

SERFF Tracking Number: UNUM-127623367 State: Arkansas  
Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 50341  
Company Tracking Number: GROUP CRITICAL ILLNESS/CANCER 1.0  
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
Limited Benefit  
Product Name: Group Critical Illness/Cancer 1.0  
Project Name/Number: Group Critical Illness/Cancer 1.0/Group Critical Illness/Cancer 1.0

## Filing at a Glance

Company: Colonial Life & Accident Insurance Company

Product Name: Group Critical Illness/Cancer 1.0 SERFF Tr Num: UNUM-127623367 State: Arkansas

TOI: H07G Group Health - Specified Disease - Limited Benefit SERFF Status: Closed-Approved- Closed State Tr Num: 50341

Sub-TOI: H07G.001 Critical Illness Co Tr Num: GROUP CRITICAL ILLNESS/CANCER 1.0 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Cathy Brooks, Angela Parker, Lauren Sease, Annette Smith, Tyra Marshall, Jessica Reece, Pam Childers

Disposition Date: 11/30/2011

Date Submitted: 11/28/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Group Critical Illness/Cancer 1.0  
Project Number: Group Critical Illness/Cancer 1.0  
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Authorized  
Date Approved in Domicile:  
Domicile Status Comments: Approved on 11/22/2011.

Explanation for Combination/Other:  
Submission Type: New Submission  
Group Market Type: Association, Employer  
Filing Status Changed: 11/30/2011  
State Status Changed: 11/30/2011

Market Type: Group  
Group Market Size: Small and Large  
Overall Rate Impact:

Created By: Lauren Sease

Deemer Date:

Corresponding Filing Tracking Number:

Submitted By: Lauren Sease

Filing Description:

November 28, 2011

SERFF Tracking Number: UNUM-127623367 State: Arkansas  
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Jay Bradford  
Commissioner of Insurance  
Arkansas Insurance Department  
1200 West 3rd Street  
Little Rock, AR 72201-1904

RE: Group /NAIC#: 0565 / 62049  
Insurer: Colonial Life & Accident Insurance Company  
Forms: GCC1.0-P-AR, et al  
Type of Filing: Group Specified Disease

Dear Commissioner Bradford:

Enclosed for your consideration and approval are the following new group specified disease forms:

Form Number	Description	Flesch Score
GCC1.0-P-AR	Group Specified Disease Policy	51.5
GCC1.0-C-AR	Group Specified Disease Certificate	50.7
R-GCC1.0-BB-AR	Group First Diagnosis Building Benefit Rider	50.2
GCC- App	Policyholder Application	
GCC- Enroll	Enrollment Form	
GCC- Port	Election of Portability Coverage election form	
GCC E of I	Evidence of Insurability	
GCC-P-Amend	Policy Amendment	
GCC-C-Amend	Certificate Amendment	
	Statement of Variability form	
	UW Statement of Variability form	

The forms do not replace any forms currently on file with your department. The readability scores for these forms are listed above. The text of the forms is uniform and no less than ten (10) point font size.

These forms will be offered and marketed as supplemental insurance and not as a substitute for hospital or medical expense insurance or major medical insurance. Benefits provided are not intended to cover all medical expenses. There is no coordination of benefits. Please note all benefits are indemnity based. The level of benefits is not based on the amount of expenses incurred.



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Enrollment methods include agent-assisted situations, in person or via call centers, and self-enrolled situations, using paper or electronic enrollment processes, such as web-based. In some situations where the premium is fully policyholder-paid, enrollment may be by an employee/member listing provided by the policyholder. Electronic enrollment processes may also be used in agent-assisted situations.

The forms were approved by our domicile state, South Carolina, on November 22, 2011. Also, included is the filing fee of \$450.00.

We reserve the right to alter the layout of these forms including ordering of the provision, color, typeface and font and to change variables as requested by a specific employer or to accommodate future product design needs as long as such changes are in compliance with your state law.

If acceptable, we shall appreciate your notifying us via SERFF. If you have any questions, please contact me at (800) 845-7330, extension 86528. My email address is lfsease@coloniallife.com. The fax number is (803) 750-7341.

Sincerely,

Lauren F. Sease  
Senior Compliance Contract Consultant

## Company and Contact

### Filing Contact Information

Lauren Sease, Senior Contract Analyst LfSease@unum.com  
1200 Colonial Life Boulevard 800-845-7330 [Phone] 86528 [Ext]  
Columbia, SC 29202

### Filing Company Information

Colonial Life & Accident Insurance Company CoCode: 62049 State of Domicile: South Carolina  
1200 Colonial Life Boulevard Group Code: 565 Company Type:  
Post Office Box 1365 Group Name: State ID Number:  
Columbia, SC 29202 FEIN Number: 57-0144607  
(803) 798-7000 ext. [Phone]

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## Filing Fees

SERFF Tracking Number: UNUM-127623367 State: Arkansas  
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Fee Required? Yes  
Fee Amount: \$450.00  
Retaliatory? No  
Fee Explanation: \$50 x 9= \$450  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Colonial Life & Accident Insurance Company	\$450.00	11/28/2011	54065615

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/30/2011	11/30/2011

*SERFF Tracking Number:* UNUM-127623367      *State:* Arkansas  
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## **Disposition**

Disposition Date: 11/30/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group Specified Disease Policy	Approved-Closed	Yes
Form	Group Specified Disease Certificate	Approved-Closed	Yes
Form	Group First Diagnosis Building Benefit Rider	Approved-Closed	Yes
Form	Policyholder Application	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Form	Election of Portability Coverage election form	Approved-Closed	Yes
Form	Evidence of Insurability	Approved-Closed	Yes
Form	Policy Amendment	Approved-Closed	Yes
Form	Certificate Amendment	Approved-Closed	Yes

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**Post Submission Update Request Processed On 11/30/2011**

**Status:** Allowed  
**Created By:** Lauren Sease  
**Processed By:** Rosalind Minor  
**Comments:**

**General Information:**

<b>Field Name</b>	<b>Requested Change</b>	<b>Prior Value</b>
Status of Filing in Domicile	Authorized	Pending
Domicile Status Comments	Approved on 11/22/2011.	

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## Form Schedule

### Lead Form Number: GCC1.0-P-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/30/2011	GCC1.0-P-AR	Policy/Contract	Group Specified Disease Policy Certificate	Initial			GCC1.0-P-AR - 75353.pdf
Approved-Closed 11/30/2011	GCC1.0-C-AR	Certificate	Group Specified Disease Certificate	Initial			GCC1.0-C-AR - 75354.pdf
Approved-Closed 11/30/2011	R-GCC1.0-BB-AR	Certificate	Group First Diagnosis Building Benefit Rider	Initial			R-GCC1.0-BB-AR - 75648.pdf
Approved-Closed 11/30/2011	GCC-App	Application/Enrollment Form	Policyholder Application	Initial			GCC - App reg 75250 john doe.pdf
Approved-Closed 11/30/2011	GCC-Enroll	Application/Enrollment Form	Enrollment	Initial			GCC - Enroll reg 75259 john doe.pdf
Approved-Closed 11/30/2011	GCC-Port	Application/Enrollment Form	Election of Portability Coverage election form	Initial			GCC Port reg 75474 John Doe.pdf
Approved-Closed 11/30/2011	GCC-E of I	Application/Enrollment Form	Evidence of Insurability	Initial			GCC- E of I - reg 75260 john doe.pdf
Approved-Closed 11/30/2011	GCC-P-Amend	Policy/Contract	Policy Amendment Certificate: Amendment	Initial			Policy Amendment - reg John Doe draft.pdf

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Approved- GCC-C-  
 Closed Amend  
 11/30/2011

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 reg John Doe  
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**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY**  
[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202  
1.800.325.4368 coloniallylife.com]  
A Stock Company

**[CRITICAL ILLNESS] [AND] [CANCER] GROUP SPECIFIED DISEASE  
INSURANCE POLICY**

**Please Read This Policy Carefully**

This policy is a legal contract between the policyholder and us. To understand the coverage, this policy must be read as a whole.

Throughout this policy, the word **policyholder** refers to the organization shown on the Policy Rate Schedule. **You** or **your** refers to a named insured who is covered under this coverage. **Named insured** refers to the person who is a member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom the policyholder remits premium. **Covered person** refers to any person covered under this policy as described on the Certificate Schedule. **We, us, our** or **company** refers to Colonial Life & Accident Insurance Company. The male pronoun includes the female whenever used.

[This policy is delivered in and is governed by the laws of the governing jurisdiction shown on the Policy Rate Schedule and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, we have discretionary authority to determine the named insured's eligibility for benefits and to interpret the terms and provisions of the policy.]

This policy is issued in consideration of the application of the policyholder, a copy of which is attached to and made a part of this policy, and the payment of premium when due. This policy takes effect at 12:01 a.m. Standard Time at the policyholder's address on the Policy Effective Date shown on the Policy Rate Schedule.

We agree to pay, in accordance with the terms of this policy, the benefit amounts of the policy to the named insureds. Details of the benefits are shown in the certificate.

Signed for Colonial Life & Accident Insurance Company:

[



Secretary



President and Chief Executive Officer]

**THIS IS A LIMITED POLICY.  
PLEASE READ IT CAREFULLY.**

**THE POLICY IS CANCELLABLE AT THE OPTION OF THE COMPANY.  
PLEASE READ THE "TERMINATION OF THIS CONTRACT" PROVISION.**

**THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If you should have any questions, need information about your coverage or assistance in resolving complaints, please contact your agent or Colonial Life at 1.800.325.4368. In the event that we fail to provide you with reasonable and adequate service, feel free to contact the Insurance Department.

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201  
1.501.371.2640

**SECTION 2 – POLICY GUIDE**

**SECTION 1 – FACE PAGE**

**SECTION 2 – POLICY GUIDE**

**SECTION 3 – POLICY RATE SCHEDULE**

**SECTION 4 – POLICYHOLDER PROVISIONS**

**SECTION 5 – PREMIUM PAYMENTS**

**SECTION 6 – TERMINATION**

# COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

## POLICY RATE SCHEDULE

Policyholder: [ABC Employer] Policy Number: [987654321]  
Policyholder Address: [123 Any Street  
Attn:  
Any Town, SC  
99999-9999] Billing Control Number: [E123456]  
Policy Effective Date: [01/01/2011] Governing Jurisdiction: [Any State]  
First Policy Anniversary: [01/01/2012]

### Description of Eligible Classes

[All employees in active employment working a minimum of [15] hours per week. Temporary and seasonal workers are excluded from coverage.]

**Active Employment** means the named insured is working for the policyholder at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. The named insured will not be considered in active employment if employment status is being continued under a severance or termination agreement. The worksite must be:

- the policyholder's usual place of business;
- an alternative work site at the direction of the policyholder; or
- a location to which the named insured's job requires him to travel.

**Material and substantial duties** means duties that are normally required for the performance of the named insured's regular occupation, and cannot be reasonably omitted or modified.

**Regular occupation** means the occupation the named insured routinely performs on his job.]

### [Policyholder Plan Choice for Critical Illness Benefit:

[A member of an eligible class chooses from the following options:

Face Amount for Named Insured in \$1,000 increments from a minimum Face Amount of \$5,000 up to a maximum Face Amount of [\$150,000].]

[A member of an eligible class receives:

Face Amount for Named Insured [\$10,000] [and Face Amount for Spouse [\$5,000]] [and Face Amount for Dependent Children [\$5,000]].]

[A member of an eligible class receives:

Face Amount for Named Insured [\$10,000] [and Face Amount for Spouse [\$5,000]] [and Face Amount for Dependent Children [\$5,000]]. In addition, a member of an eligible class may choose to purchase additional Face Amount for Named Insured in \$1,000 increments, up to a maximum Face Amount of [\$150,000].]

Critical Illnesses Covered:

Heart Attack (Myocardial Infarction), Stroke, End Stage Renal (Kidney) Failure, Major Organ Failure[, Permanent Paralysis Due to a Covered Accident][, Coma][, Blindness][, Occupational HIV or Occupational Infectious Hepatitis B, C or D][, Coronary Artery Bypass Graft Surgery][, Coronary Artery Disease].

[Benefits Payable Upon Subsequent Diagnosis of a Critical Illness]]

### [Policyholder Plan Choice for Cancer Benefits:

Diagnosis of Cancer Benefit

[A member of an eligible class chooses from the following options:

Face Amount for Named Insured in \$1,000 increments from a minimum Face Amount of \$5,000 up to a maximum Face Amount of [\$150,000].

[A member of an eligible class receives:

Face Amount for Named Insured [\$10,000] [and Face Amount for Spouse [\$5,000]] [and Face Amount for Dependent Children [\$5,000]].]

[A member of an eligible class receives:

Face Amount for Named Insured [\$10,000] [and Face Amount for Spouse [\$5,000]] [and Face Amount for Dependent Children [\$5,000]]. In addition, a member of an eligible class may choose to purchase additional Face Amount for Named Insured in \$1,000 increments, up to a maximum Face Amount of [\$150,000].]

[Cancer Treatment and Care Benefit

[A member of an eligible class chooses from the following options:

Monthly benefit amount:

[\$500]

[\$1,000]

Maximum benefit amount for a Cancer Treatment and Care Benefit:

[[12] monthly payments per covered person per lifetime]

[[24] monthly payments per covered person per lifetime]]

[A member of an eligible class receives:

Monthly benefit amount [\$500]

Maximum benefit amount for a Cancer Treatment and Care Benefit:

[12] monthly payments per covered person per lifetime]]

**[Policyholder Plan Choice for Health Screening Benefit:**

Health Screening Benefit of [\$50]

This policy may include enrollment, risk management and other support services related to the policyholder's benefit program.

**Eligibility Period:** [31 days]

**Initial Monthly Rates/Unit for [Critical Illness Benefit] [and] [Diagnosis of Cancer Benefit, Diagnosis of Carcinoma In Situ Benefit, Skin Cancer Benefit, and Cancer Vaccine Benefit]:**

[Named Insured  
\$[XX.XX]/Unit

Named Insured and Spouse  
\$[XX.XX]/Unit

One-Parent Family  
\$[XX.XX]/Unit

Two-Parent Family  
\$[XX.XX]/Unit]

**[Tobacco Premium Class**

Named Insured

Named Insured and Spouse

Issue Ages	Rates/Unit
16-29	\$[XX.XX]
30-39	\$[XX.XX]
40-49	\$[XX.XX]
50-59	\$[XX.XX]
60-74	\$[XX.XX]

Issue Ages	Rates/Unit
16-29	\$[XX.XX]
30-39	\$[XX.XX]
40-49	\$[XX.XX]
50-59	\$[XX.XX]
60-74	\$[XX.XX]

One-Parent Family

Two-Parent Family

Issue Ages	Rates/Unit
16-29	\$[XX.XX]
30-39	\$[XX.XX]
40-49	\$[XX.XX]
50-59	\$[XX.XX]
60-74	\$[XX.XX]

Issue Ages	Rates/Unit
16-29	\$[XX.XX]
30-39	\$[XX.XX]
40-49	\$[XX.XX]
50-59	\$[XX.XX]
60-74	\$[XX.XX]

**Non-Tobacco Premium Class**

Named Insured

Issue Ages	Rates/Unit
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

Named Insured and Spouse

Issue Ages	Rates/Unit
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

One-Parent Family

Issue Ages	Rates/Unit
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

Two-Parent Family

Issue Ages	Rates/Unit
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

**[Uni-Tobacco Premium Class**

Named Insured

Issue Ages	Rates/Unit
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

Named Insured and Spouse

Issue Ages	Rates/Unit
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

One-Parent Family

Issue Ages	Rates/Unit
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

Two-Parent Family

Issue Ages	Rates/Unit
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

Unit means \$1,000 of Face Amount for named insured.

**[Initial Monthly Rates for Cancer Treatment and Care Benefit:**

**[Tobacco Premium Class**

**Rate per \$500 Benefit for [12] monthly payments**

Named Insured

[\$XX.XX]

Named Insured and Spouse

[\$XX.XX]

One-Parent Family

[\$XX.XX]

Two-Parent Family

[\$XX.XX]

**Non-Tobacco Premium Class**

**Rate per \$500 Benefit for [12] monthly payments**

Named Insured

[\$XX.XX]

Named Insured and Spouse

[\$XX.XX]

One-Parent Family

[\$XX.XX]

Two-Parent Family

[\$XX.XX]



**[Uni-Tobacco Premium Class**

Named Insured

Issue Ages	Rates
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

Named Insured and Spouse

Issue Ages	Rates
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

One-Parent Family

Issue Ages	Rates
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]

Two-Parent Family

Issue Ages	Rates
16-29	[\$XX.XX]
30-39	[\$XX.XX]
40-49	[\$XX.XX]
50-59	[\$XX.XX]
60-74	[\$XX.XX]]]

**Rate Guarantee Period:** A change in the premium rate table(s) will not take effect before [one year] after the policy effective date.

**[Divisions, subsidiaries or affiliated companies include:**

Name/location (city and state)]

## SECTION 4 - POLICYHOLDER PROVISIONS

### Ownership

The policyholder is the owner of this policy and may agree with us to change it without the consent of or notice to the covered persons or their assignees.

### Entire Contract

The entire contract consists of:

- this policy;
- the application of the policyholder attached to this policy;
- each named insured's enrollment form and evidence of insurability, if applicable;
- certificates issued under this policy; and
- riders, endorsements or amendments to the policy or certificates.

### Changes to the Contract

Riders, endorsements and amendments add provisions to or change the terms of the policy.

Any changes to this policy, other than a change in the premium we charge, must be in writing and evidenced by endorsement on this policy, or by amendment to this policy signed by the policyholder and one of our executive officers at our home office. No agent or anyone else can change this policy or waive any of its provisions.

### Furnishing Certificates

The company will provide a certificate for each named insured. The certificate will provide a description of the insurance provided by this policy and will state:

- the benefits provided under the policy;
- to whom benefits are payable;
- the limitations, exclusions and requirements that apply to coverage under the policy; and
- how to file a claim against the coverage.

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

### Contestability

After two years from the Policy Effective Date, no misstatements made by the policyholder in the application will be used to void this policy or to deny a claim for loss incurred after the expiration of the two-year period.

### Conformity with State Statutes

Any provision of this policy that is in conflict with the applicable state laws of the state in which the named insured resides when he becomes insured is amended to conform to the minimum requirements of those laws.

### Our Right to Change Premiums

We have the right to change the premium we charge after notifying the policyholder in writing at least [45] days in advance. A change in premium rate table(s) will not take effect before the end of the rate guarantee period shown on the Policy Rate Schedule except for reasons which affect the risk assumed, including, but not limited to those reasons shown below:

- a change occurs in this policy;
- a division, subsidiary, or affiliated company is added or deleted;
- the number of insureds changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this policy.

After the rate guarantee period, we can change premium rate table(s) at any time. A change may take effect on an earlier date when both we and the policyholder agree in writing.

### New Entrants

Any member of an eligible class, as described on the Policy Rate Schedule, and the eligible dependents of those members will become insured when they satisfy the requirements set forth in the certificate of insurance.

### **Information to Be Furnished By the Policyholder**

The policyholder must keep a record of the named insureds and the particulars of the insurance on each and their covered spouse and dependent children, if applicable. As changes occur, the policyholder should provide us, on forms acceptable to us, information relative to any persons:

- who are eligible to enroll;
- who are insured by the coverage;
- whose status changes; and/or
- whose coverage terminates pursuant to the "Termination of Insurance" provision.

The policyholder should also provide us with any other information about the coverage that may be reasonably required, such as named insureds on leave of absence, including named insureds who are on leave under the Family and Medical Leave Act.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time. We may inspect these records at any time while this policy is in force and within one year after the termination of this policy.

All statements made in any application are considered representations and not warranties (absolute guarantees). No representation by the policyholder in applying for insurance under this policy will make it void unless the representation is contained in the application of the policyholder.

Clerical error or omission by us will not:

- prevent a covered person from receiving coverage
- affect the amount of a covered person's coverage; or
- cause a covered person's coverage to begin or continue when the coverage would not otherwise be effective.

### **Electronic Transactions**

Any transaction relating to this policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law. Any notice required by the provisions of this policy given by written, electronic, and telephonic, as applicable, means will have the same force and effect as notice given in writing.

## **SECTION 5 – PREMIUM PAYMENTS**

### **Premium Payments**

The initial premium for each type of coverage under this policy is based on the initial premium rate table(s) shown on the Policy Rate Schedule.

### **Premium Amount**

To ensure accurate premium calculations, the policyholder is responsible for reporting to us the following information during the stated time periods:

- individuals who are eligible to enroll are to be reported during the month prior to or during the month the coverage becomes effective;
- covered persons whose coverage has terminated are to be reported within a month of the date coverage terminated; and
- changes in named insureds' class are to be reported within a month of the date that the change in insurance class took place.

### **When and Where to Pay Premiums**

The premiums for each certificate must be paid to us at our home office when they are due.

The premium due dates are based on:

- the coverage effective dates shown on the Certificate Schedules; and
- the premium frequency.

The premium frequency is how often the premiums are paid. The policyholder will be liable to us for all unpaid premiums for any period, including the grace period, during which coverage under the policy was in force as to any covered person.

Premium increases or decreases which take effect during an insurance month are due on the next premium due date following the change. Changes will not be pro-rated daily.

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

#### **Grace Period (If Premiums Are Not Paid When Due)**

After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. During the grace period this coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate at the end of the grace period.

## **SECTION 6 – TERMINATION**

#### **Termination of This Contract**

This policy can be terminated:

- by the policyholder; or
- by us.

If the premium is not paid when it is due or during the grace period, this policy will terminate automatically at the end of the grace period.

Except for nonpayment of the required premium or the failure to meet continued underwriting standards, we may not cancel the policy prior to the first anniversary date of the policy effective date as specified on the Policy Rate Schedule. After the first anniversary date, we may cancel this policy for any reason.

If we cancel this policy for reasons other than the policyholder's failure to remit premium, a written notice will be delivered to the policyholder by certified mail at least 60 days prior to the cancellation date.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. This policy can be cancelled on an earlier date if we both agree. Coverage will end at 12:00 midnight Standard Time at the policyholder's address on the cancellation date.

If the policy is cancelled, the cancellation will not affect a claim for which we are liable under the terms of this policy.

#### **Policyholder Responsibility to Named Insureds**

If this policy terminates for any reason, the policyholder must:

- notify each named insured of the effective date of the termination; and
- refund or otherwise account to each named insured all contributions received or withheld from them for premiums not actually paid to us.

#### **Workers' Compensation**

This policy is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY**  
[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202  
1.800.325.4368 coloniallife.com]  
A Stock Company

**[CRITICAL ILLNESS] [AND] [CANCER] GROUP SPECIFIED DISEASE INSURANCE  
CERTIFICATE**

**THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE [CRITICAL ILLNESS] [AND]  
[CANCER] GROUP SPECIFIED DISEASE INSURANCE POLICY.**

**THIS IS A LIMITED BENEFIT CERTIFICATE.**

**Please Read This Certificate Carefully**

This is your certificate of coverage as long as you are insured under the policy. You will want to read it carefully and keep it in a safe place.

Throughout this certificate, the word **you** or **your** refers to the named insured shown on the Certificate Schedule, who is a member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom premiums are remitted. **Covered person** refers to any person covered under the policy as described on the Certificate Schedule. **We, us, our** or **company** refers to Colonial Life & Accident Insurance Company. **Policyholder** refers to the organization shown on the Policy Rate Schedule. It includes any division, subsidiary or affiliated company named in the Policy Rate Schedule. **Policy** means the group contract owned by the policyholder and available for review by you. The male pronoun includes the female whenever used. If the terms of your certificate of coverage and the policy differ, the policy will govern.

The policy and this certificate may be changed in whole or in part or cancelled as stated in the policy. Such an action may be taken without the consent of or notice to any covered person. Only an executive officer at our home office can approve a change. The approval must be in writing and evidenced by endorsement on the policy or certificate or an amendment signed by the policyholder and one of our executive officers at our home office. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes. This Certificate replaces any and all Certificates previously issued for the eligible classes under the Policy.

[The policy and this certificate are delivered in and are governed by the laws of the governing jurisdiction shown on the Policy Rate Schedule and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, we have discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.]

Signed for Colonial Life & Accident Insurance Company:

[



Secretary



President and Chief Executive Officer]

**Please read this certificate carefully.**

**THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

**If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.**

**If you should have any questions, need information about your coverage or assistance in resolving complaints, please contact your agent or Colonial Life at 1.800.325.4368. In the event that we fail to provide you with reasonable and adequate service, feel free to contact the Insurance Department.**

**Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201  
1.501.371.2640**

## **SECTION 2 – CERTIFICATE GUIDE**

<b>SECTION 1</b>	<b>FACE PAGE</b>
<b>SECTION 2</b>	<b>CERTIFICATE GUIDE</b>
<b>SECTION 3</b>	<b>CERTIFICATE SCHEDULE</b>
<b>SECTION 4</b>	<b>GENERAL DEFINITIONS</b>
<b>[SECTION [5]</b>	<b>DEFINITIONS FOR CRITICAL ILLNESS BENEFIT]</b>
<b>[SECTION [6]</b>	<b>DEFINITIONS FOR CANCER BENEFITS]</b>
<b>SECTION [7]</b>	<b>ELIGIBILITY AND EFFECTIVE DATE</b>
<b>[SECTION [8]</b>	<b>BENEFIT FOR CRITICAL ILLNESS]</b>
<b>[SECTION [9]</b>	<b>BENEFITS FOR CANCER]</b>
<b>[SECTION [10]</b>	<b>HEALTH SCREENING BENEFIT]</b>
<b>[SECTION [11]</b>	<b>EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS]</b>
<b>[SECTION [12]</b>	<b>EXCLUSIONS AND LIMITATIONS FOR CANCER]</b>
<b>SECTION [13]</b>	<b>TERMINATION OF INSURANCE</b>
<b>[SECTION [14]</b>	<b>PORTABILITY]</b>
<b>SECTION [15]</b>	<b>GENERAL PROVISIONS</b>
<b>SECTION [16]</b>	<b>CLAIM PROVISIONS</b>

# COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

## CERTIFICATE SCHEDULE

Policyholder: [ABC Employer]

Policy Number: [123456]

Named Insured: [John A. Doe]

Certificate Number: [0000000000]

Coverage Type: [Two-Parent Family]

Governing Jurisdiction: [Any State]

Coverage Effective Date: [01/01/2011]

Billing Control Number: [E123456]

[Pre-existing Condition Limitation Period: 12 months]

Premium Class: [Non-Tobacco]

### BENEFITS

Face Amount for Named Insured	[\$5,000-\$150,000 in \$1,000 increments]
[Face Amount for Spouse]	[\$1,250 -\$150,000 in \$250 increments]
[Face Amount for Dependent Children]	[\$1,250-\$150,000 in \$250 increments]

**The Face Amount(s) will reduce by 50% on the first Policy Anniversary Date after the named insured attains age 75.**

#### [Critical Illness Benefit

#### Percentage of Face Amount

Heart Attack (Myocardial Infarction)	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
[Permanent Paralysis due to a Covered Accident	100%]
[Coma	100%]
[Blindness	100%]
[Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D	100%]
[Coronary Artery Bypass Graft Surgery	25%]
[Coronary Artery Disease	25%]

[Maximum Benefit Amount for Critical Illness: 100% of the Face Amount per covered person per lifetime.]

#### [Cancer Benefits

#### Percentage of Face Amount

Diagnosis of Cancer Benefit	100%
Diagnosis of Carcinoma in Situ Benefit	25%

Maximum Benefit Amount for a Diagnosis of Cancer Benefit: 100% of the Face Amount per covered person per lifetime.

Maximum Benefit Amount for a Diagnosis of Carcinoma in Situ Benefit: 25% of the Face Amount per covered person per lifetime.

[Cancer Treatment and Care Benefit	[\$500-\$3,000 in \$500 increments] per covered person, per calendar month
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Maximum Benefit Amount for a Cancer Treatment and Care Benefit: [24] monthly payments per covered person per lifetime.]

Skin Cancer Benefit	[\$500] per covered person, per lifetime
Cancer Vaccine Benefit	\$50 per covered person, per lifetime]

#### [Health Screening Benefit

[50] [100] [150]  
per covered person, per calendar year]

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## SECTION 4 – GENERAL DEFINITIONS

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

**Calendar Year** means the period beginning on the coverage effective date shown on the Certificate Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

**Coverage Effective Date** means the date coverage begins as shown in the Certificate Schedule. The coverage effective date of this certificate is not the date you signed the application for coverage.

**Dependent Children** means your natural children, your step-children, your legally adopted children, children under your charge, care and control for whom you have filed a petition to adopt or children for whom you are ordered by a court to provide coverage [who are][:]

- [chiefly dependent on you or your spouse for support; ] [and]
- [unmarried;] [and]
- [under 26 years of age].

**Doctor or Physician** means a person who:

- is licensed by the state to practice a healing art; and
- performs services for a covered person which are allowed by his license.

For purposes of this definition, Doctor or Physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

**Evidence of Insurability** means a statement of your medical history which we will use to determine if you are approved for coverage.

**Policy Anniversary Date** means the date that occurs annually on the same day and in the same month as the First Policy Anniversary shown on the Policy Rate Schedule.

**[Pre-existing Condition** means a sickness or physical condition for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.]

**Spouse** means a person who is married to you on the day we issue your certificate.

**Temporary Layoff or Leave of Absence** means the named insured is temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the employer. Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**[Waiting Period** means the first 30 days following each covered person's coverage effective date during which no benefits are payable.]

## [SECTION] [ 5] – DEFINITIONS FOR CRITICAL ILLNESS BENEFIT

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

**[Accident** means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.]

**[Blindness** means clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity), or visual field restriction to 20° or less in both eyes.

The following are not to be construed as blindness for purposes of this certificate:

- if, in general medical opinion, any procedure, device, or implant could result in the partial or total restoration of sight;

- if the covered person has not attained age three or above on the date of diagnosis, and
- if the covered person’s reduction of sight, as defined above, occurs prior to the coverage effective date of the covered person’s coverage under this certificate.]

**Cardiologist** means a doctor who is licensed to practice medicine and who is also licensed to practice by the American Board of Internal Medicine in the subspecialty of cardiovascular disease.

**[Coma** means a continuous state of profound unconsciousness resulting from a covered accident or a covered sickness, characterized by the absence of:

- eye opening,
- motor response, and
- verbal response.

The condition must require intubation for respiratory assistance. The term “coma” does not include any medically induced coma.]

**[Coronary Artery Bypass Graft Surgery** means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.]

**[Coronary Artery Disease** means a narrowing or blockage of one or more coronary arteries for which a cardiologist recommends that coronary artery bypass graft surgery occur within 60 days following the date of the recommendation.]

**[Covered Accident** means an accident which:

- occurs on or after the coverage effective date shown on the Certificate Schedule;
- occurs while this certificate is in force; and
- is not excluded by name or specific description in this certificate.]

**[Covered Sickness** means a sickness which:

- occurs on or after the coverage effective date shown on the Certificate Schedule;
- occurs while this certificate is in force; and
- is not excluded by name or specific description in this certificate.]

**Critical Illness** means one of the specified illnesses listed in the Critical Illness Benefit section of the Certificate Schedule.

### **Date of Diagnosis**

- for *Heart Attack (Myocardial Infarction)*, the date that the ischemic death of a portion of the heart muscle (myocardium) occurred based on the applicable criteria listed under the heart attack (myocardial infarction) definition;
- for *Stroke*, the date a stroke occurred based on neuroimaging or other neurodiagnostic study consistent with an acute or subacute infarction, hemorrhage, embolism, thrombosis and presence of neurological deficits persisting for a period of 30 days or greater;
- for *End Stage Renal (Kidney) Failure*, the date that regular hemodialysis or peritoneal dialysis begins;
- for *Major Organ Failure*, the date that the covered person is placed on the UNOS list for transplantation;
- [for *Permanent Paralysis due to a Covered Accident*, the date the doctor confirms the permanent paralysis due to a covered accident continued for a period of 180 consecutive days;]
- [for *Coma*, the date a doctor confirms a coma resulting from a covered accident or a covered sickness has lasted 7 or more consecutive days;]
- [for *Blindness*, the date the doctor confirms the irreversible reduction of sight has continued for a period of 180 consecutive days;]
- [for *Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D*, the date of a positive antibody test for HIV or Hepatitis B, C or D subsequent to a prior negative test for the same condition with a lapse of between 90 and 180 days between the two tests;]
- [for *Coronary Artery Bypass Graft Surgery*, the date the covered person undergoes the open heart surgery] [; and]
- [for *Coronary Artery Disease*, the date the cardiologist recommends the covered person undergo coronary artery bypass graft surgery within the 60 days following the date of the recommendation].

**End Stage Renal (Kidney) Failure** means chronic irreversible failure of the function of both kidneys such that the covered person must undergo at least weekly hemodialysis or peritoneal dialysis.

**Heart Attack (Myocardial Infarction)** means the ischemic death of a portion of heart muscle (myocardium) as a result of obstruction of one or more of the coronary arteries. A positive diagnosis of myocardial infarction must occur and must be supported by three or more of the following:

- chest pain;
- electrocardiographic (EKG) changes indicative of myocardial infarction; in the case of myocardial infarction associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria in establishing a diagnosis;
- elevation of biochemical markers of myocardial necrosis; and
- confirmatory imaging studies.

In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying heart attack (myocardial infarction) as the cause of death will be accepted.

A heart attack (myocardial infarction) is not congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest (including arrhythmias), or any other disease, injury or dysfunction of the cardiovascular system.

**Major Organ Failure** means diagnosis of major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the covered person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

**[Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D** means diagnosis of Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C or D resulting from exposure to HIV-contaminated or Hepatitis B, C or D contaminated body fluids as the result of a covered accident during the normal course of performing an occupation for which remuneration is earned.

We will pay this benefit if:

- within five days of the covered accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards or guidelines that apply to the covered person's occupation or profession;
- the covered accident is investigated and a written investigation report is provided to us by the covered person's employer;
- a confirmatory antibody HIV or Hepatitis B, C or D test is taken within five days of the covered accident and HIV or Hepatitis B, C or D is not present;
- all HIV or Hepatitis B, C or D tests are performed by a state certified and licensed laboratory; and
- a follow-up confirmatory antibody HIV or Hepatitis B, C or D test is taken between 90 days and 180 days after the covered accident, and the result is positive.

Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D excludes:

- HIV or Hepatitis B, C or D infection as the result of IV drug use;
- HIV or Hepatitis B, C or D infection as the result of sexual transmission; and
- HIV or Hepatitis B, C or D infection determined not to have been the result of a covered accident.]

**[Permanent Paralysis Due to a Covered Accident** means the complete and permanent loss of the use of two or more limbs through paralysis as the result of a covered accident as defined in this certificate for a continuous period of 180 days, as confirmed by a doctor. Loss of use of two or more limbs through paralysis as the result of a stroke will not be construed as permanent paralysis due to a covered accident for purposes of this certificate.]

**[Sickness** means an illness, infection, disease or any other abnormal physical condition not caused by an accident. Sickness includes complications of pregnancy.]

**Stroke** means an acute or sub-acute cerebrovascular incident, including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by:

- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new stroke.

The following are not to be construed as a stroke for purposes of this certificate:

- transient ischemic attack;
- brain injury related to trauma or infection;
- brain injury associated with hypoxia/anoxia or hypotension;
- vascular disease affecting the eye or optic nerve; and
- ischemic disorders of the vestibular system.

In the event of death, an autopsy confirmation identifying stroke as the cause of death will be accepted.]

## **[SECTION [6] – DEFINITIONS FOR CANCER BENEFITS**

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

**[Ambulatory Surgical Center** means a place which:

- is equipped for surgical procedures performed by qualified physicians;
- provides anesthesia administered by a licensed anesthesiologist or licensed nurse anesthetist; and
- has written agreements with local hospitals to immediately accept patients who develop complications.]

**Cancer (internal or invasive)** means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.

The following are not to be construed as cancer (internal or invasive) for purposes of this certificate:

- pre-malignant conditions or conditions with malignant potential;
- carcinoma in situ;
- basal cell carcinoma and squamous cell carcinoma of the skin; and
- melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

**Carcinoma in Situ** means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. Skin cancer will not be considered carcinoma in situ for purposes of this certificate.

**[Chemotherapy** means treatment with chemical substances that have a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of cancer (internal or invasive).]

**Date of Diagnosis for Cancer (internal or invasive) or Carcinoma in Situ means** the date the tissue specimen, blood samples or titer(s) are taken upon which the diagnosis of cancer (internal or invasive) or carcinoma in situ is based.

**[Hospice** means an organization that provides care for the terminally ill that:

- is licensed by a governmental agency;
- is accredited by the Joint Commission on Accreditation of Hospitals; or
- is qualified to receive benefit payments from Medicare or Medicaid.

The organization must have on its staff at least one doctor and one registered nurse and must keep complete medical records for each patient.

Hospice does not include:

- food services, meals, and dietary counseling; or
- services related to well-baby care; or
- services provided by volunteers; or
- support for the family after the death of the covered person.]

**[Hospital** means a place that:

- is run according to law on a full-time basis;
- provides overnight care of injured and sick people;
- is supervised by a doctor;

- has full-time nurses supervised by a registered nurse; and
- has at its locations or uses on a pre-arranged basis: X-ray equipment, a laboratory and an operating room where surgical operations take place.

Notwithstanding the above, a hospital is not:

- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a rehabilitation center;
- a place for alcoholics or drug addicts; or
- an assisted living facility.]

**[Oral Chemotherapy** means chemotherapy taken by mouth.]

**Pathologist** means a doctor who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

**[Radiation** means the following treatments for the purpose of the destruction of malignant cells during the treatment of internal or invasive (not skin) cancer:

- teloradiotherapy, using either natural or artificially propagated radiation; or
- interstitial or intracavitary application of radium or radioisotopes in sealed or non-sealed sources.

Office visits, laboratory tests, diagnostic X-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy, laser surgery or other procedures related to these treatments will not be considered radiation.]

**Skin Cancer** means melanoma of Clark's Level I or II (Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin.

**[Supportive or Protective Care Drugs and Colony Stimulating Factors** means:

- bone marrow growth factors;
- radiation and chemotherapy protectants; and
- medications that promote bone growth.

Supportive or Protective Care Drugs must be approved for the treatment of cancer (internal or invasive) by the United States Food and Drug Administration and must be prescribed by a physician.]

**[Surgery** means the cutting into the skin or other organ to accomplish any of the following goals:

- take a biopsy of a suspicious lump that results in a diagnosis of cancer (internal or invasive) or carcinoma in situ;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- reconstruct anatomic defects that result from treatment of cancer (internal or invasive) or carcinoma in situ; or
- restore proper function.

The following will not be considered a surgical procedure for the purposes of this certificate:

- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags;

- catherization; or
- scopes not requiring biopsy or removal of tissue.]

[**Topical Chemotherapy** means a chemotherapy drug placed directly onto the skin.]

## **SECTION [7]– ELIGIBILITY AND EFFECTIVE DATE**

### **Coverage Effective Date**

Your coverage under the policy will start at 12:01 a.m. Standard Time in the time zone where you live on the coverage effective date shown on your Certificate Schedule.

### **Enrollment**

An individual who is a member of an eligible class may enroll in coverage during the eligibility period, as shown on the Policy Rate Schedule, that follows the later of:

- the policy effective date as shown on the Policy Rate Schedule;
- the date the individual first becomes a member of an eligible class;
- the date the individual completes the policyholder probationary period shown on the application of the policyholder, if applicable;
- the date the individual meets evidence of insurability requirements, if any.

An individual who fails to enroll during the eligibility period may enroll only during an open enrollment period. Evidence of insurability may be required. The policyholder and the company will determine when an open enrollment period begins and ends.

After the coverage effective date, the named insured cannot make any changes to the coverage type under the certificate until an open enrollment period, unless the named insured has a qualifying event. A qualifying event, for the purposes of this provision, means:

- birth or adoption of a child;
- issuance of a court order requiring coverage of a child;
- marriage;
- divorce; or
- death of a covered person.

The named insured will have 31 days from the date of occurrence of a qualifying event in which to:

- notify us he wishes to make a change;
- complete any required enrollment form; and
- pay any additional premium, if applicable.

### **Delayed Coverage Effective Date**

The effective date of your coverage will be delayed if you are not a member of an eligible class on the coverage effective date shown on the Certificate Schedule. The coverage will be effective on the date that you return to status as a member of an eligible class. If this is named insured and spouse coverage, one-parent family or two-parent family coverage, coverage on the spouse and/or dependent children will be effective on the date that you return to status as a member of an eligible class.

### **Who is Covered By This Certificate**

If this is named insured coverage as shown on the Certificate Schedule, we insure you, the named insured.

If this is named insured and spouse coverage as shown on the Certificate Schedule, we insure you and your spouse.

If this is one-parent family coverage as shown on the Certificate Schedule, we insure you and your dependent children.

If this is two-parent family coverage as shown on the Certificate Schedule, we insure you, your spouse and your dependent children.

You may not apply for coverage for your spouse if your spouse is covered as a named insured.

Coverage on newborn children begins from the moment of live birth. If the coverage is named insured coverage or named insured and spouse coverage, the coverage on the newborn will end on the later of 90 days from the date of birth or the next premium due date following the date of birth.

Coverage for adopted children begins with the earlier of the date you have a filed petition to adopt or from the moment of birth if the petition for adoption is filed within 60 days after the birth of the child. If the coverage is named insured coverage or named insured and spouse coverage, the coverage on the adopted child will end 60 days from the date of the filing of the petition for adoption or from the date of birth of the child if you do not request a change in coverage type as provided in the Enrollment provision above. If the coverage is named insured coverage or named insured and spouse coverage, the coverage on the newborn or newly adopted child will end 90 days later if you do not request a change in coverage type as provided in the Enrollment provision above.

## **[SECTION [8] – BENEFIT FOR CRITICAL ILLNESS**

### **Critical Illness Benefit**

We will pay this benefit if a covered person is diagnosed with a critical illness, as defined in this Certificate, and:

- [the date of diagnosis is after the waiting period;]
- the date of diagnosis is while this certificate is in force; and
- the critical illness is not excluded by name or specific description in this certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule for the critical illness diagnosed [up to the Maximum Benefit Amount for Critical Illness shown on the Certificate Schedule].

We will pay the benefit for [Coronary Artery Bypass Graft Surgery] [Coronary Artery Disease] only once per lifetime per covered person. [If a covered person receives a benefit for [Coronary Artery Bypass Graft Surgery] [Coronary Artery Disease] and is later diagnosed with a different critical illness, we will pay the face amount less the amount received for [Coronary Artery Bypass Graft Surgery] [Coronary Artery Disease].]

If, on the same day, a covered person is placed on the UNOS list for a transplant of two or more major organs listed above in the definition of major organ failure (example: heart and lungs), a single benefit will be paid.

[We will pay the benefit for Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D only once per lifetime per covered person.]

If the date of diagnosis of two or more critical illnesses is the same day, we will pay only one critical illness benefit. We will pay the larger of the critical illness benefit.

**The Critical Illness Benefit is not payable for conditions other than the critical illnesses defined in this certificate.**

### **[Benefit Payable Upon Subsequent Diagnosis of a Critical Illness**

If a covered person has been diagnosed with and received a benefit for a critical illness and is subsequently diagnosed with a **different** critical illness, we will pay the percentage of the covered person's face amount as shown on the Certificate Schedule for the critical illness diagnosed, if:

- the date of diagnosis of the subsequent critical illness is more than 180 days after any previous date of diagnosis for a critical illness;
- the subsequent date of diagnosis is while coverage under this certificate is in force; and
- the critical illness is not excluded by name or specific description in this certificate.

If a covered person has been diagnosed with and received a benefit for a critical illness and is subsequently diagnosed with the **same** critical illness (other than [Coronary Artery Bypass Graft Surgery] [Coronary Artery Disease][ and] [Occupational Infectious HIV or Occupational Infectious Hepatitis B, C or D]), we will pay an amount equal to 25 percent of the Face Amount for the covered person as shown on the Certificate Schedule, if:

- the date of diagnosis of the subsequent critical illness is more than 180 days after any previous date of diagnosis for the same critical illness;
- the covered person has not received treatment during the 180 days between the dates of diagnosis for the same critical illness. For purposes of the preceding sentence, treatment does not include medications and follow-up visits to the

- covered person's doctor;
- the subsequent date of diagnosis is while coverage under this certificate is in force; and
- the critical illness is not excluded by name or specific description in this certificate.]

### **Benefit Reduction**

The Face Amount(s) will reduce by 50 percent on the first policy anniversary date after the named insured attains age 75. All critical illness benefits payable after that date will be based on the reduced Face Amount.]

## **[SECTION [9] – BENEFITS FOR CANCER**

### **Diagnosis of Cancer Benefit**

We will pay this benefit when you are diagnosed as having cancer (internal or invasive) if:

- [the date of diagnosis is after the waiting period];
- the date of diagnosis is while this certificate is in force;
- [for a cancer (internal or invasive) diagnosed during the 12 months following the coverage effective date, the cancer (internal or invasive) is not a pre-existing condition;] and
- the cancer (internal or invasive) is not excluded by name or specific description in the certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule. We will pay no more than the Maximum Benefit Amount for the Diagnosis of Cancer shown on the Certificate Schedule per covered person per lifetime.

[We will not pay the Diagnosis of Cancer Benefit for any cancer (internal or invasive) diagnosed during the 12 months following the coverage effective date if the cancer (internal or invasive) is a pre-existing condition.]

Cancer (internal or invasive) must be diagnosed in one of two ways:

#### **1. Pathological Diagnosis**

A *pathological diagnosis* of cancer (internal or invasive) is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a pathologist whose diagnosis of malignancy is in keeping with the standards established by the American Board of Pathology. A pathological diagnosis of cancer (internal or invasive) can be made before or after death.

#### **2. Clinical Diagnosis**

A *clinical diagnosis* of cancer (internal or invasive) is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for cancer (internal or invasive).

In addition to the pathological or clinical diagnosis required, we may require additional information from the attending doctor and hospital.

If a covered person has been diagnosed with and received a benefit for carcinoma in situ and is subsequently diagnosed with cancer (internal or invasive), we will pay the Diagnosis of Cancer Benefit for the covered person as shown on the Certificate Schedule, up to the Maximum Benefit Amount for a Diagnosis of Cancer Benefit and subject to the provisions of this certificate, if the date of diagnosis of the cancer (internal or invasive) is more than 180 days after the date of diagnosis for the carcinoma in situ.

### **Diagnosis of Carcinoma In Situ Benefit**

We will pay this benefit when you are diagnosed as having carcinoma in situ, if:

- [the date of diagnosis is after the waiting period];
- the date of diagnosis is while this certificate is in force;
- [for a carcinoma in situ diagnosed during the 12 months following the coverage effective date, the carcinoma in situ is not a pre-existing condition;] and
- the carcinoma in situ is not excluded by name or specific description in the certificate.

We will pay the percentage of the covered person's face amount shown on the Certificate Schedule. We will pay no more than the Maximum Benefit Amount for the Diagnosis of Carcinoma In Situ shown on the Certificate Schedule per covered person per lifetime.

[We will not pay the Diagnosis of Carcinoma In Situ Benefit for any carcinoma in situ diagnosed during the 12 months following the coverage effective date if the carcinoma in situ is a pre-existing condition.]

Carcinoma in situ must be diagnosed in one of two ways:

### **1. Pathological Diagnosis**

A *pathological diagnosis* of carcinoma in situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a pathologist whose diagnosis of malignancy is in keeping with the standards established by the American Board of Pathology. A pathological diagnosis of carcinoma in situ can be made before or after death.

### **2. Clinical Diagnosis**

A *clinical diagnosis* of carcinoma in situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for carcinoma in situ.

In addition to the pathological or clinical diagnosis required, we may require additional information from the attending doctor and hospital.

If a covered person has been diagnosed with and received a benefit for cancer (internal or invasive) and is subsequently diagnosed with carcinoma in situ, we will pay the Diagnosis of Carcinoma In Situ Benefit for the covered person as shown on the Certificate Schedule, up to the Maximum Benefit Amount for a Diagnosis of Carcinoma In Situ Benefit and subject to the provisions of this certificate, if the date of diagnosis of the carcinoma in situ is more than 180 days after the date of diagnosis for the cancer (internal or invasive).

### **Skin Cancer Benefit**

We will pay this benefit if a covered person is diagnosed with skin cancer if:

- the date of diagnosis is while this certificate is in force;
- [for a skin cancer diagnosed during the 12 months following the coverage effective date, the skin cancer is not a pre-existing condition;] and
- the skin cancer is not excluded by name or specific description in this certificate.

We will pay the amount shown on the Certificate Schedule.

We will pay this benefit only once per covered person per lifetime.

### **[Cancer Treatment and Care Benefit**

We will pay benefits for Cancer Treatment and Care if:

- a covered person receives a covered treatment for cancer (internal or invasive) or carcinoma in situ while this certificate is in force;
- a covered person receives a covered treatment for cancer (internal or invasive) or carcinoma in situ within the United States;
- the cancer (internal or invasive) or carcinoma in situ is not excluded by name or specific description in the certificate; and
- the covered treatment is not excluded by name or specific description in the certificate.

We will pay the amount shown on the Certificate Schedule for each calendar month during which a covered person incurs charges for and receives one or more of the covered treatments listed below as a result of cancer (internal or invasive) or carcinoma in situ, up to the Maximum Benefit Amount for Cancer Treatment and Care Benefit shown on the Certificate Schedule.

We will pay no more than one Cancer Treatment and Care Benefit per calendar month per covered person.

Covered Treatments consist of the following:

- **Chemotherapy**, consisting of one or more of the following:
  - chemotherapy treatments injected by medical personnel in a doctor’s office, clinic or hospital;
  - a prescription filled for oral chemotherapy;
  - a prescription filled for topical chemotherapy;
  - a pump for chemotherapy initially filled or refilled;
  - a prescription filled for chemotherapy to be injected by yourself or anyone other than personnel in a doctor’s office, clinic or hospital; or
  - a prescription filled for supportive and protective care drugs and colony stimulating factors.
- **Radiation** delivered by medical personnel in a doctor’s office, clinic or hospital.
- **Confinement** to a bed as a resident inpatient in a hospital (including intensive care) on the advice of a doctor or confinement in an observation unit within a hospital for a period of no less than 20 continuous hours on the advice of a doctor.
- **Surgery** performed by a doctor in a hospital or ambulatory surgical center.
- **Hospice Care**, consisting of one or more of the following services received by a covered person for whom a doctor determines that cancer treatments are no longer of benefit and that he is expected to live for only six months or less:
  - a visit from a representative of a hospice care team at home;
  - the services of a hospital on an outpatient basis under the direction of a hospice;
  - a visit to a hospice on an outpatient basis for treatment or services; and
  - confinement to a hospice care facility.

[If the covered person’s cancer (internal or invasive) or carcinoma in situ [is a pre-existing condition] [has a date of diagnosis before the end of the waiting period], coverage for that cancer (internal or invasive) or carcinoma in situ will apply only to treatment of cancer (internal or invasive) or carcinoma in situ commencing after this certificate has been in force for 12 months, unless the cancer (internal or invasive) or carcinoma in situ is excluded by name or specific description in this certificate. In the alternative, you may elect to void the certificate and receive a full refund of premium.]]

**Cancer Vaccine Benefit**

We will pay this benefit if a covered person incurs a charge for and receives any cancer vaccine that is FDA approved for the prevention of cancer. The vaccine must be administered by licensed medical personnel while coverage under this certificate is in force. We will pay the amount shown on the Certificate Schedule. This benefit is limited to one payment per covered person, per lifetime.

**Benefit Reduction**

The Face Amount(s) and the Maximum Benefit Amount for a Diagnosis of Cancer Benefit and the Maximum Benefit Amount for a Diagnosis of Carcinoma In Situ will reduce by 50% on the policy anniversary date after the named insured attains age 75. All Diagnosis of Cancer Benefits and Diagnosis of Carcinoma In Situ Benefits payable after that date will be based on the reduced Face Amount and the reduced Maximum Benefit Amount.]

**[SECTION [10] – HEALTH SCREENING BENEFIT**

**Health Screening Benefit**

We will pay this benefit if any covered person incurs charges for and has one of the health screening tests listed below performed while this certificate is in force. We will pay the amount shown on the Certificate Schedule for one of the following screening tests:

Stress test on a bicycle or treadmill	Skin cancer biopsy	Hemoccult stool analysis
Fasting blood glucose test	Breast ultrasound	Mammography
Blood test for triglycerides	CA 15-3 (blood test for breast cancer)	Pap smear
Serum Cholesterol test to determine level of HDL and LDL	CA 125 (blood test for ovarian cancer)	PSA (blood test for prostate cancer)
Bone marrow testing	CEA (blood test for colon cancer)	Serum protein electrophoresis(blood test for myeloma)
Carotid Doppler	Chest x-ray	Thermography
Electrocardiogram (EKG, ECG)	Colonoscopy	ThinPrep pap test
Echocardiogram (ECHO)	Flexible sigmoidoscopy	Virtual colonoscopy

We will pay a maximum of one Health Screening Benefit per covered person per calendar year.]

## **[SECTION [11] –EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS**

We will not pay benefits for a critical illness that occurs as a result of a covered person's:

### **Alcoholism or Drug Addiction**

Addiction to alcohol or drugs, except for drugs taken as prescribed by his doctor.

### **Felonies or Illegal Occupations**

Committing or attempting to commit a felony or engaging in an illegal occupation.

### **Intoxicants and Narcotics**

Being intoxicated or under the influence of any narcotic unless administered on the advice of his doctor.

### **Psychiatric or Psychological Conditions**

Having a psychiatric or psychological condition, including neuroses, psychoneurosis, psychopathy, psychosis, mental or emotional disease or disorder of any kind. However, Alzheimer's Disease and other organic senile dementias are covered under this certificate.

### **Suicide or Injuries Which Any Covered Person Intentionally Does to Himself**

Committing or trying to commit suicide or his injuring himself intentionally, whether he is sane or not.

### **War or Armed Conflict**

Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

### **[Pre-Existing Condition Limitation**

We will not pay the Critical Illness Benefit [or Benefits Payable Upon Subsequent Diagnosis of a Critical Illness] for any covered person when the critical illness is a pre-existing condition as defined in this certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.] [Credit toward the satisfaction of the pre-existing condition limitation period will be given for any continuous time the covered person was covered under the pre-existing condition clause of previous coverage through another carrier if:

- The previous coverage was similar to or exceeded the coverage provided under this certificate;
- The covered person was insured under the previous coverage at the time of enrollment in the coverage provided by this certificate; and
- The covered person was insured under the coverage provided by this certificate on the Policy Effective Date shown on the Policy Rate Schedule.

The covered person is responsible for furnishing proof of his previous coverage, to include type of coverage, length the previous coverage was in force and the date the previous coverage terminated.]]

## **[SECTION [12] –EXCLUSIONS AND LIMITATIONS FOR CANCER**

We will not pay the Diagnosis of Cancer Benefit, Diagnosis of Carcinoma In Situ Benefit [, the Cancer Treatment and Care Benefit] or the Skin Cancer Benefit for a covered person's cancer (internal or invasive), carcinoma in situ or skin cancer that:

### **[Pre-Existing Condition Limitation**

Is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having cancer (internal or invasive), carcinoma in situ or skin cancer. No Pre-existing Condition Limitation will be applied for dependent children who are born or adopted while you are covered under this policy, and who are continuously covered from the date of birth or adoption.] [Credit toward the satisfaction of the pre-existing condition limitation period will be given for any continuous time the covered person was covered under the pre-existing condition clause of previous coverage through another carrier if:

- The previous coverage was similar to or exceeded the coverage provided under this certificate;

- The covered person was insured under the previous coverage at the time of enrollment in the coverage provided by this certificate; and
- The covered person was insured under the coverage provided by this certificate on the Policy Effective Date shown on the Policy Rate Schedule.

The covered person is responsible for furnishing proof of his previous coverage, to include type of coverage, length the previous coverage was in force and the date the previous coverage terminated.]

### **Geographical Limitation**

Is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.]

## **SECTION [13] – TERMINATION OF INSURANCE**

### **Termination of The Named Insured's Coverage**

The coverage on a named insured under the policy will terminate on the earliest of the following dates:

- the date the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for the named insured; or
- the date the named insured is no longer in an eligible class; or
- the date the named insured's class is no longer included for insurance; or
- [the date the Maximum Benefit Amount for Critical Illness as shown on the Certificate Schedule has been paid; or ]
- the date the next premium is due after the named insured asks us to end his coverage.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while you are covered.

### **When Coverage Ends on Your Spouse and Dependent Children**

If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date your coverage under the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your spouse; or
- the date the next premium is due after you ask us to end your spouse's coverage; or
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage under the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your dependent children; or
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while your spouse and/or dependent child is covered.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in this certificate. [A dependent child who reaches age 26 may remain covered if that child is and continues to be mentally or physically handicapped and is dependent on you for support and maintenance. Upon our request and at our expense, you must submit proof of incapacity for dependency to us for a child whose coverage would otherwise terminate if not incapacitated or dependent.] We will continue to charge any appropriate premium for that child as long as he meets the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

## **Leave of Absence Under the Family and Medical Leave Act**

A named insured may continue his coverage during absences for family or medical leave. If a named insured is on a family or medical leave of absence, coverage will continue under this certificate as if the named insured were in active employment, if the following conditions are met:

- the premiums are paid in accordance with the policy's provisions; and
- the policyholder has approved the named insured's leave in writing.

Coverage will be continued for up to the greater of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, upon the named insured's return to active employment:

- [no new waiting periods will be applied]; [and]
- [no new pre-existing condition limitation will be applied; and]
- no new evidence of insurability will be required to reinstate the coverage which was in effect before the leave began.

In order for these conditions to apply, the policyholder must notify us and commence paying premiums for the named insured's coverage within 31 days following a named insured's return to active employment following a leave of absence for family or medical leave.

[The time period in the pre-existing condition limitation period will continue to run through a named insured's family or medical leave of absence.]

## **Leave of Absence – Other**

If the named insured is on a temporary layoff or leave of absence other than for family or medical leave and premium is paid in accordance with the policy's provisions, he will be covered through the premium due date immediately following the date the temporary layoff or leave of absence begins.

If premium is remitted beyond the premium due date referenced above, our only liability will be to return the premium.

## **[SECTION [14] PORTABILITY**

### **Portability Privilege**

We will provide specified disease insurance portability coverage, subject to these provisions.

Such coverage will not be available for a named insured, unless:

- that named insured specified disease insurance under the policy terminates under the provision Termination of the Named Insured's Coverage for one of the following reasons:
  - the named insured is no longer in an eligible class; or
  - the named insured's class is no longer included for insurance; or,
  - in the case of a named insured's coverage under which a covered person has been diagnosed as having cancer (internal or invasive) while this certificate is in force or has received at least one Cancer Treatment and Care Benefit payment, and for whom the Maximum Benefit Amount for Cancer Treatment and Care Benefit shown on the Certificate Schedule has not been paid, the named insured specified disease insurance under the policy terminates under the provision Termination of Named Insured's Coverage for one of the reasons listed above or because the policy terminates];
- we receive a written request by the named insured and payment of all premiums due for the portability coverage not later than 63 days after such termination; and
- the request is made on a form we furnish or approve for that purpose.

### **Coverage**

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy for specified disease insurance when the named insured's insurance terminated. We will allow you to decrease the face amount at the time portability is requested; provided that the face amount cannot be decreased below a Face Amount for Named Insured of \$5,000. Portability coverage may include any eligible family members who were covered under the policy. Any change made to

the policy after a named insured is insured under the portability privilege will not apply to that named insured unless it is required by law.

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

### **Premiums**

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rates are based on the portability rates in effect on any premium due date. We have the right to change the portability premium we charge on any premium due date. Written notice will be given at least [45] days before the change is to take effect.

### **Grace Period**

The grace period provision of the policy will apply to each certificateholder of portability coverage as if such certificateholder is the policyholder.

### **Termination of Insurance**

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

- The date the named insured again becomes eligible for specified disease insurance under the policy.
- The last day for which premiums have been paid, if the named insured fails to pay premiums when due, subject to the Grace Period provision.
- The date insurance under this portability provision is cancelled by us for any reason upon 31-days notice.

With respect to insurance for your spouse and dependent children, insurance under this portability privilege will automatically end on the earliest of the following dates:

- the date the named insured's insurance terminates; or
- as to your dependent children, the date the dependent child ceases to qualify as a dependent child as defined in this certificate; or
- as to your spouse, the date the next premium is due after you divorce your spouse or your marriage is annulled.

Once insurance under this portability provision is cancelled, it can not be reinstated.

### **Termination of the Policy**

Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits, terms and conditions for portability coverage will be determined as if the policy had remained in full force and effect.]

## **SECTION [15] – GENERAL PROVISIONS**

### **Misstatement of Age**

If the age of the named insured has been misstated, we will make any equitable adjustment of premiums. We will refund any excess premium payment over the amount due based on your correct age. We will request payment for any overdue premium based on your correct age. If the misstatement is discovered after a payment is due and payable, we will reduce or increase the benefit amount payable by the amount of excess or overdue premium due to the misstatement. If a named insured is not eligible because of age we will refund all premiums paid.

### **Misstatement of Tobacco Status**

If there is a misstatement in the application of the named insured's tobacco status, we will adjust the benefits payable to the amounts which would have been purchased at the correct tobacco status in consideration of the most recent premium. We will not make such an adjustment after this policy has been in force for two years from the coverage effective date.

### **Contestability**

No statement made by any named insured relating to his insurability or the insurability of his dependents shall be used to contest the validity of the insurance after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made and unless the statement is contained in a written instrument signed by the named insured making the statement, unless the statement was fraudulent.

*Contest* means that we question the validity of coverage under this policy through a letter to the policyholder or the named insured. This contest is effective on the date we mail the letter and refund premiums.

All statements made by the policyholder or any named insured shall be deemed representations and not warranties. No written statement made by the policyholder or any named insured shall be used in any contest unless a copy of the statement is furnished to the policyholder or the named insured.

### **Policyholder as Agent**

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

## **SECTION [16] – CLAIM PROVISIONS**

### **Notice of Claim**

If a covered person has an injury or sickness that may result in a claim for benefits under the policy, written notice must be given to us at our home office. This must be done within 90 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as is reasonably possible. The notice must contain enough information to identify the covered person.

### **Claim Forms**

When we receive written or verbal notice of a claim, claim forms will be sent with which to file Proof of Loss. If these forms are not given to you within 15 days, you will be excused from filing the forms as long as you send us Proof of Loss as described below.

### **Proof of Loss**

We must receive a written proof of loss within 90 days after the covered loss begins. If you are not able to give us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

Written proof of loss must include one or more of the following: a doctor's bill, a hospital bill or other proof of charges.

### **Time of Payment of Claim**

After we receive written proof of loss and process your claim, we will immediately pay any benefits due.

### **Payment of Claim**

Benefits will be paid to you unless we receive a written authorization to pay them elsewhere, such as to a hospital or a doctor's office. This is called assignment.

If we still owe you benefits at your death, benefits due will be paid in this order to your:

- spouse; or
- children; or
- parents; or
- brothers and sisters; or
- estate.

If benefits are payable to your estate, we can pay benefits up to \$1,000 to someone related to you by blood or marriage who we feel is fairly entitled to them. If we do this, we will have no responsibility for this payment because we made it in good faith.

### **Unpaid Premium**

When a claim is paid under the policy, any premium then due and unpaid may be deducted by us from the claim payment.

### **Overpaid Claim**

We have the right to recover any overpayments due to:

- fraud; and
- any error we make in processing a claim.

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

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

### **Questions Concerning the Named Insured's Claim**

If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

### **Physical Exam and Autopsy**

We can require that any covered person be examined by a doctor of our choice as often as it is reasonably necessary while his claim is pending. We can also require an autopsy in the event of the death of any covered person in those states where this is allowed. Either or both of these will be done at our expense.

### **Legal Action**

We cannot be sued for benefits under the policy:

- until 60 days after we are sent written proof of loss; or
- more than three years after the time has passed in which we require written proof of loss.

### **Claim Review**

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

- the reason for denial; and
- the policy provision that relates to the denial;
- the right to ask for a review of the claims; and
- the right to submit any additional information that might allow us to change our decision.

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

### **Appeals Procedure**

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

### **Workers' Compensation Not Affected**

The policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY**

**FIRST DIAGNOSIS BUILDING BENEFIT RIDER TO  
[CRITICAL ILLNESS] [AND] [CANCER] GROUP SPECIFIED DISEASE INSURANCE  
CERTIFICATE**

**RIDER SCHEDULE**

<b>Policyholder:</b>	[ABC Employer]	<b>Group Policy Number:</b>	[123456]
<b>Named Insured:</b>	[John A. Doe]	<b>Certificate Number:</b>	[0000000000]
<b>Coverage Type:</b>	[Two-Parent Family]	<b>Rider Effective Date:</b>	[02/01/2011]
<b>Rider Year:</b>	[02/01- 01/31] of each year this rider is in effect		

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**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY**  
[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202  
1.800.325.4368 coloniallife.com]  
A Stock Company

**First Diagnosis Building Benefit Rider**

**THIS IS A LIMITED RIDER - READ IT CAREFULLY.**

**THIS RIDER IS NOT ATTACHED TO A MEDICARE SUPPLEMENT POLICY.**  
**If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from us.**

**All terms, definitions of terms, conditions, exclusions and limitations stated in the certificate will also apply to this rider unless we state otherwise in this rider.**

**Coverage Provided by This Rider**

We provide the benefit stated in this rider as a part of the certificate to which it is attached for the person(s) shown on the Rider Schedule, subject to any limitations in the rider or the certificate.

**First Diagnosis Building Benefit**

**Amount for Named Insured: \$1000 for each rider year this rider is in force after the rider effective date, up to a maximum of 10 rider years**

**[Amount for Spouse: \$500] for each year coverage for the spouse under this rider is in force, up to a maximum of 10 years]**

**[Amount for Dependent Children: \$500] for each year coverage for the dependent children under this rider is in force, up to a maximum of 10 years]**

We will pay the First Diagnosis Building Benefit if a covered person is diagnosed with a [critical illness (other than [Coronary Artery Bypass Graft Surgery] [Coronary Artery Disease])] [or] [cancer (internal or invasive)], as defined in the Certificate to which this rider is attached, and:

- [the date of diagnosis is after the waiting period;]
- the date of diagnosis is while this rider is in force;
- [for a date of diagnosis during the 12 months following the rider effective date, the [critical illness][or] [cancer (internal or invasive)] is not a pre-existing condition;] and
- the [critical illness] [or] [cancer (internal or invasive)] is not excluded by name or specific description in the certificate.

We will pay the First Diagnosis Building Benefit amount for the covered person, as shown above, for each rider year this rider has been in force after the rider effective date and before the covered person's diagnosis is made, up to a maximum of 10 rider years [or, in case of spouse or dependent children, each year coverage for the spouse or dependent children under this rider is in force and before the covered person's diagnosis is made, up to a maximum of 10 years]. **Rider Year** means the period shown on the Rider Schedule. **Year** means 12 calendar months. In the event the covered person's diagnosis occurs [after the waiting period and] before the end of the first rider year following the rider effective date, the First Diagnosis Building Benefit amount for that covered person will be \$500 if the covered person is the named insured and \$250 if the covered person is the named insured's covered spouse or dependent child, if applicable.

We will pay this benefit only once for each covered person insured by this rider.

[We will not pay this benefit for [skin cancer or carcinoma in situ, as defined in the Certificate to which the rider is attached, or] any [critical illness] [or] [cancer (internal or invasive)] diagnosed [during the 12 months following the rider effective date if the [critical illness] [or] [cancer (internal or invasive)] is a pre-existing condition] [during the waiting period].]

[Cancer (internal or invasive) must be diagnosed in one of two ways:

**1. Pathological Diagnosis**

A *pathological diagnosis* of cancer (internal or invasive) is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a pathologist whose diagnosis of malignancy is in keeping with the standards established by the American Board of Pathology. A pathological diagnosis of cancer (internal or invasive) can be made before or after death.

**2. Clinical Diagnosis**

A *clinical diagnosis* of cancer (internal or invasive) is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a doctor is treating the covered person for cancer (internal or invasive).

In addition to the pathological or clinical diagnosis required, we may require additional information from the attending doctor and hospital.]

**Termination of the Named Insured's Coverage**

The coverage on a named insured under this rider will terminate on the earliest of the following dates:

- the date coverage terminates under the certificate to which this rider is attached; or
- the end of the grace period following the premium due date we fail to receive the required premium for the named insured; or
- the date the next premium is due after the named insured asks us to end his coverage.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while you are covered.

**When Coverage Ends on Your Spouse and Dependent Children**

If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date your coverage under the certificate terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your spouse; or
- the date the next premium is due after you ask us to end your spouse's coverage; or
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage under the certificate terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your dependent children; or
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in the certificate to which this rider is attached. [A dependent child who reaches age 26 may remain covered if that child is and continues to be mentally or physically handicapped and is dependent on you for support and maintenance. Upon our request and at our expense, you must submit proof of incapacity for dependency to us for a child whose coverage would otherwise terminate if not incapacitated or dependent.] We will continue to charge any appropriate premium for that child as long as he meets the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

We will provide coverage for a claim for which we are liable under the terms of this rider if the loss occurs while your spouse and/or dependent child is covered.



Secretary

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365, COLUMBIA, SC 29202  
APPLICATION FOR GROUP SPECIFIED DISEASE INSURANCE**

<b>Policyholder Section</b>	
Policyholder Name ABC Company	Billing Control Number E5555555
Policyholder Home (or Corporate) Address Street                      City                      State                      Zip Code 123 Any Street              Any City                      Any State                      12345	Policyholder Phone Number 555-555-5555
Do you have [employees] located in other states? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," please list states here:	Plan Administrator Name: Betty Plan Admin
Nature of Business Any	Effective Date of Coverage (mm/dd/yyyy) 11/1/2011
Are any divisions, subsidiaries or affiliated companies to be covered under this policy?    Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	If "yes," provide the name/location (city/state)

<b>Enrollment Information</b>	
Initial Enrollment Dates Start Date (mm/dd/yyyy)    -    Stop Date (mm/dd/yyyy) 10/1/2011                              11/1/2011	Subsequent Open Enrollment Dates, if any, are subject to the agreement of the Policyholder and Colonial Life & Accident Insurance Company each year.

<b>Eligible Class</b>
<input checked="" type="checkbox"/> [All employees in active employment working a minimum of [15] regularly scheduled hours per week. Temporary and seasonal workers are excluded from coverage.] Active employees are those who are working at the worksite for earnings that are paid regularly, and they are performing the material and substantial duties of their regular occupation. The worksite must be: <ul style="list-style-type: none"> <li>• the policyholder's usual place of business;</li> <li>• an alternative worksite at the direction of the policyholder; or</li> <li>• a location to which the named insured's job requires him to travel</li> </ul> <input type="checkbox"/> Other:

Number of Eligible [Employees]: [XX]	New Hire Waiting Period: [XX days]	New Hire Eligibility Period : [31 days]
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<b>Policyholder Contribution</b>	
Is there any policyholder contribution? If yes, indicate appropriate contribution type and amount below.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<input type="checkbox"/> <b>Policyholder Contribution (Complete 1- 4):</b> 1. <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> Other _____ up to a maximum lump sum face amount of: \$ _____ 2.    A Cancer Treatment and Care Benefit of (Choose one option): <input type="checkbox"/> [\$500]/[12] months <input type="checkbox"/> [\$500]/[24] months <input type="checkbox"/> [\$1,000]/[12] months <input type="checkbox"/> [\$1,000]/[24] months <input type="checkbox"/> Other: \$ _____ per month to a maximum of _____ months] <input type="checkbox"/> None 3.    Will the policyholder contribution include the First Diagnosis Building Benefit Rider? <input type="checkbox"/> Yes <input type="checkbox"/> No 4.    Who does the policyholder contribution apply to? <input type="checkbox"/> Named Insured <input type="checkbox"/> Named Insured, Spouse, Dependent Children	
<input type="checkbox"/> <b>Flat Dollar Amount Contribution:</b>  A Flat Dollar Amount of \$ _____ toward monthly premium.	

<b>Replacement Section</b>	
Is this a replacement of similar coverage?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Previous Company Name	Termination Date of Prior Plan



**Agreement Section**

All statements and information found in the application are deemed representations and not warranties. With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby confirm that the answers and statements above are true and have been completed to the best of my knowledge and belief. It is understood and agreed that this application shall be attached as a part of the Policy applied for and that no Insurance shall be effective until approved by Colonial Life & Accident Insurance Company at its Home Office.

Signed at: City \_\_\_\_\_ Any City \_\_\_\_\_ State \_Any State\_\_\_\_\_ Date \_\_\_09/30/2011\_\_\_\_\_ mm/dd/yyyy

(x) \_\_\_ Jack R. Employer \_\_\_\_\_

**Agent Section**

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance policy in detail; and (d) to the best of my knowledge and belief the proposed Policyholder is financially sound.

(x) \_\_\_ Joe R. Agent \_\_\_\_\_ License No. \_\_\_12345\_\_\_\_\_ Code No. \_\_\_67890\_\_\_\_\_ Signature of Licensed Agent

## Fraud Warning Notice

<b>For all states except those listed below:</b>	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
<b>Arkansas, Louisiana, Rhode Island and West Virginia</b>	Any person who knowingly presents a false or fraudulent claim for payment for 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.
<b>Colorado</b>	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
<b>District of Columbia</b>	<b>WARNING:</b> It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
<b>Florida</b>	<b>Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.</b>
<b>Kentucky Kansas North Carolina</b>	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.
<b>Maine and Washington</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
<b>Maryland</b>	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
<b>New Jersey</b>	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
<b>New Mexico</b>	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
<b>Oklahoma</b>	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 is guilty of a felony.
<b>Oregon and Texas</b>	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
<b>Pennsylvania</b>	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. If coverage is <u>contested</u> , the company's only obligation will be to refund all premiums paid.
<b>Tennessee</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. <u>Penalties include imprisonment, fines and denial of coverage.</u>
<b>Virginia</b>	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**Colonial Life & Accident Insurance Company  
P.O. Box 1365, Columbia, SC 29202-1365**

**GROUP SPECIFIED DISEASE INSURANCE ENROLLMENT FORM**

<b>Enrollment Type:</b> <input checked="" type="checkbox"/> Initial Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Event: Date (mm/dd/yyyy): _____ Event: _____
--

<b>NAMED INSURED SECTION – Always complete</b>					
Proposed Insured Name (First, MI, Last) John E. Doe		Gender M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy) 01/01/1974	Social Security No. 111-11-1111	
Home Address – Street 345 Any Street		City Any City	State Any State	Zip Code 12345	Employee ID/Payroll No. 111-11-1111
Email Address anyemail@anywhere.com			Home Phone No. (555)555-5555 Business Phone No. (555)555-5555		
Date Employed 01/01/2010	Occupation/Job Title any	Annual Base Salary \$xx,xxxx	Hrs. Worked/Wk 40	Employee Class	
Employer Name ABC Company		Employer Address (Street-City-State-Zip) 123 Any Street      Any City      Any State      12345			Section/Dept. No.

<b>SPOUSE/ DEPENDENT SECTION</b>					
Is your spouse applying for coverage? If yes, provide identifying information below.				Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Name of Spouse (First, MI, Last)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.	
Are there any eligible dependent children applying for coverage?				Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
				Number Deps:	

<b>PLAN SECTION</b>					
Type of Coverage	Plan Code(s)	Units	Rider Code	P = Pre-Tax A = After-Tax	Monthly Premium
<input checked="" type="checkbox"/> Named Insured <input type="checkbox"/> Named Insured & Spouse <input type="checkbox"/> One-Parent Family <input type="checkbox"/> Two-Parent Family	xxxx	xx	xxxx	P <input checked="" type="checkbox"/> A <input type="checkbox"/>	\$xx.xx

<b>ELIGIBILITY INFORMATION – Required for all levels of underwriting</b>	
[1. Within the past [12] months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
[2]. Are you actively working?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

**AGREEMENT SECTION**

All exceptions and limitations pertaining to the coverage(s) for which I have applied have been explained to me, including any pertaining to pre-existing conditions.

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the coverage indicated, I hereby request cancellation of my Colonial Life Policy/Certificate Number(s) \_\_\_\_\_. Transfer or cancellation of the base plan will also mean cancellation of all attached riders. If for any reason the coverage applied for above is not issued, this request for cancellation shall be null and void.

With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby confirm the answers and statements above are true and complete to the best of my knowledge and belief.

Signed at: City \_\_\_\_\_ Any City \_\_\_\_\_ State \_\_\_ Any \_\_\_ Date \_\_\_ 10/10/2011 \_\_\_\_\_  
mm/dd/yyyy

(x) \_\_\_\_\_ **John E Doe** \_\_\_\_\_

Signature of Proposed Insured (if applicable)

**AGENT SECTION**

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

(x) \_\_\_\_\_ **Joe R Agent** \_\_\_\_\_ Date \_\_\_ 10/10/2011 \_\_\_\_\_

Signature of Licensed Agent (if applicable)

Agent Name \_\_\_ Joe R Agent \_\_\_\_\_ License No. \_\_\_ 12345 \_\_\_\_\_ Code No. \_\_\_ 67890 \_\_\_\_\_

## Fraud Warning Notice

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<b>District of Columbia</b>	<b>WARNING:</b> It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
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<b>New Jersey</b>	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
<b>New Mexico</b>	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
<b>Oklahoma</b>	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 is guilty of a felony.
<b>Oregon and Texas</b>	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
<b>Pennsylvania</b>	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. If coverage is <u>contested</u> , the company's only obligation will be to refund all premiums paid.
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<b>Virginia</b>	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.



**Colonial Life & Accident Insurance Company  
P.O. Box 1365, Columbia, SC 29202-1365**

**GROUP SPECIFIED DISEASE INSURANCE EVIDENCE OF INSURABILITY**

**Enrollment Type :**     Initial Enrollment         New Hire         Late entrant  
 Qualifying Event: Date (mm/dd/yyyy): \_\_\_\_\_ Event: \_\_\_\_\_

<b>NAMED INSURED SECTION – Always complete</b>				
Proposed Insured Name (First, MI, Last) John E. Doe#		Gender M <input checked="" type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy) 01/01/1974	Social Security No. 111-11-1111
Home Address – Street 345 Any Street		City Any City	State Any State	Zip Code 12345
Employee ID/Payroll No. 111-11-1111			Home Phone No. (555)555-5555 Business Phone No. (555)555-5555	
Email Address anyemail@anywhere.com				
Date Employed 01/01/2010	Occupation/Job Title Any	Annual Base Salary \$xx,xxxx	Hrs. Worked/Wk 40	Employee Class
Employer Name ABC Company		Employer Address (Street-City-State-Zip) 345 Any Street      Any City      Any State      12345		Section/Dept. No.

<b>SPOUSE/DEPENDENT SECTION</b>			
Is your spouse applying for coverage? If yes, provide identifying information below.			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Name of Spouse (First, MI, Last)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Relationship
Social Security No.			
Are there any eligible dependent children applying for coverage?			Yes <input type="checkbox"/> No <input type="checkbox"/> Number Deps:

<b>PLAN SECTION</b>					
Type of Coverage	Plan Code(s)	Units	Rider Code	P = Pre-Tax A = After-Tax	Monthly Premium
<input checked="" type="checkbox"/> Named Insured <input type="checkbox"/> Named Insured & Spouse <input type="checkbox"/> One-Parent Family <input type="checkbox"/> Two-Parent Family]	xxxx	x	xxxx	P <input checked="" type="checkbox"/> A <input type="checkbox"/>	\$xx.xx

<b>ELIGIBILITY INFORMATION – Required for all levels of underwriting</b>	
[1. Within the past [12] months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
[2]. Are you actively working?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

<b>AIDS SECTION – Complete for all Products</b>	Proposed Insured	Spouse	Dependent
[3]. Have you tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or received medical advice or sought treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>SIMPLIFIED ISSUE – Complete [questions 4 and 5] for Cancer. Complete question [6] for Critical Illness.</b>			
	<b>Proposed Insured</b>	<b>Spouse</b>	<b>Dependent</b>
[4]. In the past [5] years, have you received medical advice or sought treatment for cancer, other than basal cell carcinoma, squamous cell carcinoma or melanoma Clark's level I or II?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
[5]. In the past [12] months have you received preventative hormonal therapy?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
[6]. Within the past [10] years, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI)                      Blood Pressure Reading of 160/100 or above Hepatitis B or C                          Heart Disease Heart Surgery                              Kidney Disease except stones Organ Transplant                         Emphysema Cirrhosis of the Liver                    Chronic Obstructive Pulmonary Disease Transient Ischemic Attack              Congestive Heart Failure Stroke                                        Diabetes Macular Degeneration                  Abnormal Catheterization Retinitis Pigmentosa                    Glaucoma	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Any dependent with a "Yes" answer on questions [4 - 6] must be listed below and will be excluded under the Group Specified Disease Insurance certificate to which a copy of this evidence of insurability form is attached.</b>			
Name (First, MI, Last)	Relationship	Birthdate (mm/dd/yyyy)	Social Security No.

<b>SIMPLIFIED ISSUE LEVEL 1 – Complete question [7] for Cancer. Complete questions [8 – 10] for Critical Illness.</b>	<b>Proposed Insured</b>	<b>Spouse</b>	<b>Dependent</b>
[7]. Within the last [12] months, have you received medical advice, sought treatment, had surgery or had an abnormal diagnostic test for the presence of cancer? If yes, provide details in the health details section.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
[8]. Indicate Current Height / Weight (Proposed Insured and spouse, if spouse coverage applied for) Proposed Insured: Height ___5'8"___      Weight ___185___  Spouse:                      Height _____      Weight _____			
[9]. Are you currently prescribed any medication? If "Yes", provide details in the health details section.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
[10]. Within the last [5] years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease, mental or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application? If yes, please provide details in the health	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>[SIMPLIFIED ISSUE LEVEL 2 – Complete [questions 11 and 12] for Cancer. Complete question [13] for Critical Illness.</b>	<b>Proposed Insured</b>	<b>Spouse</b>	<b>Dependent</b>
[[11]. Have you [ever] received medical advice or sought treatment for Cancer, other than basal cell carcinoma, squamous cell carcinoma or melanoma Clark's level I or II? If yes, provide details in health details section.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
[12]. Have you [ever] received preventative hormonal therapy?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
[[13]. Have you [ever] received medical advice or sought treatment for: heart disease, lung disease, kidney disease, cancer, cirrhosis or liver disease, hepatitis B,C, circulatory disease, respiratory disease, blood pressure reading of 140/90 or above? If yes, provide details in the health details section.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**HEALTH DETAILS SECTION**

Name	Detailed Description	Date	Duration	Treatment Received	Name & Address of Physician / Hospital

**ADDITIONAL DATA SECTION****AGREEMENT SECTION**

All exceptions and limitations pertaining to the coverage(s) for which I have applied have been explained to me including any pertaining to pre-existing conditions.

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the coverage indicated, I hereby request cancellation of my Colonial Life Policy/Certificate Number(s) \_\_\_\_\_. Transfer or cancellation of the base plan will also mean cancellation of all attached riders. If for any reason the coverage applied for above is not issued, this request for cancellation shall be null and void.

With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby confirm the answers and statements above are true and have been completed to the best of my knowledge and belief.

Signed at: City Any City State Any Date 10/10/2011  
mm/dd/yyyy

(x) John E Doe  
Signature of Proposed Insured (if applicable)

**AGENT SECTION**

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

(x) John A Agent Date 10/10/2011  
Signature of Licensed Agent (if applicable)

Agent Name John A Agent License No. 12345 Code No. 67890

## Fraud Warning Notice

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<b>District of Columbia</b>	<b>WARNING:</b> It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
<b>Florida</b>	<b>Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.</b>
<b>Kentucky Kansas North Carolina</b>	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.
<b>Maine and Washington</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
<b>Maryland</b>	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
<b>New Jersey</b>	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
<b>New Mexico</b>	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
<b>Oklahoma</b>	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 is guilty of a felony.
<b>Oregon and Texas</b>	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
<b>Pennsylvania</b>	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. If coverage is <u>contested</u> , the company's only obligation will be to refund all premiums paid.
<b>Tennessee</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. <u>Penalties include imprisonment, fines and denial of coverage.</u>
<b>Virginia</b>	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**POLICY AMENDMENT NO. [000]**

This amendment forms a part of the Policy No. [000-0] issued to the Policyholder:

[JOHN DOE COMPANY]

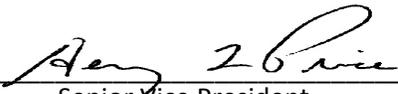
The Policy is changed to read as follows:

The effective date of these changes is mm/dd/yyyy. The changes only apply to covered losses which start on or after the effective date. Claims for covered losses that occur prior to mm/dd/yyyy will be determined according to the Policy in effect prior to this amendment.

All other terms, conditions and provisions of the policy remain unchanged.

(x) \_\_\_\_\_ Date \_\_\_\_\_  
Authorized Signature/Title (mm/dd/yyyy)

Colonial Life & Accident Insurance Company

By: [  ]  
Senior Vice President

**CERTIFICATE AMENDMENT**

The changes shown below are made a part of the certificate which was issued to you under the terms of the Policy issued to:

[JOHN DOE COMPANY]

Group Policy No. [000-0]

Certificate No. [000-0]

The Certificate is changed to read as follows:

The effective date of these changes is mm/dd/yyyy or the effective date of your certificate, whichever is later.

The changes only apply to covered losses which start on or after the effective date. Claims for covered losses that occur prior to the effective date of these changes will be determined according to the Certificate in effect prior to this amendment.

All other terms and provisions of the certificate remain unchanged.

Dated at Columbia, SC this [ ] day of [ ]

Colonial Life & Accident Insurance Company

By: [  ]  
Senior Vice President

SERFF Tracking Number: UNUM-127623367 State: Arkansas  
 Filing Company: Colonial Life & Accident Insurance Company State Tracking Number: 50341  
 Company Tracking Number: GROUP CRITICAL ILLNESS/CANCER 1.0  
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
 Limited Benefit  
 Product Name: Group Critical Illness/Cancer 1.0  
 Project Name/Number: Group Critical Illness/Cancer 1.0/Group Critical Illness/Cancer 1.0

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> See attached. <b>Attachments:</b> READABILITY COMPLIANCE CERTIFICATION.pdf COMPLIANCE CERTIFICATION.pdf	Approved-Closed	11/30/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> The master application and the enrollment form have been added under the Form Schedule Tab.	Approved-Closed	11/30/2011

## READABILITY COMPLIANCE CERTIFICATION

<u>Form No.</u>	<u>Flesch Score</u>
GCC1.0-P-AR	51.5
GCC 1.0-C-AR	50.7
R-GCC1.0-BB-AR	50.2

This is to certify that the attached Forms (listed above) have achieved the above Flesch Reading Ease Score and comply with the requirements of Arkansas Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

11/28/2011  
Date



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Lauren F. Sease  
Senior Compliance Contract Consultant

## COMPLIANCE CERTIFICATION

FORM: GCC 1.0-C-AR  
GCC 1.0-P-AR  
R-GCC1.0-BB-AR

I certify that this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements.

11/28/2011

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Date



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Lauren F. Sease  
Senior Compliance Contract Consultant