

SERFF Tracking Number: CLTR-126438315 State: Arkansas
 Filing Company: National Guardian Life Insurance Company State Tracking Number: 45093
 Company Tracking Number: NCI POL 2/10 AR
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness/Specified Disease
 Project Name/Number: Specified Disease Filing/

The policy is an incorporated document that incorporates the provisions of the certificate to form the entire contract.

The policyholder will select from a variety of covered critical illnesses based on its employees'/member's needs.

Benefit levels are offered on a guaranteed issue basis (if certain participating levels are satisfied) with a buy-up option provided on a medically underwritten basis.

Bracketed language is either included or deleted and not amended within the brackets. Numerical ranges are included within the brackets.

National Guardian Life provides a portfolio of worksite marketing products including dental, vision and personal accident. I mention this because the enrollment material is reflective of other products available to the worksite market. The attached group application and enrollment form are new forms and will replace currently approved enrollment materials. The evidence form is for use with the critical illness program

Company and Contact

Filing Contact Information

Susan Coulter, Consultant susan@coulter-and-associates.com
 379 Princeton-Hightstown Rd 609-443-7540 [Phone]
 Cranbury, NJ 08512 609-443-4103 [FAX]

Filing Company Information

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

National Guardian Life Insurance Company	CoCode: 66583	State of Domicile: Wisconsin
Two East Gilman Street	Group Code: -99	Company Type: Life
P.O. Box 1191	Group Name:	State ID Number:
Madison, WI 53701	FEIN Number: 39-0493780	
(888) 729-5433 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? No

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Fee Explanation: 5 FORMS TIMES \$50
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
National Guardian Life Insurance Company	\$250.00	03/03/2010	34576969

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/08/2010	03/08/2010

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	03/05/2010	03/05/2010	Susan Coulter	03/05/2010	03/05/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
General Information Tab	Note To Reviewer	Susan Coulter	03/05/2010	03/05/2010

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	AR CERTIFICATION AND AUTHORIZATION TO FILE	Approved-Closed	Yes
Supporting Document	GENERAL USE COMPLAINT NOTICE	Approved-Closed	Yes
Form	POLICY	Approved-Closed	Yes
Form	GROUP APPLICATION	Approved-Closed	Yes
Form	CERTIFICATE	Approved-Closed	Yes
Form	ENROLLMENT FORM	Approved-Closed	Yes
Form	EVIDENCE FORM	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 03/05/2010
Submitted Date 03/05/2010

Respond By Date

Dear Susan Coulter,

This will acknowledge receipt of the captioned filing.

Objection 1

- EVIDENCE FORM, (Form)

Comment:

If this form is used as a stand alone form, it must contain a Fraud Statement.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 03/05/2010
Submitted Date 03/05/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: the evidence form is used with the enrollment form which contains fraud language. It is not intended to be a stand alone form. Please let me know if you need me to add fraud language the E of I form and I will get you a revised copy right away. Regards, Susan

Related Objection 1

Applies To:

- EVIDENCE FORM, (Form)

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Comment:

If this form is used as a stand alone form, it must contain a Fraud Statement.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Susan Coulter

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Note To Reviewer

Created By:

Susan Coulter on 03/05/2010 09:52 AM

Last Edited By:

Rosalind Minor

Submitted On:

03/08/2010 09:33 AM

Subject:

General Information Tab

Comments:

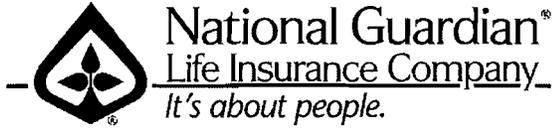
Please note that with regard to the statement in the general information tab, the enrollment form and application are new forms but will NOT replace currently approved forms. Regards, Susan Coulter

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Form Schedule

Lead Form Number: NCI POL 2/10

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 03/08/2010		Policy/Contract/Fraternal Certificate	Initial			NCI POL 2-10.pdf
Approved-Closed 03/08/2010		Application/Enrollment Form	Initial	GROUP APPLICATION		NGRAPP 02-10.pdf
Approved-Closed 03/08/2010		Certificate	Initial	CERTIFICATE		NCI CERT 2-10 AR.pdf
Approved-Closed 03/08/2010		Application/Enrollment Form	Initial	ENROLLMENT FORM		NEenroll 2-10.pdf
Approved-Closed 03/08/2010		Application/Enrollment Form	Initial	EVIDENCE FORM		CI E OF I 2-10.pdf



A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 800-988-0826

**GROUP CRITICAL ILLNESS INSURANCE
GROUP POLICY**

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: 
AlwaysCare Benefits Inc.
[8485 Goodwood Boulevard
Baton Rouge, LA 70806-7878]

In return for the application, which is attached, and payment of premium as it becomes due, National Guardian Life Insurance Company (called "We," "Our," and "Us") agrees to pay the benefits described in the Policy.

This Policy is issued to the Policyholder. It takes effect at 12:01 a.m. at the Policyholder's principal address shown on the application on the Policy Effective Date. The Effective Date is shown on the Policy Schedule. This Policy may be continued in force by payment of premium at the rates We establish until the insurance ends as provided.

The following documents are made part of this Policy: the provisions of the attached Certificates; all riders; all endorsements; and all amendments issued on and after the Effective Date.

This Policy is governed by the laws of the jurisdiction shown below.

POLICYHOLDER:	[Group Name]
GROUP POLICY NUMBER:	[Group Number]
POLICY EFFECTIVE DATE:	[November 1, 2004]
ANNIVERSARY DATE:	[November 1, 2005]
JURISDICTION:	[Louisiana]
PREMIUM DUE DATE:	[1 st of every Month]
COVERAGE PROVIDED:	[See Incorporated Certificate's Schedule of Benefits]
INITIAL TERM:	[12 Months]

Signed for National Guardian Life Insurance Company

[Sherri Kliczak, Secretary]

[John Larson, President]

**NON-PARTICIPATING
THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US.**

THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ THE POLICY CAREFULLY.

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PART I: PREMIUMS

A. PREMIUM SCHEDULE

[Minimum Number of Insureds: XX insured members]

[Minimum Participation Level: XX%]

Plan Year: [Calendar Year Basis][Policy Year Basis]

Premium Schedule:

Initial Premium Rate is guaranteed for Initial Term: From _____, 20__ to _____, 20__.]

Initial Term - The period following the group's initial Effective Date and shown in the Schedule. Rates are guaranteed not to change during this period.

B. PAYMENT OF PREMIUMS: The premiums due under this Policy are payable in advance directly to Us at the Administrator's Office. The first premium is due on the Effective Date of this Policy. Premiums after the first are due on the Premium Due Date shown on the face page of this Policy. Premiums are remitted to Us in one of two ways:

1. the Member contributes to the cost of the insurance through the Policyholder, who then submits payment to Us;
or
2. the Member pays the premiums directly to Us.

The Certificate Schedule of Benefits shows the method of premium payment.

The payment of any premium will not maintain the insurance in force beyond the day next following the Premium Due Date, except as provided under the GRACE PERIOD provision.

C. PREMIUM ADJUSTMENTS: When additional or increased insurance begins or insurance ends and such change is due to a change in the terms of this Policy, any adjustment in the premium will be made as of the date the change is effective. Otherwise, any adjustment in premium will be made on the Premium Due Date which occurs on or next follows the date of change (or the first day of the calendar month which occurs on or next follows the date of change if premiums are payable other than monthly).

Upon agreement between the Policyholder and Us, the mode of premium payment may be changed as of any Premium Due Date.

D. PREMIUM CALCULATION: The total premium for insurance coverage under this Policy is the sum of the premiums for each Insured.

E. CHANGES IN PREMIUM RATES: Premium rates are guaranteed for the Initial Term that the Policy is in force beginning on the Effective Date. After the first policy anniversary, rates may be changed on any premium due date subject to advanced written notice of [45, 60] days. Rates may be changed for the following reasons:

1. Changes in plan design;
2. Adding or removing divisions or subsidiaries of the Policyholder;
3. The number of insured Members changes by 20% or more;
4. Newly affected laws impact the Policy;
5. The group participation level falls below its required participation level; [or]
6. [Emerging credible experience of the Policy] *{large group language}* [or a block of business as a whole through the use of community rating] *{small group language}*.

F. GRACE PERIOD: A Grace Period of 31 days (without interest charge) is granted for the payment of any premium due after the first. This Policy will continue in effect during this period unless the Policyholder has given written notice to Us that the insurance under this Policy is to be ended on the first day before the Grace Period would otherwise start. If the premium is not paid by the end of the Grace Period, all insurance under this Policy will end on the last day of the Grace Period. The Policyholder [or the Member if he or she pays the premium directly to Us] will owe Us premium then due and unpaid including the premium for the Grace Period.

If the Policyholder gives Us written notice that insurance under this Policy is to be ended during the Grace Period, all insurance will end on the date We receive the written notice or the date specified, if later.

The Policyholder will owe Us the pro-rata premium for the time the insurance was in effect during the Grace Period.

[PART II: CONTINUING INSURANCE ON ACTIVE MEMBERS ABSENT FROM WORK

Coverage may be continued on Active Members absent from work subject to the following provisions. If an Active Member is absent from work because of injury, sickness, approved leave of absence or temporary lay-off, or is placed on part-time employment, the Employer, acting on a basis which does not discriminate for or against any person, may consider the Active Member as still employed until the Employer notifies Us differently or stops paying premiums for the Active Member. However, in any event, insurance cannot be continued in this way for longer than the Maximum Continuation Period stated below:

FOR ABSENCE DUE TO:	MAXIMUM CONTINUATION PERIOD:
----------------------------	-------------------------------------

[Temporary Lay-Off	One Year]
--------------------	-----------

[Approved Leave of Absence	One Year]
----------------------------	-----------

[Part-Time Employment	One Year]
-----------------------	-----------

[Injury or Sickness	One-year periods, each of which begins on the Anniversary Date of this Policy, subject to the following conditions:
---------------------	---

1. The first period begins on the date the Active Member stops Active Work due to injury or sickness and ends on the next following Anniversary Date of this Policy (up to six months);
2. Request to continue insurance must be made by the Employer to Us within 31 days before each Anniversary Date.]]

PART III: WHEN INSURANCE UNDER THIS POLICY ENDS

By giving the Policyholder written notice at least 60 days in advance, We have the right to terminate this Policy and end coverage under this Policy as follows:

1. The Policyholder fails to pay the premium when due, subject to the Grace Period Provision;
2. If participation falls below the Minimum Participation Level;
3. If the Policyholder commits fraud or a material misrepresentation in obtaining the Policy; or
4. If the number of covered Insured Persons falls below the Minimum Number of Insureds.

All insurance or any part may be ended on any date by mutual agreement between the Policyholder and Us.

After the Initial Term, the Policy shall continue on a 12 month basis. It will automatically renew on the first day of each renewal period unless We have given to the Policyholder at least 60 days advance written notice of cancellation.

Cancellation: We may cancel the Policy at any time by providing at least 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid as required by the law of the state in which the Policy is issued. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any.

Insurance will end as provided above without the consent of, or notice to, any Insured Person.

PART IV: GENERAL PROVISIONS

A. ENTIRE CONTRACT: The entire contract consists of:

1. this Policy;
2. the application of the Policyholder;
3. the provisions shown in the Certificate;
4. the Insured enrollment forms and evidence forms, if required; and
5. riders and endorsements, if any, adding or changing the provisions of the Policy or Certificate.

A copy of the Policyholder's application is attached to this Policy on the date it is signed. All statements made in the applications, in the absence of fraud, are representations and not warranties. No statement made by an Insured under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured or to his or her personal representative, if any.

B. INCONTESTABILITY: This Policy will be incontestable, except for non-payment of premium, after it has been in force for two years.

C. CHANGES IN POLICY: The terms of this Policy can be changed only by written agreement between the Policyholder and Us. Agreement for Us can only be made by Our President or Our Secretary. Any changes will be made without the consent of, or notice to, any Insured or Beneficiary, if any. No agent has authority to make this Policy or to change, alter or amend any of its terms or provisions in any way.

D. CONFORMITY WITH LAW: If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law.

E. POLICY NON-PARTICIPATING: This Policy is not entitled to share in the surplus earnings of Our company.

F. INFORMATION TO BE FURNISHED BY POLICYHOLDER: The Policyholder will furnish Us with all information which pertains to this Policy. Failure to furnish Us with such information without good and sufficient cause will permit Us to terminate this Policy. We may inspect at all reasonable times (while this Policy is in effect and thereafter until all rights and payments have been made) any records of the Policyholder which have a bearing on the insurance or premiums.

G. CLERICAL ERROR: Clerical error (whether by the Policyholder or Us) in keeping records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

H. POLICYHOLDER NOT AGENT: The Policyholder will in no event be considered Our agent for any purpose under this Policy.

I. ASSIGNMENT: No assignment of this Policy is binding upon Us unless We agree to it in writing and not until it is filed with Us at Our Home Office.

J. INDIVIDUAL CERTIFICATES: We will issue to the Policyholder, to make available to each person insured under this Policy, a Certificate of insurance that describes the essential features of this Policy. The Certificate may be made available electronically. The word Certificate includes Certificate riders and Certificate supplements, if any.

K. ADDITIONAL INSUREDS: The following will be added to the group originally insured under the Policy:

1. All new persons becoming eligible to and applying for insurance in such group or class, including new members of a family; and
2. Any persons required to be provided coverage under federal law who apply for insurance in such group or class.

L. LEGAL ACTIONS: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

M. INCORPORATION PROVISION: The provisions of the attached Certificate of Insurance, any Rider(s), and any Endorsement(s), including any Rider or Endorsement added after the Policy is issued are incorporated into and made a part of this Policy. The Certificate(s) and Rider(s) attached to this Policy will control each Insured Person's coverage eligibility, effective date, termination date, benefits, limitations and exclusions.



Application is hereby made to National Guardian Life on the basis of the information contained in this application, the group risk specifications, the enrollment data, and available experience data. The application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective.

Once approved, the application will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date shown below, unless written notice of a different effective date is sent.

If this application is not approved, no insurance is in effect at any time, and any deposit premium AlwaysCare has received will be returned.

This application is made with the following deposit premium. The premium amount is estimated, as the amount due for the first month, and will be applied toward the first premium on the proposed Group Policy(ies): \$ _____

If any insurance requires member contributions, any underwriting requirements for enrollment must be met before insurance can become effective.

Legal Name of Group _____
Physical Address _____
City\State\Zip _____
Billing Address (If different) _____
City\State\Zip _____
Federal Tax ID _____
Members: ____ **# Eligible:** ____ **# of Members with Dependents:** ____
Group Effective Date: ____ / ____ / ____

Contact for Administration & Eligibility:

Phone: (____) _____
Fax: (____) _____
E-mail Address: _____
Contact for Billing _____
Phone: (____) _____
Fax: (____) _____
E-mail Address: _____

Plan Selection: Policy Year Calendar Year

- Dental Insurance** **Hearing Rider (where applicable):**
- Vision Insurance** Attached to: Dental Vision
- Basic Life (Policyholder Funded)**
 - AD&D** **Dependent Life**
- Supplemental / Voluntary Life**
 - AD&D** **Dependent Life**
- Short Term Disability**
- Long Term Disability**
- Critical Illness**
- Accident**

Policyholder contributions:

Dental	\$_____ per month or _____ % of premium
Vision	\$_____ per month or _____ % of premium
Basic Life and AD&D	\$_____ per month or _____ % of premium
Supplemental / Voluntary Life and AD&D	\$_____ per month or _____ % of premium
Short Term Disability	\$_____ per month or _____ % of premium
Long Term Disability	\$_____ per month or _____ % of premium
Critical Illness	\$_____ per month or _____ % of premium
Accident	\$_____ per month or _____ % of premium

Eligibility: [Permanent, full-time employees working 30 hours (Standard) or _____ (other) per week are eligible for coverage. An eligible employee must have been actively at work on a full-time basis for _____ months in order to be eligible for coverage.]
 [A member in good standing with the Policyholder.]
 An eligible dependent must be less than ____ yrs. old or less than ____ yrs. old if a full-time student. Coverage becomes effective the first of the month following eligibility.

[W-2 Services Option (for Short Term Disability and Long Term Disability coverage only):

- Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
- Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.]

Participation: Depending on group size and coverage elected, specific participation requirements may apply. Participation must be met before the insurance can be effective and must be maintained continuously while insurance is in force to prevent cancellation of coverage.

I understand and agree that audits will be made by National Guardian Life Insurance Company now and in the future to verify the number and names of full-time [employees/members] of this group. I will furnish with application, [and upon any future request, a current census and State Quarterly Unemployment Tax Report,] and any other information requested.

[Monthly Administration Fee: I understand there is a **\$5.00** monthly administrative billing charge for groups with less than 10 employees enrolled.]

IMPORTANT NOTES:

Unless agreed to otherwise, membership cards, welcome letters and coverage summaries are printed and provided in a single package following group approval. The certificate of coverage, group policy, administration manuals and other information will be provided on a customized, group-specific CD-ROM to enable the Policyholder to distribute as needed via email or printouts to all enrolled Members. Members may also print ID Cards and certificates by visiting our website at www.AlwaysCareBenefits.com.

Please send Membership Materials and Enrollment Materials to (CHECK ONE):
 Group Attn: _____ Phone: (_____) _____
 Broker or Agent

[Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree that if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.]

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and an authorized National Guardian Life Insurance Co. representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement.

The applicant understands that the requested group insurance will:

- a. be issued only if the requested insurance is acceptable to National Guardian Life (the Company) and is legally permissible;
- b. be issued under a group Policy or Policies in the language customarily used by the Company;
- c. be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
- d. be subject to all exclusions and limitations of the policy; and take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, [and will be subject to the Active Work requirement]. The applicant agrees not to:

- a. collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or
- b. distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

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

Applicant Signature: _____ / /
Name Title Date

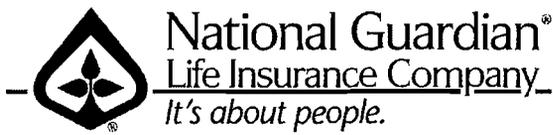
National Guardian Representative: _____ / /

Agent (if applicable)	Tax I.D. Number _____ Date _____
Firm Name (if applicable)	National Guardian Life Insurance Company appointment on file <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach Appointment Paperwork if not appointed)
Address City/State/Zip	Phone _____ Fax _____ Email Address _____

TO BE COMPLETED BY ALWAYS CARE BENEFITS

Group Set Up Information	Account Management Approval
Group Code: _____	Account Manager: _____
SIC Code: _____	Signature _____ Date ____/____/____

Notes: _____



A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 800-988-0826

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: 
AlwaysCare Benefits Inc.
[8485 Goodwood Boulevard
Baton Rouge, LA 70806-7878]

This Certificate explains the Critical Illness insurance coverage under the Group Policy (the Policy) issued to the Policyholder.

The Policyholder and the Group Policy Number are shown in the Certificate Schedule page.

This, together with the Schedule of Benefits, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your Critical Illness benefits. All benefits are governed by the terms and conditions of the Policy. The Policy alone constitutes the entire contract between the Policyholder and Us. You may examine the Policy during regular business hours by contacting the Policyholder.

Signed for National Guardian Life Insurance Company



[Sherri Kliczak, Secretary]



[John Larson, President]

NON-PARTICIPATING

THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

PLEASE READ YOUR CERTIFICATE CAREFULLY

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PART I. CERTIFICATE SCHEDULE

[Insured: [John Doe and his or her Eligible Dependents]]

[Certificate Number: 12345]

Policyholder: [Group Name]

[Policyholder's Address: [Address]

Group Policy Number: [12345]

Your Effective Date: [August 1, 2001]

Plan Year: [Calendar Year][Policy Year]

Eligible Classes: [Class 1: All full time Members working at least [30] hours per week after completing [60] days of service
Class 2: Part-time Members who work at least [17.5] hours per week, but less than 30 hours per week and have completed [60] days of service.]
[As defined by the Policyholder]
[Member in good standing as determined by the Policyholder]
[Dependents of the Member]

Service Waiting Period: [60] [Days][Months] from the first day of Active Work] [60] [Days][Months]from the date a person first became a Member in good standing of the Policyholder]

Benefit Waiting Period: 30 days [and 90 days for cancer]

Mode of Premium Payment: [MONTHLY]

Method of Premium Payment: [Remitted by Policyholder] [Remitted by Insured To Us]

[Premium Due Date: 1st of every month]

[Premium Amount: [\$xx.xx]

Covered Critical Illnesses: [Heart Attack][Stoke][Coronary Artery By-Pass Graft][Heart Transplant][Major Organ Transplantation][End Stage Renal Failure] [Paralysis][Blindness][Advanced Alzheimer's Disease][Occupational HIV][Invasive Cancer][Non-Invasive Carcinoma in Situ].

PART II. SCHEDULE OF BENEFITS

Your Basic Benefit Amount [including Guaranteed Issue Benefit Amount]: [\$5,000 - \$50,000 in \$1,000 increments]

[Guaranteed Issue Basic Benefit Amount for You: \$ _____]

[Covered Spouse [Domestic Partner] Basic Benefit Amount [including Guaranteed Issue Benefit Amount]:
[25%][50%] of the Member's Basic Benefit Amount]

[Guaranteed Issue Basic Benefit Amount for Spouse[Domestic Partner]: \$ _____]

[Covered Child Basic Benefit Amount [including Guaranteed Issue Benefit Amount]: [25%][50%] of the Member's Basic Benefit Amount]

[Guaranteed Issue Basic Benefit Amount for Children: \$ _____]

Per Person Lifetime Benefit Maximum Payout: [150%, 200%, 250%] of the Basic Benefit Amount for all occurrences combined.

BENEFITS:

[{PLAN 1 OPTION – PER CRITICAL ILLNESS MAXIMUM PLAN}]

Categories 1 and 2

Category	Specified Critical Illness	Percent of the Basic Benefit Amount	[Recurrence Benefits Maximum Number and Percent of Basic Benefit		Maximum Total Percent of Basic Benefit Amount
[1]	[Heart Attack	100%]	[0,1]	[25%, 50%, 75%, 100%]	[100%, 125%, 150%, 175%, 200%]
[1]	[Stroke	100%]	[0,1]	[25%, 50%, 75%, 100%]	
[1]	[Heart Transplant	100%]	[0,1]	[25%, 50%, 75%, 100%]	
[1]	[Coronary Artery By-Pass Surgery	25%]	Not applicable	Not applicable	
[2]	[Major Organ Transplant (excluding Heart Transplant)	100%]	[0,1]	[25%, 50%, 75%, 100%]	
[2]	[End Stage Renal Failure	100%]	[0,1]	[25%, 50%, 75%, 100%]	

[2]	[Paralysis]	[50%-100%]	Not applicable	Not applicable	[100%, 125%, 150%, 175%, 200%]
[2]	[Blindness]	50%-100%	Not applicable	Not applicable	
[2]	[Occupational HIV]	50%-100%	Not applicable	Not applicable	
[2]	[Advanced Alzheimer's]	25%-100%	Not applicable	Not applicable	

CANCER BENEFIT (Category 3): We pay this benefit if the Insured is diagnosed with a new form or type of Invasive Cancer or Non-Invasive Carcinoma in Situ

Category	Specified Critical Illness	Percent of the Basic Benefit Amount	[Recurrence Benefits Maximum Number and Percent]		[Maximum Total Percent of Basic Benefit Amount]
[3]	[Invasive Cancer]	100%	[0,1]	[25%, 50%, 75%, 100%]	[100%, 125%, 150%, 175%, 200%]
[3]	[Non-Invasive Carcinoma in Situ]	25%	[0,1]	[25%, 50%, 75%, 100%]	

1

[{PLAN 2 OPTION – COMBINED CRITICAL ILLNESS MAXIMUM PLAN}]
Categories 1 and 2

Category	Specified Critical Illness	Percent of the Basic Benefit Amount	[Recurrence Benefits Maximum Number and Percent of Basic Benefit]	
[1]	[Heart Attack]	100%	[0,1]	[25%, 50%, 75%, 100%]
[1]	[Stroke]	100%	[0,1]	[25%, 50%, 75%, 100%]
[1]	[Coronary Artery Bypass Surgery]	25%	[0,1]	[25%, 50%, 75%, 100%]
[2]	[Major Organ Transplant (including Heart Transplant)]	100%	[0,1]	[25%, 50%, 75%, 100%]
[2]	[End Stage Renal Failure]	100%	[0,1]	[25%, 50%, 75%, 100%]
[2]	[Paralysis]	50%-100%	Not applicable	Not applicable

[2]	[Blindness]	100%	Not applicable	Not applicable
[2]	[Occupational HIV]	100%	Not applicable	Not applicable
[2]	[Advanced Alzheimer's]	100%	Not applicable	Not applicable

CANCER BENEFIT (Category 3): We pay this benefit if the Insured is diagnosed with a new form or type of Invasive Cancer or Non-Invasive Carcinoma in Situ

Category	Specified Critical Illness	Percent of the Basic Benefit Amount	[Recurrence Benefits Maximum Number and Percent]	
[3]	[Invasive Cancer]	100%	[0,1]	[25%, 50%, 75%, 100%]
[3]	[Non-Invasive Carcinoma in Situ]	25%	[0,1]	[25%, 50%, 75%, 100%]

[Wellness Benefit: [\$50, \$75, \$100]

]

[Reduction in Coverage

On the Premium Due Date on or next following the date an Insured Member attains age [65, 70, 75], his or her Benefit Amount will be reduced. The Covered Dependent's Basic Benefit Amount will be reduced on a pro rata basis when Your benefit amount is reduced. Reductions are based on previously reduced amounts.

[If the Recurrence Benefit Option is in effect, recurrence benefit amounts will be reduced by [50%] on the date that the age reduction is applied.

Benefits reduce as follows:

[Option 1: 50% at age 70]

[Option 2: 35% at ages 65, 70, and 75; 25% at 80, 85, 90, and 95]

[Option 3: 50% at age 75]

]

PART III DEFINITIONS

General Definitions

[Active Member – [An Actively at Work Member of the Employer/Policyholder according to such Employer/Policyholder.][A Member in good standing with the Policyholder.]

[Active Work and Actively at Work – The Active Member is performing all of the usual and customary duties of his or her or her job on a full-time basis for the Policyholder, as defined in the Certificate Schedule. This must be done at the Policyholder's customary place of employment or business, or at some location to which the employment requires the Active Member to travel.]

Administrator - The entity which provides complete service and facilities for the writing and servicing of the Policy as agreed to in a contract with Us.

[Calendar Year Plan - Benefits begin anew on January 1 of each Calendar Year.]

Claim - A request for payment of benefits under this Certificate.

[Covered Dependent –an Eligible Dependent who is insured under this Certificate.]

Eligible Class –the group of people who are eligible for coverage under the Policy. Eligible Classes are shown in the Certificate Schedule. Each Member of the Eligible Class will qualify for insurance on the date he or she completes the required Service Waiting Period, if any.

Eligible Dependent - Means a person listed below:

1. Your spouse; [or lawful Domestic Partner]
2. Your unmarried dependent child under age [18-30], who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
- [3.] Your unmarried child age [Insert same age as in 2, above] or older but less than age [21, 22, 23, 24, 25, 26, 27, 28, 29 or 30] who is:
 - a. Not regularly employed on a full-time basis;
 - b. Primarily dependent upon You for support and maintenance; and
 - c. Enrolled as a full-time student in an accredited educational institution or licensed trade school.]
- [4.] Your unmarried child who has reached age [Insert same age as in 2, above] and who is:
 - a. primarily dependent upon You for support and maintenance; and
 - b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

Immediate Family Member – An Insured's parent, step-parent, spouse, child, step-child, brother or sister.

Insured –You (the Insured Member) [and each Covered Dependent.]

Late Entrant - Any Member or Eligible Dependent enrolling more than [31] days after first becoming eligible for

coverage, unless due to a change in family status as described in this Certificate.

Member – a person in an Eligible Class as defined by the Policyholder.

Open Enrollment Period - the period of time specified by the Policyholder. It usually occurs once each Plan Year but may, at the Policyholder's discretion, occur more frequently, if approved by Us.

Policyholder - The entity stated on the front page of the Policy.

[Policy Year - The period of time starting on the Certificate Effective Date and running for 12 consecutive months.]

[Prior Plan – A group insurance program underwritten by a different insurance company than Us providing substantially similar benefits to this Policy and was in effect within at least [60] days of the Policy Effective Date.]

Service Waiting Period - The period of time a Member must wait before he or she is eligible for coverage. The Service Waiting Period, if any, is specified in the Policyholder's Group Application and shown in the Certificate Schedule.

You or Your – The Insured Member.

Benefit Definitions

[Advanced Alzheimer's Disease - The Diagnosis, by a Physician board-certified as a neurologist, of Advanced Alzheimer's Disease. The Insured must exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. It must result in significant reduction in mental and social functioning such that the Insured requires Substantial Assistance in performing at least three of the six Activities of Daily Living (as defined below). No other dementing brain disorders or psychiatric illnesses shall meet the definition of Advanced Alzheimer's Disease, nor will they be considered a Critical Illness:

1. Activities of Daily Living (ADLs) refer to certain basic daily tasks necessary to maintain a person's health and safety. In this Policy, ADLs refer to the activities described below:
 - a) Transfer and mobility - The ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment.
 - b) Continence - The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
 - c) Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
 - d) Toileting - Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.
 - e) Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
 - f) Bathing - Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.
2. Substantial Assistance means hands-on assistance and stand-by assistance as described below. For the purposes of the Policy "stand-by assistance" will be used to determine that substantial assistance by another person is required by You to perform the ADL.
 - a) "Hands-on Assistance" means the physical assistance of another person without which You would be unable to perform the ADL.

- b) "Stand-by Assistance" means the presence of another person within Your arm's reach, to prevent, by physical intervention, injury to You while You perform an ADL (such as being ready to catch You if You fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from Your throat if You choke while eating).]

Basic Benefit Amount - the total benefit for an Insured on which the percent of benefit is payable for a Diagnosis of a Critical Illness or Procedure related to a Critical Illness. The Basic Benefit Amount [is][includes the Guaranteed Issue Basic Benefit Amount plus the amounts in excess of the Guaranteed Issued amount as] selected on the application and shown in Part II, Schedule of Benefits.]

Benefit Waiting Period - the number of days shown in the Schedule immediately following each Insured 's Effective Date of Coverage [or Request for an increase in coverage].

[Blindness – clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity) or visual field restriction to 20° or less in both eyes. Blindness does not include:

1. If in general medical opinion any Procedure, device, or implant that could result in partial or total restoration of sight;
2. Any Insured who has not attained age 3 on the Date of Diagnosis;
3. If the Insured's reduction of sight as defined herein occurred prior to the Effective Date of the Insured 's coverage.]

[Clinical Diagnosis of Invasive Cancer – a Diagnosis of Invasive Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Invasive Cancer only if the following conditions are met:

1. A Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
2. there is medical evidence to support the Diagnosis; and
3. A Physician is treating the Insured for Invasive Cancer.]

[Coronary Artery Bypass Graft – major heart surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must be recommended by a cardiologist licensed and practicing in the United States. Coronary Artery Bypass Surgery does not include non-surgical techniques such as balloon angioplasty, laser embolectomy or other non-bypass techniques; minimally invasive endoscopic or keyhole heart surgery, stent Procedures, and atherectomy.]

Critical Illness – as defined in the Schedule of Benefits.

Diagnosis - means the definitive establishment of the Critical Illness, as defined herein, using clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist and qualified to make the Diagnosis. [With respect to [Major Organ Transplant] [Coronary Artery By-Pass Surgery], Diagnosis requires a Physician's recommendation that the [Covered Person] undergo such Procedure.]

[End Stage Renal Failure - chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis is started, or renal transplant is performed.

[Heart Attack (Myocardial Infarction) - ischemic death of a portion of the heart muscle due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be made by a Physician board-certified as a Cardiologist and the following criteria must be satisfied:

1. Typical symptoms such as central chest pain;
2. Diagnostic increase of specific cardiac markers; and

3. New electrocardiographic changes of infarction.]

[Heart Transplant – the transplantation of the heart from a patient who has died and whose heart was intact and capable of functioning in the recipient Insured . The transplanted heart must come from a human.]

[Invasive Cancer – a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. Leukemia, Hodgkin’s disease, carcinoma, sarcoma, malignant tumor and lymphomas are included. The following are not considered Invasive Cancer:

1. Pre-malignant lesions (such as intraepithelial neoplasia) or;
2. Benign tumors or polyps; or
3. Carcinoid of the appendix; or
4. Non-Invasive Cancer in Situ;
5. Stage 0 transitional carcinoma in the urinary bladder;
6. Any tumors in the presence of any human immuno-deficiency virus (HIV); or
7. Any skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic.

Invasive Cancer must be diagnosed according to a Pathological Diagnosis or Clinical Diagnosis.]

[Major Organ Transplantation – human to human organ transplant from a donor to the Insured of:

1. Bone marrow solely for the treatment of cancer or bone marrow failure; or
2. transplant of an entire liver, [heart], lung, or pancreas.]

[Non-Invasive Cancer in Situ – a Diagnosis of cancer where the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. It includes early prostate cancer diagnosed as T1N0M0 or equivalent staging and melanoma not invading the dermis. It does not include other skin malignancies, pre-malignant lesions such as intraepithelial neoplasia, or benign tumors or polyps. Non-Invasive Cancer in Situ must be diagnosed pursuant to a Pathological Diagnosis or Clinical Diagnosis.]

[Occupational Human Immunodeficiency Virus (HIV) – The Diagnosis of Human Immunodeficiency Virus infection resulting from an accident which exposed the Insurance Person to HIV-contaminated body fluids. The accidental injury must occur during the normal course of duties for the occupation in which the Insured is regularly engaged and for which remuneration is earned. Occupational HIV excludes HIV Infection as a result of drug use, sexual transmission, or HIV infection determined to not to be accidental.]

[Paralysis – the complete and permanent loss of function of two or more limbs.]

[Pathological Diagnosis – a Diagnosis of Invasive Cancer based on a microscopic study of fixed tissue or preparations from the blood systems. This type of Diagnosis must be done by a Physician who is a board certified pathologist and who Diagnosis of malignancy conforms to the standards set by the American College of Pathology.]

Physician - means a person, other than You, an Immediate Family Member, or a business associate of Yours, who is duly licensed and practicing medicine in the United States, and who is legally qualified to diagnose and treat a Critical Illness. The Physician must be providing services within the scope of his or her license and must be a board certified specialist where required under the Policy.

Pre-existing Condition - A disease or physical condition for which: (1) symptoms existed within the [3, 6] month period prior to the Effective Date of coverage that would cause a person to seek medical advice or treatment or; (2) medical advice or treatment was recommended or received from a member of the medical
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profession within the [3, 6,] month period prior to the Effective Date of the coverage.

Procedure - a medical Procedure involving an incision with instruments and performed to repair damage or arrest disease related to a Critical Illness in an Insured.

[**Stroke** – The death of brain tissue due to an acute cerebrovascular event. All of the following criteria must be satisfied:

1. Clinical evidence of infarction or brain tissue, or intracranial or subarachnoid hemorrhage;
2. Clear evidence on a CT, MRI or similar imaging technique that a stroke has occurred; and
3. Permanent neurologic deficit measured three months or more after the event that results in a score of two or higher on the Modified Rankin Scale for stroke outcome. Stroke does not include symptoms due to:
 - a) Transient ischemic attack,
 - b) Migraine;
 - c) Hypoxia
 - d) Traumatic injury to brain tissue or blood vessels; or
 - e) Vascular disease affecting the eye, optic nerve, or vestibular functions.]

TNM Classification - The classification standards for Invasive Cancer and Non-Invasive Cancer as developed by the American Joint Committee on Cancer.

PART IV. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:

1. be in an Eligible Class of the Policyholder, as defined in the Certificate Schedule; and
2. satisfy the Service Waiting Period, if any.

The Member's Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his or her spouse [or Domestic Partner] are in an Eligible Class of the Policyholder, each may enroll individually as the Insured or as a dependent of the other, but not as both. Any Eligible Dependent child may also only be enrolled by one parent. If the spouse [or Domestic Partner] carrying dependent coverage ceases to be eligible, dependent coverage automatically becomes effective under the other spouse's [or Domestic Partner's] coverage]. **OR** [enrollment will default to the Policyholder's rules.]

B. ENROLLMENT

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any, and provided satisfactory proof of insurability, if required, on a form provided by Us.

[Initial Enrollment: Members should enroll themselves and their Eligible Dependents within [31 days] of the Service Waiting Period.] [Individuals who enroll after this time are considered Late Entrants.]

[Guaranteed Issue: Members may enroll for up the Guaranteed Issue Basic Benefit Amount without providing evidence of insurability. If a Member enrolls for a Basic Benefit Amount in excess of the Guaranteed Issue Amount, he or she must provide satisfactory evidence of insurability using a form provided by us.]

[Open Enrollment: Members may enroll themselves and their Eligible Dependents during an Open Enrollment Period, subject to providing satisfactory evidence of insurability on a form provided by Us. Other changes may also be restricted to Open Enrollment periods.]

[Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.]

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within [31 days] of the event. A change in family status means any of the following events:

1. Marriage [or Domestic Partnership];
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART V. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

For You:

For Guaranteed Issue Basic Benefit Amounts, the later of:

1. The Policyholder's Effective Date, shown on the Certificate Schedule; or
2. The date You meet all the Eligibility and Enrollment requirements, subject to payment of premium when due.

[You must be Actively At Work on the date Your insurance becomes effective. (If the date that insurance was to go into effect is not a normally scheduled work day for You, You must have been Actively at Work on the last scheduled work day prior to the date insurance becomes effective under the Policy). If You are not so Actively at Work, Your insurance will be deferred until the date You are Actively at Work.]

[You must not be hospital confined on the date Your insurance would otherwise become effective. If You are hospital confined, Your insurance will be deferred until the date You are no longer confined.]

For Basic Benefits Amounts in excess of the Guaranteed Issue Amount, the additional coverage will be effective on the first of the month following the date We approve Your evidence of insurability, subject to payment of the premium due.

[For Your covered Dependents:

For Guaranteed Issue Basic Benefit Amounts, the later of:

1. The Policyholder's Effective Date, shown on the Certificate Schedule; or
2. The date Your insurance becomes effective, subject to payment of premium when due.

[The Dependent must not be hospital confined on the date his or her insurance would otherwise become effective. If he or she is hospital confined, such insurance will be deferred until the date he or she is no longer confined.]

For Basic Benefits Amounts in excess of the Guaranteed Issue Amount, additional coverage will be effective for a covered Dependent on the first of the month following the date We approve that person's evidence of insurability, subject to payment of the premium due.

For Eligible Dependents acquired after Your Effective Date of coverage, by reason of marriage, [Domestic Partnership,] birth or adoption, coverage is effective [[30] days after][on] [the date such dependent was acquired.][the date specified by the Policyholder.] Except for newborn children and adopted children, this is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Dependent [spouse] [or Domestic Partner] is covered from the moment of birth for 31 days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within 31 days of the birth in order to continue the coverage beyond the initial 31-day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within 60 days of the placement in order to continue the coverage beyond the initial 60-day period.]

[Benefit Changes: Once You have made Your benefit elections for a given year, You may not change the Basic Benefit Amount until the Policyholder's next Open Enrollment Period.

Increases in the Basic Benefit Amount are effective on the first of the month following the date We approve the evidence of insurability, provided You are [Actively at Work][not Hospital Confined] on the date the increased benefit would otherwise become effective. Decreases in the Basic Benefit Amount are effective on the first day of the month following the request.]

PART VI. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. The date the Policy terminates;
2. The last day of the month in which You are no longer an eligible Member;
3. [The date You are no longer Actively at Work];
4. [The date You attain age [65, 70, 75, 80]];
5. The date the maximum benefit is paid under the Policy; or
6. On any premium due date, if full payment for Your insurance is not made within 31 days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. The date he or she is no longer an Eligible Dependent;
2. The date We receive Your request to terminate Covered Dependent coverage. [This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.]

Termination shall be without prejudice to any claim originating prior to the Effective Date of such termination.

PART VII. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Certificate Schedule shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of 31 days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period. We may require payment of any pro-rata premium for the time the insurance was in effect during the Grace Period.

Right to Change Premiums: Premiums are guaranteed for [12,24] months starting on the Policy Effective Date. After the [first][second]policy anniversary, rates may be changed on any premium due date subject to advanced written notice of [45, 60] days. All changes in rates are subject to terms outlined in the Policy.

PART VIII. DESCRIPTION OF COVERAGE

BENEFIT:

{PLAN 1 OPTION – PER CRITICAL ILLNESS MAXIMUM PLAN}

We will pay the Percent of the Basic Benefit Amount shown in the Schedule of Benefits for:

1. A Critical Illness Diagnosis that is made after the Benefit Waiting Period; or
2. A Critical Illness Procedure that is performed after the Benefit Waiting Period.

Benefit Waiting Period: Benefits will not be paid for a Critical Illness:

1. If the First Ever Occurrence is during the Benefit Waiting Period; or
2. For which an Insured exhibits symptoms of a covered Critical Illness during the Benefit Waiting Period.

[If :

1. the date of Your First Ever Occurrence of a covered Critical Illness occurs during the Benefit Waiting Period; and
2. the Policy is a new program for the Policyholder and there is no Prior Plan,

You may return the certificate for a full premium refund and the coverage will be terminated.]

[If :

3. the date of an Insured's (other than Yourself)First Ever Occurrence of a covered Critical Illness occurs during the Benefit Waiting Period; and
4. the Policy is a new program for the Policyholder and there is no Prior Plan,

You may terminate the person's coverage under the certificate for a premium refund of that person's cost and his or her coverage will be terminated. You must notify Us in writing.]

[Survival Period: No benefit will be paid if the Insured dies within the [30] day period immediately following the First Ever Occurrence. The Insured must remain alive and exhibit symptoms of the Critical Illness throughout the [30] day survival period.]

[First Ever Occurrence*: We will pay the Percent of the Basic Benefit Amount shown in the Schedule of Benefits for each and every covered Critical Illness up to the Lifetime Benefit Maximum Payout if the following conditions are met:

1. With respect to [Cancer][Heart Attack] [End Stage Renal Failure][Stroke][Paralysis] [Occupational HIV][Blindness], the first time ever in an Insured Person's lifetime that he or she experiences such Critical Illness and he or she is diagnosed with such Critical Illness.
2. [With respect to Coronary Artery Bypass Graft, the first time ever in an Insured 's lifetime that he or she undergoes such Procedure.]
3. [With respect to [Major Organ Transplant][Heart Transplant], the first time ever in an Insured 's lifetime that he or she undergoes a [Major Organ Transplant][Heart Transplant].]
4. Benefits for a First Ever Occurrence are paid [one] time for each category of Critical Illness[except as paid under the Recurrence Benefit option].

If the Date of Diagnosis for two or more specified Critical Illnesses is the same day, We will pay for only one specified Critical Illness Benefits. We will pay the larger benefit.

* The reference to First Ever Occurrence is subject to the Pre-existing Conditions provision.

[Additional Occurrence Benefit: If an Insured received benefits under the First Ever Occurrence for a Critical Illness, he or she will receive benefits for a First Ever Occurrence of a different Critical Illness as long as the Date of Diagnosis or Procedure for each Critical Illness is separated by at least [6,12,18,24] consecutive months. We will pay the Percent of the Basic Benefit Amount shown in the Schedule of Benefits

[Recurrence Benefit

If a benefit is paid for a First Ever Occurrence of a Critical Illness, the Insured has not exhibited symptoms or received care and treatment for that same Critical Illness for at least [6, 12, 18, 24] consecutive months since the First Ever Occurrence and the Insured is re-diagnosed for the same Critical Illness, We will pay a Recurrence Benefit as follows:

1. With respect to [Heart Attack] [End Stage Renal Failure][Stroke][Paralysis], the second time ever in an Insured's lifetime that: (a) he or she experiences such Critical Illness; and (b) he or she is diagnosed with such Critical Illness.
2. With respect to [Major Organ Transplant][Heart Transplant], the second time ever in an Insured's lifetime that he or she or she undergoes a [Major Organ Transplant][Heart Transplant].

Care and treatment does not include preventive medications in the absence of a sickness or disease or routine scheduled follow up visits to a Physician.

The Recurrence Benefit is shown in the Schedule of Benefits. Benefits are not paid for a [recurrence of Cancer] [Coronary Artery Bypass Graft] [Occupational HIV][Blindness].]

Maximum Total Percent of Basic Benefit: Within each category, the most We will pay for the First Ever Occurrence Benefit, [all Additional Occurrence Benefits], [and all Recurrence Benefits] combined is the Maximum Total Percent of Basic Benefit shown in the Schedule.

Lifetime Benefit Maximum Payout: The Lifetime Benefit Maximum Payout is shown in the Schedule of Benefits. Once the Maximum Total Percent of Basic Benefit Amount is has been met for each category of Critical Illness individually or the Lifetime Benefit Maximum Payout is met for an Insured , if earlier, no additional benefits are payable for that Insured . If the Insured is You, the coverage will terminate for You and Your covered Dependents.

[Wellness Benefit

We will pay this benefit if You [or Your Insured][Spouse][Insured Domestic Partner] have has one of the following screening tests performed [after the Benefit Waiting Period and] while coverage under this certificate is in force. We will pay the amount shown in the Schedule of Benefits for one of the following screening tests. Payment of this benefit will not reduce the Benefit Amount Payable for a Critical Illness. This benefit is payable only once for one test per Plan Year for You [or Your Covered [Spouse][Domestic Partner].

Screening test is defined as:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (cancer antigen 15-3 - blood test for breast cancer)
- CA125 (cancer antigen 125 - blood test for ovarian cancer)
- CEA (carcinoembryonic antigen - blood test for colon cancer)

- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- ThinPrep Pap Test
- Virtual Colonoscopy
- [H1N1] vaccination *{carrier may add other vaccines as deemed appropriate }*

{PLAN 2 OPTION – COMBINED CRITICAL ILLNESS MAXIMUM PLAN}

We will pay the Percent of the Basic Benefit Amount shown in the Schedule of Benefits for:

1. A Critical Illness Diagnosis that is made after the Benefit Waiting Period; or
2. Critical Illness Procedure that is performed after the Benefit Waiting Period.

Benefit Waiting Period: Benefits will not be paid for a Critical Illness:

1. If the First Ever Occurrence is during the Benefit Waiting Period; or
2. For which an Insured exhibits symptoms of a covered Critical Illness during the Benefit Waiting Period.

[If :

1. The date of Your First Ever Occurrence of a covered Critical Illness occurs during the Benefit Waiting Period; and
2. The Policy is a new program for the Policyholder and there is no Prior Plan,

You may return the certificate for a full premium refund and the coverage will be terminated.]

[If :

1. the date of an Insured's (other than Yourself) First Ever Occurrence of a covered Critical Illness occurs during the Benefit Waiting Period; and
2. the Policy is a new program for the Policyholder and there is no Prior Plan,

You may terminate the person's coverage under the certificate for a premium refund of that person's cost and his or her coverage will be terminated. You must notify Us in writing.]

[Survival Period: No benefit will be paid if the Insured dies within the [30] day period immediately following the First Ever Occurrence. The Insured must remain alive and exhibit symptoms of the Critical Illness throughout the [30] day survival period.]

[First Ever Occurrence*: We will pay the Percent of the Basic Benefit Amount shown in the Schedule of Benefits for each and every covered Critical Illness up to the Lifetime Benefit Maximum Payout if the following conditions are met:

1. With respect to [Cancer][Heart Attack] [End Stage Renal Failure][Stroke][Paralysis] [Occupational HIV][Blindness], the first time ever in an Insured Person's lifetime that he or she experiences such Critical Illness and he or she is diagnosed with such Critical Illness.
2. [With respect to Coronary Artery Bypass Graft, the first time ever in an Insured's lifetime that he or she undergoes such Procedure.]
3. [With respect to [Major Organ Transplant][Heart Transplant], the first time ever in an Insured 's lifetime that he or she undergoes a [Major Organ Transplant][Heart Transplant].]

4. Benefits for a First Ever Occurrence are paid [one] time for each category of Critical Illness [except as paid under the Recurrence Benefit option].

If the Date of Diagnosis for two or more specified Critical Illnesses is the same day, We will pay for only one specified Critical Illness Benefits. We will pay the larger benefit.

* The reference to First Ever Occurrence is subject to the Pre-existing Conditions provision.

[Additional Occurrence Benefit: If an Insured received benefits under the First Ever Occurrence for a Critical Illness, he or she may receive benefits for a First Ever Occurrence of a different Critical Illness as long as the Date of Diagnosis or Procedure for each Critical Illness is separated by at least [6,12,18,24] consecutive months. Benefits are payable up to the Lifetime Benefit Maximum Payout as shown in the Schedule of Benefits.]

[Recurrence Benefit

If a benefit is paid for a First Ever Occurrence of a Critical Illness, the Insured has not exhibited symptoms or received care and treatment for that same Critical Illness for at least [6, 12, 28, 24] consecutive months since the First Ever Occurrence and the Insured is re-diagnosed for the same Critical Illness, We will pay a Recurrence Benefit as follows:

1. With respect to [Heart Attack] [End Stage Renal Failure][Stroke][Paralysis], the second time ever in an Insured 's lifetime that: (a) he or she experiences such Critical Illness; and (b) he or she is diagnosed with such Critical Illness.
2. With respect to [Major Organ Transplant][Heart Transplant], the second time ever in an Insured 's lifetime that he or she or she undergoes a [Major Organ Transplant][Heart Transplant].

Care and treatment does not include preventive medications in the absence of a sickness or disease or routine scheduled follow up visits to a Physician.

The Recurrence Benefit is shown in the Schedule of Benefits. Benefits are not paid for a [recurrence of Cancer] [Coronary Artery Bypass Graft] [Occupational HIV][Blindness].]

Lifetime Benefit Maximum Payout: The Lifetime Benefit Maximum Payout is shown in the Schedule of Benefits. Once its has been met for an Insured , no additional benefits are payable for that Insured . If the Insured is You, the coverage will terminate for You and Your covered Dependents.

[Wellness Benefit

We will pay this benefit if You [or Your Insured[Spouse][Insured Domestic Partner] has one of the following screening tests performed [after the Benefit Waiting Period and] while coverage under this certificate is in force. We will pay the amount shown in the Schedule of Benefits for one of the following screening tests. Payment of this benefit will not reduce the Benefit Amount Payable for a Critical Illness. This benefit is payable once per calendar year for each Insured .

Screening test is defined as:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (cancer antigen 15-3 - blood test for breast cancer)
- CA125 (cancer antigen 125 - blood test for ovarian cancer)

- CEA (carcinoembryonic antigen - blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography
- ThinPrep Pap Test
- Virtual Colonoscopy
- [H1N1] vaccination] *{carrier may add other vaccines as deemed appropriate }*

PART IX. LIMITATIONS AND EXCLUSIONS

This plan will not pay benefits for any Critical Illness:

1. caused by, contributed by or resulting from:
 - a. Intentional self-inflicted injuries;
 - b. A Pre-existing Condition, as described below;
 - c. Injury incurred while engaging in an illegal occupation or committing / attempting to commit a felony, participation in a riot or insurrection;
 - d. Suicide or attempted suicide, whether sane or insane;
 - e. Injury sustained while under the influence of alcohol or any narcotic;
 - f. Participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft;
 - g. Engaging in any illegal activity;
 - h. Serving in the armed forces or any auxiliary unit of the armed forces of any country; or
 - i. Act of war, whether or not declared, participation in a riot, insurrection or rebellion.
2. For which Diagnosis is made outside the United States, unless the Diagnosis is confirmed in the United States. In that case, the Critical Illness will be deemed to occur on the date the Diagnosis was made outside the United States.
3. That is caused by the Insured's voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (a) it was prescribed for him or her by a Physician, and (b) it was used as prescribed. In the case of a non-prescription drug, the Policy does not pay for any Critical Illness resulting from or contributed to by the Insured's use in a manner inconsistent with package instructions. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time
4. That is caused by, contributed to by, or results from an Insured 's involvement in an incident where he or she is legally intoxicated at the time of the incident. This includes, but is not limited to, his or her or her operation of a motor vehicle. "Legally intoxicated" means that the Insured 's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.
5. Unless it is diagnosed while the Insured is alive.
6. For which proof is submitted by a Physician who is an Immediate Family Member or business associate.

[This Policy will not pay benefits for any Diagnosis of Invasive Cancer for:

1. any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
2. any papillary tumor of the bladder classified as Ta under TNM Classification;

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3. any tumor of the prostate classified as T1N0M0 under TNM Classification;
4. any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Classification and is
5. one centimeter or less in diameter, unless there is metastasis;
6. any tumor in the presence of human immuno-deficiency virus;
7. any non-melanoma skin cancer, unless there is metastasis;
8. any malignant tumor classified as less than T1N0M0 under TNM Classification; or
9. Chronic Lymphocytic Leukemia (CLL), less than Stage III, as defined by RAI classification.

[This Policy will not pay benefits for any Diagnosis of Non-Invasive Carcinoma in Situ Cancer for:

1. any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
2. any papillary tumor of the bladder classified as Ta under TNM Classification;
3. any tumor of the prostate classified as T1N0M0 under TNM Classification;
4. any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Classification and is one centimeter or less in diameter, unless there is metastasis;
5. any tumor in the presence of human immuno-deficiency virus;
6. any non-melanoma skin cancer; or
7. any melanoma in situ classified as TisN0M0 under TNM Classification.]

[This Policy will not pay benefits for any Coronary Artery Bypass Graft performed outside of the United States.]

[This Policy will not pay benefits for a Major Organ Transplant:

1. involving organs other than:
 - a. bone marrow solely for treatment of cancer or bone marrow failure; or
 - b. an entire kidney, liver, heart, lung, or pancreas;
2. involving transplants of parts of organs, tissues or cells;
3. involving organs transplanted from the same Insured ;
4. performed outside the United States;
5. involving organs received from non-human donors;
6. involving implantation of mechanical devices or mechanical organs;
7. involving stem cell generated transplants (other than for a bone marrow transplant);
8. involving islet cell transplants; or
9. involving bone marrow transplanted from the same Insured .]

Pre-existing Condition Limitation

No benefits are payable for a Pre-existing Condition, except as follows:

[If the Policy replaces a Prior Policy, We will pay for an Pre-existing Condition if the Insured is insured under the Policy on its Effective Date and was covered under the Prior Policy on the date the Prior Policy terminated as follows:

1. The Insured must satisfy the Pre-existing Condition provision under the Policy; or
2. The Insured must have satisfied the Pre-existing Conditions provision under the Prior Plan, if benefits would otherwise have been paid had the Prior Plan remained in force, if earlier.]

A condition will no longer be considered a Pre-existing Condition after the Insured's coverage under the Policy has been in effect for [6, 12] consecutive months.

PART X. GENERAL PROVISIONS

A. Notice of Claim

Written notice of claim must be given to Us within 20 days after the loss starts or as soon as reasonably possible. Notice should be sent to Our Administrator at the following address:

[National Guardian Life Insurance Company
c/o AlwaysCare Benefits, Inc., 8485 Goodwood Boulevard, Baton Rouge, LA 70806-7878

B. Claim Forms

When the Administrator receives notice of Claim that does not contain all necessary information, forms for filing proof of loss will be sent to You along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, You will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss within the time stated in the Proof of Loss provision.

C. Proof Of Loss

Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

D. Payment Of Claims

Benefits will be paid within 30 days after our Administrator receives written proof of loss. Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

E. Time of Payment of Claims

Benefits payable under this Policy will be paid immediately upon Our receipt of written proof of loss.

F. Legal Actions

No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.

G. Physical Examination and Autopsy

While a claim is pending We have the right at Our expense:

1. to have the person who has a loss examined by a Physician when and as often as We feel is necessary; and
2. to make an autopsy in case of death where it is not forbidden by law.

H. Assignment

We will recognize any assignment made by the Insured under the Policy provided it is duly executed and a copy is on file with Us. We and the Policyholder assume no responsibility for the validity or effect of an assignment.

I. Time Limit on Certain Defenses

After two years from the date on which a person becomes covered under the Policy, no statements, except fraudulent misstatements made by the Insured in the application for coverage, shall be used to void the Policy or deny a claim. No statement by an Insured concerning his or her insurability will be used by Us to deny liability unless:

1. it is stated on a written application signed by the Insured or his or her personal representative; and
2. a copy of such application is given to such Insured or personal representative.

Any increase in coverage, as requested by application from You, shall begin a new two year contestable period for the amount of the increase from the Effective Date of such coverage.

J. Fraudulent Misstatement

If an Insured makes a fraudulent misstatement in the application for coverage under the Policy, We may reduce or deny any claim or void the Policy at any time.

K. Misstatement of Age

If the age of an Insured has been misstated, We will make an equitable adjustment of the premium and benefits. The premium will be the difference between the premiums paid and the premiums that would have been paid at Your true age. If coverage would not have been issued, We will refund the premiums paid for such insurance and terminate the insurance, if no benefits have been paid. Benefits payable will be based on the correct age and premium paid.

[PART XII. PORTABILITY

If Your insurance under the Policy terminates for any of the reasons described below, You may port the insurance provided under this certificate. You must have been insured under the Policy [or the one it replaces] for Critical Illness Insurance coverage for at least [12 consecutive months] prior to the date Your coverage under the Policy ends.

You may port Your Critical Illness Insurance coverage [and dependent Critical Illness Insurance coverage,] subject to the following terms:

1. You may port Your coverage [or coverage for any of Your dependents] if coverage under the Policy ends because You:
 - a) have terminated [employment][membership]; or
 - b) stop being a member of an eligible class of people; or
 - c) the Policy ends.
2. You may not port Your coverage [or coverage for any of Your dependents] if:
 - a) coverage ends due to failure to pay any required premiums; or
 - b) You have reached age [65,70, 75, 80] on or before the date Your coverage under the Policy ends; or
 - c) the Policy ends.
3. You may port Your Critical Illness Benefits that were in effect on the date Your insurance under this certificate terminates [, subject to any benefit amount reductions based on age,] less the amount of any Critical Illness benefits paid by the Policy . [You may port Your dependents' Critical Illness Benefits that were in effect on the date Your insurance under this certificate terminates [, subject to any benefit amount reductions based on the Your age,] less the amount of any critical illness benefit paid by the Policy on behalf of each dependent.
4. You may port:
 - a) Your coverage only;
 - b) Your coverage and coverage of Your spouse [or Domestic Partner];
 - c) Your coverage and coverage of all of Your dependents; or
 - d) if You are a single parent, Your coverage and coverage for all of Your dependent children.

No other combinations will be allowed. To be eligible to port, a dependent must be covered under the Policy on the day Your coverage under the Policy ends.

If You die while insured for Dependent Critical Illness Insurance coverage, Your spouse [or Domestic Partner] may port the coverage of Your dependents as described above. However, the spouse [or Domestic Partner] and dependents

must be covered under the Policy on Your date of death. No dependents will be allowed to port if: (a) there is no surviving spouse [or Domestic Partner]; or (b) the surviving spouse [or Domestic Partner] has reached age [65, 70, 75, 80] on the date You die.

You [or surviving spouse [or Domestic Partner]] will receive a portable certificate of coverage under a program that We usually use for the portability option. The certificate provides group Critical Illness Coverage. The benefits provided by the portable certificate of coverage will be substantially similar to the benefits of this group plan. [However, each Insured 's coverage under the portable certificate of coverage ends when You reach age [65,70,75,80]

The premium will be based on: (a) Your [and/or dependent's] rate class under the Policy; and (b) Your [or surviving spouse [or Domestic Partner]'s] age bracket and will be shown in the Critical Illness Portability Coverage Premium Notice.]

[PART XIII: REPLACEMENT OF EXISTING COVERAGE]

This provision applies when the Policy replaces coverage the Policyholder previously obtained through another plan or policy, herein called the Prior Plan.

In the absence of this provision, an Member who was covered by the Prior Plan at the date of discontinuance might not qualify for coverage under this Policy because the person is [not Actively at Work][or is confined in a hospital.]

Each such person will be insured under this Policy if:

1. the person was insured under the Prior Plan, including coverage under the Prior Plan's extension of benefits provision, on the date the Policyholder's coverage with the Prior Plan ended;
2. the Prior Plan covered more than [fifteen (15)]Members; and
3. the person is a Member of an Eligible Class under the Policy.

The Service Waiting Period and Benefit Waiting Period will be waived for any Member who was covered under the Prior Plan on the date such Prior Plan terminated.

The benefits payable for the persons described above will be the benefits of the Policy less any amount payable under the Prior Plan pursuant to any extension of benefits provision.]



Administered by:

Enrollment Form for Group Insurance

Underwritten by: National Guardian Life Insurance Company
 Administered by: AlwaysCare Benefits, Inc. (a Stamount Life Insurance company)
 [P.O. Box 98100 Baton Rouge, LA 70898-9100, (225)926-2888 or 1-888-729-5433]

1. MEMBER INFORMATION **A: Add (enroll) T: Terminate C: Change (change of name or coverage)**

[Group/Policyholder] Name		Group Number	Location		Effective Date	
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (Member or subscriber)	First Name	M.I.	Date of Birth	Social Security Number
Home Street Address		City/State/Zip	Home Phone	Work Phone	Cell Phone	
Email:						

[COMPLETED BY EMPLOYER]

[Date of Hire]	<input type="checkbox"/> Full time <input type="checkbox"/> Part time If part time: Hrs worked per week: _____	[Occupation]	[Class]
[Salary \$: _____ <input type="checkbox"/> Yearly <input type="checkbox"/> monthly <input type="checkbox"/> bi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly <input type="checkbox"/> hourly]			

2. FAMILY INFORMATION (Only those eligible may be enrolled. Use additional paper if needed) (Relationship – If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.)

	Gender	Relationship	Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)	
<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Husband <input type="checkbox"/> Wife	(Spouse)				
<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	(Dependent)				Unmarried child/ FT student/handicapped? Yes No
<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	(Dependent)				Yes No
<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____	(Dependent)				Yes No

3. BENEFIT ELECTIONS ([Employer][Association] determines benefits available for election):

[Dental]	[Member Only] <input type="checkbox"/>	[Member & Spouse] <input type="checkbox"/>	[Member & Child(ren)] <input type="checkbox"/>	[Member & Family] <input type="checkbox"/>	[Waive] <input type="checkbox"/>	[Mode Premium] \$ _____
[Vision]	[Member Only] <input type="checkbox"/>	[Member & Spouse] <input type="checkbox"/>	[Member & Child(ren)] <input type="checkbox"/>	[Member & Family] <input type="checkbox"/>	[Waive] <input type="checkbox"/>	[Mode Premium] \$ _____
[Basic Life / AD&D]	[Member:] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Mode Premium \$ _____]	[Spouse:] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Mode Premium \$ _____]	[Child(ren):] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Mode Premium \$ _____]			
[Supplemental/ Voluntary Term Life/ AD&D]	[Member:] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Benefit Amount \$ _____ or ____ X annual salary] [Mode Premium \$ _____]	[Spouse:] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Benefit Amount \$ _____] [Mode Premium \$ _____]	[Child(ren)] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Benefit Amount \$ _____] [Mode Premium \$ _____]			
[Critical Illness]	[Member:] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Benefit Amount \$ _____] [If Buy-up available: <input type="checkbox"/> Elect <input type="checkbox"/> Waive]	[Spouse:] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Benefit Amount \$ _____]	[Child(ren)] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Benefit Amount \$ _____]	[Mode Premium] \$ _____		

3. BENEFIT ELECTIONS CONTINUED ((Employer)[Association] determines benefits available for election):

[Accident]	[Member:] <input type="checkbox"/> Elect <input type="checkbox"/> Waive [Benefit Amount \$ _____] [If Buy-up available: <input type="checkbox"/> Elect <input type="checkbox"/> Waive]	[Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Waive] [Benefit Amount \$ _____]	[Child(ren) <input type="checkbox"/> Elect <input type="checkbox"/> Waive] [Benefit Amount \$ _____]	[Mode Premium] \$
[Short Term Disability]	<input type="checkbox"/> Elect <input type="checkbox"/> Waive	If Buy-up available: <input type="checkbox"/> Elect <input type="checkbox"/> Waive	Total Mode Premium \$	
[Long Term Disability]	<input type="checkbox"/> Elect <input type="checkbox"/> Waive	If Buy-up available: <input type="checkbox"/> Elect <input type="checkbox"/> Waive	Total Mode Premium \$	

4. BENEFICIARY INFORMATION (Complete ONLY for Life/AD&D):

[Primary Beneficiary:]	[Relationship:]	[Date of Birth:]
[Contingent Beneficiary:]	[Relationship:]	[Date of Birth:]

5. The following questions should ONLY be completed if applying for Critical Illness coverage

	[Member]		[Spouse]		[Child]	
	Yes	No	Yes	No	Yes	No
[a. Has any person to be insured used tobacco products in any form during the previous 12 months?]	<input type="checkbox"/>					
[b. Has any person[ever][in the past [2,5,7,10 years]] tested positive for exposure to HIV infection or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex caused by the HIV infection or other sickness or condition derived from such infection?]	<input type="checkbox"/>					
[c. Has any person[ever had,][in the past [2,5,7,10 years]] been treated for, or been told by a member of the medical profession that he or 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"/>					
[e. Is any person now being treated for, or [ever] [in the past [2,5,7,10 years] 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"/>					
[f. Is any person currently undergoing any diagnostic test for, now being treated for, or [ever] [in the past [2,5,7,10 years] been treated for cancer (except basal cell skin cancer) or any malignancy, which includes: carcinoma; Hodgkin's disease; leukemia; lymphoma; or any malignant tumor?]	<input type="checkbox"/>					
[If includes coverage for Alzheimer's] [g. Has any person [ever] [in the past [2,5,7,10 years], had, been treated for, or been told by a member of the medical profession that he or she has: Alzheimer's, Senility, Dementia or organic brain disease?]	<input type="checkbox"/>					
[If includes coverage for blindness] [h. Has any person [ever] [in the past [2,5,7,10 years] had, been treated for, or been told by a member of the medical profession that he or she has: Glaucoma; retinitis pigmentosa; Macular Degenerations; optic neuritis?]	<input type="checkbox"/>					
[If includes coverage for Children] [If Answer Yes for any child please indicate Child's name?]						

STATEMENTS AND AGREEMENTS:

- My dependents are not eligible for coverages I don't have. [If I refuse dental or vision coverage, I and/or my dependents may enroll later but this will affect the level of benefits.] [If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health.] If I refuse coverage, I cannot enroll after retirement. If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution: [(1) I authorize my employer to deduct from my pay; and (2)] I understand that no insurance is in force until the first premium is paid.
- I represent all information on this form and attachments are complete and true to the best of my knowledge. They are part of this request for coverage.
- I agree National Guardian Life Insurance Company is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date. Any person who knowingly presents a false or fraudulent claim for payment of a 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.
- I authorize National Guardian Life Insurance Company to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date of signature. I may revoke authorization for information not yet obtained. I understand data obtained will be used by National Guardian Life Insurance Company for claims administration and determining eligibility for life and disability insurance. Information will not be used for any purpose prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers from myself and/or my dependents will be used by National Guardian Life Insurance Company only as allowed by law.
- [NOTE for Dental: Coverage for a Late Entrant or Re-enrollee will be limited to those procedures listed under Coverage A in the Schedule of Covered Procedures during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date.]
- [NOTE for Vision: Coverage for a Late Entrant or Re-enrollee will be limited to the Vision Examination benefit in the Benefits Summary during the first 24 months after the Late Entrant's or Re-enrollee's Effective Date. These limited coverages also apply to the Late Entrant's or Re-enrollee's Dependents, if enrolled.]

In the past 12 months, have you had continuous group coverage providing like or similar benefits (for yourself and/or your dependents) with a prior carrier?
 Yes No

If yes, please provide: Policyholder _____ and Insurance Company _____

Important! If declining any coverage for yourself or any dependent, give reason. Covered under: Spouse's group coverage
 Individual insurance other coverage offered by my [employer][association] other _____

[AUTHORIZATION AND AGREEMENT: I hereby declare that all the statements made in this application are, to the best of my knowledge and belief, true and complete, and that they are the basis on which insurance requested by me may be issued. I understand that coverage will not become effective until NATIONAL GUARDIAN LIFE INSURANCE COMPANY grants its underwriting approval if required. I understand that there is no coverage for a Pre-existing Condition except as described in the Certificate of Insurance.

I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, or other medically related facility, insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, [or that of any member of my family whose name appears in the application to which this is attached,] to give NATIONAL GUARDIAN LIFE INSURANCE COMPANY and its affiliates or authorized representative any such information. This information will be used to determine eligibility for insurance. I understand that I may revoke this authorization at any time by sending a written revocation to NATIONAL GUARDIAN LIFE INSURANCE COMPANY at the address above. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right NATIONAL GUARDIAN LIFE INSURANCE COMPANY has to contest an insurance policy / certificate, or to contest a claim under an insurance policy / certificate. I understand that if I revoke this authorization, NATIONAL GUARDIAN LIFE INSURANCE COMPANY may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement. I understand that once this information is received by the authorized person/organization, then this information may be subject to redisclosure, and may no longer be protected by federal privacy laws. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation. I also certify that the producer and I, if applicable, also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Information Practices Notice.]

I declare that the information I have completed on this enrollment form is complete and true. I have read and understand the statements and understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from National Guardian Life Insurance Company.

Your Signature: x _____ Date signed _____

[Spouse's Signature: x _____ Date signed _____]

A copy of this form will be as valid as the original. After this form is completed and signed, make one copy for the Policyholder and a copy of page one only for the Member.



Administered by:

AlwaysCare

Evidence of Insurability Form CRITICAL ILLNESS INSURANCE

Underwritten by National Guardian Life Insurance Company
[Administered by: AlwaysCare Benefits, Inc. (a Starmount Life Insurance company)
8485 Goodwood Boulevard Baton Rouge, LA 70806-7878
1-888-729-5433, Ext 2013 (in Baton Rouge, call 926-2888)]

Name of [Employer]Policyholder: _____

Please complete this form for each proposed Insured Person and submit it with the Enrollment Form to Your [Employer][Association].

Name of Proposed Insured: _____

Name of Member, if different: _____

Member's Phone Number: _____ Member's Email Address: _____

Health Questions:

Part A: For an Eligible Person who applies for a Basic Benefit Amount in excess of the Guaranteed Issue amount up to and including [\$25,000], please answer the following questions:

1. Have you [ever][in the past 2,5,7,10 years] been treated for or counseled for alcohol or drug abuse?
 Yes No
2. Have you [ever][in the past 2,5,7,10 years] had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time? Yes No

Part B: If an Eligible Person applies for a Basic Benefit Amount in excess of [\$25,001], please also answer the following questions:

1. Are You currently taking any prescribed medication? If yes, please provide details in the space provided below. Yes No
2. Have You[ever][in the past 2,5,7,10 years] been diagnosed with hypertension or high blood pressure? If yes, please provide details in the space provided below. Yes No
3. Have You [ever][in the past 2,5,7,10 years] or any two or more of either Your natural parents or natural siblings been diagnosed with the same disease before age 60, based on the following list: heart disease, stroke; diabetes; cancer; kidney disease; or multiple sclerosis? If yes, please provide details in the space provided below. Yes No
4. Have You [ever][in the past 2,5,7,10 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 listed here? Yes No
5. Please provide Your height and weight: _____
6. Have You been absent from work for more than 10 consecutive days due to illness or injury in the past 12 months? If yes, please provide details in the space provided below. Yes No
7. Have You ever been declined for Critical Illness insurance coverage? If yes, please provide details in the space provided below. Yes No
8. Please indicate the names and addresses of all physicians for each person to be insured in the space provided below.

If You answered "Yes" to the questions above, please explain fully in the chart below. Should You require additional space, please use a separate sheet of paper and attach it to this form.

Question #	Condition/Prognosis	Date Occurred	Duration	Names, Addresses And Phone Numbers of Hospitals, Physicians or Clinics Consulted

AGREEMENT AND AUTHORIZATION

I hereby declare that all the statements made in this application are, to the best of my knowledge and belief, true and complete, and that they are the basis on which insurance requested by me may be issued. I understand that coverage will not become effective until NATIONAL GUARDIAN LIFE INSURANCE COMPANY grants its underwriting approval if required. I understand that there is no coverage for a Pre-existing Condition except as described in the Certificate of Insurance.

I hereby authorize any licensed physician, psychologist, medical practitioner, hospital, clinic, or other medically related facility, insurance company or its reinsurer, the Medical Information Bureau (MIB), or other organization, institution, or person that has any records or knowledge of me or my physical or mental health, drug or alcohol use history, other insurance coverage or employment status, [or that of any member of my family whose name appears in the application to which this is attached,] to give NATIONAL GUARDIAN LIFE INSURANCE COMPANY and its affiliates or authorized representative any such information. This information will be used to determine eligibility for insurance. I understand that I may revoke this authorization at any time by sending a written revocation to NATIONAL GUARDIAN LIFE INSURANCE COMPANY at the address below. Such revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right NATIONAL GUARDIAN LIFE INSURANCE COMPANY has to contest an insurance policy / certificate, or to contest a claim under an insurance policy / certificate. I understand that if I revoke this authorization, NATIONAL GUARDIAN LIFE INSURANCE COMPANY may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement. I understand that once this information is received by the authorized person/organization, then this information may be subject to redisclosure, and may no longer be protected by federal privacy laws. I agree that a photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I or a person authorized to act on my behalf is entitled to receive a copy of this authorization form and that I may cancel this Authorization at any time by notifying the company in writing, subject to the rights of any individual who acted in reliance on this Authorization prior to my notice of revocation. I also certify that the producer and I, if applicable, also certify that I have read, or have had read to me, this completed application and that I realize any false statements or misrepresentation in it may result in loss of coverage under the policy. I certify that I have received the Information Practices Notice.

Signature of Proposed Insured: _____ Date: _____

Signature of Member, if Proposed Insured is a minor: _____

SERFF Tracking Number: CLTR-126438315 State: Arkansas
 Filing Company: National Guardian Life Insurance Company State Tracking Number: 45093
 Company Tracking Number: NCI POL 2/10 AR
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness/Specified Disease
 Project Name/Number: Specified Disease Filing/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: CI Readability Certification.pdf	Approved-Closed	03/08/2010

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: APPLICATION BEING FILED FOR APPROVAL - ATTACHED TO FORMS LIST Comments:	Approved-Closed	03/08/2010

	Item Status:	Status Date:
Satisfied - Item: AR CERTIFICATION AND AUTHORIZATION TO FILE Comments: Attachments: NGL CI and Accident Authorization Letter.pdf AR Rule Reg 19 49 Certification.pdf	Approved-Closed	03/08/2010

	Item Status:	Status Date:
Satisfied - Item: GENERAL USE COMPLAINT NOTICE Comments: Attachment: AR Consumer Information Notice.pdf	Approved-Closed	03/08/2010



CERTIFICATION OF COMPLIANCE
FOR
READABILITY

<u>Form Number(s)</u>	<u>Form Name</u>	<u>Flesch Readability Score</u>
NCI POL 2/10	Group Policy	50.4
NCI CERT 2/10	Group Certificate	50.6
NGRPAPP 02/10	Group Application	39.1*
NEnroll 02/10	Enrollment Form	45.0
CI Eofl 2/10	Evidence Form	47.9

I hereby certify on behalf of National Guardian Life Insurance Company that the Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores. I further certify that in my judgment, the enclosed forms are readable under the rules and standards of your State.

* when group application and policy scored together, comply with readability requirements

Signature: Mathew J. Dew

Typed Name and Title: Mathew Dew, Vice President and General Counsel

Date: February 22, 2010



NGL Insurance Group

*Mathew J. Dew
Vice President & General Counsel
(800) 626-7931, ext 5253
FAX (608) 443-5153
mjdew@nglic.com*

DATE: February 19, 2010

TO: State Insurance Departments

RE: Policy Filings – Group Critical Illness and Group Accident Insurance Policy

To Whom It May Concern:

National Guardian Life Insurance Company has engaged the services of Coulter & Associates to assist with its form filings. I hereby authorize Coulter & Associates, to represent National Guardian Life Insurance Company in regard to its Group Critical Illness and Group Accident filings in your state.

Very truly ours

Mathew J. Dew
Vice President and General Counsel

MJD/c



A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 800-988-0826

CONSUMER INFORMATION NOTICE

Policyholder Service Office of Company

Address: AlwaysCare Benefits, Inc.
7800 Office Park Blvd
PO Drawer 80139
Baton Rouge, LA 70898-9100

Telephone Number: 1-888-729-5433

Agent (to be completed at time of application)

Name of Agent _____

Address _____

Telephone Number _____

If we at National Guardian Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Divisions
1200 West Third Street
Little Rock, Arkansas 72201-1904
Phone: (501) 371-2640