

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
Filing Company: USAbLe Life State Tracking Number: 49795
Company Tracking Number: AR001460100001
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Hospital Indemnity, HIP2-R
Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Filing at a Glance

Company: USAbLe Life

Product Name: Hospital Indemnity, HIP2-R SERFF Tr Num: LSVX-G127566147 State: Arkansas

TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved State Tr Num: 49795
Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: AR001460100001 State Status: Approved-Closed
Filing Type: Form/Rate Reviewer(s): Donna Lambert

Author: SPI Life and Specialty Ventures
Disposition Date: 10/20/2011

Date Submitted: 09/15/2011 Disposition Status: Approved
Implementation Date: 11/21/2011

Implementation Date Requested: 09/15/2011

State Filing Description:

General Information

Project Name: Hospital Indemnity, HIP2-R
Project Number: AR001460100001
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/20/2011
State Status Changed: 10/20/2011
Created By: SPI Life and Specialty Ventures
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI Life and Specialty Ventures

Filing Description:

We are enclosing for your review and approval an Individual Hospital Confinement Indemnity Policy, applications, and the miscellaneous riders which will be used with this policy. These forms are new and do not replace any forms previously approved by your department. This policy has been designed with additional benefits being optional riders. The base policy and riders have been priced by unit to make this policy very versatile to sell. This policy will be marketed to individuals by contracted agents and brokers.

The forms have been tested for readability and the certification is enclosed for your review. We have also enclosed an actuarial memorandum prepared by an actuary.

Forms that are approved and will also be used with this product are:

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
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 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

CONV-APP (12-01) - Conversion Application - 12/19/2001
 APP-NOTICE (9-08) - Notice to Proposed Insured - 10/23/2008
 END (9-96) - Endorsement for Accident & Health - 10/15/1996
 IND-CHG (8-00) - Request for Change & Request for Duplicate Policy - 08/04/2000

USable Life reserves the right to change the type style, paper size, and logo, or to issue the forms in electronic format. We also reserve the right to change our address or officers' signatures as necessary.

The applications may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document, but we assure that its content will not change and its readability compliance will not be affected. Also, at some point, we anticipate utilizing electronic signatures in a form compliant with your state's laws and regulations.

Company and Contact

Filing Contact Information

Rae Lynn Boehm, Regulatory Resource Analyst rboehm@usablelife.com
 PO Box 1650 501-375-7200 [Phone] 8932 [Ext]
 Little Rock, AR 72203-1650 501-235-8484 [FAX]

Filing Company Information

USable Life CoCode: 94358 State of Domicile: Arkansas
 PO Box 1650 Group Code: 876 Company Type: Life & Health
 Little Rock, AR 72203-1650 Group Name: Life and Speciality State ID Number:
 Ventures (LSV)
 (501) 375-7200 ext. [Phone] FEIN Number: 71-0505232

Filing Fees

Fee Required? Yes
 Fee Amount: \$700.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
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<i>SERFF Tracking Number:</i>	<i>LSVX-G127566147</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>USable Life</i>	<i>State Tracking Number:</i>	<i>49795</i>
<i>Company Tracking Number:</i>	<i>AR001460100001</i>		
<i>TOI:</i>	<i>H14I Individual Health - Hospital Indemnity</i>	<i>Sub-TOI:</i>	<i>H14I.000 Health - Hospital Indemnity</i>
<i>Product Name:</i>	<i>Hospital Indemnity, HIP2-R</i>		
<i>Project Name/Number:</i>	<i>Hospital Indemnity, HIP2-R/AR001460100001</i>		
USable Life	\$700.00	09/15/2011	51634457

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
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 Company Tracking Number: AR001460100001
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 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/20/2011	10/20/2011

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	Donna Lambert	09/30/2011	09/30/2011	SPI Life and Specialty Ventures	10/20/2011	10/20/2011

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
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 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Disposition

Disposition Date: 10/20/2011
 Implementation Date: 11/21/2011
 Status: Approved
 Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
USable Life	%	%	\$		\$	%	%

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
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 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Form (revised)	Hospital Confinement Indemnity Policy	Approved	Yes
Form	Hospital Confinement Indemnity Policy	Replaced	Yes
Form	Hospital Confinement Indemnity Application	Approved	Yes
Form	Emergency Accident Benefit Rider	Approved	Yes
Form	Surgery and Anesthesia Benefit Rider	Approved	Yes
Form	Outpatient Sickness Benefit Rider	Approved	Yes
Form	Ambulance Benefit Rider	Approved	Yes
Form	Specified Injury Benefit Rider	Approved	Yes
Form	Wellness Benefit Rider	Approved	Yes
Form	Annual Hospital Admission Benefit Rider	Approved	Yes
Form	Heart Attack, Stroke, Coma, Paralysis Benefit Rider	Approved	Yes
Form	Hospital Intensive Care Confinement Benefit Rider	Approved	Yes
Form (revised)	Hospital Confinement Indemnity Outline of Coverage	Approved	Yes
Form	Hospital Confinement Indemnity Outline of Coverage	Replaced	Yes
Form	Hospital Indemnity Plan Reinstatement Application	Approved	Yes
Form	Hospital Confinement Indemnity Exclusion of Coverage Rider	Approved	Yes
Rate	Monthly Premium Schedule	Approved	Yes

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Product Name: Hospital Indemnity, HIP2-R
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/30/2011
Submitted Date 09/30/2011
Respond By Date 10/31/2011

Dear Rae Lynn Boehm,

This will acknowledge receipt of the captioned filing.

Objection 1

- Hospital Confinement Indemnity Application, HIP2-RAPP (6-11) (Form)

Comment: Health questions cannot go back further than 5 years. RR 18 Sec. 5F

Objection 2

- Hospital Confinement Indemnity Policy, HIP2-R (3-07) (Form)

Comment: Please revise the pertinent parts of Part H of the policy to comply with 29-79-144. Coverage of a minor child cannot be limited because the child does not live with the insured. In addition, this statute does not allow the dependent to be excluded from coverage because he is not claimed on the insured's tax return. How will you verify that the child receives more than 50% of his support from the insured? Please consider removing the 50% requirement from the form.

In exclusion 12, well baby care, please add something similar to, "except as provided in the newborn children provision . . .," since well baby care is provided for newborns immediately after birth.

Objection 3

- Hospital Indemnity Plan Reinstatement Application, HIP2-R-REIN (6-11) (Form)

Comment: Health questions cannot go back further than 5 years. Please revise #3.

Objection 4

- Hospital Confinement Indemnity Outline of Coverage, HIP2-R-SOC (6-11) (Form)

Comment: The exclusion of well baby care should be changed to match that of the policy.

I will be happy to continue the review when your response is received.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

SERFF Tracking Number: LSVX-G127566147 *State:* Arkansas
Filing Company: USable Life *State Tracking Number:* 49795
Company Tracking Number: AR001460100001
TOI: H14I Individual Health - Hospital Indemnity *Sub-TOI:* H14I.000 Health - Hospital Indemnity
Product Name: Hospital Indemnity, HIP2-R
Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Please feel free to contact me if you have questions.

Sincerely,
Donna Lambert

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Product Name: Hospital Indemnity, HIP2-R
Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/20/2011
Submitted Date 10/20/2011

Dear Donna Lambert,

Comments:

The following is in response to your September 30, 2011 objection letter:

Response 1

Comments: We respectfully ask that you reconsider your objection to the health questions on our application. RR 18 Sec. 5F appears to be a requirement for the Pre-existing Condition definition in the policy. It requires the definition to limit the exclusion of pre-existing conditions to the "five (5) year period preceding the effective date of the coverage of the insured person." When a proposed insured is applying for the coverage using the application, the coverage is not yet effective. The questions on the application are used for underwriting purposes to decide whether or not the proposed insured is eligible for coverage in the first place. If they are found to be coverable, they will be issued the policy, which has a pre-existing condition definition that only limits the exclusion of pre-existing conditions to the twelve month period preceding the effective date of the coverage. This appears to comply with the intent of RR 18 Sec. 5F. Additionally, our pre-existing condition definitions states the following: "Conditions which are fully disclosed to us on the application and not excluded or limited by us in the policy are not considered pre-existing conditions."

Related Objection 1

Applies To:

- Hospital Confinement Indemnity Application, HIP2-RAPP (6-11) (Form)

Comment:

Health questions cannot go back further than 5 years. RR 18 Sec. 5F

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

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 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Response 2

Comments: Under the Dependent Provisions, we removed the requirements for the dependent to reside with the covered person and to be dependent upon the covered person for more than 50% of their support. Under the Exceptions provision, we added "except as provided in the Newborn Children provision" to exclusion 12 as requested.

Related Objection 1

Applies To:

- Hospital Confinement Indemnity Policy, HIP2-R (3-07) (Form)

Comment:

Please revise the pertinent parts of Part H of the policy to comply with 29-79-144. Coverage of a minor child cannot be limited because the child does not live with the insured. In addition, this statute does not allow the dependent to be excluded from coverage because he is not claimed on the insured's tax return. How will you verify that the child receives more than 50% of his support from the insured? Please consider removing the 50% requirement from the form.

In exclusion 12, well baby care, please add something similar to, "except as provided in the newborn children provision . . .," since well baby care is provided for newborns immediately after birth.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Hospital Confinement Indemnity Policy	HIP2-R (3-07)		Policy/Contract/Fraternal Certificate	Initial		47.700	AR HIP2-R rev.PDF
Previous Version							
Hospital Confinement Indemnity Policy	HIP2-R (3-07)		Policy/Contract/Fraternal Certificate	Initial		47.700	AR HIP2-R.PDF

No Rate/Rule Schedule items changed.

Response 3

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
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Company Tracking Number: AR001460100001
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Hospital Indemnity, HIP2-R
Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Comments: We respectfully ask that you reconsider your objection to the questions on our reinstatement application. These questions are part of a non-medical questionnaire and are not used for underwriting purposes. RR 18 Sec. 5F appears to be a requirement for the Pre-existing Condition definition in the policy. It requires the definition to limit the exclusion of pre-existing conditions to the "five (5) year period preceding the effective date of the coverage of the insured person." When a proposed insured is applying for reinstatement of coverage using the reinstatement application, the coverage is not effective at that time.

Related Objection 1

Applies To:

- Hospital Indemnity Plan Reinstatement Application, HIP2-R-REIN (6-11) (Form)

Comment:

Health questions cannot go back further than 5 years. Please revise #3.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments: Under the Exceptions and Limitations provision, we added "except as provided in the Newborn Children provision of the policy" to exclusion 12 to match the policy.

Related Objection 1

Applies To:

- Hospital Confinement Indemnity Outline of Coverage, HIP2-R-SOC (6-11) (Form)

Comment:

The exclusion of well baby care should be changed to match that of the policy.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form	Edition	Form Type	Action	Action	Readability Attach
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SERFF Tracking Number: LSVX-G127566147 State: Arkansas
 Filing Company: US Able Life State Tracking Number: 49795
 Company Tracking Number: AR001460100001
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

	Number	Date		Specific Data	Score	Document
Hospital Confinement Indemnity Outline of Coverage	HIP2-R-SOC (6-11)		Outline of Coverage Initial		47.700	HIP2-R-SOC (6-11) rev.PDF
Previous Version						
Hospital Confinement Indemnity Outline of Coverage	HIP2-R-SOC (6-11)		Outline of Coverage Initial		47.700	HIP2-R-SOC (6-11).PDF

No Rate/Rule Schedule items changed.

We hope that with this additional information, this filing may now be considered for final approval. If you have any questions or comments, please call me at (800) 648-0271 ext. 8932. Thank you for your assistance.

Sincerely,

Rae Lynn Craig

Sincerely,

SPI Life and Specialty Ventures

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 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Form Schedule

Lead Form Number: HIP2-R (3-07)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/20/2011	HIP2-R (3-07)	Policy/Cont ract/Fratern al Certificate	Hospital Confinement Indemnity Policy	Initial		47.700	AR HIP2-R rev.PDF
Approved 10/20/2011	HIP2-RAPP (6-11)	Application/ Enrollment Form	Hospital Confinement Indemnity Application	Initial		47.700	HIP2-RAPP (6-11).PDF
Approved 10/20/2011	HIP2-R-EA (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Emergency Accident Benefit Rider	Initial		47.700	HIP2-R-EA (3-07).PDF
Approved 10/20/2011	HIP2-R-SA (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Surgery and Anesthesia Benefit Rider	Initial		47.700	HIP2-R-SA (3-07).PDF
Approved 10/20/2011	HIP2-R-OS (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Outpatient Sickness Benefit Rider	Initial		47.700	HIP2-R-OS (3-07).PDF
Approved 10/20/2011	HIP2-R-AM (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Ambulance Benefit Rider	Initial		47.700	HIP2-R-AM (3-07).PDF

<i>SERFF Tracking Number:</i>	<i>LSVX-G127566147</i>	<i>State:</i>	<i>Arkansas</i>			
<i>Filing Company:</i>	<i>US Able Life</i>	<i>State Tracking Number:</i>	<i>49795</i>			
<i>Company Tracking Number:</i>	<i>AR001460100001</i>					
<i>TOI:</i>	<i>H141 Individual Health - Hospital Indemnity</i>	<i>Sub-TOI:</i>	<i>H141.000 Health - Hospital Indemnity</i>			
<i>Product Name:</i>	<i>Hospital Indemnity, HIP2-R</i>					
<i>Project Name/Number:</i>	<i>Hospital Indemnity, HIP2-R/AR001460100001</i>					
Approved 10/20/2011	HIP2-R-SI (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Specified Injury Benefit Rider	Initial	47.700	HIP2-R-SI (3-07).PDF
Approved 10/20/2011	HIP2-R-WL (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Wellness Benefit Rider	Initial	47.700	HIP2-R-WL (3-07).PDF
Approved 10/20/2011	HIP2-R-AH (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Annual Hospital Admission Benefit Rider	Initial	47.700	HIP2-R-AH (3-07).PDF
Approved 10/20/2011	HIP2-R-HS (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Heart Attack, Stroke, Coma, Paralysis Benefit Rider	Initial	47.700	HIP2-R-HS (3-07).PDF
Approved 10/20/2011	HIP2-R- ICU (3-07)	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Hospital Intensive Care Confinement Benefit Rider	Initial	47.700	HIP2-R-ICU (3-07).PDF
Approved 10/20/2011	HIP2-R- SOC (6-11)	Outline of Coverage	Hospital Confinement Indemnity Outline of Coverage	Initial	47.700	HIP2-R-SOC (6-11) rev.PDF
Approved 10/20/2011	HIP2-R- REIN (6-11)	Application/ Enrollment Form	Hospital Indemnity Plan Reinstatement Application	Initial	47.700	HIP2-R-REIN (6-11).PDF
Approved 10/20/2011	HIP2-R- EXC (3-07)	Certificate Amendmen	Hospital Confinement Indemnity Exclusion	Initial	47.700	HIP2-R-EXC (3-07).PDF

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Product Name: Hospital Indemnity, HIP2-R
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t, Insert of Coverage Rider
Page,
Endorsement or Rider



[320 West Capitol] • P.O. Box 1650 • Little Rock, AR 72203-1650
[(501) 375-7200 • (800) 648-0271]

Policy Number: [999999999999]
Primary Insured: [TEST HIP2 A ARKANSAS]
Effective Date: [JANUARY 01, 2007]

We agree, subject to all policy provisions, to pay the benefits of this policy and to provide the owner with all other rights of this policy.

The premium you paid and the application you completed place this policy in force as of the effective date. The effective date is shown in the Policy Schedule. A copy of your application is attached.

PART A IMPORTANT PLEASE READ

Your application is a part of this policy. PLEASE READ the copy of your application that is attached to this policy. Your policy was issued on the basis that all information in the application is correct and complete. If not, your policy may not be valid. If anything in your application is not correct, you should write to us within 30 days of the date you received this policy and let us know. Incorrect information could result in the denial of a claim or termination of this policy.

PART B 30-DAY RIGHT TO EXAMINE AND CANCEL POLICY

It is important to us that you are satisfied with this policy and that it meets your insurance needs. If you are not satisfied, you may return this policy to us within 30 days of the date you received it. The premium you paid will be promptly refunded. Then, the policy was never in force.

PART C RENEWAL AGREEMENT – GUARANTEED RENEWABLE FOR LIFE

We will renew your policy when you timely pay the premium. It must be paid on or before the date it is due or during the 31 days that follow. Your policy stays in force during this time.

You may cancel this policy at any time. The cancellation will be effective on the first day of the policy month following the date we receive your written cancellation notice, or on a later date if you so specify. Upon cancellation, we shall promptly return any unearned premium.

This policy is a legal contract between you and us. PLEASE READ THIS POLICY CAREFULLY.

Signed for us at our Home Office on the effective date.

Secretary

President

This is a Limited Policy – Read It Carefully!
GUARANTEED RENEWABLE FOR LIFE
HOSPITAL CONFINEMENT INDEMNITY POLICY

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POLICY SCHEDULE

This page shows specific information about this policy and is referred to throughout this policy.

Type of Coverage: [Individual]

Policy or Rider:	Number of Units or Amount of Coverage:	Monthly Premiums:
Hospital Confinement Benefit (Base Policy)		
[Daily Hospital Confinement	2 units	\$3.88
Emergency Accident Benefit Rider	1 units	\$2.80
Surgery & Anesthesia Benefit Rider	1 units	\$3.50
Ambulance Benefit Rider	1 units	\$1.82
Specified Injury Benefit Rider	1 units	\$1.60
Annual Hospital Admission Benefit Rider	5 units	\$4.60
Hospital Intensive Care Confinement Benefit Rider	2 units	\$1.56
Heart, Stroke, Coma, Paralysis Rider	1 units	\$0.28
Exclusion Rider]		

Premium Schedule	Annual	Semiannual	Quarterly	Monthly
Total Premiums	[\$240.43	\$120.21	\$60.11	\$20.04]

Premium Frequency Selected By You: [Monthly]

The monthly premium is available [only by bank draft].

Policy Number: [999999999999]
Primary Insured: [TEST HIP2 A ARKANSAS]
Effective Date: [JANUARY 01, 2007]

PART D

PREMIUM CHANGE

We may change the premium rates for this policy. We can only change the premium if we change it for all policies of this form number and premium classification in your state of issue that are then in force. We will not change the premium more than once in a 12-month period.

We will notify you in writing of any change in premium 31 days or more before the change is effective. Notice will be mailed to you at the address shown on our records. Please notify us of any change in address.

PART E

DEFINITIONS

When we use the following words, this is what we mean:

“Calendar Year” means the period of time from the policy effective date until December 31 of that year, and from January 1 to December 31 of the same year, thereafter.

“Charges Incurred” means charges the covered person is legally required to pay.

“Confined” or “Confinement” means medically necessary care as a resident bed patient in a hospital because of a covered accident or sickness. It must be for at least 12 hours in the same facility. A physician must recommend and supervise the confinement. Confinement does include care as an outpatient or in an emergency or observation room.

“Covered Accident” means only accidental bodily injury which:

- (1) is sustained on or after the effective date of coverage; and
- (2) is the direct cause of the loss independent of sickness, disease, bodily infirmity, or any other cause; and
- (3) occurs while the policy is in force.

All injuries sustained in any one accident and all complications and recurrence of complications are considered to be a single “covered accident.”

“Covered Person” means a person, in addition to you, insured under this policy.

There are four types of coverage under this policy:

- (1) “Individual” coverage;
- (2) “Individual and Spouse” coverage[;
- (3) “One-Parent Family” coverage; or
- (4) “Full Family” coverage].

If this policy is issued as an “Individual” policy, the word “Applicant” as shown on the application shall mean that we insure only you.

If this policy is issued as an “Individual and Spouse” policy, the words “Applicant and Spouse” as shown on the application shall mean that we insure you and your spouse.

[If this policy is issued as a “One-Parent Family” policy, the words “Applicant and Children” as shown on the application shall mean that we insure you and all your dependent children who are eligible for coverage as stated in the Dependent provisions of this policy.]

[If this policy is issued as a “Full Family” policy, the words “Applicant, Spouse and Children” as shown on the application shall mean that we insure you, your spouse and all dependent children (of yours or your spouse) who are eligible for coverage as stated in the Dependent provisions of this policy.]

“Effective Date” means the date shown on the Policy Schedule for all covered persons accepted for coverage at the time of issue provided the application has been accepted and approved by us, the policy is issued and the full first premium has been paid; or the date shown by endorsement for all covered persons added to coverage after the policy has been issued. The effective date is assigned by us in accordance with our policy dating rules in effect at the time this policy is issued. The coverage provided by this policy will not be effective unless there has been no change since the date of the application and the effective date of the policy in the health of any proposed covered person listed on the application.

“Gainful Occupation” means any employment that exists in the national economy that the covered person may be expected to follow based on his education, training, experience, age, and physical and mental capacity.

“He” or “His” The use of the male pronoun also includes the female.

“Home Office” means the principal office of US Able Life in Little Rock, Arkansas.

“Hospital” means a primary care institution operated pursuant to law, which is licensed or approved as a hospital by the responsible state agency. It must have organized facilities on its premises to provide first level treatment of sick and injured persons on an inpatient basis for which a charge is made. Organized facilities include emergency services, admission services, clinical laboratory, diagnostic X-ray and surgical services. Treatment facilities for emergency, medical and surgical services must be provided within the institution. The institution must provide 24 hour nursing services by or under the supervision of a licensed graduate registered nurse on duty or call, and be supervised by a staff of one or more physicians. It must maintain on its premises the patient's written history and medical records.

Not included in the term hospital is an institution or part of an institution which is licensed or used principally: (a) for the treatment or care of drug addicts or alcoholics; or (b) as a clinic, continued or extended care hospital or rehabilitation facility, convalescent home, rest home, skilled nursing facility or home for the aged; or (c) as a stand-alone psychiatric facility.

“Immediate Family” means anyone related to a covered person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or spouses of any of these.

“Injury” means only accidental bodily injury which:

- (1) is sustained on or after the effective date of coverage; and
- (2) is the direct cause of the loss independent of sickness, disease, bodily infirmity, or any other cause; and
- (3) occurs while the policy is in force.

All injuries sustained in any one accident and all complications and recurrence of complications are considered to be a single “injury.”

“Medically Necessary” means the treatment, services or supplies necessary and appropriate for the treatment of the covered accident or sickness during confinement based upon generally accepted medical practice. The fact that a physician may prescribe, authorize, or direct a service does not of itself make it medically necessary or covered by the policy.

“Nurse” means any of the following who is not a member of your immediate family:

- (1) licensed practical nurse (L.P.N.);
- (2) licensed vocational nurse (L.V.N.); or
- (3) graduate registered nurse (R.N.)

“Period of Confinement” means a period of time that begins on the first day the covered person is confined in a hospital. It ends when no benefits have been paid under the base policy for 30 consecutive days.

“Physician” means a person who is providing services within the scope of his license, and is either: (a) licensed to practice medicine and prescribe and administer drugs or to perform surgery; or is (b) legally qualified and licensed as a medical practitioner and is required to be recognized, according to the insurance statutes or the insurance regulations of the governing jurisdiction. Such person must not be an immediate family member of any covered person. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible physicians under this policy.

“Policy” means this document, any riders, endorsements, or amendments to it, and the application.

“Pre-existing Condition” means a sickness or injury which is diagnosed or for which treatment is received within the twelve month period prior to the effective date of coverage for each covered person, or a pregnancy existing on the effective date of coverage. Conditions which are fully disclosed to us on the application and not excluded or limited by us in the policy are not considered pre-existing conditions. “Treatment” means consultation, care, or services provided by a physician including diagnostic measures and taking prescription drugs and medicines.

“Primary Insured” means the person named on page 1.

“Regular Care” means the covered person visits a physician as often as medically required to effectively manage and treat his condition(s), according to generally accepted medical standards; and he is receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing the covered person’s loss must be given by a physician whose specialty or experience is appropriate.

“Renewal Date” means the date your next premium payment is due.

“Sickness” means any illness, infection, disease, pregnancy or any other abnormal physical condition that is not caused by an injury.

“War” means declared or undeclared war or conflict involving the armed forces of any country, group of countries, governments, or international organization.

“We,” “Our,” or “Us” means USAble Life.

“You” or “Your” means the person named as the primary insured on the Policy Schedule on page 3. You are insured for the benefits of the policy as of the effective date.

Please include the child's name and date of birth, date of adoption, or date placed for adoption with your notice. This notice must be received by us before the later of these dates: (1) 90 days from the date of birth, adoption, or placement for adoption; or (2) the next renewal date following birth, adoption or adoption placement.

If the required notice is not received by us during this period, a newborn child, newly adopted child or child placed for adoption may be covered after this date only if the following conditions are met: (1) your written application for coverage is approved by us; and (2) the payment of any required premium is made. Additional premium, if any, will begin on the first renewal date following the date of birth, adoption, or adoption placement.]

Coverage for such newborn child will be the same as we provide for you. We will pay benefits for well baby care (routine hospital and nursing care) following birth. This will be paid for up to five (5) full days or until the mother is discharged from the hospital following the birth of the child, whichever is less.

[IF THIS IS A "FAMILY" PLAN THE FOLLOWING APPLIES: If this is a "Full Family" policy, it means that we insure you, your spouse if not legally separated from you, and all dependent children (of yours or your spouse) listed on the application. If this is a "One-Parent Family" policy it means that we insure you and all your dependent children listed on the application. The term "Dependent children" includes your unmarried natural or step children and legal wards under age 23 who are full-time students in an accredited school.

Any family member specifically excluded from coverage by endorsement to this policy is not included in the family definition. Any person who becomes a family member after the effective date of this policy must be added by endorsement (except newborn children who are automatically covered from the moment of birth, and newly adopted children including children placed for adoption who are automatically covered from the moment of placement). Persons added as family members by endorsement will be subject to the pre-existing conditions provision. It is not necessary to notify us of a child's birth, adoption, or placement for adoption and no additional premium will be required for coverage of newborn children, adopted children, children placed for adoption, or children added as family members by endorsement. Additional premium is required when a spouse is added to a "one-parent" family policy.]

TERMINATION OF COVERAGE: [Coverage for dependent persons may terminate as explained in the following paragraphs. Coverage for each dependent child will terminate on the renewal date following the earlier of: (a) his or her 23rd birthday; (b) marriage; or (c) his or her termination of dependency upon you for support and maintenance.

If we accept a premium applicable to any such dependent after his or her 23rd birthday, or termination of dependency, or after receiving notice of his or her marriage, coverage for such dependent will continue until the end of the period for which premium has been accepted.

If a child reaches the termination date stated above and continues to be incapable of self-sustaining employment by reason of mental incapacity or physical handicap, and you notify us about this, coverage for such child will continue while the policy is in force and so long as such disability continues and the applicable premium is paid. We will continue to charge any appropriate premium for that child as long as he/she qualifies as a handicapped dependent.]

BENEFICIARY: The beneficiary is the person(s) you name in writing on your application to receive any amount of insurance that is left unpaid at your death. The beneficiary's name is on record in our Home Office. If you name more than one beneficiary, those who survive will share equally unless you specify otherwise.

CHANGE OF BENEFICIARY: You may change a beneficiary by giving us written notice at our Home Office on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it. The consent of the beneficiary or beneficiaries is not required to surrender, assign, or change beneficiaries, or to make any other changes in this policy.

TERMINATION OF BENEFITS: No benefits are payable after the termination of this policy except for covered losses which begin prior to such termination. Provided, if the covered person is totally disabled or hospital confined from a condition covered by this policy at the time of termination, benefits shall continue during the term of such total disability or hospital confinement. See "Extension of Benefits" below.

EXTENSION OF BENEFITS: If a covered person is totally disabled or hospital confined from a covered condition on his termination date, the coverage provided for that covered person by this policy and any attached riders will be extended. During the extended coverage period, the applicable policy and rider provisions, exclusions, exceptions and limitations will be the same as would have applied had coverage not terminated for such covered person. This extension is limited to confinement and/or expenses incurred:

- (1) for the injury or sickness which caused the total disability or hospital confinement, and
- (2) during the uninterrupted continuance of the total disability or hospital confinement, and
- (3) shall be limited to the policy benefit period or payment of the maximum benefits.

For the purposes of this provision, total disability means the complete incapacity of the covered person as the result of the covered injury or sickness:

- (1) to engage in any gainful occupation for pay or profit for which he is or may become reasonably qualified by training, education, experience, age, and physical and mental capacity;
or
- (2) if not employed, to engage in the normal activities of a person of the same age and sex who is free of any physical or mental disease or disorder; and
- (3) which requires the regular care of a physician.

PHYSICAL EXAMINATION AND AUTOPSY: We, at our own expense, have the right to have a covered person examined by a physician of our choice when and as often as is reasonable during the handling of a claim and to do an autopsy where it is not forbidden by law.

LEGAL ACTIONS: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

UNPAID PREMIUM: We may deduct any unpaid premium then due from the payment of a claim under this policy.

REFUND OF PREMIUM: On the death of the covered person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death

occurred. Payment shall be made in one lump sum no later than 30 days after proof of the covered person's death has been furnished us.

INSURANCE FRAUD: Warning — Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud and prosecuted. US Able Life may terminate this policy if the covered person has filed a fraudulent claim or statement with us.

PART K **GENERAL INFORMATION**

ENTIRE CONTRACT AND CHANGES: This policy is a legal contract between you and us. The entire contract consists of the policy, which includes the application, and any attached papers. No change in this policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to this policy. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date a covered person becomes insured under this policy, we cannot use misstatements, except fraudulent misstatements, in your application to void coverage or deny a claim for loss that occurs after the two-year period.

Except for fraud, no claim for loss incurred after two years from the date a covered person becomes insured under this policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description existed prior to the effective date of such covered person's coverage.

The above provisions also apply to any riders, endorsements, or amendments attached to this policy. In applying them, the words "rider," "endorsement," or "amendment" will be used for the word "policy."

GRACE PERIOD: A grace period will apply to payment of premiums (except the initial premium). During the grace period, your policy will stay in force. This grace period means that if you pay your premiums within 31 days after they are due, your policy remains continuously in force. If you do not, your policy is terminated at the end of the 31-day grace period.

MISSTATEMENT OF AGE: This policy is only available for issue at ages 64 and below. If the age of a covered person has been misstated one of the following will apply:

- (1) the benefits will be those the premium paid would have purchased at the correct age; or
- (2) if the covered person was age 65 or over when this policy was issued, we will refund premium and no benefits will be payable.

REINSTATEMENT: If any renewal premium is not paid within the time allowed for payment and we accept a premium without requiring an application for reinstatement, that payment shall reinstate this policy. If we require an application, this policy will be reinstated when we approve it. If we do not approve the application, this policy will be reinstated on the 45th day after the date of the application unless we notify you in writing of its disapproval. The reinstated policy only covers loss due to sickness that is first manifested more than 10 days after the date of reinstatement, and loss due to injury that takes place after the date of reinstatement.

In all other respects you and we have the same rights under this policy as we both had before it lapsed, unless special conditions are added to this policy in connection with the reinstatement. Any premium

accepted in connection with this provision will be used for a period for which payment has not been made, but not to any period more than 60 days before the date of reinstatement.

OTHER INSURANCE WITH US: If you are covered under more than one policy of this form or like form with us, only one policy, chosen by you or your estate, will be effective (this includes coverage for any covered person). We will refund all premiums paid for all other policies from the date of duplication less any benefits paid under these policies from such date.

NON-PARTICIPATING: This policy is non-participating. Its premiums do not include a charge for participation in surplus.

TERM OF COVERAGE: Coverage starts on the effective date at 12:01 a.m., standard time where you live. It ends at 12:01 a.m. on the same standard time on the renewal date, subject to the grace period. This policy may be renewed only as stated in the Renewal Agreement. Each time this policy is renewed, the new term begins when the old term ends.

CHARTER AND BY-LAWS: No provisions of our charter or by-laws not included in this policy shall void this policy or be used in defense of any legal proceedings with regard to it.

CONFORMITY WITH STATE STATUTES: The provisions of this policy conform with the law of the state in which you reside on the policy effective date. If any do not, they are hereby amended so that they do conform.

POLICY SCHEDULE: The Policy Schedule and information it contains is a part of the policy.

Important Notice

The following information is provided to assist you in answering any questions you might have:

Soliciting Agent

The name, address and telephone number of our soliciting agent is available to you, if needed, by calling our Customer Service Department at [501-375-7200].

USAbLe Life

USAbLe Life
P. O. Box 1650
Little Rock, AR 72203-1650
Phone [(501) 375-7200 or
Toll Free (800) 648-0271]

If we fail to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone (501) 371-2640 or
Toll Free 1-800-852-5494

We appreciate the opportunity to serve your insurance needs.



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc.	

New Application Change Form Reinstatement Policy Replaces Policy No. _____

SECTION 1 - PERSONAL IDENTIFICATION

Name (First, MI, Last)		For Name Change, Give Prior Last Name		Social Security No.	
Home Address		City	State	Zip	County
Date of Birth	Birth State or Country		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (ft-in)	Weight (lbs.)
Occupation		Applicant's email address (if any)		Home Phone ()	Other Phone ()
Name of Employer			Type of Business		
1. Are you a US citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		2. If no to question 1, have you been issued a permanent residency VISA? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. If yes to question 2, have you lived continuously in the US or Canada for the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					

SPOUSE [& CHILDREN] INFORMATION - Complete if Applying for Dependent's Coverage

Full Name	Occupation	Gender	Date of Birth			Birth State or Country	Height ft/in	Weight lbs
			mo	day	yr			
(spouse)								
[child]								
[child]								
[child]								

SECTION 2 - PLAN SELECTION New Applicant Application for Change

CHECK COVERAGE DESIRED: Applicant Applicant & Spouse Applicant & Children Applicant, Spouse & Children

Hospital Confinement Plan(s):	PREMIUM
<input type="checkbox"/> Plan I - \$50 Daily Hospital Confinement, \$100 Emergency Accident, \$1,000 Surgery & Anesthesia, \$250/\$500 Ambulance Ground/Air, and Specified Injury.	
<input type="checkbox"/> Plan II - \$100 Daily Hospital Confinement, \$250 Emergency Accident, \$1,500 Surgery & Anesthesia, \$75 Outpatient Sickness, \$250/\$500 Ambulance Ground/Air, \$75 Wellness, and Specified Injury.	
<input type="checkbox"/> Plan III - \$200 Daily Hospital Confinement, \$500 Emergency Accident, \$2,500 Surgery & Anesthesia, \$75 Outpatient Sickness, \$500/\$1,000 Ambulance Ground/Air, \$75 Wellness, and Specified Injury.	\$
<input type="checkbox"/> Optional Annual Hospital Admission Rider	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 \$
<input type="checkbox"/> Optional Hospital Intensive Care Confinement Rider	<input type="checkbox"/> \$200 <input type="checkbox"/> \$400 <input type="checkbox"/> \$600 \$
<input type="checkbox"/> Optional Heart Attack, Stroke, Coma & Paralysis Benefit Rider	<input type="checkbox"/> \$1,000/\$500 <input type="checkbox"/> \$2,000/\$1,000 \$
TOTAL MONTHLY PREMIUM: \$ _____	

SECTION 3 - BENEFICIARY Name Beneficiary Change of Beneficiary

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Birthdate	Relationship	Primary or Contingent	Indicate Percentage
			<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary or <input type="checkbox"/> Contingent	
Total must equal 100% =				

Applicant's Name (Last, First, M.I.)

Social Security No.

SECTION 5 – AUTHORIZATION

- 1. Does any person applying for coverage currently have a Hospital Indemnity Policy with us or any other insurance company? Yes No
If yes, give name of company, list type of policy and amount of coverage. _____
- 2. REPLACEMENT: Is this insurance to replace or change other insurance? Yes No If "Yes", give details including name of company.

- 3. OUTLINE: Have you received the Outline of Coverage? Yes No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" below; (c) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (d) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (e) agree that this authorization shall be valid for two (2) years from the application date; (f) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (g) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy. [I understand and accept that the coverage I am purchasing does not include dependent (child) coverage except for the initial 90 days from birth or adoption as stated in the policy and that no dependent (child) will be covered for an additional time period without the prior express written consent and approval of USAble Life.]

Insurance Fraud 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.

I have read and understand the above statements and agreements.

X _____ Signed at: _____
Applicant's Signature (City and State)

Date of Application: _____
(Month, Day, Year)

Agent's Statement: I have truly and accurately recorded the information supplied by the applicant.

X _____ Agent's License ID Number
Agent's Signature

Agent's Printed Name

Date Received Home Office



P.O. Box 1650 • Little Rock, AR 72203-1650

EMERGENCY ACCIDENT BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$_____

BENEFITS

EMERGENCY TREATMENT: We will pay the charges incurred, not to exceed \$100 per unit of coverage, if the covered person is injured in a covered accident and receives treatment in a hospital emergency room, physician's office, or standalone emergency center within 72 hours after the accident. This benefit is payable two times per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children combined is two visits per calendar year.

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider.

This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider.

Signed for us at our Home Office on the effective date.

A handwritten signature in black ink that reads "James Touze".

Secretary

A handwritten signature in black ink that reads "Jason Allen".

President



P.O. Box 1650 • Little Rock, AR 72203-1650

SURGERY AND ANESTHESIA BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$_____

BENEFITS

We will pay the benefit shown in the following Surgical & Anesthesia Benefit Schedule, per unit of coverage, for a surgical procedure and for anesthesia that was administered during the surgical procedure, in or out of a hospital, when surgery is due to a covered accident or sickness, as defined in the policy. Each unit of coverage is subject to a maximum surgical benefit of \$1,000 per operation.

For operations not listed, we will pay you an amount comparable to the amount shown in the following schedule for the operation most nearly similar in severity and gravity. Surgical procedures performed through the same incision or in the same body opening will be considered one operation. We will pay the amount shown in the Surgical & Anesthesia Benefit Schedule for the one procedure with the largest benefit. **The schedule starting on the next page is for one unit of coverage. See the Policy Schedule for the number of units of coverage you have in force.**

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider. This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider. Signed for us at our Home Office on the effective date.

Secretary

President

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
AMPUTATIONS		
Arm at shoulder joint	\$380	\$95
Arm below shoulder joint	\$200	\$50
Finger	\$110	\$28
Leg at hip joint	\$400	\$100
Leg at knee	\$280	\$70
Leg above or below knee	\$290	\$73
Toe	\$62	\$16
ARTERIES		
Arteriectomy, extremity	\$300	\$75
Carotid endarterectomy	\$780	\$195
Excision and graft, abdominal aortic aneurysm	\$530	\$133
Injection, varicose veins	\$18	\$5
Thromboendarterectomy	\$400	\$100
BREAST		
Biopsy	\$70	\$18
Excision of chest wall tumor	\$340	\$85
Excision of cyst of benign tumor	\$100	\$25
Mastectomy, radical	\$380	\$95
Mammoplasty, reconstructive	\$360	\$90
Mastectomy, simple	\$208	\$52
DIGESTIVE SYSTEM		
Appendectomy	\$220	\$55
Aspiration biopsy of liver, pancreas or bile duct	\$40	\$10
Cholecystectomy	\$284	\$71
Cholecystotomy	\$250	\$63
Colostomy	\$240	\$60
Diverticulectomy	\$240	\$60
Enterectomy	\$352	\$88
Enterotomy	\$354	\$89
Enterostomy	\$180	\$45
Enterolysis	\$292	\$73
Fissurectomy or hemorrhoidectomy	\$80	\$20
Fistulotomy	\$60	\$15
Gastrectomy, partial	\$480	\$120
Gastrectomy, total	\$560	\$140
Gastrorrhaphy	\$280	\$70
Gastroscopy	\$84	\$21
Gastrostomy	\$230	\$58

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
DIGESTIVE SYSTEM (continued)		
Gastrotomy	\$270	\$68
Herniotomy	\$210	\$53
Laparotomy	\$170	\$43
Pancreatectomy, partial	\$350	\$88
Pancreatectomy, total	\$700	\$175
Proctectomy	\$560	\$140
Proctoplasty	\$200	\$50
Proctosigmoidoscopy	\$14	\$4
Removal of external hemorrhoids	\$50	\$13
Sphincterotomy	\$24	\$6
DISLOCATIONS		
Ankle	\$54	\$14
Collar bone (requiring reduction)	\$48	\$12
Fingers or toes	\$10	\$3
Hip or knee	\$155	\$39
Jaw	\$40	\$10
Shoulder (humerus with anesthesia) or elbow	\$27	\$7
Wrist	\$30	\$8
EAR		
Drainage of abscess	\$20	\$5
Labyrinthotomy or labyrinthectomy	\$560	\$140
Mastoidectomy, simple	\$300	\$75
Myringotomy	\$20	\$5
Tympanoplasty	\$620	\$155
ENDOCRINE SYSTEM		
Adrenalectomy	\$390	\$98
Incision and drainage of thyroid gland	\$18	\$5
Local excision of thyroid cyst or adenoma	\$200	\$50
Thyroidectomy or parathyroidectomy	\$520	\$130
EYE		
Excision of lacrimal gland or sac	\$260	\$65
Excision of pterygium	\$140	\$35
Extraction of lens (including cataract extraction)	\$560	\$140
Iridectomy	\$440	\$110
Muscle operation (one or more muscles)	\$380	\$95
Reattachment of retina	\$820	\$205
Removal of eye	\$250	\$63
Sclerotomy, anterior	\$200	\$50
Sclerotomy, posterior	\$200	\$50

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
FRACTURES		
Ankle	\$130	\$33
Collar bone	\$70	\$18
Fingers	\$30	\$8
Foot	\$64	\$16
Hand	\$50	\$13
Jaw	\$160	\$40
Lower arm (radius)	\$86	\$22
Lower arm (ulna)	\$66	\$17
Lower leg (fibula)	\$80	\$20
Lower leg (tibia)	\$60	\$15
Nose	\$30	\$8
Vertebrae, one or more	\$200	\$50
Shoulder blade (scapula)	\$230	\$58
Skull	\$360	\$90
Toes	\$22	\$6
Upper arm	\$100	\$25
Upper leg	\$200	\$50
GENITAL SYSTEM – MALE		
Biopsy, prostate	\$40	\$10
Circumcision	\$20	\$5
Excision of epididymis, hydrocele, varicocele	\$160	\$40
Orchiectomy	\$126	\$32
Prostatectomy, partial	\$440	\$110
Prostatectomy – radical	\$520	\$130
Reduction of torsion of testis	\$200	\$50
Vasectomy	\$90	\$23
GENITAL SYSTEM – FEMALE		
Amniocentesis	\$20	\$5
Biopsy or removal of cervical lesion or polyp	\$16	\$4
Dilation and curettage	\$80	\$20
Cesarean section	\$290	\$73
Hysterectomy, radical for cancer including lymph nodes	\$480	\$120
Hysterectomy, vaginal or abdominal	\$380	\$95
Myomectomy	\$240	\$60
Obstetrical delivery	\$210	\$53
Repair of cystocele or rectocele	\$140	\$35
Repair of uterine suspension	\$242	\$61
Salpingo-oophorectomy	\$340	\$85
Tubal ligation	\$200	\$50

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
HEART –CARDIOVASCULAR SYSTEM		
Angioplasty, percutaneous	\$460	\$115
Catheterization of heart	\$230	\$58
Coronary bypass, single or multiple	\$1,000	\$250
Heart transplant	\$1,000	\$250
Pervenous or transvenous insertion of pacemaker	\$390	\$98
Repair of myocardial aneurysm	\$760	\$190
Repair of septal defect	\$780	\$195
Suture of heart wound or injury	\$480	\$120
Valvotomy, aortic and pulmonic valve	\$740	\$185
Valvotomy, mitral valve	\$860	\$215
Valvuloplasty or replacement aortic and mitral valve	\$1,000	\$250
HEMIC & LYMPHATIC SYSTEMS		
Biopsy of lymph node	\$30	\$8
Radical lymphadenectomy	\$420	\$105
Splenectomy	\$320	\$80
JOINTS		
Ankle, arthrotomy	\$240	\$60
Ankle, arthroplasty	\$400	\$100
Hammertoe	\$96	\$24
Hip, arthrotomy	\$282	\$71
Hip, arthroplasty	\$650	\$163
Knee, arthrotomy	\$250	\$63
Knee, arthroplasty	\$460	\$115
Shoulder or elbow, arthrotomy	\$220	\$55
Shoulder or elbow, arthroplasty	\$440	\$110
Wrist, arthrotomy	\$160	\$40
Wrist, arthroplasty	\$300	\$75
LARYNX		
Laryngectomy	\$500	\$125
Laryngoscopy	\$20	\$5
LUNGS		
Pneumocentesis	\$30	\$8
Pneumonectomy, total	\$600	\$150
Pneumonotomy	\$280	\$70
Thoracentesis	\$40	\$10
Thoracoscopy (including biopsy)	\$140	\$35
Thoracotomy	\$280	\$70
Wedge resection of lung, single or multiple	\$380	\$95

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
MUSCULOSKELETAL SYSTEM		
BONE OR CARTILAGE GRAFT		
Spinal fusion	\$360	\$90
Spinal fusion for scoliosis	\$600	\$150
NERVOUS SYSTEM		
Burr holes	\$200	\$50
Cranioplasty	\$480	\$120
Craniotomy or craniectomy	\$176	\$44
Laminectomy	\$700	\$175
Median nerve decompression (carpal tunnel)	\$168	\$42
Paravertebral block, lumbar, or thoracic nerve	\$30	\$8
Spinal puncture	\$40	\$10
NOSE		
Excision of nasal polyps	\$48	\$12
Sumusous resection, classic nasal sept	\$220	\$55
SINUSES		
Frontal sinusotomy – radical	\$250	\$63
Frontal sinusotomy – simple	\$210	\$53
SKIN – INTEGUMENTARY SYSTEM		
Acne surgery	\$10	\$3
Biopsy	\$20	\$5
Chemosurgery – malignancies of skin	\$92	\$23
Electro-surgical destruction of chemocautery	\$18	\$5
Excision of benign tumor	\$40	\$10
Excision of malignant tumor (trunk, arms or legs)	\$30	\$8
Excision of malignant tumor (face, scalp, ears, neck, hands, feet, genitalia)	\$60	\$15
Excision of malignant tumor (eyelids, nose, lips, mucous membrane)	\$60	\$15
Excision of nail	\$76	\$19
Incision and drainage of cyst	\$16	\$4
Repair, complex wounds (linear repair)	\$35	\$9
Repair, skin grafts (multiple stage)	\$70	\$18
Repair, skin grafts (single stage)	\$35	\$9
Repair, simple wounds	\$16	\$4
TENDONS		
Lengthening or shortening (e.g. Achilles tendon)	\$160	\$40
Repair or suture	\$60	\$15

SURGICAL & ANESTHESIA BENEFIT SCHEDULE

SURGICAL PROCEDURE	Maximum Surgical Benefit	Maximum Anesthesia Benefit
TRACHEA & BRONCHI		
Bronchoscopy	\$120	\$30
Closure of tracheotomy	\$98	\$25
Tracheotomy	\$20	\$5
URINARY SYSTEM		
Cystectomy, complete	\$510	\$128
Cystectomy, partial	\$245	\$62
Cystoplasty	\$400	\$100
Cystotomy	\$340	\$85
Dilation of urethra	\$30	\$8
Kidney transplant	\$600	\$150
Lithotripsy	\$375	\$94
Nephrectomy	\$420	\$105
Nephrolithotomy	\$400	\$100
Renal biopsy	\$56	\$14
Urethroscopy or cystoscopy	\$40	\$10



P.O. Box 1650 • Little Rock, AR 72203-1650

OUTPATIENT SICKNESS BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$_____

BENEFITS

When a covered person is treated by a physician in the physician's office, clinic, urgent care facility, or emergency room for a covered sickness, we will pay you \$25 per visit per unit of coverage shown in the Policy Schedule.

These benefits are limited to five visits per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children combined is five visits per calendar year.

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider.

This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider.

Signed for us at our Home Office on the effective date.

Handwritten signature of James Touse in black ink.

Secretary

Handwritten signature of Jason Allen in black ink.

President



P.O. Box 1650 • Little Rock, AR 72203-1650

AMBULANCE BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$_____

BENEFITS

AMBULANCE: We will pay **\$250 per unit of coverage** if, due to a covered accident or sickness, a licensed professional ambulance company transports the covered person to or from a hospital or between medical facilities, by ground transportation.

AIR AMBULANCE: We will pay **\$500 per unit of coverage** if, due to a covered accident or sickness, a licensed professional air ambulance company transports the covered person to or from a hospital or between medical facilities.

We will pay only one of these benefits, whichever occurs first, once per calendar year per covered person.

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider.

This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider.

Signed for us at our Home Office on the effective date.

A handwritten signature in black ink that reads "James Touse".

Secretary

A handwritten signature in black ink that reads "Jason Allen".

President



P.O. Box 1650 • Little Rock, AR 72203-1650

SPECIFIED INJURY BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$ _____

BENEFITS

A. BURN: We will pay **\$375 per unit of coverage** if the covered person receives burns that require medical treatment due to a covered accident. The burns must be second degree burns that cover at least thirty-six percent (36%) of the body surface or third degree burns, which cover at least nine square inches of the body surface. They must be treated by a physician within 72 hours after the accident. We will pay this amount once for each covered accident.

B. TENDON/LIGAMENT: We will pay **\$150 per unit of coverage** for each covered accident if the covered person receives one or more injured tendons or ligaments in a covered accident. The tendon or ligament must be torn, ruptured or severed. A physician must repair it through surgery within one year after the accident.

If the covered person is in an accident and receives a fracture or a dislocation and tears, ruptures, or severs a tendon or ligament, we will pay only one benefit. We will pay the larger of either the Tendon/Ligament benefit, the Fracture benefit, or the Dislocation benefit. If exploratory arthroscopic surgery is performed and no repair is done, we will only pay \$25 per unit of coverage.

C. DISLOCATION (SEPARATED JOINT): We will pay the benefit shown below per unit of coverage for the treatment listed if the covered person receives treatment for a dislocation sustained in a covered accident. A dislocation is a completely separated joint. It must be diagnosed as a dislocation by a physician within 30 days after the accident. It can be corrected by open (surgical) or closed (non-surgical) reduction. If the dislocation requires reduction without anesthesia by a physician, we will pay the amount shown for the joint involved under Without Anesthesia.

If the covered person receives more than one dislocation in a covered accident, we will pay for all dislocations. However, we will pay no more than 150% of the amount for the joint involved that has the highest benefit amount.

If the covered person receives a fracture and a dislocation in the same accident, we will pay for both. However, we will pay no more than 150% of the amount for the bone or joint involved which has the highest benefit amount.

If a physician diagnoses the dislocation as an incomplete dislocation, we will pay 25% of the amount shown for the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.

We will pay this benefit only for the first dislocation of a joint after the policy effective date. Subsequent dislocations of the same joint after the effective date will not be covered.

Dislocations	Open Reduction	Closed Reduction	Without Anesthesia
Hip	\$625	\$155	\$40
Knee	\$155	\$60	\$15
Shoulder	\$155	\$60	\$15
Collarbone	\$250	\$50	\$15
Ankle or Foot (other than Toes)	\$155	\$50	\$15
Lower Jaw	\$155	\$80	\$20
Wrist	\$125	\$60	\$15
Elbow	\$125	\$60	\$15
One Toe or Finger	\$30	\$15	\$5

D. EYE INJURY: We will pay the benefit shown below per unit of coverage for the treatment listed if the covered person receives treatment for an eye injury sustained in a covered accident. The eye injury must require surgery or the removal of a foreign object by a physician within 30 days after the accident. We will pay this amount for each covered accident. An examination with anesthesia will not be considered surgery.

	Amount
With surgical repair	\$75
Removal of foreign body by Physician	\$15

E. FRACTURE (BROKEN BONE): We will pay the benefit shown below per unit of coverage for the treatment listed if the covered person receives treatment for a fracture sustained in a covered accident. A fracture is a break in a bone, which can be seen by X-ray. It must be diagnosed as a fracture by a physician within 14 days after the accident. The fracture must require open (surgical) or closed (non-surgical) reduction by a physician.

If the covered person receives more than one fracture in a covered accident, and they require open or closed reduction, we will pay for all fractures. However, we will pay no more than 150% of the amount for the bone involved, which has the highest benefit amount.

If a physician diagnoses the fracture as a chip fracture, we will pay the amount shown for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

If the covered person receives a fracture and a dislocation in the same accident, we will pay for both. However, we will pay no more than 150% of the amount for the bone or joint involved that has the highest benefit amount.

Fractures	Open Reduction	Closed Reduction	Chip Fractures
Hip	\$625	\$315	\$40
Leg	\$315	\$160	\$20
Hand (excluding fingers)	\$155	\$80	\$10
Foot (excluding toes/heel)	\$155	\$80	\$10
Wrist	\$155	\$80	\$10
Elbow	\$155	\$80	\$10
Shoulder Blade	\$155	\$80	\$10
Forearm	\$155	\$80	\$10
Ankle or Kneecap	\$155	\$80	\$10
Sternum or lower jaw	\$155	\$80	\$10
Vertebrae (body of)	\$315	\$160	\$20
Pelvis (excluding coccyx)	\$315	\$160	\$20
Upper Jaw	\$185	\$90	\$12
Upper Arm	\$185	\$90	\$12
Face (excluding nose)	\$185	\$90	\$12
Rib or Ribs	\$315	\$35	\$20
Nose, Heel, or Fingers	\$155	\$35	\$10
Coccyx	\$65	\$35	\$4
Toes	\$65	\$35	\$4
Vertebral Processes	\$315	\$50	\$20
Skull			
Depressed	\$470	\$470	\$470
Simple	\$155	\$155	\$155

F. KNEE CARTILAGE – TORN: We will pay the benefit shown below per unit of coverage for the treatment listed if the covered person receives treatment for a torn knee cartilage sustained in a covered accident. It must be treated by a physician within 60 days after the covered accident. A physician must repair it through surgery within one year after the accident. Only one payment amount under this benefit will be paid.

	Amount
Exploratory surgery without repair or if the cartilage is shaved (debridement)	\$75
Surgical Repair	\$155

G. RUPTURED DISC: We will pay **\$155 per unit of coverage** if the covered person receives treatment for a ruptured disc sustained in a covered accident. A ruptured disc is a herniated, ruptured or prolapsed intervertebral disc that is diagnosed by myelography, computed tomography (CT) or magnetic resonance imaging (MRI). A physician must treat it within 60 days after the accident. It must be repaired through surgery by a physician within one year after the accident.

H. TORN ROTATOR CUFF: We will pay **\$155 per unit of coverage** if the covered person receives treatment for one or two torn rotator cuffs sustained in a covered accident. A physician must repair the torn rotator cuff through surgery within 90 days after the accident.

I. INTERNAL INJURIES: We will pay **\$315 per unit of coverage** if the covered person receives treatment for internal injuries sustained in a covered accident. “Internal Injuries” are injuries that result in open abdominal, hernia or thoracic surgery within 30 days after the accident.

J. CONCUSSION: We will pay **\$15 per unit of coverage** if the covered person receives treatment for a concussion sustained in a covered accident. Concussion must result in electroencephalogram abnormality within 30 days after the accident.

K. LACERATION: We will pay the benefit shown below per unit of coverage for the treatment listed if the covered person receives treatment for a laceration sustained in a covered accident. A laceration is a cut. A physician must repair the laceration within 72 hours after the accident.

Length of Lacerations	Amount
Single laceration less than 2 inches (less than 5.08 centimeters)	\$15
Total of all lacerations:	
At least 2 but not more than 6 inches (5.08 – 15.24 centimeters)	\$65
Over 6 inches (greater than 15.24 centimeters)	\$125
Lacerations not requiring stitches, staples or glue	\$8

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider.

This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider.

Signed for us at our Home Office on the effective date.



Secretary



President



P.O. Box 1650 • Little Rock, AR 72203-1650

WELLNESS BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$ _____

BENEFITS

WELLNESS BENEFIT: We will pay a total of **\$75 per calendar year** for a covered person to undergo a routine examination or other preventive testing. This benefit is payable once per covered person per calendar year and two times per family per calendar year.

Covered tests and exams are:

- | | |
|------------------------------------|--------------------------------------|
| Mammography | Colonoscopy |
| Flexible Sigmoidoscopy | PSA (Blood Test for Prostate Cancer) |
| Chest X-Ray | Hearing Exams |
| EKG | Vision Exams |
| Pap Smear | Dental X-rays |
| Cholesterol and Diabetes Screening | |

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider.

This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider.

Signed for us at our Home Office on the effective date.

Secretary

President



P.O. Box 1650 • Little Rock, AR 72203-1650

ANNUAL HOSPITAL ADMISSION BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$ _____

BENEFITS

HOSPITAL ADMISSION: We will pay **\$100 per unit of coverage** if the covered person is admitted to a hospital and confined as a resident bed patient because of a covered accident or sickness. This benefit is payable only once per calendar year for each covered person.

We will not pay this benefit for confinement to an observation unit, for emergency room treatment or outpatient treatment.

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider.

This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider.

Signed for us at our Home Office on the effective date.

Handwritten signature of James Touse in black ink.

Secretary

Handwritten signature of Jason Allen in black ink.

President



P.O. Box 1650 • Little Rock, AR 72203-1650

HEART ATTACK, STROKE, COMA, PARALYSIS BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$ _____

BENEFITS

First Diagnosis Benefit: We will pay \$1,000 per unit of coverage the first time a covered person is diagnosed as having had any one of the following, whichever occurs first: heart attack, stroke, coma, or paralysis. This benefit is payable once per covered person.

Reoccurrence Benefit: We will pay \$500 per unit of coverage if a covered person is later diagnosed as having had any one of the following, whichever occurs first: heart attack, stroke, coma, or paralysis. The heart attack, stroke, coma or paralysis must occur more than 180 days after the First Diagnosis Benefit becomes payable. This benefit will again become payable for a diagnosis occurring more than 180 days after it was last paid. There is no lifetime maximum on this benefit.

The following conditions must be met for either of the above benefits to be payable:

- (1) the date of diagnosis is after the waiting period;
- (1) the date of diagnosis is while this rider is in force; and
- (2) the illness is not excluded by name or specific description in an elimination rider attached to the policy.

DEFINITIONS

Coma means a profound state of unconsciousness that lasts for a period of at least 7 days (168 hours) and from which the covered person cannot be aroused to consciousness, even by powerful stimulation, as determined by a physician. **Date of Diagnosis of coma** means the date of occurrence of the profound state of unconsciousness and includes documented evidence of the illness or injury that caused the neurological deficit.

Heart Attack or Myocardial Infarction means unequivocal diagnosis of the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area as evidenced by all of the following criteria:

- (1) New electrocardiographic (EKG) changes consistent with injury; and
- (2) Elevation of serum cardiac markers such as certain cardiac enzymes and/or isoenzymes; and
- (3) Confirmatory imaging studies such as thallium scans, multigated angiogram (MUGA), or stress echocardiogram. After this rider has been issued and approved by us, we may decide to accept other newly developed studies approved by the American College of Cardiology that are deemed to be at least as accurate in the positive diagnosis of heart attack as those previously listed.

In the event of death, an autopsy confirmation and death certificate identifying heart attack as the cause of death will be accepted. **Date of Diagnosis of heart attack** means the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

Paralysis means quadriplegia, paraplegia, hemiplegia or uniplegia which has lasted 30 days and is expected to last for a continuous period of 12 months or more from the date of the accident causing paralysis or the date of diagnosis of the sickness causing paralysis. It means loss of use, without severance of a limb. Quadriplegia is the complete and irreversible paralysis of both upper and lower limbs. Paraplegia is the complete and irreversible paralysis of both lower limbs. Hemiplegia is the complete and irreversible paralysis of the upper and lower limbs of the same side of the body. Uniplegia is the complete and irreversible paralysis of one limb. Limb means entire arm or entire leg. **Date of Diagnosis of paralysis** means the date of occurrence of the permanent loss of use of your limbs and includes documented evidence of the illness or injury that caused the paralysis.

Stroke means a cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage, or embolization of brain tissue from an extracranial source. Diagnosis of a stroke for the purposes of this policy must be based on documented neurological deficits and confirmatory neuroimaging studies.

Cerebral symptoms due to transient ischemic attack (TIA), reversible neurological deficit, migraine, cerebral injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions are excluded. **Date of Diagnosis of stroke** means the date a stroke occurred based on documented neurological deficits and neuroimaging studies. The diagnosis must be made by a licensed neurologist.

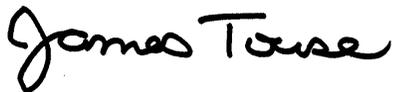
Waiting Period means (a) the first thirty days following the covered person's effective date under this rider, or (b) the first thirty days following the effective date of any increase in the covered person's coverage amount. No benefits will be paid for a heart attack, stroke, coma, or paralysis which is diagnosed during the waiting period.

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider.

This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider.

Signed for us at our Home Office on the effective date.



Secretary



President



P.O. Box 1650 • Little Rock, AR 72203-1650

HOSPITAL INTENSIVE CARE CONFINEMENT BENEFIT RIDER

US Able Life (herein called we, our or us) has issued this rider as part of the policy to which it is attached.

The premium you paid in advance and the application you completed has put this rider in force as of the rider date. A copy of your application is attached. This rider is a part of the policy. All provisions of the policy not in conflict with the provisions of this rider apply to this rider.

RIDER DATE (same as the Effective Date of the policy if no date shown): _____

RIDER PREMIUM (included in the policy premium if no amount shown): \$_____

BENEFITS

This rider provides an intensive care unit benefit. Some hospitals may classify and bill for intensive care in sub-acute, intermediate or step-down units which are not covered under this rider.

HOSPITAL INTENSIVE CARE BENEFIT: When injuries or sickness result in necessary confinement of a covered person in a hospital intensive care or coronary care unit, we will pay you \$100 per day per unit of coverage shown in the Policy Schedule. This benefit is in addition to the Hospital Confinement benefit. The daily benefit will be paid beginning with the first day of confinement. This benefit is limited to 30 days for any one period of confinement.

Recurrent Provision: Successive periods of confinement will be considered to be the same period of confinement unless they are separated by more than 30 days.

“Hospital Intensive Care Unit” means a place which (a) is a specifically designated area of the hospital that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; (b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement; (c) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; (d) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a twenty-four hour basis; and (e) has a physician assigned to the unit on a full-time basis.

Notwithstanding the above, an intensive care unit is not any of the following step down units: (a) a progressive care unit, (b) an intermediate care unit, (c) a private monitored room, (d) sub-acute intensive care unit, (e) an observation unit, (f) a telemetry unit, or (g) any facility not meeting the definition of a hospital intensive care unit as defined above.

TERMINATION

This rider will automatically terminate with the policy or with the failure to pay premiums associated with this rider.

This rider is subject to all provisions of the policy to which it is attached which are not inconsistent with the terms of this rider.

Signed for us at our Home Office on the effective date.



Secretary



President



HOSPITAL CONFINEMENT INDEMNITY POLICY

Outline of Coverage ~ Policy Form HIP2-R (3-07)

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

Hospital Confinement Indemnity Coverage – Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any *additional benefits described below*.

BENEFITS	<input type="checkbox"/> PLAN I	<input type="checkbox"/> PLAN II	<input type="checkbox"/> PLAN III
<p>Daily Hospital Confinement Pays a daily benefit for inpatient hospital confinement due to a covered accident or sickness. <i>Maximum 180 days per confinement.</i></p>	\$50 per day	\$100 per day	\$200 per day
<p>Surgery and Anesthesia Pays according to the policy surgical schedule, up to the amount selected, for a surgical procedure, inpatient or outpatient, when surgery is due to a covered accident or sickness. Anesthesia pays 25% of the amount payable under the surgical benefit.</p>	Up to \$1,000 per operation	Up to \$1,500 per operation	Up to \$2,500 per operation
<p>Emergency Accident Pays the charges incurred, up to the maximum selected, if the covered person is injured in a covered accident and received treatment in a hospital emergency room, physician's office, or standalone emergency center within 72 hours after the accident. <i>Benefit is paid 2 times per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children combined is 2 visits per calendar year.</i></p>	Maximum \$100 per covered accident	Maximum \$250 per covered accident	Maximum \$500 per covered accident
<p>Outpatient Sickness Pays for treatment by a physician in a physician's office, clinic, urgent care facility, or emergency room for a covered sickness. <i>Benefits are limited to 5 visits per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children (combined) is 5 visits per calendar year.</i></p>	None	\$75 per visit	\$75 per visit
<p>Ambulance Pays for ground ambulance or air ambulance to or from a hospital or between medical facilities. <i>Pays only one benefit, whichever occurs first, per calendar year per person.</i></p>	Ground Ambulance \$250 Air Ambulance \$500	Ground Ambulance \$250 Air Ambulance \$500	Ground Ambulance \$500 Air Ambulance \$1,000
<p>Wellness Benefit Pays per calendar year for a covered person to undergo a routine examination or other preventative testing. <i>Payable once per insured per calendar year and 2 times per family per calendar year.</i></p> <ul style="list-style-type: none"> ▪ Mammogram ▪ Pap Smear ▪ Flexible Sigmoidoscopy ▪ Prostatic Specific Antigen (PSA) Test ▪ Chest X-Ray ▪ EKG ▪ Colonoscopy ▪ Cholesterol & Diabetes Screening ▪ Vision Examination ▪ Hearing Examination ▪ Dental X-Ray 	none	\$75	\$75

BENEFITS (continued)	ALL PLANS
Burns treated within 72 hours. <i>Payable once per accident.</i>	\$375
Tendon / Ligament surgically repaired within 1 year.*	\$150
Dislocation (separated joint) diagnosed within 30 days.* <i>Payable only for the first dislocation of a joint. Subsequent dislocation of the same joint will not be covered.</i>	Up to \$625
Eye injury requiring surgery or removal of a foreign object within 30 days. <i>Payable once per accident.</i>	Up to \$75
Fractures diagnosed within 14 days and requiring open or closed reduction by a physician.*	Up to \$625
Torn Knee Cartilage and Ruptured Disc treated within 60 days and surgically repaired within 1 year. <i>Payable once per accident.</i>	Up to \$155
Torn Rotator Cuff surgically repaired within 90 days.	\$155
Internal Injuries resulting in open abdominal, hernia or thoracic surgery within 30 days.	\$315
Concussion resulting in EEG abnormality within 30 days.	\$15
Lacerations repaired within 72 hours.	Up to \$125

* If the insured receives a fracture or a dislocation and tears, ruptures, or severs a tendon or ligament, we will pay only one benefit, whichever is the largest. If the insured receives a fracture and a dislocation in the same accident, we will pay for both, but no more than 150% of the bone or joint with the highest amount.

OPTIONAL COVERAGE	YOUR CHOICES You have applied for:
Annual Hospital Admission Rider, HIP2-R-AH (3-07) Pays an annual benefit if the covered person is admitted to a hospital and confined as a resident bed patient because of a covered accident or sickness. <i>This benefit is payable only once per calendar year for each covered person.</i>	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> None
Hospital Intensive Care Confinement Rider, HIP2-R-ICU (3-07) Pays a daily benefit when a covered person is confined in a hospital intensive care or coronary care unit, due to a covered injury or sickness. <i>Limited to 30 days for any one period of confinement.</i>	<input type="checkbox"/> \$200 <input type="checkbox"/> \$400 <input type="checkbox"/> \$600 <input type="checkbox"/> None
Heart Attack, Stroke, Coma, or Paralysis Rider, HIP2-R-HS (3-07) Pays a lump sum benefit for first diagnosis and reoccurrence, upon diagnosis of a Heart Attack, Stroke, Coma or Paralysis. <i>First diagnosis benefit is only paid once per covered person. Reoccurrence benefit is paid for a diagnosis occurring more than 180 days after this benefit was last paid. No lifetime benefit maximum.</i>	<input type="checkbox"/> \$1,000 first diagnosis \$500 reoccurrence <input type="checkbox"/> \$2,000 first diagnosis \$1,000 reoccurrence <input type="checkbox"/> None

PRE-EXISTING CONDITIONS

Benefits will not be paid for pre-existing conditions during the first twelve months the coverage is in force. A "pre-existing condition" means a sickness or injury which was diagnosed or treated within twelve months before the effective date of coverage, or a pregnancy existing on the effective date of coverage. After the coverage has been in force for twelve months, we will pay benefits for any pre-existing condition not specifically excluded.

EXCEPTIONS AND LIMITATIONS

The policy pays only for loss resulting from a covered sickness or accident as defined in the policy. It DOES NOT cover loss caused directly or indirectly by:

1. War or any act of war, or while serving in the armed forces of any country or international authority.
2. Attempted suicide or intentional, self-inflicted injury, whether sane or insane.
3. Active participation in a riot or insurrection.
4. Voluntary commission of, or attempting to commit, an assault or felony.
5. Participating in an illegal occupation.
6. Voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician.
7. Mental, nervous or emotional disorder without organic origin.
8. Alcoholism or drug addiction.
9. Intoxication as defined by the laws of the jurisdiction in which the loss occurred. Conviction is not necessary for a determination of being intoxicated.
10. Dental, elective, or cosmetic surgery or treatment, except as a result of a covered injury or congenital defect of a newborn child.
11. Hernia, tonsils, or adenoids during the first six (6) months of coverage, unless treated on an emergency basis.
12. Well baby care, except as provided in the Newborn Children provision of the policy.
13. Voluntarily acting as an organ donor.

RENEWABILITY AND CONTINUATION

The Hospital Confinement policy and riders are guaranteed renewable during your lifetime. The company may change the established premium rate, but only if the rate is changed for all policies and riders like yours in your state. This coverage will not be issued to anyone 65 years of age or over. If you purchase the policy and riders prior to your 65th birthday, you may continue coverage after age 65, as long as you continue to pay the premium by the due date or during the 31 days that follow. Covered dependents who no longer meet eligibility requirements, may convert to a comparable individual policy without evidence of insurability. A spouse can continue coverage under this policy upon your death.

COVERAGE EFFECTIVE DATE

Effective date means the date shown on the Policy Schedule page for all persons accepted for coverage at the time of issue, provided the application has been accepted and approved by us; the policy is issued; and the first premium has been paid; or the date shown by endorsement for all persons added to coverage after the policy has been issued. The effective date is assigned by the Company in accordance with our policy dating rules in effect at the time your policy is issued. The coverage provided by the policy will not be effective unless there has been no change since the date of application and the effective date of the policy in the health of any proposed covered person listed on the application.

**HOSPITAL INDEMNITY PLAN
REINSTATEMENT APPLICATION**

SECTION 1 – PERSONAL IDENTIFICATION

Name (First, MI, Last)			Policy #		
Home Address		City	State	Zip	County
Work Phone ()	Home Phone ()	Insured's Occupation (Be Exact)		Spouse's Occupation (if covered)	
Your Height (ft-in.)	Your Weight (lbs.)	Spouse's Height if covered (ft-in.)		Spouse's (if covered) Weight (lbs.)	

SECTION 2 – NON-MEDICAL QUESTIONNAIRE

I wish to reinstate my policy and any attached rider(s) or amendments(s). Enclosed is payment for my past due premium.

- Is anyone to be reinstated currently confined in a hospital or nursing home, or has hospitalization been recommended by a physician? Yes No
- Has anyone to be reinstated been confined in a hospital or nursing home within the last 12 months because of internal cancer, melanoma, heart surgery, heart attack, congestive heart failure, vascular disease, hypertension, chronic obstructive pulmonary disease, chronic liver disease, stroke, emphysema, sickle-cell anemia, asthma, chronic bronchitis, Parkinson's disease, multiple sclerosis, or rheumatoid arthritis? Yes No
- Has anyone to be reinstated ever been diagnosed as having or treated by a member of the medical profession for: Alzheimer's disease, senile dementia, systemic lupus erythematosus, kidney failure, diabetes, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)? Yes No
- Is anyone to be covered now pregnant? Yes No
- If questions 1, 2, 3, or 4 were answered "yes," list the person(s) and condition(s) in the following space.

- PRIMARY PHYSICIAN'S NAME: _____ Address: _____
Phone #: _____ City, State, Zip: _____

The above representations are true and all exceptions have been fully stated to the best of the knowledge and belief of the undersigned. Each person applying for reinstatement adopts, as his own, the above representations and stated exceptions and agrees to be bound thereby. It is agreed that this policy shall not be considered reinstated and the Company shall have no liability (other than to return payments made with this application, without interest) until all amounts required for reinstatement of this policy have been paid and until this application has been approved by the Company at its Home Office during the lifetime and good health of all persons who would be insured under this policy if reinstated. It is further agreed that reinstatement of this policy, if granted by the Company, shall be contestable for fraud or misrepresentation of any material facts stated in, or in connection with, this application for the same period after reinstatement as is provided in this policy (or predecessor policy if this policy resulted from a conversion) with respect to the original date of issue.

In signing below, I: (a) represent that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Authorization to Obtain and Disclose Information" and the "Notice of Information Practices" on the back of this application; and (c) authorize the collection and release of the information noted in the authorization on the reverse side. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information. I have received copies of the "MIB Notice," the "Fair Credit Reporting Act Notice," and the "Insurance Fraud Warning." I understand that I, or my representative, may receive a copy of this authorization. I understand that failure to disclose a proposed insured person's true health condition may void this policy.

_____	_____
Date	Signature of Policyowner
_____	_____
Date	Witness

Date Received Home Office

HIP2-R-REIN (6-11)

NOTIFICATION — Please read carefully and detach for your records.

NOTICE TO PROPOSED INSURED

Insurance Fraud 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.

Federal Fair Credit Reporting Act Notice - In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

Insurance Fraud 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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The terms that follow have the respective meanings when used in this Authorization.

COMPANY: USABLE Life

INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency

BUREAU: Medical Information Bureau, Inc.

AUTHORIZATION: Authorization to Obtain and Disclose Information

I understand that the Company, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) reinsurer; (6) insurance support organization; (7) financial source; and (8) employer, to give the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid as the original.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) finances; and (7) vocation.

The Company and its reinsurers will use the information in order to determine whether I am insurable.

Those parties named in the first paragraphs of this Authorization may disclose the information that they have collected. They may disclose the information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) the Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose this information as may be otherwise allowed by law.

This Authorization will be valid for two years after the date of application.

HIP2-R-REIN (6-11)

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

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

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Braintree, Massachusetts 02184-8734. USABLE Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.



P.O. Box 1650 • Little Rock, AR 72203-1650

HOSPITAL CONFINEMENT INDEMNITY EXCLUSION OF COVERAGE RIDER

RIDER DATE (same as Policy Date if no date shown):

In consideration of the issuance or reinstatement of the Policy to which this Rider is attached, it is hereby understood and agreed that the person named below is completely excluded from all coverage under the policy:

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy other than as stated above.

Signed for us at our Home Office on the Rider Date.

Accepted by:

US Able Life

A handwritten signature in black ink, appearing to read "Jason Allen", is written over a horizontal line.

President

Signature of Applicant

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
 Filing Company: USAbLe Life State Tracking Number: 49795
 Company Tracking Number: AR001460100001
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Rate Information

Rate data applies to filing.

Filing Method: Prior Approval
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
USAbLe Life	%	%				%	%

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
 Filing Company: USable Life State Tracking Number: 49795
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 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 10/20/2011	Monthly Premium Schedule	HIP2-R (3-07), HIP2-R-AH (3-07), HIP2-R-AM (3-07), HIP2-R-EA (3-07), HIP2-R-HS (3-07), HIP2-R-ICU (3-07), HIP2-R-OS (3-07), HIP2-R-SA (3-07), HIP2-R-SI (3-07), HIP2-R-WL (3-07)	New		Rates - Individual HIP Product - Retail - AR.PDF

USABLE LIFE INSURANCE COMPANY
Individual Hospital Indemnity Policy Form HIP2-R (3-07), Et Al
Exhibit A - Gross Monthly Premium Rates Per Unit

Ages 18-29

<u>Coverage</u>	<u>Benefit Amount</u>	<u>Employee</u>	<u>Employee & Spouse</u>	<u>1 Parent Family</u>	<u>2 Parent Family</u>
Daily Hospital Confinement Benefit	\$25/day	1.32	2.62	2.46	3.56
Annual First Occurrence Hospital Confinement Rider	\$100	0.82	1.62	1.56	2.18
Hospital Emergency Room Benefit Rider	\$100 max ben	4.54	9.06	12.88	14.84
Intensive Care/Coronary Care Rider	\$100/day	1.10	2.20	3.10	3.62
Surgery and Anesthesia Rider	\$1,000 Schedule	2.70	5.38	3.00	5.58
Outpatient Sickness Benefit Rider	\$25/visit	3.74	7.48	9.90	12.02
Ambulance Benefit Rider	\$250	2.98	5.96	5.06	7.24
Specified Injury Benefit Rider	Schedule	1.64	3.30	6.16	6.34
Heart, Stroke, Coma, Paralysis Rider	\$1,000 1st Diag & \$500 Recurrent Diag	0.10	0.20	0.10	0.16

Ages 30-39

<u>Coverage</u>	<u>Benefit Amount</u>	<u>Employee</u>	<u>Employee & Spouse</u>	<u>1 Parent Family</u>	<u>2 Parent Family</u>
Daily Hospital Confinement Benefit	\$25/day	1.76	3.56	3.02	4.66
Annual First Occurrence Hospital Confinement Rider	\$100	1.04	2.10	1.74	2.70
Hospital Emergency Room Benefit Rider	\$100 max ben	3.80	7.58	12.44	15.12
Intensive Care/Coronary Care Rider	\$100/day	1.12	2.24	3.14	4.00
Surgery and Anesthesia Rider	\$1,000 Schedule	4.88	9.78	5.24	10.12
Outpatient Sickness Benefit Rider	\$25/visit	4.36	8.70	10.68	14.22
Ambulance Benefit Rider	\$250	3.36	6.72	5.18	8.30
Specified Injury Benefit Rider	Schedule	1.26	2.52	5.78	6.44
Heart, Stroke, Coma, Paralysis Rider	\$1,000 1st Diag & \$500 Recurrent Diag	0.26	0.52	0.26	0.52

Ages 40-49

<u>Coverage</u>	<u>Benefit Amount</u>	<u>Employee</u>	<u>Employee & Spouse</u>	<u>1 Parent Family</u>	<u>2 Parent Family</u>
Daily Hospital Confinement Benefit	\$25/day	2.36	4.72	3.30	5.50
Annual First Occurrence Hospital Confinement Rider	\$100	1.26	2.50	1.76	2.96
Hospital Emergency Room Benefit Rider	\$100 max ben	3.32	6.62	9.78	12.12
Intensive Care/Coronary Care Rider	\$100/day	1.12	2.26	2.64	3.56
Surgery and Anesthesia Rider	\$1,000 Schedule	6.48	12.98	6.74	13.18
Outpatient Sickness Benefit Rider	\$25/visit	5.20	10.40	9.92	14.40
Ambulance Benefit Rider	\$250	3.88	7.78	5.22	8.92
Specified Injury Benefit Rider	Schedule	1.10	2.20	4.44	5.04
Heart, Stroke, Coma, Paralysis Rider	\$1,000 1st Diag & \$500 Recurrent Diag	0.60	1.20	0.60	1.20

Ages 50-59

<u>Coverage</u>	<u>Benefit Amount</u>	<u>Employee</u>	<u>Employee & Spouse</u>	<u>1 Parent Family</u>	<u>2 Parent Family</u>
Daily Hospital Confinement Benefit	\$25/day	3.22	6.46	3.96	7.16
Annual First Occurrence Hospital Confinement Rider	\$100	1.62	3.22	2.00	3.60
Hospital Emergency Room Benefit Rider	\$100 max ben	3.08	6.16	8.06	11.04
Intensive Care/Coronary Care Rider	\$100/day	1.10	2.18	2.26	3.34
Surgery and Anesthesia Rider	\$1,000 Schedule	5.58	11.18	5.80	11.38
Outpatient Sickness Benefit Rider	\$25/visit	6.18	12.36	9.82	15.92
Ambulance Benefit Rider	\$250	4.36	8.70	5.38	9.72
Specified Injury Benefit Rider	Schedule	1.00	2.00	3.58	4.54
Heart, Stroke, Coma, Paralysis Rider	\$1,000 1st Diag & \$500 Recurrent Diag	1.02	2.06	1.02	2.06

Ages 60-64

<u>Coverage</u>	<u>Benefit Amount</u>	<u>Employee</u>	<u>Employee & Spouse</u>	<u>1 Parent Family</u>	<u>2 Parent Family</u>
Daily Hospital Confinement Benefit	\$25/day	5.74	11.48	6.68	12.20
Annual First Occurrence Hospital Confinement Rider	\$100	2.74	5.50	3.32	5.92
Hospital Emergency Room Benefit Rider	\$100 max ben	3.56	7.14	9.26	12.18
Intensive Care/Coronary Care Rider	\$100/day	1.44	2.88	2.62	4.08
Surgery and Anesthesia Rider	\$1,000 Schedule	2.74	5.50	3.46	5.72
Outpatient Sickness Benefit Rider	\$25/visit	8.92	17.84	12.90	21.54
Ambulance Benefit Rider	\$250	7.56	15.12	11.50	16.16
Specified Injury Benefit Rider	Schedule	1.24	2.48	2.94	5.10
Heart, Stroke, Coma, Paralysis Rider	\$1,000 1st Diag & \$500 Recurrent Diag	2.00	4.00	2.00	4.00

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
 Filing Company: US Able Life State Tracking Number: 49795
 Company Tracking Number: AR001460100001
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR - READABILITY CERTIFICATION.PDF	Approved	10/20/2011

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Comply	Approved	10/20/2011

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage Comments: Attached to the Forms tab	Approved	10/20/2011

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: HIP2-R Statement of Variability.PDF	Approved	10/20/2011

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification Comments: Attachment: Individual HIP Product - Retail - AR.PDF	Approved	10/20/2011

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: USAble Life

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

Form Number	Score
HIP2-R (3-07)	47.7
HIP2-RAPP (6-11)	47.7
HIP2-R-EA (3-07)	47.7
HIP2-R-SA (3-07)	47.7
HIP2-R-OS (3-07)	47.7
HIP2-R-AM (3-07)	47.7
HIP2-R-SI (3-07)	47.7
HIP2-R-WL (3-07)	47.7
HIP2-R-AH (3-07)	47.7
HIP2-R-HS (3-07)	47.7
HIP2-R-ICU (3-07)	47.7
HIP2-R-SOC (6-11)	47.7
HIP2-R-REIN (6-11)	47.7
HIP2-R-EXC (3-07)	47.7

STATE OF ARKANSAS
READABILITY CERTIFICATION

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

Signed: 
Name: Connie Phillips
Title: Assistant General Counsel & Assistant Secretary
Date: 9/15/2011

STATEMENT OF VARIABILITY

Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

SPECIFIC VARIABLES HIP2-R (3-07)

Policy Face Page

1. The bracketed material consists of those items which are customarily varied to apply to a particular policyholder's contract. Such items include policy number, policyholder's name, and effective date.
2. Company officer signatures may change.

Policy Schedule

1. Type of Coverage: Individual, Individual/Spouse, Single Parent, or Full Family
2. Policy/Riders - Number of units or Amount of Coverage (premiums vary according to the selected benefit plan):
 - a. Hospital Confinement - Available in \$25 per unit of coverage with a minimum and maximum units available range from 2-50.
 - b. Annual Hospital Admission Benefit Rider – Available in \$100 per unit of coverage with a minimum and maximum units available range from 1-25.
 - c. Emergency Accident Benefit Rider - Available in \$100 per unit of coverage with a minimum and maximum units available range from 1-5.
 - d. Hospital Intensive Care Confinement Benefit Rider - Available in \$100 per unit of coverage with a minimum and maximum units range from 1-25.
 - e. Surgery & Anesthesia Benefit Rider - Minimum and maximum units available range from 1-5.
 - f. Outpatient Sickness Benefit Rider - Available in \$25 per unit with a minimum and maximum units range from 0-8.
 - g. Wellness Benefit Rider - \$75 benefit amount.
 - h. Ambulance Benefit Rider - \$250 per unit of coverage for ground and \$500 per unit of coverage for air with a minimum and maximum units range from 1-2.
 - i. Specified Injury Benefit Rider - Only one unit of coverage is available for this benefit.
 - j. Heart Attack, Stroke, Paralysis Benefit Rider - Minimum and maximum units available range from 1-2.
 - k. Exclusion Rider – Will appear in the policy schedule if the policyholder selects it.
3. Premium Schedule: Total Premiums vary according to the selected benefit plan.
4. Premium Frequency: Annual, Semiannual, Quarterly, or Monthly.
5. The reference to “only by bank draft” can be varied to apply to a particular policyholder's contract.
6. The bracketed material consists of those items which are customarily varied to apply to a particular policyholder's contract. Such items include policy number, policyholder's name, and effective date.

Covered Person Definition

1. The reference to “four” can be changed to “two.”
2. Items 3 and 4 of the first paragraph can be removed if the policy does not provide coverage for

Specific Variables (continued)

dependent children.

3. Paragraphs 4 and 5 can be removed if the policy does not provide coverage for dependent children.

Dependent Provisions

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

SPECIFIC VARIABLES HIP2-RAPP

Section 1 – Personal Identification

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

Section 2 – Plan Selection

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

Section 5 – Authorization

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

SERFF Tracking Number: LSVX-G127566147 State: Arkansas
 Filing Company: US Able Life State Tracking Number: 49795
 Company Tracking Number: AR001460100001
 TOI: H141 Individual Health - Hospital Indemnity Sub-TOI: H141.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity, HIP2-R
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100001

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/15/2011	Form	Hospital Confinement Indemnity Outline of Coverage	10/20/2011	HIP2-R-SOC (6-11).PDF (Superseded)

HOSPITAL CONFINEMENT INDEMNITY POLICY

Outline of Coverage ~ Policy Form HIP2-R (3-07)

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

Hospital Confinement Indemnity Coverage – Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any *additional benefits described below*.

BENEFITS	<input type="checkbox"/> PLAN I	<input type="checkbox"/> PLAN II	<input type="checkbox"/> PLAN III
<p>Daily Hospital Confinement Pays a daily benefit for inpatient hospital confinement due to a covered accident or sickness. <i>Maximum 180 days per confinement.</i></p>	\$50 per day	\$100 per day	\$200 per day
<p>Surgery and Anesthesia Pays according to the policy surgical schedule, up to the amount selected, for a surgical procedure, inpatient or outpatient, when surgery is due to a covered accident or sickness. Anesthesia pays 25% of the amount payable under the surgical benefit.</p>	Up to \$1,000 per operation	Up to \$1,500 per operation	Up to \$2,500 per operation
<p>Emergency Accident Pays the charges incurred, up to the maximum selected, if the covered person is injured in a covered accident and received treatment in a hospital emergency room, physician’s office, or standalone emergency center within 72 hours after the accident. <i>Benefit is paid 2 times per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children combined is 2 visits per calendar year.</i></p>	Maximum \$100 per covered accident	Maximum \$250 per covered accident	Maximum \$500 per covered accident
<p>Outpatient Sickness Pays for treatment by a physician in a physician’s office, clinic, urgent care facility, or emergency room for a covered sickness. <i>Benefits are limited to 5 visits per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children (combined) is 5 visits per calendar year.</i></p>	None	\$75 per visit	\$75 per visit
<p>Ambulance Pays for ground ambulance or air ambulance to or from a hospital or between medical facilities. <i>Pays only one benefit, whichever occurs first, per calendar year per person.</i></p>	Ground Ambulance \$250 Air Ambulance \$500	Ground Ambulance \$250 Air Ambulance \$500	Ground Ambulance \$500 Air Ambulance \$1,000
<p>Wellness Benefit Pays per calendar year for a covered person to undergo a routine examination or other preventative testing. <i>Payable once per insured per calendar year and 2 times per family per calendar year.</i></p> <ul style="list-style-type: none"> ▪ Mammogram ▪ Pap Smear ▪ Flexible Sigmoidoscopy ▪ Prostatic Specific Antigen (PSA) Test ▪ Chest X-Ray ▪ EKG ▪ Colonoscopy ▪ Cholesterol & Diabetes Screening ▪ Vision Examination ▪ Hearing Examination ▪ Dental X-Ray 	none	\$75	\$75

BENEFITS (continued)	ALL PLANS
Burns treated within 72 hours. <i>Payable once per accident.</i>	\$375
Tendon / Ligament surgically repaired within 1 year.*	\$150
Dislocation (separated joint) diagnosed within 30 days.* <i>Payable only for the first dislocation of a joint. Subsequent dislocation of the same joint will not be covered.</i>	Up to \$625
Eye injury requiring surgery or removal of a foreign object within 30 days. <i>Payable once per accident.</i>	Up to \$75
Fractures diagnosed within 14 days and requiring open or closed reduction by a physician.*	Up to \$625
Torn Knee Cartilage and Ruptured Disc treated within 60 days and surgically repaired within 1 year. <i>Payable once per accident.</i>	Up to \$155
Torn Rotator Cuff surgically repaired within 90 days.	\$155
Internal Injuries resulting in open abdominal, hernia or thoracic surgery within 30 days.	\$315
Concussion resulting in EEG abnormality within 30 days.	\$15
Lacerations repaired within 72 hours.	Up to \$125

* If the insured receives a fracture or a dislocation and tears, ruptures, or severs a tendon or ligament, we will pay only one benefit, whichever is the largest. If the insured receives a fracture and a dislocation in the same accident, we will pay for both, but no more than 150% of the bone or joint with the highest amount.

OPTIONAL COVERAGE	YOUR CHOICES You have applied for:
Annual Hospital Admission Rider, HIP2-R-AH (3-07) Pays an annual benefit if the covered person is admitted to a hospital and confined as a resident bed patient because of a covered accident or sickness. <i>This benefit is payable only once per calendar year for each covered person.</i>	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> None
Hospital Intensive Care Confinement Rider, HIP2-R-ICU (3-07) Pays a daily benefit when a covered person is confined in a hospital intensive care or coronary care unit, due to a covered injury or sickness. <i>Limited to 30 days for any one period of confinement.</i>	<input type="checkbox"/> \$200 <input type="checkbox"/> \$400 <input type="checkbox"/> \$600 <input type="checkbox"/> None
Heart Attack, Stroke, Coma, or Paralysis Rider, HIP2-R-HS (3-07) Pays a lump sum benefit for first diagnosis and reoccurrence, upon diagnosis of a Heart Attack, Stroke, Coma or Paralysis. <i>First diagnosis benefit is only paid once per covered person. Reoccurrence benefit is paid for a diagnosis occurring more than 180 days after this benefit was last paid. No lifetime benefit maximum.</i>	<input type="checkbox"/> \$1,000 first diagnosis \$500 reoccurrence <input type="checkbox"/> \$2,000 first diagnosis \$1,000 reoccurrence <input type="checkbox"/> None

PRE-EXISTING CONDITIONS

Benefits will not be paid for pre-existing conditions during the first twelve months the coverage is in force. A "pre-existing condition" means a sickness or injury which was diagnosed or treated within twelve months before the effective date of coverage, or a pregnancy existing on the effective date of coverage. After the coverage has been in force for twelve months, we will pay benefits for any pre-existing condition not specifically excluded.

EXCEPTIONS AND LIMITATIONS

The policy pays only for loss resulting from a covered sickness or accident as defined in the policy. It DOES NOT cover loss caused directly or indirectly by:

1. War or any act of war, or while serving in the armed forces of any country or international authority.
2. Attempted suicide or intentional, self-inflicted injury, whether sane or insane.
3. Active participation in a riot or insurrection.
4. Voluntary commission of, or attempting to commit, an assault or felony.
5. Participating in an illegal occupation.
6. Voluntary use of any drug, hallucinogen, controlled substance, or narcotic unless taken as prescribed by a physician.
7. Mental, nervous or emotional disorder without organic origin.
8. Alcoholism or drug addiction.
9. Intoxication as defined by the laws of the jurisdiction in which the loss occurred. Conviction is not necessary for a determination of being intoxicated.
10. Dental, elective, or cosmetic surgery or treatment, except as a result of a covered injury or congenital defect of a newborn child.
11. Hernia, tonsils, or adenoids during the first six (6) months of coverage, unless treated on an emergency basis.
12. Well baby care.
13. Voluntarily acting as an organ donor.

RENEWABILITY AND CONTINUATION

The Hospital Confinement policy and riders are guaranteed renewable during your lifetime. The company may change the established premium rate, but only if the rate is changed for all policies and riders like yours in your state. This coverage will not be issued to anyone 65 years of age or over. If you purchase the policy and riders prior to your 65th birthday, you may continue coverage after age 65, as long as you continue to pay the premium by the due date or during the 31 days that follow. Covered dependents who no longer meet eligibility requirements, may convert to a comparable individual policy without evidence of insurability. A spouse can continue coverage under this policy upon your death.

COVERAGE EFFECTIVE DATE

Effective date means the date shown on the Policy Schedule page for all persons accepted for coverage at the time of issue, provided the application has been accepted and approved by us; the policy is issued; and the first premium has been paid; or the date shown by endorsement for all persons added to coverage after the policy has been issued. The effective date is assigned by the Company in accordance with our policy dating rules in effect at the time your policy is issued. The coverage provided by the policy will not be effective unless there has been effective date of the policy in the health of any proposed covered person listed on the application.