or not, for which, during the [12] months just prior to the effective date of coverage, either:

1. symptoms existed; or
2. medical advice or treatment was recommended by or received from a physician or other member of the medical profession, acting within the scope of their license.]

EXCLUSIONS

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from:

1. War, declared or undeclared, participation in a riot, insurrection or rebellion.
2. Intentionally self-inflicted injury or action.
3. Illegal activities or participation in an illegal occupation.
4. Suicide while sane, or self-destruction while insane, or any attempt at either.
5. Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.

(This space intentionally left blank.)

CRITICAL ILLNESS BENEFIT

GENERAL

Subject to the conditions, limitations and exclusions of this coverage, we will pay a benefit when a covered person is diagnosed with a critical illness described in this coverage if:

1. the date of diagnosis for the critical illness is while the covered person is insured under the policy; and
2. the critical illness is not excluded by name or specific description.

A covered person can receive a benefit for each critical illness only once, unless the Second Event Critical Illness Benefit for that critical illness is included in the coverage.

A covered person can receive benefits for different critical illnesses described in the policy if the dates of diagnosis for each critical illness are separated by at least 90 days.

Coverage for a covered person terminates when the covered person is not eligible for any further benefits.

Each critical illness must be diagnosed by a physician in the United States. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

We do not pay any benefit for any condition or loss not described below.

18

INITIAL CRITICAL ILLNESS BENEFIT

- A. BENEFIT AMOUNT.** The benefit amount for each initial critical illness is the percentage shown below for that initial critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Initial Critical Illness	Percentage of Basic Benefit Amount
Heart Attack	[100%]
Stroke	[100%]
Coronary Artery By-Pass Surgery	[25%]
Major Organ Transplant	[100%]
End Stage Renal Failure	[100%]

- B. BENEFIT DESCRIPTION.** The initial critical illnesses are:

1. **Heart Attack.** The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis must be based on both:

- a. new electrocardiographic changes; and
- b. elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

Heart attack does not include an established (old) myocardial infarction.

The date of diagnosis for Heart Attack is the date of death (infarction) of a portion of the heart muscle.

2. **Stroke.** The death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke does not include: transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits.

The date of diagnosis for Stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.

CRITICAL ILLNESS BENEFIT (Continued)

B. BENEFITS DESCRIPTION. (Continued)

3. **Coronary Artery By-Pass Surgery.** The surgical operation to correct narrowing or blockage of one or more coronary arteries with by-pass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required.

Coronary artery by-pass surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

The date of diagnosis for Coronary Artery By-Pass Surgery is the date the actual coronary artery by-pass surgery occurs.

4. **Major Organ Transplant.** The surgical transplantation of a heart, lung, liver, pancreas, or kidney. The transplanted organ must come from a human donor.

The date of diagnosis for Major Organ Transplant is the date the actual surgery occurs for the covered transplant.

5. **End Stage Renal Failure.** The irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis.

End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas.

The date of diagnosis for End Stage Renal Failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.

[INSERT AS APPLICABLE OPTIONAL BENEFITS:

[SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT]

[CANCER CRITICAL ILLNESS BENEFIT]

[SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT]

[SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT]

[SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT]

[WELLNESS BENEFIT]]

[OPTIONAL BENEFITS

20 SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT

We will pay a Second Event Initial Critical Illness Benefit if a covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the INITIAL CRITICAL ILLNESS BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the initial critical illness; and
2. the second date of diagnosis is while the covered person is insured under the policy.

The benefit amount is equal to the benefit amount previously paid for that initial critical illness. A covered person can receive a Second Event Initial Critical Illness Benefit only once for each initial critical illness.

(This space intentionally left blank.)

[OPTIONAL BENEFITS]

21 **CANCER CRITICAL ILLNESS BENEFIT**

A. BENEFIT AMOUNT. The benefit amount for each cancer critical illness is the percentage shown below for that cancer critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Cancer Critical Illness	Percentage of Basic Benefit Amount
Carcinoma in situ	[25%]
Invasive Cancer	[100%]

B. BENEFIT DESCRIPTION. The cancer critical illnesses are:

1. **Carcinoma In Situ.** A cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

Carcinoma in situ includes:

- a. early prostate cancer diagnosed as stages A, I or II or equivalent staging; and
- b. melanoma not invading the dermis.

Carcinoma in situ does not include:

- a. other skin malignancies; or
- b. pre-malignant lesions (such as intraepithelial neoplasia); or
- c. benign tumors or polyps.

2. **Invasive Cancer.** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Invasive Cancer includes Leukemia and Lymphoma.

Invasive cancer does not include:

- a. carcinoma in situ; or
- b. tumors in the presence of any human immuno-deficiency virus; or
- c. skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or
- d. early prostate (stages A, I or II) cancer.

C. DIAGNOSIS REQUIREMENTS. A cancer critical illness must be diagnosed in one of two ways:

1. **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology.

2. **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis only if:

- a. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- b. there is medical evidence to support the diagnosis.

The date of diagnosis for cancer critical illness is the day the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based.

The "first diagnosis of cancer" includes a diagnosis of a recurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the recurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter.

For purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

"Maintenance drug therapy" means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

[OPTIONAL BENEFITS

22

SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT

We will pay Second Event Cancer Critical Illness Benefit if a covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the CANCER CRITICAL ILLNESS BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the cancer critical illness; and
2. the covered person did not receive treatment during that 12 month period; and
3. the second date of diagnosis is while the covered person is insured under the policy.

For purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

The benefit amount is equal to the benefit amount previously paid for that cancer critical illness. A covered person can receive a Second Event Cancer Critical Illness Benefit only once for each cancer critical illness.

(This space intentionally left blank.)

[OPTIONAL BENEFITS

23

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each supplemental critical illness is the percentage shown below for that supplemental critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Supplemental Critical Illness	Percentage of Basic Benefit Amount
Advanced Alzheimer's Disease	[25%]
Advanced Parkinson's Disease	[25%]
Benign Brain Tumor	[100%]
Coma	[100%]
Complete Blindness	[100%]
Complete Loss of Hearing	[100%]
Paralysis	[100%]
Occupational HIV	[100%]

B. BENEFITS DESCRIPTION. The supplemental critical illnesses are:

1. **Advanced Alzheimer's Disease.** Alzheimer's disease that causes the covered person to be incapacitated.

"Alzheimer's disease" is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease.

"Incapacitated" means that, due to Alzheimer's disease, the covered person:

- a. exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
- b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease.

2. **Advanced Parkinson's Disease.** Parkinson's disease that causes the covered person to be incapacitated.

"Parkinson's disease" is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease.

"Incapacitated" means that, due to Parkinson's disease, the covered person:

- a. exhibits 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); and
- b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

3. **Benign Brain Tumor.** A non-cancerous brain tumor:
 - a. confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
 - b. resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- a. tumors of the skull; or
- b. pituitary adenomas; or
- c. germinomas.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

4. **Coma.** A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

5. **Complete Blindness.** A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:
 - a. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
 - b. visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

6. **Complete Loss of Hearing.** The total and irreversible loss of hearing in both ears.

Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

7. **Paralysis.** The total and permanent voluntary loss of movement or motor function of 2 or more limbs.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

8. **Occupational HIV.** An accidental occupational exposure to HIV-contaminated body fluids due to a needle stick or splash from which the covered person is infected with HIV. The accidental exposure must occur during the normal course of duties of the occupation in which the covered person is regularly engaged and for which remuneration is earned. The covered person must have never previously tested HIV positive.

For a benefit to be paid under Occupational HIV, the following additional requirements must be met:

- a. an incident report (notice of exposure) which describes the nature of the exposure to HIV is filed with the employer within 48 hours of the exposure and sent to us as soon as reasonably possible; and
- b. a preliminary screening test, such as an enzyme-linked immunoabsorbent assay (ELISA) or other approved test by the Food and Drug Administration (FDA), other than saliva or urine testing, is performed within 14 days of the accidental exposure; and
- c. a subsequent screening test is performed within 26 weeks of the accidental exposure and we receive notification of the HIV positive test results as soon as reasonably possible.

“HIV positive” means the presence of HIV antibodies in the blood of a covered person as substantiated through both a positive screening test such as ELISA, and a positive supplemental test such as the Western Blot. All such tests must be approved by the FDA with the interpretation of positive results as specified by the manufacturer(s). If the Western blot is negative and remains so for 6 months, HIV infection is not present.

The date of diagnosis for Occupational HIV is the date a physician determines the covered person is HIV positive as supported by the ELISA test, Western Blot test or another FDA approved test.

C. ACTIVITIES OF DAILY LIVING. As used in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision, “activities of daily living” are:

1. Bathing — to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing — to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting — to get on and off the toilet and maintain personal hygiene.
4. Bladder and Bowel Continence — to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
6. Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

[OPTIONAL BENEFITS

23

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each supplemental critical illness is the percentage shown below for that supplemental critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Table with 2 columns: Supplemental Critical Illness, Percentage of Basic Benefit Amount. Rows include: Advanced Alzheimer's Disease (25%), Advanced Parkinson's Disease (25%), Benign Brain Tumor (100%), Coma (100%), Complete Blindness (100%), Complete Loss of Hearing (100%), Paralysis (100%).

B. BENEFITS DESCRIPTION. The supplemental critical illnesses are:

1. Advanced Alzheimer's Disease. Alzheimer's disease that causes the covered person to be incapacitated.

"Alzheimer's disease" is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease.

"Incapacitated" means that, due to Alzheimer's disease, the covered person:

- a. exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease.

2. Advanced Parkinson's Disease. Parkinson's disease that causes the covered person to be incapacitated.

"Parkinson's disease" is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease.

"Incapacitated" means that, due to Parkinson's disease, the covered person:

- a. exhibits 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

3. **Benign Brain Tumor.** A non-cancerous brain tumor:
 - a. confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
 - b. resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- a. tumors of the skull; or
- b. pituitary adenomas; or
- c. meningiomas.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

4. **Coma.** A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

5. **Complete Blindness.** A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:
 - c. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
 - d. visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

6. **Complete Loss of Hearing.** The total and irreversible loss of hearing in both ears.

Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

7. **Paralysis.** The total and permanent voluntary loss of movement or motor function of 2 or more limbs.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

C. ACTIVITIES OF DAILY LIVING. As used in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision, "activities of daily living" are:

1. Bathing — to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing — to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting — to get on and off the toilet and maintain personal hygiene.
4. Bladder and Bowel Continence — to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
6. Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.]

[OPTIONAL BENEFITS**WELLNESS BENEFIT**

We pay the amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] per calendar year per covered person for any one of the below. Each covered person is covered for no more than the amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] per calendar year. The eligible Wellness Benefits are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

(This space intentionally left blank.)

WAIVER OF PREMIUM BENEFIT

We will waive your premiums for this coverage if, while covered under the policy, you:

1. become disabled due to a critical illness for which a benefit is paid; and
2. remain disabled for at least 90 consecutive days.

After the 90th day, we will waive the premiums due for the first 90 days and each consecutive day thereafter you are disabled, until the earliest of:

1. the date you are no longer disabled; or
- 25 2. [2 years from the first day of disability; or]
3. [upon your reaching age 65 or 2 years from the first day of disability, whichever occurs last; or]
4. the date coverage ends according to the TERMINATION OF COVERAGE provision.

“Disabled” means you are:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

“Unable to work” means:

1. During the first 365 days of disability, you are unable to work at the occupation you were performing when your disability began.
2. [During the second 365 days of disability] [After the first 365 days of disability], you are unable to work at any gainful occupation for which you are suited by education, training or experience.

This benefit is payable only for the disability of the insured [employee] [or] [member]. It does not apply to any other covered person. You must provide sufficient proof of disability at least once every 6 months.

(This space intentionally left blank.)

CLAIM INFORMATION

NOTICE OF CLAIM

26

We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any benefit covered by the policy, or as soon as is reasonably possible. Notice given to us by, or on behalf of, you or the beneficiary at [1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687], or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the form is not received from us within 15 days of the request, written proof of claim may be sent to us without waiting for the form.

FILING A CLAIM

You must complete all applicable sections of the claim form and then give it to your attending physician. The physician should complete his or her section statement of the form and send it directly to us.

PROOF OF CLAIM

Written proof must be furnished to us within 90 days of each critical illness or payable loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have you examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under this certificate and we will make payment to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid you.

UNPAID PREMIUM

Upon the payment of a claim under the policy, any unpaid premium may be deducted.

CLAIM INFORMATION (Continued)

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. your right to submit any additional information that might allow us to change our decision.

You may, upon written request, have any reports that are not confidential. For a fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

(This space intentionally left blank.)

GLOSSARY

Active Employment or **Actively Employed** means that the covered person is working for his/her employer for earnings that are paid regularly and that the covered person is performing the material and substantial duties of his/her regular occupation. When used in connection with you:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not one of your employer's scheduled work days only if you were actively employed on the preceding scheduled work day.

The covered person's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the covered person's job requires travel.

27

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. [Temporary and seasonal workers are excluded from coverage.]

Calendar Year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

28

Covered Person means any of the following:

1. any eligible family member (including you) named on the enrollment [or evidence of insurability] and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

Critical Illness means one of the critical illnesses described in the CRITICAL ILLNESS BENEFIT provision for which a benefit may be paid.

[Domestic Partner means your same-sex or opposite-sex partner who is eligible for coverage provided that:

29

1. Both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. If your state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, you must satisfy the definition of domestic partner as defined by the policyholder; or
3. If your state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both you and your same-sex or opposite-sex partner must:
 - a. have resided together in the same permanent residence; and
 - b. be at least 18 years of age; and
 - c. intend to remain each other's sole domestic partner indefinitely; and
 - d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon you for care and financial assistance; and
 - e. not be legally married to or the legal domestic partner of anyone else; and
 - f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.]

Employer means the individual, company or corporation where the covered person is in active employment, and includes any division, subsidiary, or affiliated company of the employer.

GLOSSARY (Continued)

30 **[Evidence of Insurability]** means a statement of your or your dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.]

31 **Family Coverage** means coverage that includes you, your spouse [or domestic partner] and eligible children.

32 **Grace Period** means a period of [31] days following the premium due date during which premium payment may be made.

Individual Coverage means coverage that includes only you, as defined.

33 **[Individual and Children Coverage]** means coverage that includes only you, as defined, and eligible children.]

[Individual and Spouse Coverage] means coverage that includes only you, as defined, and your eligible spouse [or domestic partner.]

Initial Enrollment Period means one of the following periods during which you may first apply, in writing, for coverage under the policy:

1. a period before the policy effective date as set by us and the policyholder if you are eligible for coverage on the policy effective date; or
2. the period ending 31 days after the date you are first eligible to apply for coverage if you become eligible for coverage after the policy effective date.

Injury means accidental bodily injury.

Material and Substantial Duties means duties that:

1. are normally required for the performance of the covered person's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the covered person is required to work on average in excess of 40 hours per week. We will consider the covered person able to perform that requirement if he/she is working or has the capacity to work 40 hours per week.

Payable Claim means a claim for which we are liable under the terms of the policy.

34 **Physician** means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize you, or your [domestic partner,] spouse, children, parents, or siblings as a physician for a claim.

Policy means the policy of insurance issued by us to the policyholder.

Policy Date means the effective date of the policy.

Policyholder means the legal entity to whom the policy is issued.

Re-enrollment Period means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if you are currently enrolled.

Sickness means an illness or disease.

GLOSSARY (Continued)

Symptoms mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

We, Us and **Our** mean American Heritage Life Insurance Company.

35 **You** and **Your** mean the named insured [employee][or][member] shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

(This space intentionally left blank.)



Allstate[®]

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

**THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS
ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED.
THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**



Allstate

Workplace Division

Application is Hereby Made to

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Jacksonville, Florida

by _____ **[ABC COMPANY, INC.]** _____ whose main office address is _____ **[Any City, Any State]** _____, for Policy Number _____ **[XXXX]** _____, which is attached. The Applicant hereby approves such policy and accepts its terms.

Two copies of this application are signed. One copy remains attached to the policy. The other is returned to AMERICAN HERITAGE LIFE INSURANCE COMPANY.

It is agreed that this Application takes the place of any previous application for the policy.

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ **[ABC COMPANY, INC.]** _____

(Full or Corporate Name of Applicant)

Dated at _____ **[Any City, Any State]** _____
(City and State)

By _____ **[/s/ James Brown, President]** _____
(Signature and Title)

On _____ **[June 20, 2004]** _____
(Date)

Witness _____ **[/s/ Joe Smith]** _____

GCIAPPAR

New Issue-Critical Illness

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

APPLICATION FOR GROUP INSURANCE

Applicant/Policyholder
[ABC Company]

Address (street, city, state and zip)
[Any City, Any State]

Type of group: Employer Association Union Other

Type of coverage(s) applied for:

Note: Coverage applied for may be issued under one or more policies.

Requested Effective Date:
[January 1, 2009]

If this application is approved by the Company, group insurance will take effect: (a) on the Requested Effective Date; or (b) on the date the Company approves issuance of the group coverage, whichever is later. If this application is not approved, no insurance will take effect, and any premium submitted by the Applicant will be refunded.

As the applicant, I declare to the best of my knowledge and belief, that the statements and answers shown above are true and complete. I understand and agree that: (a) this application will form a part of any policy that is issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company, unless it is in writing on this application; (c) no waiver or modification will bind the Company, unless it is in writing and signed by an executive officer of the applicant; and (d) only those persons eligible under the terms of the policy or policies will be covered.

Fraud Notice: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

[ABC COMPANY, INC.]

(Full or Corporate Name of Applicant)

Dated at [Any City, Any State]
(City and State)

By [/s/ James Brown, President]
(Authorized Signature and Title)

On [January 1, 2009]
(Date)

Witness [/s/ Joe Smith]

 [123456]
*(Agent's License Number)**

Witness [Joe Smith]
(Print Agent's Name as Shown on License)*

*Where required by law.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

Amendment No. ____ to Group Policy No. ____
issued to

(the "Policyholder")

It is hereby agreed that, effective _____, the Group Policy is amended as follows:

I.

-

-

-

-

-

-

This Amendment will be attached to and form a part of the Group Policy, and will not be held to alter or affect any of the terms of such Policy other than as specifically stated, but not unless both the Company and the Policyholder have executed this Amendment.

Signed on _____
(Date)

Signed on _____
(Date)

**AMERICAN HERITAGE
LIFE INSURANCE COMPANY**
(the "Company")

(XYZ COMPANY, INC.)
(the "Policyholder")

by _____
(Signature of Officer) (Title)

by _____
(Authorized Representative) (Title)

SERFF Tracking Number: ALST-126529305 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
 Company Tracking Number: GVCIP2 AND GCIP3
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: GVCIP2 and GCIP3/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: GVCIP2 Readability Cert.pdf	Approved-Closed	03/29/2010

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Attachment: AWD4530AR.pdf	Approved-Closed	03/29/2010

	Item Status:	Status Date:
Satisfied - Item: Forms List Comments: Attachment: Froms List.pdf	Approved-Closed	03/29/2010

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: GVCIP2, AR et al. Statement of Variability.pdf	Approved-Closed	03/29/2010

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

To the Policy Review Section, Alabama Department of Insurance.

I certify that I have carefully reviewed the form(s) listed below and to the best of my knowledge and ability, find that the form(s) meet the minimum reading ease score on the test used.

<u>Form</u>	<u>Score</u>
GVCIP2	50.3
GVCIC2AR	50.6
GCIP3	50.3
GCIC3AR	50.6

Date: March 8, 2010



Diane Ierna
Assistant Vice President, Compliance Department



AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Group Voluntary Critical Illness

New Certificate Change/Increase Certificate # _____

This box for AHL Home Office use only

GENERAL INFORMATION SECTION

(Please complete entire section)

Please print with black ink

EMPLOYEE'S NAME Last (Sr, Jr, etc.)		First	M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER		<input type="checkbox"/> Married <input type="checkbox"/> Single
RESIDENT ADDRESS (Street or P.O. Box)				CITY		STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER	EMPLOYER/ASSOCIATION/UNION			DATE HIRED (MM/DD/YEAR)		
OCCUPATION				PLANT OR DIVISION			
EMPLOYEE'S EMAIL		BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP		
Are you adding any coverage or changing any of your existing coverage due to marriage, birth, adoption, employment status change, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If "Yes", indicate type of change: _____							
Date of change _____ Current Certificate Number _____							
Do you currently have any Critical Illness products with AHL? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If "Yes", please enter the Policy Number _____							
Do you wish to terminate this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please enter effective date of termination _____							

DEPENDENT COVERAGE SECTION

(Please complete if dependent coverage elected. Use additional paper if needed.)

Dependent's Name(s) (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number	Used Tobacco in any form in the last 12 months?
	Employee				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No
					N/A
					N/A

SELECTION OF COVERAGE SECTION

[Employer Paid Critical Illness (GVCIP3)] <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Family		Basic Benefit Amount \$ _____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.		Total Mode Premium \$ _____	
Cancer CI Option <input type="checkbox"/>	2 nd Event Cancer CI Option <input type="checkbox"/>	2 nd Event CI Option <input type="checkbox"/>	Supp. CI Option I (HIV) <input type="checkbox"/>	Supp. CI Option II <input type="checkbox"/>	Wellness Option <input type="checkbox"/> Units: _____		
[Employee Paid Critical Illness (GVCIP2)] <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee+Spouse <input type="checkbox"/> Employee+Child(ren) <input type="checkbox"/> Family		Section 125 <input type="checkbox"/> Yes <input type="checkbox"/> No		Basic Benefit Amount \$ _____ If requesting coverage for spouse or dependents, the basic benefit amount is 50% of the employee.	
Cancer CI Option <input type="checkbox"/>	2 nd Event Cancer CI Option <input type="checkbox"/>	2 nd Event CI Option <input type="checkbox"/>	Supp. CI Option I (HIV) <input type="checkbox"/>	Supp. CI Option II <input type="checkbox"/>	Inc. CI Benefit <input type="checkbox"/> Units: _____	Wellness Option <input type="checkbox"/> Units: _____	
Strike/Layoff Riders: (Only one Rider may be selected.) <input type="checkbox"/> Continuation During Strike or Layoff Rider <input type="checkbox"/> Premium Refund Upon Layoff Rider (Not available on Section 125 plans)							

[Premium/Billing Mode] <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Other		Case Number	Producer/ Agent Number	Percentage Credit
Date of First Deduction _____		Employee ID		
Requested Issue Date _____		Situs State		

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

EVIDENCE OF INSURABILITY SECTION FOR EMPLOYEE PAID CRITICAL ILLNESS (GVCIP2)

(Please complete each question applicable to coverages selected.)

If any of the questions below are answered “yes”, please list the required health history on the next page.

Non-Medical Questionnaire		
1. Is the proposed insured actively at work now and has he/she worked at least [20] hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Level 1 – Evidence of Insurability		
2. Is any person to be insured now being treated, or ever been treated or diagnosed, by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has ever tested positive for antigens or antibodies to an AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3a. Has any person to be insured in the last 2 years had, been treated for, or been told by a member of the medical profession that he/she has: diabetes; emphysema; asthma; epilepsy; hepatitis; mental or nervous illness; any disorder of the central nervous system; Parkinson’s disease; lupus; any disorder of the kidneys, liver, lungs, pancreas or back (including neck); or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3b. Is any person to be insured now being treated for, or ever been treated for: a stroke or transient ischemic attack (TIA); a heart attack; a heart condition; heart trouble; any abnormality of the heart; or any artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3c. Has any person to be insured in the last year had either: (1) a systolic blood pressure reading higher than 150 more than once; or (2) a diastolic blood pressure reading higher than 100 more than once?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3d. Has any person to be insured in the last 2 years been treated for or counseled for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3e. Has any person to be insured had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
[Cancer: Evidence of Insurability, if Cancer Critical Illness Benefit Option selected		
4a. Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4b. If the answer to 4a is yes, has any person to be insured ever been diagnosed with or treated for leukemia; Hodgkin’s disease; lymphoma; or cancer with any lymph node involvement or more than one metastasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4c. Has any person to be insured been diagnosed with or received treatment for any other type of cancer (other than those listed in 4b and/or basal cell skin cancer) during the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
[Supplemental: Evidence of Insurability, if Supplemental Critical Illness Benefit Option selected		
5. Has any person to be insured received any advice, treatment or consultation for any disorder of the central nervous system; Parkinson’s disease, Alzheimer’s disease, dementia, senility or organic brain syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Has any person to be insured been diagnosed with or received treatment for macular degeneration, glaucoma, optic neuritis or cataracts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Has any person to be insured had an average hearing threshold sensitivity for air conduction of 40 decibels or greater?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Has any person to be insured had, in the last 2 years, a prolonged state of unconsciousness lasting more than 48 hours or that left the proposed insured with a significant neurological disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
[Level 2 – Additional Evidence of Insurability, if required		
9. Has any person to be insured or ANY 2 of their natural parents or natural siblings been diagnosed with the same disease before age 60, based on this list: heart disease, stroke, diabetes, cancer, kidney disease, or multiple sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Are any persons to be insured currently taking any prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Has any person to be insured, in the past 5 years, received medical advice, sought treatment or had surgery or an abnormal diagnostic test for any disease or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this Evidence of Insurability form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Please indicate height and weight	Employee Height: Weight:	Spouse Height: Weight:
13. Please indicate the names and addresses of all physicians for each person to be insured; use the space provided on page 3 for additional explanations.]		

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

REQUIRED HEALTH HISTORY

List physician's name, address and telephone number

Name	Nature of Illness/Injury or Medical Attention/Reason Last Consulted	Date and/or Duration	Name and Address of Physician or Hospital/Clinic

Use this space for any additional explanation of questions 1-[13] on page [2]. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.

[ELECTRONIC ACCEPTANCE (Please check YES or NO)]

By checking the "Yes" box below, I agree to electronic delivery of my certificate of insurance, describing my coverage under the group policy ("my Certificate"), and all future correspondence regarding my Certificate, to include claim correspondence, explanations of benefit, periodic notices (such as privacy notices) and certificate administration correspondence. If electronically delivered, I will be provided instructions on how to receive my Certificate and correspondence regarding my Certificate via the following address: www.allstateatwork.com/mybenefits.

My consent is valid while I am covered under the group policy. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my Certificate, free of charge, by calling, toll-free: [1-800-521-3535]; or by writing to: [Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224].

- YES, I agree to receive my Certificate and all correspondence regarding my Certificate electronically via the internet.
- NO, I prefer to receive paper copies of my Certificate and all correspondence regarding my Certificate.]

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. · **I AUTHORIZE** any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, its subsidiaries or its reinsurers any information. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so. · **I ALSO AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Any person who is already covered by Medicaid should not purchase specified disease coverage.

Employee's Signature _____ Signed at _____ Date Signed _____
(City and State)

[Dependent's Signature _____ Signed at _____ Date Signed _____]
(Required for Spouse or Child over 18) (City and State)

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

Forms list for filing dated March 8, 2010

<u>Form</u>	<u>Description</u>
GVCIP2	Group Critical Illness Insurance Policy
GVCIC2AR	Group Critical Illness Certificate of Insurance
GCIP3	Group Critical Illness Insurance Policy
GCIC3AR	Group Critical Illness Certificate of Insurance
GCIAPPAR	Employer Application
ERAPPAR	Employer Application
G-AMD	Policy Amendment
AWD4530AR	Evidence of Insurability and Enrollment Forms

American Heritage Life Insurance Company (AHL)

Variables for Group Voluntary Critical Illness Policy Form (GVCIP2)

This group policy will be available to issue to employer groups, labor union groups, associations and trusts. The following explain the variables included in the policy. The numbers correspond to the number within the boxes in the left margin of the text.

1. The logo of the company will be on all policies and will be the current logo of AHL.
2. The signature of the Secretary and President will be on all policies issued and will be that of the current Secretary and President of AHL.
3. If variable material in the policy is deleted when issued, the pages may be renumbered and the table of contents updated with the revised page numbers.
4. The complete legal name of each policyholder will be inserted. A unique alphanumeric number will be assigned to each group policy. The effective date requested by the policyholder, and agreed to by AHL, will be inserted. The policy anniversary date will be one year from the policy effective date. The jurisdiction where the policy will be issued will be inserted.
5. The classes of employees or members who are eligible will be accurately described here. The number of hours may vary, and other categories of employees or members may be included. If the policyholder does not have any employees or members insured under an individual plan with AHL, we will delete the phrase "excluding employees who are insured under any individual critical illness policy through American Heritage Life Insurance Company".
6. The eligibility waiting period requested by the policyholder will be described here. The eligibility waiting period may vary by classes of employees or members, or the policyholder may choose to permit their employees or members to enroll immediately without having to complete an eligibility waiting period.
7. The Basic Benefit Amount will be described here. The Policyholder can choose a basic benefit amount from \$1,000 to \$100,000 ranging in \$1,000 increments. Coverage for all dependents, including spouse, will be 50% of the primary insured, but may be more if agreed to by the us and the policyholder.
8. Guaranteed Issue Limits can range from \$1,000 to \$100,000 depending upon participation. This section may be deleted if evidence of insurability will not be required; for example, employer paid benefits or a flat amount of \$15,000 offered to all employees would not require evidence of insurability.
9. The Optional Benefits consist of a Second Event Critical Illness Benefit, a Cancer Critical Illness Benefit, a Second Event Cancer Critical Illness Benefit, a Supplemental Critical Illness Benefit (which has 2 plan types), a Wellness Benefit and an Increasing Critical Illness Benefit. The policyholder may elect to have any or all of these optional benefits except for the Supplemental Critical Illness Benefit of which the policyholder can only have 1 plan type.

The Wellness Benefit will be sold in units of \$25 from 1 to 10 units.

The Increasing Critical Illness Benefit will increase the basic benefit amount \$250 per unit for the insured employee and \$125 per unit for each insured dependent for each coverage year from years 2 – 5. This benefit will be sold in units from 1 to 100.

All other benefits will be the same as the Initial Critical Illness Benefit amount.
10. The Initial Rate is per covered employee for Individual Coverage, Individual and Spouse Coverage, Individual and Child(ren) Coverage or Family Coverage. If the policyholder chooses, rates may be on a 2-tier basis (Individual Coverage or Family Coverage). If sold as 2-tiers, the other coverage types

may be deleted when the policy is issued. Rates may vary according to the currently approved rates for these plans.

11. AHL may guarantee the initial rate for a period no less than 12 months from the policy effective date, but the period can be 24 months or 36 months subject to participation requirements agreed to by the policyholder.
12. The premium may be paid annually, semi-annually, quarterly, monthly, semi-monthly, bi-weekly or weekly. The first premium due date is the effective date of the policy.
13. Only one of these statements will be shown here, to indicate whether or not the employer shares in the cost of coverage under this policy.
14. Any of the policyholder's divisions, subsidiaries or affiliated companies whose employees are to be eligible for coverage under this policy will be named here.
15. The percent of change in items 3 and 5 will be the percentage taken into consideration when underwriting the group and determining the initial rate. The time period for notice of change in premium rate will not be less than 30 days, but could be more.
16. Evidence of insurability requirements will vary by case size and may be required at the initial enrollment period and any time after the initial enrollment period if the individual did not enroll when first eligible. For groups with 200 or more employees that meet participation requirements, no evidence of insurability will be required at initial enrollment. All members of a union or association may be subject to evidence of insurability at initial enrollment, regardless of the number of members within the group.
17. The time of notice of cancellation or offer to modify may be any period of 31 days or greater. Item 1 may be deleted or the participation percentage and number of employees may be changed to any reasonable amounts taken into consideration when underwriting the group. In item 2, the policy will never be cancelled or modified within 12 months of the policy being effective, but may be cancelled or modified after a time period greater than 12 months. In item 5, employees participating will never be less than 5 and no more than 50% of the total group size.

The time period for cancellation of the policy may be 31 days or more. If the period for AHL to cancel or modify is more than 31 days, that same period may be entered here.
18. The bracketed text may be deleted when issued if we and the policyholder agree to not include temporary or seasonal employees in their eligible class.
19. The definition of "Evidence of Insurability" will be deleted if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
20. The number of days listed for this definition will never be less than 31, but may be more if agreed to by us and the policyholder.
21. Coverage can be sold in either 2 or 4 tiers of rates. If the coverage is sold with 2 tiers, "Individual and Spouse Coverage" and "Individual and Child(ren) Coverage" will be removed from the policy when it is issued.
22. The number of days listed for this definition will never be less than 31, but may be more if agreed to by us and the policyholder.
23. Evidence of insurability will be deleted from this definition if not applicable to the specific group the policy will be issued to, as explained above.

One of the terms listed will be deleted depending on how the certificate is delivered to the insured employee or member.

24. The bracketed text will be included in this definition if the policyholder chooses to offer coverage to members who may not be actively employed at the time of enrollment, but are able to work and are seeking such employment. If the policyholder chooses not to allow this, then the bracketed text will be deleted.
25. If the policyholder does not want to offer dependent coverage to their employees, the bracketed text will be deleted when the policy is issued.

**American Heritage Life Insurance Company (AHL)
Variables for Group Voluntary Critical Illness Certificate of Insurance Form
(GVCIC2AR)**

The following explain the variables included in the certificate. The numbers correspond to the number within the boxes in the left margin of the text.

1. The logo of the company will be on all certificates and will be the current logo of AHL.
2. When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.
3. The signature of the Secretary and President will be on all certificates issued and will be that of the current Secretary and President of AHL.
4. If variable material in the certificate is deleted when issued, the pages may be renumbered and the table of contents updated with the revised page numbers.
5. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.
6. The Certificate Specifications page will be customized for each insured employee or member to show their benefit amounts, optional benefits and coverage tier.
7. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Evidence of Insurability will be deleted from this provision if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
8. The time to enroll, change or terminate coverage will be determined by the policyholder. Reference to evidence of insurability will be deleted if not applicable to the specific group the policy will be issued to, as explained above.

Evidence of Insurability will be deleted from this provision if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
9. The Evidence of Insurability provision may be deleted in its entirety if not applicable to the specific group the policy will be issued to, as explained above.
10. Reference to domestic partners and children of a domestic partner will be deleted if the policyholder chooses not to offer coverage to domestic partners.

All reference to evidence of insurability will be deleted if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.

Coverage can be sold in either 2 or 4 tiers of rates. If the coverage is sold with 2 tiers, "Individual and Spouse Coverage" and "Individual and Child(ren) Coverage" will be removed from the certificate when it is issued.

11. When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

Reference to domestic partners and children of a domestic partner will be deleted if the policyholder chooses not to offer coverage to domestic partners.

Termination of a dependent child can fall on a certificate anniversary date or at the end of the month, depending on the policyholder's preference for billing purposes.

The limiting age for children may be changed to comply with state laws or to match a policyholder's other plans. The age will never be lower than required by state law. The limiting age will be reflected throughout the policy.

Reference to COBRA and/or Portability will be deleted if not applicable to the group when the policy is issued.

12. If issued to an employer group, reference to membership may be deleted. If issued to an association, reference to employment may be deleted.

Continuation of coverage due to a temporary layoff, leave of absence or family and medical leave of absence will continue for a period of time agreed to by the policyholder.

All reference to evidence of insurability will be deleted if not applicable to the specific group the policy will be issued to.

13. If we are not replacing a prior carrier with similar benefits, these provisions will be omitted. If the prior insurance was issued by another company, reference to our company will be deleted.

14. Discretionary Authority may be removed if not allowed by state in which the policy is delivered.

15. The entire COBRA provision may be deleted if the group the coverage is issued to is not subject to COBRA.

Reference to domestic partners and children of a domestic partner will be included in this provision if the policyholder requests COBRA Continuation Coverage be extended to domestic partners and their dependents.

16. The entire Portability provision may be deleted if we and the policyholder agree not to include it in their policy.

When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

Notice for change of premiums will never be less than 31 days, but may be more if agreed to by us and the policyholder.

17. The Pre-Existing Condition Limitation may be deleted if agreed to by us and the policyholder. It may also be removed if federal laws are passed that no longer permit pre-existing condition limitations. If included, the time frame for the date of diagnosis will never be more than 12 months, but may be less.

18. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

The Percentage of the Basic Benefit Amount can vary from 0 to 100% for Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Major Organ Transplant, and End Stage Renal Failure.

19. The bracketed text shows all possible optional benefits in the order they will be attached for illustrative purposes. When the certificate is issued, this information will be deleted and the actual optional benefit pages chosen by the policyholder will be attached.
20. The Second Event Critical Illness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise, this benefit page will not be shown.
21. The Cancer Critical Illness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise, this benefit page will not be shown. If included, the employee or member's benefit amounts may be listed on a Certificate Specifications page or a benefit statement, depending on how the certificate is delivered to them.

The Percentage of the Basic Benefit Amount can vary from 0 to 100% for Carcinoma in situ or Invasive Cancer.

22. The Second Event Cancer Critical Illness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise, this benefit page will not be shown.
23. The Supplemental Critical Illness I Benefit and the Supplemental Critical Illness II Benefit are optional benefits only to be included in the certificate if elected by the policyholder. If elected, the policyholder will choose either the Supplemental Critical Illness I Benefit or the Supplemental Critical Illness II Benefit, they cannot have both. If the policyholder does not choose to include either option, the benefit pages for both options will not be shown. The difference between the two options is that benefit II does not include Occupational HIV. If either option is included, the employee or member's benefit amounts may be listed on a Certificate Specifications page or a benefit statement, depending on how the certificate is delivered to them.

The Percentage of the Basic Benefit Amount can vary from 0 to 100% for Advanced Alzheimer's Disease, Advanced Parkinson's Disease, Benign Brain Tumor, Coma, Complete Blindness, Complete Loss of Hearing, Paralysis and Occupational HIV.

24. The Increasing Critical Illness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise this benefit page will not be shown. If included, the employee or member's benefit amounts may be listed on a Certificate Specifications page or a benefit statement, depending on how the certificate is delivered to them.
25. The Wellness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise this benefit page will not be shown. If included, the employee or member's benefit amounts may be listed on a Certificate Specifications page or a benefit statement, depending on how the certificate is delivered to them.

26. The waiver of premium benefit will end after 2 years, or later if agreed to by us and the policyholder. Only one of these time frames will be included the other will be deleted and the items renumbered.

Only one of the bracketed time frames for being unable to work will be included when the certificate is issued. This will depend on the length of the time the waiver of premium benefit will last as agreed to by us and the policyholder.

When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

27. The address for submitting claims will be the current address of AHL.
28. If the policyholder chooses to offer coverage to their temporary and seasonal workers, then the bracketed text will be included. If these workers are to be excluded then the text will be deleted.

29. Evidence of insurability will be deleted from this definition if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
30. The “Domestic Partner” definition will be deleted if the policyholder does not want to offer coverage for such dependents.
31. If evidence of insurability is not applicable to the specific group the policy will be issued to, this definition will be deleted. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
32. Domestic Partner language will be deleted if the policyholder does not want to offer coverage for such dependents.
33. The time frame for the grace period will never be less than 31 days, but may be more.
34. Coverage can be sold in either 2 or 4 tiers of rates. If the coverage is sold with 2 tiers, the “Individual and Spouse Coverage” and “Individual and Child(ren) Coverage” definitions will be removed from the certificate when it is issued.
35. If domestic partner language is not included in the certificate, reference to such will be deleted from this definition.
36. When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Variables for Group Critical Illness Policy Form (GCIP3)

This group policy will be available to issue to employer groups, labor union groups, associations and trusts. The following explain the variables included in the policy. The numbers correspond to the number within the boxes in the left margin of the text.

1. The logo of the company will be on all policies and will be the current logo of AHL.
2. The signature of the Secretary and President will be on all policies issued and will be that of the current Secretary and President of AHL.
3. If variable material in the policy is deleted when issued, the pages may be renumbered and the table of contents updated with the revised page numbers.
4. The complete legal name of each policyholder will be inserted. A unique alphanumeric number will be assigned to each group policy. The effective date requested by the policyholder, and agreed to by AHL, will be inserted. The policy anniversary date will be one year from the policy effective date. The jurisdiction where the policy will be issued will be inserted.
5. The classes of employees or members who are eligible will be accurately described here. The number of hours may vary, and other categories of employees or members may be included. If the policyholder does not have any employees or members insured under an individual plan with AHL, we will delete the phrase “excluding employees who are insured under any individual critical illness policy through American Heritage Life Insurance Company”.
6. The eligibility waiting period requested by the policyholder will be described here. The eligibility waiting period may vary by classes of employees or members, or the policyholder may choose to

permit their employees or members to enroll immediately without having to complete an eligibility waiting period.

7. The Basic Benefit Amount will be described here. The Policyholder can choose a basic benefit amount from \$1,000 to \$100,000 ranging in \$1,000 increments. Coverage for all dependents, including spouse, will be 50% of the primary insured, but may be more if agreed to by the us and the policyholder.
8. Guaranteed Issue Limits can range from \$1,000 to \$100,000 depending upon participation. This section may be deleted if evidence of insurability will not be required; for example, employer paid benefits or a flat amount of \$15,000 offered to all employees would not require evidence of insurability.
9. The Optional Benefits consist of a Second Event Critical Illness Benefit, a Cancer Critical Illness Benefit, a Second Event Cancer Critical Illness Benefit, a Supplemental Critical Illness Benefit (which has 2 plan types) and a Wellness Benefit. The policyholder may elect to have any or all of these optional benefits except for the Supplemental Critical Illness Benefit of which the policyholder can only have 1 plan type.

The Wellness Benefit will be sold in units of \$25 from 1 to 10 units.

All other benefits will be the same as the Initial Critical Illness Benefit amount.

10. The Initial Rate is per covered employee for Individual Coverage, Individual and Spouse Coverage, Individual and Child(ren) Coverage or Family Coverage. If the policyholder chooses, rates may be on a 2-tier basis (Individual Coverage or Family Coverage). If sold as 2-tiers, the other coverage types may be deleted when the policy is issued. Rates may vary according to the currently approved rates for these plans.
11. AHL may guarantee the initial rate for a period no less than 12 months from the policy effective date, but the period can be 24 months or 36 months subject to participation requirements agreed to by the policyholder.
12. The premium may be paid annually, semi-annually, quarterly, monthly, semi-monthly, bi-weekly or weekly. The first premium due date is the effective date of the policy.
13. Only one of these statements will be shown here, to indicate whether or not the employer shares in the cost of coverage under this policy.
14. Any of the policyholder's divisions, subsidiaries or affiliated companies whose employees are to be eligible for coverage under this policy will be named here.
15. The percent of change in items 3 and 5 will be the percentage taken into consideration when underwriting the group and determining the initial rate. The time period for notice of change in premium rate will not be less than 30 days, but could be more.
16. Evidence of insurability requirements will vary by case size and may be required at the initial enrollment period and any time after the initial enrollment period if the individual did not enroll when first eligible. For groups with 200 or more employees that meet participation requirements, no evidence of insurability will be required at initial enrollment. All members of a union or association may be subject to evidence of insurability at initial enrollment, regardless of the number of members within the group.
17. The time of notice of cancellation or offer to modify may be any period of 31 days or greater. Item 1 may be deleted or the participation percentage and number of employees may be changed to any reasonable amounts taken into consideration when underwriting the group. In item 2, the policy will never be cancelled or modified within 12 months of the policy being effective, but may be cancelled or modified after a time period greater than 12 months. In item 5, employees participating will never be less than 5 and no more than 50% of the total group size.

The time period for cancellation of the policy may be 31 days or more. If the period for AHL to cancel or modify is more than 31 days, that same period may be entered here.

18. The bracketed text may be deleted when issued if we and the policyholder agree to not include temporary or seasonal employees in their eligible class.
19. The definition of "Evidence of Insurability" will be deleted if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
20. The number of days listed for this definition will never be less than 31, but may be more if agreed to by us and the policyholder.
21. Coverage can be sold in either 2 or 4 tiers of rates. If the coverage is sold with 2 tiers, "Individual and Spouse Coverage" and "Individual and Child(ren) Coverage" will be removed from the policy when it is issued.
22. The number of days listed for this definition will never be less than 31, but may be more if agreed to by us and the policyholder.
23. Evidence of insurability will be deleted from this definition if not applicable to the specific group the policy will be issued to, as explained above.

One of the terms listed will be deleted depending on how the certificate is delivered to the insured employee or member.

24. The bracketed text will be included in this definition if the policyholder chooses to offer coverage to members who may not be actively employed at the time of enrollment, but are able to work and are seeking such employment. If the policyholder chooses not to allow this, then the bracketed text will be deleted.
25. If the policyholder does not want to offer dependent coverage to their employees, the bracketed text will be deleted when the policy is issued.

Variables for Group Critical Illness Certificate of Insurance Form (GCIC3AR)

The following explain the variables included in the certificate. The numbers correspond to the number within the boxes in the left margin of the text.

1. The logo of the company will be on all certificates and will be the current logo of AHL.
2. When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page (page 3) or a benefit statement.

3. The signature of the Secretary and President will be on all certificates issued and will be that of the current Secretary and President of AHL.
4. If variable material in the certificate is deleted when issued, the pages may be renumbered and the table of contents updated with the revised page numbers.
5. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

6. The Certificate Specifications page will be customized for each insured employee or member to show their benefit amounts, optional benefits and coverage tier.
7. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Evidence of Insurability will be deleted from this provision if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
8. The time to enroll, change or terminate coverage will be determined by the policyholder. Reference to evidence of insurability will be deleted if not applicable to the specific group the policy will be issued to, as explained above.

Evidence of Insurability will be deleted from this provision if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
9. The Evidence of Insurability provision may be deleted in its entirety if not applicable to the specific group the policy will be issued to, as explained above.
10. Reference to domestic partners and children of a domestic partner will be deleted if the policyholder chooses not to offer coverage to domestic partners.

All reference to evidence of insurability will be deleted if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.

Coverage can be sold in either 2 or 4 tiers of rates. If the coverage is sold with 2 tiers, "Individual and Spouse Coverage" and "Individual and Child(ren) Coverage" will be removed from the certificate when it is issued.
11. When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

Reference to domestic partners and children of a domestic partner will be deleted if the policyholder chooses not to offer coverage to domestic partners.

Termination of a dependent child can fall on a certificate anniversary date or at the end of the month, depending on the policyholder's preference for billing purposes.

The limiting age for children may be changed to comply with state laws or to match a policyholder's other plans. The age will never be lower than required by state law. The limiting age will be reflected throughout the policy.

Reference to COBRA and/or Portability will be deleted if not applicable to the group when the policy is issued.
12. If issued to an employer group, reference to membership may be deleted. If issued to an association, reference to employment may be deleted.

Continuation of coverage due to a temporary layoff, leave of absence or family and medical leave of absence will continue for a period of time agreed to by the policyholder.

All reference to evidence of insurability will be deleted if not applicable to the specific group the policy will be issued to.
13. If we are not replacing a prior carrier with similar benefits, these provisions will be omitted. If the prior insurance was issued by another company, reference to our company will be deleted.
14. Discretionary Authority may be removed if not allowed by state in which the policy is delivered.

15. The entire COBRA provision may be deleted if the group the coverage is issued to is not subject to COBRA.

Reference to domestic partners and children of a domestic partner will be included in this provision if the policyholder requests COBRA Continuation Coverage be extended to domestic partners and their dependents.

16. The entire Portability provision may be deleted if we and the policyholder agree not to include it in their policy.

When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

Notice for change of premiums will never be less than 31 days, but may be more if agreed to by us and the policyholder.

17. The Pre-Existing Condition Limitation may be deleted if agreed to by us and the policyholder. It may also be removed if federal laws are passed that no longer permit pre-existing condition limitations. If included, the time frame for the date of diagnosis will never be more than 12 months, but may be less.

18. Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

The Percentage of the Basic Benefit Amount can vary from 0 to 100% for Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Major Organ Transplant, and End Stage Renal Failure.

19. The bracketed text shows all possible optional benefits in the order they will be attached for illustrative purposes. When the certificate is issued, this information will be deleted and the actual optional benefit pages chosen by the policyholder will be attached.

20. The Second Event Critical Illness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise, this benefit page will not be shown.

21. The Cancer Critical Illness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise, this benefit page will not be shown. If included, the employee or member's benefit amounts may be listed on a Certificate Specifications page or a benefit statement, depending on how the certificate is delivered to them.

The Percentage of the Basic Benefit Amount can vary from 0 to 100% for Carcinoma in situ or Invasive Cancer.

22. The Second Event Cancer Critical Illness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise, this benefit page will not be shown.

23. The Supplemental Critical Illness I Benefit and the Supplemental Critical Illness II Benefit are optional benefits only to be included in the certificate if elected by the policyholder. If elected, the policyholder will chose either the Supplemental Critical Illness I Benefit or the Supplemental Critical Illness II Benefit, they cannot have both. If the policyholder does not chose to include either option, the benefit pages for both options will not be shown. The difference between the two options is that benefit II does not include Occupational HIV. If either option is included, the employee or member's benefit amounts may be listed on a Certificate Specifications page or a benefit statement, depending on how the certificate is delivered to them.

The Percentage of the Basic Benefit Amount can vary from 0 to 100% for Advanced Alzheimer's Disease, Advanced Parkinson's Disease, Benign Brain Tumor, Coma, Complete Blindness, Complete Loss of Hearing, Paralysis and Occupational HIV.

24. The Wellness Benefit is an optional benefit only to be included in the certificate if the policyholder elects it. Otherwise this benefit page will not be shown. If included, the employee or member's

benefit amounts may be listed on a Certificate Specifications page or a benefit statement, depending on how the certificate is delivered to them.

25. The waiver of premium benefit will end after 2 years, or later if agreed to by us and the policyholder. Only one of these time frames will be included the other will be deleted and the items renumbered.

Only one of the bracketed time frames for being unable to work will be included when the certificate is issued. This will depend on the length of the time the waiver of premium benefit will last as agreed to by us and the policyholder.

When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

26. The address for submitting claims will be the current address of AHL.
27. If the policyholder chooses to offer coverage to their temporary and seasonal workers, then the bracketed text will be included. If these workers are to be excluded then the text will be deleted.
28. Evidence of insurability will be deleted from this definition if not applicable to the specific group the policy will be issued to. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
29. The "Domestic Partner" definition will be deleted if the policyholder does not want to offer coverage for such dependents.
30. If evidence of insurability is not applicable to the specific group the policy will be issued to, this definition will be deleted. We may choose to waive medical questions based on participation or if the coverage is to be employer paid.
31. Domestic Partner language will be deleted if the policyholder does not want to offer coverage for such dependents.
32. The time frame for the grace period will never be less than 31 days, but may be more.
33. Coverage can be sold in either 2 or 4 tiers of rates. If the coverage is sold with 2 tiers, the "Individual and Spouse Coverage" and "Individual and Child(ren) Coverage" definitions will be removed from the certificate when it is issued.
34. If domestic partner language is not included in the certificate, reference to such will be deleted from this definition.
35. When issued to an employer group, the term employee will be used through the certificate and the term member may be deleted. When issued to an association, the term member will be used through the certificate and the term employee may be deleted.

Depending on how the certificate is delivered to the insured employee or member, their benefit amounts may be listed on a Certificate Specifications page or a benefit statement.

Variables for Evidence of Insurability and Enrollment Form (AWD4530)

The following explain the variables included in the Evidence of Insurability and Enrollment Form. This form will be used by employees and members to enroll in coverage and to provide medical information to be used for underwriting purposes only. The variable language is intended for the customization of the form for a policyholder, removing non-applicable items to allow for a shorter and easier form for their employees or members to complete.

1. If the policyholder is not offering dependent coverage, the Dependent Coverage Section will be deleted from the form.

2. If the policyholder is not offering employer paid Critical Illness coverage, then the Employer Paid Critical Illness section will be deleted from the form. The marketing name may be revised to match brochures given to the applicants.
3. If the policyholder is not offering employee paid Critical Illness coverage, then the Employee Paid Critical Illness section will be deleted from the form. The marketing name may be revised to match brochures given to the applicants.
4. The Premium/Billing Mode box is for our home office use only and may be adjusted to allow us to capture applicant information in our systems.
5. The number of hours required to be actively at work may be adjusted as agreed to by us and the policyholder.
6. If the policyholder is not offering the Cancer Critical Illness Benefit, which is optional coverage, then the questions meant for this option will be deleted from the form. The text of the questions will never be altered without re-filing the form with the Department of Insurance, they will simply be removed if not applicable to the group when customizing the form.
7. If the policyholder is not offering the Supplemental Critical Illness Benefit, which is optional coverage, then the questions meant for this option will be deleted from the form. The text of the questions will never be altered without re-filing the form with the Department of Insurance, they will simply be removed if not applicable to the group when customizing the form.
8. The Additional Evidence of Insurability is intended for applicants requesting over the Guaranteed Issue amount. If the policyholder is offering a flat benefit amount below our usual Guaranteed Issue amounts, the Level 2 – Additional Evidence of Insurability, if required section will be deleted from the form. The text of the questions will never be altered without re-filing the form with the Department of Insurance, they will simply be removed if not applicable to the group when customizing the form.
9. If the policyholder does not want their employees to receive their certificates electronically, The Electronic Acceptance section will be deleted from the form. The website address will be the current address for retrieving benefit information. The mailing address and phone number will be the current address and phone number for our customer service department.
10. If the policyholder is not offering dependent coverage, the Dependent's Signature line will be deleted from the form.
11. If any variable information is deleted during customization, the questions and pages may be renumbered.

SERFF Tracking Number: ALST-126529305 State: Arkansas
 Filing Company: American Heritage Life Insurance Company State Tracking Number: 45128
 Company Tracking Number: GVCIP2 AND GCIP3
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness
 Project Name/Number: GVCIP2 and GCIP3/

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/04/2010	Form	Group Critical Illness Certificate	03/22/2010	GVCIC2AR.pdf (Superceded)
03/04/2010	Form	Group Critical Illness Certificate	03/22/2010	GCIC3AR.pdf (Superceded)

1



Allstate

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

2

In this certificate, the words:

"You" and "your" mean the named insured [employee][or][member] shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"This policy" and "the policy" mean the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

3

Secretary

President

THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

TABLE OF CONTENTS

[CERTIFICATE SPECIFICATIONS 3]

GENERAL PROVISIONS [4 – 7]

[CONTINUATION OF INSURANCE (COBRA) 8 – 9]

[PORTABILITY 10]

LIMITATIONS AND EXCLUSIONS [11]

BENEFITS.....[12-15]

CLAIM INFORMATION [16-17]

GLOSSARY [18 – 20]

[AMERICAN HERITAGE LIFE INSURANCE COMPANY
 1776 American Heritage Life Drive, Jacksonville, Florida 32224

5

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	ANNUAL PREMIUM AMOUNT	
6	GVCIC2AR INITIAL CRITICAL ILLNESS		
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	SECOND EVENT INITIAL CRITICAL ILLNESS	SAME AMOUNT AS INITIAL CRITICAL ILLNESS	\$00.00
	CANCER CRITICAL ILLNESS		
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	SECOND EVENT CANCER CRITICAL ILLNESS	SAME AMOUNT AS CANCER CRITICAL ILLNESS	\$00.00
	SUPPLEMENTAL CRITICAL ILLNESS [I][II]		
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
	INSURED CHILD(REN)	\$25,000	
	INCREASING CRITICAL ILLNESS BENEFIT		
INSURED EMPLOYEE	\$250/PER COVERAGE YEAR*	\$00.00	
INSURED SPOUSE	\$125.00/PER COVERAGE YEAR*		
INSURED CHILD(REN)	\$125.00/PER COVERAGE YEAR*		
	*FOR COVERAGE YEARS 2-5		
WELLNESS BENEFIT	\$25/TEST	\$00.00	
FAMILY COVERAGE			

The effective date of each benefit is the Effective Date unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
\$000.00	\$000.00	\$00.00	\$00.00	\$00.00

Premium Payment Method PAYROLL – MONTHLY Premium Class TOBACCO/NON-TOBACCO

INSURED: JOHN DOE ISSUE AGE: 35

EFFECTIVE DATE: MAY 01, 2010 CERTIFICATE NUMBER: 123456

POLICY NUMBER: GROUP106

BENEFICIARY: AS NAMED AT ENROLLMENT OR LATER CHANGED

GROUP CRITICAL ILLNESS COVERAGE

GVCIC2AR

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

7 Your coverage will be effective at 12:01 a.m. on the effective date shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] provided you are actively employed on that date.

If you are not actively employed on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage [that is subject to evidence of insurability], the change in coverage is effective on the date we approve such change.

[For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.]

8 WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
 - a. the initial enrollment period; or
 - b. [at any other time] [at the next re-enrollment period] [, subject to evidence of insurability].
2. You may increase coverage [at any time] [at the next re-enrollment period] [, subject to evidence of insurability].
3. You may discontinue coverage at any time.

9 [WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. you:
 - a. voluntarily canceled coverage and are reapplying; or
 - b. are applying for an amount of coverage over the guaranteed issue limit; or
 - c. are applying for the coverage, or an increase in the amount of coverage, at any time after your initial enrollment period; or
2. an eligible dependent did not enroll within 31 days of eligibility.]

(This space intentionally left blank.)

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. your legal spouse [or domestic partner]; and
2. your unmarried children including adopted children from the moment of placement in the residence, stepchildren, [children of a domestic partner] or legal ward who are [under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school]. Your children must be dependent on you for support or reside with you over 50% of the time in a regular parent-child relationship and be named on the enrollment [or evidence of insurability] form.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to the certificate if we are notified within 31 days after they become eligible.

If you have Individual Coverage [or Individual and Child(ren) Coverage], then marry and desire coverage for your spouse, we must be notified within 31 days of the marriage. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.]

[If you have Individual Coverage [or Individual and Child(ren) Coverage], then establish a domestic partnership and desire coverage for your domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the date a domestic partnership was formed, then evidence of insurability will be required.]]

A child born to you or your spouse [or domestic partner], while [Individual and Child(ren) Coverage] [or] [Family Coverage] is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under the certificate. No additional premium will be required for newborns added if [Individual and Child(ren) Coverage or] Family Coverage is in force at the time the newborn is added.

If you have Individual Coverage [or Individual and Spouse Coverage,] newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for a newborn child, you must notify us within 31 days of that child's birth. Upon notification, we will convert your Individual Coverage [to Individual and Child(ren) Coverage] [or Individual and Spouse Coverage] to Family Coverage and provide notification of the additional premium due. If you do not notify us within 31 days of the birth of the child, the temporary automatic coverage ends.

An adopted child or child pending adoption will be covered as follows, as long as [Individual and Child(ren) Coverage or] Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 60 days after the date of birth.
2. If adoption proceedings have been instituted by you 60 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

GENERAL PROVISIONS (Continued)

11

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day you are [actively employed with your employer] [or] [a member in good standing in the labor union, association or other entity] that is the policyholder, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. the date you have received the maximum total percentage of the basic benefit amount for each critical illness; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

We will provide coverage for a payable claim that occurs while a covered person is covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

[If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death.]

Coverage for a dependent child ends on your death or [the certificate anniversary next following the date the child is no longer eligible] [the end of month in which the dependent child is no longer eligible]. This is the earlier of when the child: (a) marries; or (b) reaches age [22 (26 if a full-time student attending an educational institution of higher learning beyond high school)]; or (c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as the certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if you have Individual and Children Coverage or Family Coverage and there are other eligible dependents insured under the policy.

Coverage may be eligible for continuation as outlined in [the CONTINUATION OF INSURANCE (COBRA) provision] [or] [the PORTABILITY PRIVILEGE provision].

12

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease [active employment] [or] [membership in the union or association] because of a temporary layoff or leave of absence while coverage is in force, we will continue your coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved your leave in writing. Coverage will be continued for [3 months] following the date you ceased [active employment] [or] [membership in the union or association].

If your coverage ends while on a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active status.

We will not:

1. apply a new pre-existing condition exclusion[]; or
2. require evidence of insurability].

GENERAL PROVISIONS (Continued)

13

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] GROUP INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior group policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior group policy when it terminated; and
3. the covered person making the claim:
 - a. has been continuously insured under this policy since the policy date; and
 - b. was insured under the prior group policy when it terminated; and
4. the prior group policy:
 - a. [was issued by us; and]
 - b. had the same policyholder as this policy; and
 - c. provided coverage substantially similar to this policy; and
 - d. was issued before the policy date of this policy; and
 - e. terminated within 60 days of the policy date of this policy.]

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] INDIVIDUAL INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior individual policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior individual policy when it terminated; and
3. the covered person making the claim:
 - a. has been continuously insured under this policy since the policy date; and
 - b. was insured under the prior individual policy when it terminated; and
4. the prior individual policy:
 - a. [was issued by us; and]
 - b. provided coverage substantially similar to this policy; and
 - c. was issued before the policy date of this policy; and
 - d. terminated within 60 days of the policy date of this policy.]

14

[DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

GENERAL PROVISIONS (Continued)

INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder documenting any clerical errors.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

(This space intentionally left blank.)

[CONTINUATION OF INSURANCE (COBRA)]

15

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if your insurance would otherwise end due to one of the following events, called a qualifying event:

1. Termination of employment (other than by reason of gross misconduct), or of your eligibility due to reduction in your hours. Insurance may be continued for you and any dependents[, except for domestic partners and their covered dependents].
2. Your death. Insurance may be continued for any covered person[, except for domestic partners and their covered dependents].
3. Divorce or legal separation. Insurance may be continued for any dependent whose insurance would otherwise end. [However, COBRA does not extend continuation of coverage to domestic partners and their dependents.]
4. Your becoming eligible for Medicare. Insurance may be continued for any insured's dependents who are not entitled to Medicare[, except for domestic partners and their covered dependents]
5. A child ceasing to be an eligible dependent as defined in the policy. Insurance may be continued for that child.
6. Your employer files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of critical illness insurance, you must be insured under the policy on the day before the qualifying event. In the case of bankruptcy, you must also be: (a) an employee who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

You will not be denied continuation solely because you are covered under another group critical illness plan or eligible for Medicare on the date the qualifying event occurs.

COVERAGE CONTINUED

The insurance being continued by this section is subject to all terms and provisions of the policy that do not conflict with this section. The insurance will be the same as if the qualifying event had not occurred. The continued insurance will be subject to any changes to the policy affecting the benefits of your class following the qualifying event.

NOTIFICATION AND PAYMENT REQUIREMENTS

You have the responsibility to inform your employer of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

Your employer has the responsibility of notifying the plan administrator of: (a) your death, termination of employment, or reduction in hours; or (b) your employer's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify you of the right to continue within 14 days of the notice described above. You will then have 60 days to elect to continue your insurance. Failure to elect to continue insurance within 60 days after you are notified by the plan administrator will result in loss of the right to continue such insurance.

You will be required to pay a premium for the continued insurance to the policyholder. You will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

CONTINUATION OF INSURANCE (COBRA) – (Continued)

15

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

TERMINATION

Insurance being continued by this section will terminate on the first of the following dates that apply:

1. The date the policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverages have been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date you become covered under any other group critical illness policy, whether as an insured employee or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date you become entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees of employers under Chapter 11 Bankruptcy and their dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
 - a. If you are totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, you must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
 1. within 60 days of the Social Security determination of total disability; and
 2. within the initial 18 months of continuation coverage.
 - b. If you have a qualifying event (termination or reduction in hours worked) and you had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
 1. 36 months from the date you first became entitled to Medicare; or
 2. 18 months from your termination or reduction in hours.
 - c. For a qualifying event involving retired employees of employers under Chapter 11 Bankruptcy and their dependents, the maximum period of continuation coverage is:
 1. the lifetime of the retiree; or
 2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
 3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.]

[PORTABILITY PRIVILEGE

16

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

1. coverage under the policy terminates under the TERMINATION OF COVERAGE provision; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after you are insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured [employees][or][members] and may change on any premium due date. If you are on portability coverage, we will give you written notice at least [31] days before a change is to take effect.

GRACE PERIOD

The grace period, as defined in the policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
 - a. the date your insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.]

[PRE-EXISTING CONDITION LIMITATION

17

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from, a pre-existing condition when the date of diagnosis for the critical illness is within [12] months after the effective date of coverage.

A pre-existing condition is a sickness, injury or other condition, whether diagnosed or not, for which, during the [12] months just prior to the effective date of coverage, either:

1. symptoms existed; or
2. medical advice or treatment was recommended by or received from a physician or other member of the medical profession, acting within the scope of their license.]

EXCLUSIONS

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from:

1. War, declared or undeclared, participation in a riot, insurrection or rebellion.
2. Intentionally self-inflicted injury or action.
3. Illegal activities or participation in an illegal occupation.
4. Suicide while sane, or self-destruction while insane, or any attempt at either.
5. Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.

(This space intentionally left blank.)

CRITICAL ILLNESS BENEFIT

GENERAL

Subject to the conditions, limitations and exclusions of this coverage, we will pay a benefit when a covered person is diagnosed with a critical illness described in this coverage if:

1. the date of diagnosis for the critical illness is while the covered person is insured under the policy; and
2. the critical illness is not excluded by name or specific description.

A covered person can receive a benefit for each critical illness only once, unless the Second Event Critical Illness Benefit for that critical illness is included in the coverage.

A covered person can receive benefits for different critical illnesses described in the policy if the dates of diagnosis for each critical illness are separated by at least 90 days.

Coverage for a covered person terminates when the covered person is not eligible for any further benefits.

Each critical illness must be diagnosed by a physician in the United States. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

We do not pay any benefit for any condition or loss not described below.

18

INITIAL CRITICAL ILLNESS BENEFIT

- A. BENEFIT AMOUNT.** The benefit amount for each initial critical illness is the percentage shown below for that initial critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Initial Critical Illness	Percentage of Basic Benefit Amount
Heart Attack	[100%]
Stroke	[100%]
Coronary Artery By-Pass Surgery	[25%]
Major Organ Transplant	[100%]
End Stage Renal Failure	[100%]

- B. BENEFIT DESCRIPTION.** The initial critical illnesses are:

1. **Heart Attack.** The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis must be based on both:

- a. new electrocardiographic changes; and
- b. elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

Heart attack does not include an established (old) myocardial infarction.

The date of diagnosis for Heart Attack is the date of death (infarction) of a portion of the heart muscle.

2. **Stroke.** The death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke does not include: transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits.

The date of diagnosis for Stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.

CRITICAL ILLNESS BENEFIT (Continued)

B. BENEFITS DESCRIPTION. (Continued)

3. **Coronary Artery By-Pass Surgery.** The surgical operation to correct narrowing or blockage of one or more coronary arteries with by-pass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required.

Coronary artery by-pass surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

The date of diagnosis for Coronary Artery By-Pass Surgery is the date the actual coronary artery by-pass surgery occurs.

4. **Major Organ Transplant.** The surgical transplantation of a heart, lung, liver, pancreas, or kidney. The transplanted organ must come from a human donor.

The date of diagnosis for Major Organ Transplant is the date the actual surgery occurs for the covered transplant.

5. **End Stage Renal Failure.** The irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis.

End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas.

The date of diagnosis for End Stage Renal Failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.

19

[INSERT AS APPLICABLE OPTIONAL BENEFITS:

[SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT]

[CANCER CRITICAL ILLNESS BENEFIT]

[SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT]

[SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT]

[SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT]

[INCREASING CRITICAL ILLNESS BENEFIT]

[WELLNESS BENEFIT]]

[OPTIONAL BENEFITS

20 SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT

We will pay a Second Event Initial Critical Illness Benefit if a covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the INITIAL CRITICAL ILLNESS BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the initial critical illness; and
2. the second date of diagnosis is while the covered person is insured under the policy.

The benefit amount is equal to the benefit amount previously paid for that initial critical illness. A covered person can receive a Second Event Initial Critical Illness Benefit only once for each initial critical illness.

(This space intentionally left blank.)

[OPTIONAL BENEFITS]

21 **CANCER CRITICAL ILLNESS BENEFIT**

A. BENEFIT AMOUNT. The benefit amount for each cancer critical illness is the percentage shown below for that cancer critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Cancer Critical Illness	Percentage of Basic Benefit Amount
Carcinoma in situ	[25%]
Invasive Cancer	[100%]

B. BENEFIT DESCRIPTION. The cancer critical illnesses are:

1. **Carcinoma In Situ.** A cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

Carcinoma in situ includes:

- a. early prostate cancer diagnosed as stages A, I or II or equivalent staging; and
- b. melanoma not invading the dermis.

Carcinoma in situ does not include:

- a. other skin malignancies; or
- b. pre-malignant lesions (such as intraepithelial neoplasia); or
- c. benign tumors or polyps.

2. **Invasive Cancer.** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Invasive Cancer includes Leukemia and Lymphoma.

Invasive cancer does not include:

- a. carcinoma in situ; or
- b. tumors in the presence of any human immuno-deficiency virus; or
- c. skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or
- d. early prostate (stages A, I or II) cancer.

C. DIAGNOSIS REQUIREMENTS. A cancer critical illness must be diagnosed in one of two ways:

1. **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology.

2. **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis only if:

- a. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- b. there is medical evidence to support the diagnosis.

The date of diagnosis for cancer critical illness is the day the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based.

The “first diagnosis of cancer” includes a diagnosis of a recurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the recurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter.

For purposes of this benefit, “treatment” does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

“Maintenance drug therapy” means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

[OPTIONAL BENEFITS

22

SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT

We will pay Second Event Cancer Critical Illness Benefit if a covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the CANCER CRITICAL ILLNESS BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the cancer critical illness; and
2. the covered person did not receive treatment during that 12 month period; and
3. the second date of diagnosis is while the covered person is insured under the policy.

For purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

The benefit amount is equal to the benefit amount previously paid for that cancer critical illness. A covered person can receive a Second Event Cancer Critical Illness Benefit only once for each cancer critical illness.

(This space intentionally left blank.)

[OPTIONAL BENEFITS

23

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each supplemental critical illness is the percentage shown below for that supplemental critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Supplemental Critical I Illness	Percentage of Basic Benefit Amount
Advanced Alzheimer’s Disease	[25%]
Advanced Parkinson’s Disease	[25%]
Benign Brain Tumor	[100%]
Coma	[100%]
Complete Blindness	[100%]
Complete Loss of Hearing	[100%]
Paralysis	[100%]
Occupational HIV	[100%]

B. BENEFITS DESCRIPTION. The supplemental critical illnesses are:

1. **Advanced Alzheimer’s Disease.** Alzheimer’s disease that causes the covered person to be incapacitated.

“Alzheimer’s disease” is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer’s disease.

“Incapacitated” means that, due to Alzheimer’s disease, the covered person:

- a. exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
- b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Alzheimer’s Disease if the covered person was diagnosed with Alzheimer’s disease, regardless of the covered person’s symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Alzheimer’s Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer’s disease.

2. **Advanced Parkinson’s Disease.** Parkinson’s disease that causes the covered person to be incapacitated.

“Parkinson’s disease” is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson’s disease.

“Incapacitated” means that, due to Parkinson’s disease, the covered person:

- a. exhibits 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); and
- b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Parkinson’s Disease if the covered person was diagnosed with Parkinson’s disease, regardless of the covered person’s symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Parkinson’s Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson’s disease.

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

3. **Benign Brain Tumor.** A non-cancerous brain tumor:
- confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
 - resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- tumors of the skull; or
- pituitary adenomas; or
- germanomas.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

4. **Coma.** A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

5. **Complete Blindness.** A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:
- sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
 - visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

6. **Complete Loss of Hearing.** The total and irreversible loss of hearing in both ears.

Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

7. **Paralysis.** The total and permanent voluntary loss of movement or motor function of 2 or more limbs.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

8. **Occupational HIV.** An accidental occupational exposure to HIV-contaminated body fluids due to a needle stick or splash from which the covered person is infected with HIV. The accidental exposure must occur during the normal course of duties of the occupation in which the covered person is regularly engaged and for which remuneration is earned. The covered person must have never previously tested HIV positive.

For a benefit to be paid under Occupational HIV, the following additional requirements must be met:

- a. an incident report (notice of exposure) which describes the nature of the exposure to HIV is filed with the employer within 48 hours of the exposure and sent to us as soon as reasonably possible; and
- b. a preliminary screening test, such as an enzyme-linked immunoabsorbent assay (ELISA) or other approved test by the Food and Drug Administration (FDA), other than saliva or urine testing, is performed within 14 days of the accidental exposure; and
- c. a subsequent screening test is performed within 26 weeks of the accidental exposure and we receive notification of the HIV positive test results as soon as reasonably possible.

“HIV positive” means the presence of HIV antibodies in the blood of a covered person as substantiated through both a positive screening test such as ELISA, and a positive supplemental test such as the Western Blot. All such tests must be approved by the FDA with the interpretation of positive results as specified by the manufacturer(s). If the Western blot is negative and remains so for 6 months, HIV infection is not present.

The date of diagnosis for Occupational HIV is the date a physician determines the covered person is HIV positive as supported by the ELISA test, Western Blot test or another FDA approved test.

C. ACTIVITIES OF DAILY LIVING. As used in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision, “activities of daily living” are:

1. Bathing — to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing — to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting — to get on and off the toilet and maintain personal hygiene.
4. Bladder and Bowel Continence — to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
6. Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

[OPTIONAL BENEFITS

23

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each supplemental critical illness is the percentage shown below for that supplemental critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Table with 2 columns: Supplemental Critical Illness, Percentage of Basic Benefit Amount. Rows include: Advanced Alzheimer's Disease [25%], Advanced Parkinson's Disease [25%], Benign Brain Tumor [100%], Coma [100%], Complete Blindness [100%], Complete Loss of Hearing [100%], Paralysis [100%].

B. BENEFITS DESCRIPTION. The supplemental critical illnesses are:

1. Advanced Alzheimer's Disease. Alzheimer's disease that causes the covered person to be incapacitated.

"Alzheimer's disease" is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease.

"Incapacitated" means that, due to Alzheimer's disease, the covered person:

- a. exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease.

2. Advanced Parkinson's Disease. Parkinson's disease that causes the covered person to be incapacitated.

"Parkinson's disease" is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease.

"Incapacitated" means that, due to Parkinson's disease, the covered person:

- a. exhibits 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

3. **Benign Brain Tumor.** A non-cancerous brain tumor:
 - a. confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
 - b. resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- a. tumors of the skull; or
- b. pituitary adenomas; or
- c. meningiomas.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

4. **Coma.** A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

5. **Complete Blindness.** A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:
 - c. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
 - d. visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

6. **Complete Loss of Hearing.** The total and irreversible loss of hearing in both ears.

Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

7. **Paralysis.** The total and permanent voluntary loss of movement or motor function of 2 or more limbs.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

C. ACTIVITIES OF DAILY LIVING. As used in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision, "activities of daily living" are:

1. Bathing — to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing — to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting — to get on and off the toilet and maintain personal hygiene.
4. Bladder and Bowel Continence — to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
6. Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.]

[OPTIONAL BENEFITS

24

INCREASING CRITICAL ILLNESS BENEFIT

We will increase the basic benefit amounts shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] on each of the first 5 coverage year anniversaries. This increase will be the specified amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] and will increase the basic benefit amount for each covered person. This increase only applies to the basic benefit amount. It does not apply to any other benefit included with this certificate. Each increase in the basic benefit amount will be automatically processed by us.

“Coverage year anniversary” means the same day and month each year as the effective date of the certificate for each succeeding year the certificate remains in force.

(This space intentionally left blank.)

[OPTIONAL BENEFITS**WELLNESS BENEFIT**

We pay the amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] per calendar year per covered person for any one of the below. Each covered person is covered for no more than the amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] per calendar year. The eligible Wellness Benefits are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

(This space intentionally left blank.)

WAIVER OF PREMIUM BENEFIT

We will waive your premiums for this coverage if, while covered under the policy, you:

1. become disabled due to a critical illness for which a benefit is paid; and
2. remain disabled for at least 90 consecutive days.

After the 90th day, we will waive the premiums due for the first 90 days and each consecutive day thereafter you are disabled, until the earliest of:

1. the date you are no longer disabled; or
- 26 2. [2 years from the first day of disability; or]
3. [upon your reaching age 65 or 2 years from the first day of disability, whichever occurs last; or]
4. the date coverage ends according to the TERMINATION OF COVERAGE provision.

“Disabled” means you are:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

“Unable to work” means:

1. During the first 365 days of disability, you are unable to work at the occupation you were performing when your disability began.
2. [During the second 365 days of disability] [After the first 365 days of disability], you are unable to work at any gainful occupation for which you are suited by education, training or experience.

This benefit is payable only for the disability of the insured [employee] [or] [member]. It does not apply to any other covered person. You must provide sufficient proof of disability at least once every 6 months.

(This space intentionally left blank.)

CLAIM INFORMATION

NOTICE OF CLAIM

27 We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any benefit covered by the policy, or as soon as is reasonably possible. Notice given to us by, or on behalf of, you or the beneficiary at [1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687], or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the form is not received from us within 15 days of the request, written proof of claim may be sent to us without waiting for the form.

FILING A CLAIM

You must complete all applicable sections of the claim form and then give it to your attending physician. The physician should complete his or her section statement of the form and send it directly to us.

PROOF OF CLAIM

Written proof must be furnished to us within 90 days of each critical illness or payable loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have you examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under this certificate and we will make payment to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid you.

UNPAID PREMIUM

Upon the payment of a claim under the policy, any unpaid premium may be deducted.

CLAIM INFORMATION (Continued)

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. your right to submit any additional information that might allow us to change our decision.

You may, upon written request, have any reports that are not confidential. For a fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

(This space intentionally left blank.)

GLOSSARY

Active Employment or **Actively Employed** means that the covered person is working for his/her employer for earnings that are paid regularly and that the covered person is performing the material and substantial duties of his/her regular occupation. When used in connection with you:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not one of your employer's scheduled work days only if you were actively employed on the preceding scheduled work day.

The covered person's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the covered person's job requires travel.

28

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. [Temporary and seasonal workers are excluded from coverage.]

Calendar Year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

29

Covered Person means any of the following:

1. any eligible family member (including you) named on the enrollment [or evidence of insurability] and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

Critical Illness means one of the critical illnesses described in the CRITICAL ILLNESS BENEFIT provision for which a benefit may be paid.

[Domestic Partner means your same-sex or opposite-sex partner who is eligible for coverage provided that:

30

1. Both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. If your state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, you must satisfy the definition of domestic partner as defined by the policyholder; or
3. If your state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both you and your same-sex or opposite-sex partner must:
 - a. have resided together in the same permanent residence; and
 - b. be at least 18 years of age; and
 - c. intend to remain each other's sole domestic partner indefinitely; and
 - d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon you for care and financial assistance; and
 - e. not be legally married to or the legal domestic partner of anyone else; and
 - f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.]

Employer means the individual, company or corporation where the covered person is in active employment, and includes any division, subsidiary, or affiliated company of the employer.

GLOSSARY (Continued)

31 **[Evidence of Insurability]** means a statement of your or your dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.]

32 **Family Coverage** means coverage that includes you, your spouse [or domestic partner] and eligible children.

33 **Grace Period** means a period of [31] days following the premium due date during which premium payment may be made.

Individual Coverage means coverage that includes only you, as defined.

34 **[Individual and Children Coverage]** means coverage that includes only you, as defined, and eligible children.]

[Individual and Spouse Coverage] means coverage that includes only you, as defined, and your eligible spouse [or domestic partner.]

Initial Enrollment Period means one of the following periods during which you may first apply, in writing, for coverage under the policy:

1. a period before the policy effective date as set by us and the policyholder if you are eligible for coverage on the policy effective date; or
2. the period ending 31 days after the date you are first eligible to apply for coverage if you become eligible for coverage after the policy effective date.

Injury means accidental bodily injury.

Material and Substantial Duties means duties that:

1. are normally required for the performance of the covered person's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the covered person is required to work on average in excess of 40 hours per week. We will consider the covered person able to perform that requirement if he/she is working or has the capacity to work 40 hours per week.

Payable Claim means a claim for which we are liable under the terms of the policy.

35 **Physician** means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize you, or your [domestic partner,] spouse, children, parents, or siblings as a physician for a claim.

Policy means the policy of insurance issued by us to the policyholder.

Policy Date means the effective date of the policy.

Policyholder means the legal entity to whom the policy is issued.

Re-enrollment Period means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if you are currently enrolled.

Sickness means an illness or disease.

GLOSSARY (Continued)

Symptoms mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

We, Us and **Our** mean American Heritage Life Insurance Company.

36 **You** and **Your** mean the named insured [employee][or][member] shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

(This space intentionally left blank.)



Allstate[®]

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

**THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS
ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED.
THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**

1



Allstate

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

2

In this certificate, the words:

"You" and "your" mean the named insured [employee][or][member] shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"This policy" and "the policy" mean the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

3

Secretary

President

THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.

TABLE OF CONTENTS

[CERTIFICATE SPECIFICATIONS 3]

GENERAL PROVISIONS [4 – 7]

[CONTINUATION OF INSURANCE (COBRA) 8 – 9]

[PORTABILITY 10]

LIMITATIONS AND EXCLUSIONS [11]

BENEFITS.....[12-15]

CLAIM INFORMATION [16-17]

GLOSSARY [18 – 20]

[AMERICAN HERITAGE LIFE INSURANCE COMPANY
 1776 American Heritage Life Drive, Jacksonville, Florida 32224

5

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	ANNUAL PREMIUM AMOUNT
6	GCIC3AR	
	INITIAL CRITICAL ILLNESS	
	INSURED EMPLOYEE	BASIC BENEFIT AMOUNT \$50,000
	INSURED SPOUSE	\$25,000
	INSURED CHILD(REN)	\$25,000
	SECOND EVENT INITIAL CRITICAL ILLNESS	SAME AMOUNT AS INITIAL CRITICAL ILLNESS \$00.00
	CANCER CRITICAL ILLNESS	
	INSURED EMPLOYEE	BASIC BENEFIT AMOUNT \$50,000
	INSURED SPOUSE	\$25,000
	INSURED CHILD(REN)	\$25,000
	SECOND EVENT CANCER CRITICAL ILLNESS	SAME AMOUNT AS CANCER CRITICAL ILLNESS \$00.00
	SUPPLEMENTAL CRITICAL ILLNESS [I][II]	
INSURED EMPLOYEE	BASIC BENEFIT AMOUNT \$50,000	
INSURED SPOUSE	\$25,000	
INSURED CHILD(REN)	\$25,000	
WELLNESS BENEFIT	\$25/TEST	\$00.00

FAMILY COVERAGE

The effective date of each benefit is the Effective Date unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
\$000.00	\$000.00	\$00.00	\$00.00	\$00.00

Premium Payment Method PAYROLL – MONTHLY Premium Class TOBACCO/NON-TOBACCO

INSURED: JOHN DOE ISSUE AGE: 35
 EFFECTIVE DATE: MAY 01, 2010 CERTIFICATE NUMBER: 123456
 POLICY NUMBER: GROUP106
 BENEFICIARY: AS NAMED AT ENROLLMENT OR LATER CHANGED

GROUP CRITICAL ILLNESS COVERAGE

GCIC3AR

GENERAL PROVISIONS

EFFECTIVE DATE OF COVERAGE

7 Your coverage will be effective at 12:01 a.m. on the effective date shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] provided you are actively employed on that date.

If you are not actively employed on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage [that is subject to evidence of insurability], the change in coverage is effective on the date we approve such change.

[For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.]

8 WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
 - a. the initial enrollment period; or
 - b. [at any other time] [at the next re-enrollment period] [, subject to evidence of insurability].
2. You may increase coverage [at any time] [at the next re-enrollment period] [, subject to evidence of insurability].
3. You may discontinue coverage at any time.

9 [WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. you:
 - a. voluntarily canceled coverage and are reapplying; or
 - b. are applying for an amount of coverage over the guaranteed issue limit; or
 - c. are applying for the coverage, or an increase in the amount of coverage, at any time after your initial enrollment period; or
2. an eligible dependent did not enroll within 31 days of eligibility.]

(This space intentionally left blank.)

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. your legal spouse [or domestic partner]; and
2. your unmarried children including adopted children from the moment of placement in the residence, stepchildren, [children of a domestic partner] or legal ward who are [under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school]. Your children must be dependent on you for support or reside with you over 50% of the time in a regular parent-child relationship and be named on the enrollment [or evidence of insurability] form.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to the certificate if we are notified within 31 days after they become eligible.

If you have Individual Coverage [or Individual and Child(ren) Coverage], then marry and desire coverage for your spouse, we must be notified within 31 days of the marriage. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.]

[If you have Individual Coverage [or Individual and Child(ren) Coverage], then establish a domestic partnership and desire coverage for your domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to [Individual and Spouse Coverage or] Family Coverage and provide notification of the additional premium due. [If we are not notified within 31 days of the date a domestic partnership was formed, then evidence of insurability will be required.]]

A child born to you or your spouse [or domestic partner], while [Individual and Child(ren) Coverage] [or] [Family Coverage] is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under the certificate. No additional premium will be required for newborns added if [Individual and Child(ren) Coverage or] Family Coverage is in force at the time the newborn is added.

If you have Individual Coverage [or Individual and Spouse Coverage,] newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for a newborn child, you must notify us within 31 days of that child's birth. Upon notification, we will convert your Individual Coverage [to Individual and Child(ren) Coverage] [or Individual and Spouse Coverage] to Family Coverage and provide notification of the additional premium due. If you do not notify us within 31 days of the birth of the child, the temporary automatic coverage ends.

An adopted child or child pending adoption will be covered as follows, as long as [Individual and Child(ren) Coverage or] Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 60 days after the date of birth.
2. If adoption proceedings have been instituted by you within 60 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

GENERAL PROVISIONS (Continued)

11

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day you are [actively employed with your employer] [or] [a member in good standing in the labor union, association or other entity] that is the policyholder, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. the date you have received the maximum total percentage of the basic benefit amount for each critical illness; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

We will provide coverage for a payable claim that occurs while a covered person is covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

[If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death.]

Coverage for a dependent child ends on your death or [the certificate anniversary next following the date the child is no longer eligible] [the end of month in which the dependent child is no longer eligible]. This is the earlier of when the child: (a) marries; or (b) reaches age [22 (26 if a full-time student attending an educational institution of higher learning beyond high school)]; or (c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as the certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if you have Individual and Children Coverage or Family Coverage and there are other eligible dependents insured under the policy.

Coverage may be eligible for continuation as outlined in [the CONTINUATION OF INSURANCE (COBRA) provision] [or] [the PORTABILITY PRIVILEGE provision].

12

TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease [active employment] [or] [membership in the union or association] because of a temporary layoff or leave of absence while coverage is in force, we will continue your coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved your leave in writing. Coverage will be continued for [3 months] following the date you ceased [active employment] [or] [membership in the union or association].

If your coverage ends while on a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active status.

We will not:

1. apply a new pre-existing condition exclusion[]; or
2. require evidence of insurability[].

GENERAL PROVISIONS (Continued)

13

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] GROUP INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior group policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior group policy when it terminated; and
3. the covered person making the claim:
 - a. has been continuously insured under this policy since the policy date; and
 - b. was insured under the prior group policy when it terminated; and
4. the prior group policy:
 - a. [was issued by us; and]
 - b. had the same policyholder as this policy; and
 - c. provided coverage substantially similar to this policy; and
 - d. was issued before the policy date of this policy; and
 - e. terminated within 60 days of the policy date of this policy.]

[WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR [AMERICAN HERITAGE LIFE] INDIVIDUAL INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior individual policy [issued by us] if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. you:
 - a. were in active employment on the policy date of this policy; and
 - b. had been continuously insured under this policy since the policy date; and
 - c. were insured under the prior individual policy when it terminated; and
3. the covered person making the claim:
 - a. has been continuously insured under this policy since the policy date; and
 - b. was insured under the prior individual policy when it terminated; and
4. the prior individual policy:
 - a. [was issued by us; and]
 - b. provided coverage substantially similar to this policy; and
 - c. was issued before the policy date of this policy; and
 - d. terminated within 60 days of the policy date of this policy.]

14

[DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of the policy and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of the policy, such determinations shall be final and conclusive.]

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

GENERAL PROVISIONS (Continued)

INCONTESTABILITY

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder documenting any clerical errors.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

(This space intentionally left blank.)

[CONTINUATION OF INSURANCE (COBRA)]

15

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if your insurance would otherwise end due to one of the following events, called a qualifying event:

1. Termination of employment (other than by reason of gross misconduct), or of your eligibility due to reduction in your hours. Insurance may be continued for you and any dependents[, except for domestic partners and their covered dependents].
2. Your death. Insurance may be continued for any covered person[, except for domestic partners and their covered dependents].
3. Divorce or legal separation. Insurance may be continued for any dependent whose insurance would otherwise end. [However, COBRA does not extend continuation of coverage to domestic partners and their dependents.]
4. Your becoming eligible for Medicare. Insurance may be continued for any insured's dependents who are not entitled to Medicare[, except for domestic partners and their covered dependents]
5. A child ceasing to be an eligible dependent as defined in the policy. Insurance may be continued for that child.
6. Your employer files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of critical illness insurance, you must be insured under the policy on the day before the qualifying event. In the case of bankruptcy, you must also be: (a) an employee who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

You will not be denied continuation solely because you are covered under another group critical illness plan or eligible for Medicare on the date the qualifying event occurs.

COVERAGE CONTINUED

The insurance being continued by this section is subject to all terms and provisions of the policy that do not conflict with this section. The insurance will be the same as if the qualifying event had not occurred. The continued insurance will be subject to any changes to the policy affecting the benefits of your class following the qualifying event.

NOTIFICATION AND PAYMENT REQUIREMENTS

You have the responsibility to inform your employer of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

Your employer has the responsibility of notifying the plan administrator of: (a) your death, termination of employment, or reduction in hours; or (b) your employer's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify you of the right to continue within 14 days of the notice described above. You will then have 60 days to elect to continue your insurance. Failure to elect to continue insurance within 60 days after you are notified by the plan administrator will result in loss of the right to continue such insurance.

You will be required to pay a premium for the continued insurance to the policyholder. You will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

CONTINUATION OF INSURANCE (COBRA) – (Continued)

15

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

TERMINATION

Insurance being continued by this section will terminate on the first of the following dates that apply:

1. The date the policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverages have been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date you become covered under any other group critical illness policy, whether as an insured employee or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date you become entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees of employers under Chapter 11 Bankruptcy and their dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
 - a. If you are totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, you must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
 1. within 60 days of the Social Security determination of total disability; and
 2. within the initial 18 months of continuation coverage.
 - b. If you have a qualifying event (termination or reduction in hours worked) and you had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
 1. 36 months from the date you first became entitled to Medicare; or
 2. 18 months from your termination or reduction in hours.
 - c. For a qualifying event involving retired employees of employers under Chapter 11 Bankruptcy and their dependents, the maximum period of continuation coverage is:
 1. the lifetime of the retiree; or
 2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
 3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.]

[PORTABILITY PRIVILEGE

16

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

1. coverage under the policy terminates under the TERMINATION OF COVERAGE provision; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

PORTABILITY COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after you are insured under the portability privilege will not apply to that covered person unless it is required by law.

Portability coverage will be effective on the day after insurance under the policy terminates.

PORTABILITY PREMIUMS

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured [employees][or][members] and may change on any premium due date. If you are on portability coverage, we will give you written notice at least [31] days before a change is to take effect.

GRACE PERIOD

The grace period, as defined in the policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
 - a. the date your insurance terminates; or
 - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.]

[PRE-EXISTING CONDITION LIMITATION

17

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from, a pre-existing condition when the date of diagnosis for the critical illness is within [12] months after the effective date of coverage.

A pre-existing condition is a sickness, injury or other condition, whether diagnosed or not, for which, during the [12] months just prior to the effective date of coverage, either:

1. symptoms existed; or
2. medical advice or treatment was recommended by or received from a physician or other member of the medical profession, acting within the scope of their license.]

EXCLUSIONS

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from:

1. War, declared or undeclared, participation in a riot, insurrection or rebellion.
2. Intentionally self-inflicted injury or action.
3. Illegal activities or participation in an illegal occupation.
4. Suicide while sane, or self-destruction while insane, or any attempt at either.
5. Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.

(This space intentionally left blank.)

CRITICAL ILLNESS BENEFIT

GENERAL

Subject to the conditions, limitations and exclusions of this coverage, we will pay a benefit when a covered person is diagnosed with a critical illness described in this coverage if:

1. the date of diagnosis for the critical illness is while the covered person is insured under the policy; and
2. the critical illness is not excluded by name or specific description.

A covered person can receive a benefit for each critical illness only once, unless the Second Event Critical Illness Benefit for that critical illness is included in the coverage.

A covered person can receive benefits for different critical illnesses described in the policy if the dates of diagnosis for each critical illness are separated by at least 90 days.

Coverage for a covered person terminates when the covered person is not eligible for any further benefits.

Each critical illness must be diagnosed by a physician in the United States. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

We do not pay any benefit for any condition or loss not described below.

18

INITIAL CRITICAL ILLNESS BENEFIT

- A. BENEFIT AMOUNT.** The benefit amount for each initial critical illness is the percentage shown below for that initial critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Initial Critical Illness	Percentage of Basic Benefit Amount
Heart Attack	[100%]
Stroke	[100%]
Coronary Artery By-Pass Surgery	[25%]
Major Organ Transplant	[100%]
End Stage Renal Failure	[100%]

- B. BENEFIT DESCRIPTION.** The initial critical illnesses are:

1. **Heart Attack.** The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis must be based on both:

- a. new electrocardiographic changes; and
- b. elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

Heart attack does not include an established (old) myocardial infarction.

The date of diagnosis for Heart Attack is the date of death (infarction) of a portion of the heart muscle.

2. **Stroke.** The death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke does not include: transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits.

The date of diagnosis for Stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.

CRITICAL ILLNESS BENEFIT (Continued)

B. BENEFITS DESCRIPTION. (Continued)

3. **Coronary Artery By-Pass Surgery.** The surgical operation to correct narrowing or blockage of one or more coronary arteries with by-pass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required.

Coronary artery by-pass surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

The date of diagnosis for Coronary Artery By-Pass Surgery is the date the actual coronary artery by-pass surgery occurs.

4. **Major Organ Transplant.** The surgical transplantation of a heart, lung, liver, pancreas, or kidney. The transplanted organ must come from a human donor.

The date of diagnosis for Major Organ Transplant is the date the actual surgery occurs for the covered transplant.

5. **End Stage Renal Failure.** The irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis.

End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas.

The date of diagnosis for End Stage Renal Failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.

[INSERT AS APPLICABLE OPTIONAL BENEFITS:

[SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT]

[CANCER CRITICAL ILLNESS BENEFIT]

[SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT]

[SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT]

[SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT]

[WELLNESS BENEFIT]]

[OPTIONAL BENEFITS

20 SECOND EVENT INITIAL CRITICAL ILLNESS BENEFIT

We will pay a Second Event Initial Critical Illness Benefit if a covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the INITIAL CRITICAL ILLNESS BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the initial critical illness; and
2. the second date of diagnosis is while the covered person is insured under the policy.

The benefit amount is equal to the benefit amount previously paid for that initial critical illness. A covered person can receive a Second Event Initial Critical Illness Benefit only once for each initial critical illness.

(This space intentionally left blank.)

[OPTIONAL BENEFITS]

21 **CANCER CRITICAL ILLNESS BENEFIT**

A. BENEFIT AMOUNT. The benefit amount for each cancer critical illness is the percentage shown below for that cancer critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Cancer Critical Illness	Percentage of Basic Benefit Amount
Carcinoma in situ	[25%]
Invasive Cancer	[100%]

B. BENEFIT DESCRIPTION. The cancer critical illnesses are:

1. **Carcinoma In Situ.** A cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

Carcinoma in situ includes:

- a. early prostate cancer diagnosed as stages A, I or II or equivalent staging; and
- b. melanoma not invading the dermis.

Carcinoma in situ does not include:

- a. other skin malignancies; or
- b. pre-malignant lesions (such as intraepithelial neoplasia); or
- c. benign tumors or polyps.

2. **Invasive Cancer.** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Invasive Cancer includes Leukemia and Lymphoma.

Invasive cancer does not include:

- a. carcinoma in situ; or
- b. tumors in the presence of any human immuno-deficiency virus; or
- c. skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or
- d. early prostate (stages A, I or II) cancer.

C. DIAGNOSIS REQUIREMENTS. A cancer critical illness must be diagnosed in one of two ways:

1. **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology.

2. **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis only if:

- a. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- b. there is medical evidence to support the diagnosis.

The date of diagnosis for cancer critical illness is the day the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based.

The “first diagnosis of cancer” includes a diagnosis of a recurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the recurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter.

For purposes of this benefit, “treatment” does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

“Maintenance drug therapy” means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

[OPTIONAL BENEFITS

22

SECOND EVENT CANCER CRITICAL ILLNESS BENEFIT

We will pay Second Event Cancer Critical Illness Benefit if a covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the CANCER CRITICAL ILLNESS BENEFIT provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the cancer critical illness; and
2. the covered person did not receive treatment during that 12 month period; and
3. the second date of diagnosis is while the covered person is insured under the policy.

For purposes of this benefit, "treatment" does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

The benefit amount is equal to the benefit amount previously paid for that cancer critical illness. A covered person can receive a Second Event Cancer Critical Illness Benefit only once for each cancer critical illness.

(This space intentionally left blank.)

[OPTIONAL BENEFITS

23

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each supplemental critical illness is the percentage shown below for that supplemental critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Table with 2 columns: Supplemental Critical Illness, Percentage of Basic Benefit Amount. Rows include: Advanced Alzheimer's Disease [25%], Advanced Parkinson's Disease [25%], Benign Brain Tumor [100%], Coma [100%], Complete Blindness [100%], Complete Loss of Hearing [100%], Paralysis [100%], Occupational HIV [100%].

B. BENEFITS DESCRIPTION. The supplemental critical illnesses are:

1. Advanced Alzheimer's Disease. Alzheimer's disease that causes the covered person to be incapacitated.

"Alzheimer's disease" is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease.

"Incapacitated" means that, due to Alzheimer's disease, the covered person:

- a. exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease.

2. Advanced Parkinson's Disease. Parkinson's disease that causes the covered person to be incapacitated.

"Parkinson's disease" is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease.

"Incapacitated" means that, due to Parkinson's disease, the covered person:

- a. exhibits 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

3. **Benign Brain Tumor.** A non-cancerous brain tumor:
- a. confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
 - b. resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- a. tumors of the skull; or
- b. pituitary adenomas; or
- c. germinomas.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

4. **Coma.** A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

5. **Complete Blindness.** A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:
- a. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
 - b. visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

6. **Complete Loss of Hearing.** The total and irreversible loss of hearing in both ears.

Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

7. **Paralysis.** The total and permanent voluntary loss of movement or motor function of 2 or more limbs.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

SUPPLEMENTAL CRITICAL ILLNESS I BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

8. **Occupational HIV.** An accidental occupational exposure to HIV-contaminated body fluids due to a needle stick or splash from which the covered person is infected with HIV. The accidental exposure must occur during the normal course of duties of the occupation in which the covered person is regularly engaged and for which remuneration is earned. The covered person must have never previously tested HIV positive.

For a benefit to be paid under Occupational HIV, the following additional requirements must be met:

- a. an incident report (notice of exposure) which describes the nature of the exposure to HIV is filed with the employer within 48 hours of the exposure and sent to us as soon as reasonably possible; and
- b. a preliminary screening test, such as an enzyme-linked immunoabsorbent assay (ELISA) or other approved test by the Food and Drug Administration (FDA), other than saliva or urine testing, is performed within 14 days of the accidental exposure; and
- c. a subsequent screening test is performed within 26 weeks of the accidental exposure and we receive notification of the HIV positive test results as soon as reasonably possible.

“HIV positive” means the presence of HIV antibodies in the blood of a covered person as substantiated through both a positive screening test such as ELISA, and a positive supplemental test such as the Western Blot. All such tests must be approved by the FDA with the interpretation of positive results as specified by the manufacturer(s). If the Western blot is negative and remains so for 6 months, HIV infection is not present.

The date of diagnosis for Occupational HIV is the date a physician determines the covered person is HIV positive as supported by the ELISA test, Western Blot test or another FDA approved test.

C. ACTIVITIES OF DAILY LIVING. As used in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision, “activities of daily living” are:

1. Bathing — to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing — to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting — to get on and off the toilet and maintain personal hygiene.
4. Bladder and Bowel Continence — to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
6. Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

[OPTIONAL BENEFITS

23

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

A. BENEFIT AMOUNT. The benefit amount for each supplemental critical illness is the percentage shown below for that supplemental critical illness multiplied by the basic benefit amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] applicable to the covered person.

Table with 2 columns: Supplemental Critical Illness, Percentage of Basic Benefit Amount. Rows include: Advanced Alzheimer's Disease [25%], Advanced Parkinson's Disease [25%], Benign Brain Tumor [100%], Coma [100%], Complete Blindness [100%], Complete Loss of Hearing [100%], Paralysis [100%].

B. BENEFITS DESCRIPTION. The supplemental critical illnesses are:

1. Advanced Alzheimer's Disease. Alzheimer's disease that causes the covered person to be incapacitated.

"Alzheimer's disease" is a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's disease.

"Incapacitated" means that, due to Alzheimer's disease, the covered person:

- a. exhibits the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Alzheimer's Disease is the date a physician diagnoses the covered person as incapacitated due to Alzheimer's disease.

2. Advanced Parkinson's Disease. Parkinson's disease that causes the covered person to be incapacitated.

"Parkinson's disease" is a brain disorder that is diagnosed by a psychiatrist or neurologist as Parkinson's disease.

"Incapacitated" means that, due to Parkinson's disease, the covered person:

- a. exhibits 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses); and
b. requires substantial physical assistance from another adult to perform at least 3 of the activities of daily living, as defined in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision.

Benefit Limitation. We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Date of diagnosis for Advanced Parkinson's Disease is the date a physician diagnoses the covered person as incapacitated due to Parkinson's disease.

SUPPLEMENTAL CRITICAL ILLNESS II BENEFIT

B. BENEFITS DESCRIPTION. (Continued)

3. **Benign Brain Tumor.** A non-cancerous brain tumor:
- confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination; and
 - resulting in persistent neurological deficits including but not limited to: loss of vision; loss of hearing; or balance disruption.

Benign brain tumor does not include:

- tumors of the skull; or
- pituitary adenomas; or
- germanomas.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a benign brain tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

4. **Coma.** A continuous profound state of unconsciousness lasting 14 or more consecutive days due to an underlying sickness or traumatic brain injury. It is associated with severe neurologic dysfunction and unresponsiveness of a prolonged nature requiring significant medical intervention and life support measures.

Coma does not include a medically induced coma.

The date of diagnosis for Coma is the first day of the period for which a physician confirms a coma has lasted for 14 consecutive days.

5. **Complete Blindness.** A clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:
- sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (snellen or E-chart Acuity); or
 - visual field restriction to 20 degrees or less in both eyes.

The date of diagnosis for Complete Blindness is the date an ophthalmologist makes an accurate certification of complete blindness.

6. **Complete Loss of Hearing.** The total and irreversible loss of hearing in both ears.

Complete Loss of Hearing does not include loss of hearing that can be corrected by the use of any hearing aid or device.

The date of diagnosis for Complete Loss of Hearing is the date the audiologist makes an accurate certification of total and permanent hearing loss.

7. **Paralysis.** The total and permanent voluntary loss of movement or motor function of 2 or more limbs.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of paralysis based on clinical and/or laboratory findings as supported by medical records.

C. ACTIVITIES OF DAILY LIVING. As used in this SUPPLEMENTAL CRITICAL ILLNESS BENEFIT provision, "activities of daily living" are:

- Bathing — to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing — to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting — to get on and off the toilet and maintain personal hygiene.
- Bladder and Bowel Continence — to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- Transferring — to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- Eating — to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.]

[OPTIONAL BENEFITS**WELLNESS BENEFIT**

We pay the amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] per calendar year per covered person for any one of the below. Each covered person is covered for no more than the amount shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] per calendar year. The eligible Wellness Benefits are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

(This space intentionally left blank.)

WAIVER OF PREMIUM BENEFIT

We will waive your premiums for this coverage if, while covered under the policy, you:

1. become disabled due to a critical illness for which a benefit is paid; and
2. remain disabled for at least 90 consecutive days.

After the 90th day, we will waive the premiums due for the first 90 days and each consecutive day thereafter you are disabled, until the earliest of:

1. the date you are no longer disabled; or
- 25 2. [2 years from the first day of disability; or]
3. [upon your reaching age 65 or 2 years from the first day of disability, whichever occurs last; or]
4. the date coverage ends according to the TERMINATION OF COVERAGE provision.

“Disabled” means you are:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

“Unable to work” means:

1. During the first 365 days of disability, you are unable to work at the occupation you were performing when your disability began.
2. [During the second 365 days of disability] [After the first 365 days of disability], you are unable to work at any gainful occupation for which you are suited by education, training or experience.

This benefit is payable only for the disability of the insured [employee] [or] [member]. It does not apply to any other covered person. You must provide sufficient proof of disability at least once every 6 months.

(This space intentionally left blank.)

CLAIM INFORMATION

NOTICE OF CLAIM

26 We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any benefit covered by the policy, or as soon as is reasonably possible. Notice given to us by, or on behalf of, you or the beneficiary at [1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687], or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the form is not received from us within 15 days of the request, written proof of claim may be sent to us without waiting for the form.

FILING A CLAIM

You must complete all applicable sections of the claim form and then give it to your attending physician. The physician should complete his or her section statement of the form and send it directly to us.

PROOF OF CLAIM

Written proof must be furnished to us within 90 days of each critical illness or payable loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have you examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under this certificate and we will make payment to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid you.

UNPAID PREMIUM

Upon the payment of a claim under the policy, any unpaid premium may be deducted.

CLAIM INFORMATION (Continued)

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. your right to submit any additional information that might allow us to change our decision.

You may, upon written request, have any reports that are not confidential. For a fee, we will make copies of those reports.

APPEALS PROCEDURE

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your beneficiary must appeal any denial of benefits under the policy by making a written request for review of the denial.

(This space intentionally left blank.)

GLOSSARY

Active Employment or **Actively Employed** means that the covered person is working for his/her employer for earnings that are paid regularly and that the covered person is performing the material and substantial duties of his/her regular occupation. When used in connection with you:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not one of your employer's scheduled work days only if you were actively employed on the preceding scheduled work day.

The covered person's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the covered person's job requires travel.

27

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. [Temporary and seasonal workers are excluded from coverage.]

Calendar Year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

28

Covered Person means any of the following:

1. any eligible family member (including you) named on the enrollment [or evidence of insurability] and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

Critical Illness means one of the critical illnesses described in the CRITICAL ILLNESS BENEFIT provision for which a benefit may be paid.

[Domestic Partner means your same-sex or opposite-sex partner who is eligible for coverage provided that:

29

1. Both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. If your state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, you must satisfy the definition of domestic partner as defined by the policyholder; or
3. If your state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both you and your same-sex or opposite-sex partner must:
 - a. have resided together in the same permanent residence; and
 - b. be at least 18 years of age; and
 - c. intend to remain each other's sole domestic partner indefinitely; and
 - d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon you for care and financial assistance; and
 - e. not be legally married to or the legal domestic partner of anyone else; and
 - f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.]

Employer means the individual, company or corporation where the covered person is in active employment, and includes any division, subsidiary, or affiliated company of the employer.

GLOSSARY (Continued)

30 **[Evidence of Insurability]** means a statement of your or your dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.]

31 **Family Coverage** means coverage that includes you, your spouse [or domestic partner] and eligible children.

32 **Grace Period** means a period of [31] days following the premium due date during which premium payment may be made.

Individual Coverage means coverage that includes only you, as defined.

33 **[Individual and Children Coverage]** means coverage that includes only you, as defined, and eligible children.]

[Individual and Spouse Coverage] means coverage that includes only you, as defined, and your eligible spouse [or domestic partner.]

Initial Enrollment Period means one of the following periods during which you may first apply, in writing, for coverage under the policy:

1. a period before the policy effective date as set by us and the policyholder if you are eligible for coverage on the policy effective date; or
2. the period ending 31 days after the date you are first eligible to apply for coverage if you become eligible for coverage after the policy effective date.

Injury means accidental bodily injury.

Material and Substantial Duties means duties that:

1. are normally required for the performance of the covered person's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the covered person is required to work on average in excess of 40 hours per week. We will consider the covered person able to perform that requirement if he/she is working or has the capacity to work 40 hours per week.

Payable Claim means a claim for which we are liable under the terms of the policy.

34 **Physician** means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize you, or your [domestic partner,] spouse, children, parents, or siblings as a physician for a claim.

Policy means the policy of insurance issued by us to the policyholder.

Policy Date means the effective date of the policy.

Policyholder means the legal entity to whom the policy is issued.

Re-enrollment Period means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if you are currently enrolled.

Sickness means an illness or disease.

GLOSSARY (Continued)

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Symptoms mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

We, Us and **Our** mean American Heritage Life Insurance Company.

35 **You** and **Your** mean the named insured [employee][or][member] shown [in this certificate] [on the Certificate Specifications page] [on page 3] [(in your benefit statement)] who is a member of an eligible class as described in the policy and for whom premiums are remitted.

(This space intentionally left blank.)



Allstate[®]

Workplace Division

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

**THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS
ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED.
THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**