Filing at a Glance

Company: Time Insurance Company

Product Name: ASC (Voluntary Products)	SERFF Tr Num: ASWX-G127862889	State: Arkansas
TOI: H07I Individual Health - Specified Disease - - Limited Benefit	SERFF Status: Closed-Approved-Closed	State Tr Num: 50444
Sub-TOI: H07I.002 Dread Disease	Co Tr Num: AR01476FI00017	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: SPI AssurantHealthandEmployeeBenef	Disposition Date: 12/13/2011
	Date Submitted: 12/09/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 12/12/2011		Implementation Date:

State Filing Description:

General Information

Project Name: ASC (Voluntary Products)
Project Number: AR01476FI00017
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:

Submitted By: SPI AssurantHealthandEmployeeBenef
Filing Description:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 12/13/2011
State Status Changed: 12/13/2011
Created By: SPI AssurantHealthandEmployeeBenef
Corresponding Filing Tracking Number:

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

www.assurant.com

December 9, 2011

Arkansas Department of Insurance
1200 W Third Street
Little Rock, AR 72201

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Individual Specified Disease Indemnity forms: 8230.POL.AR et al.
Company Reference No.: ASWX-G127862889
Dear Sir/Madam:

The enclosed forms are hereby submitted for your review seeking approval along with the actuarial memorandum and rates. These forms are new and do not replace any forms currently on file with your office. These forms will be used to issue specified disease indemnity insurance in the individual market. This plan is designed to provide fixed indemnity benefits upon first ever diagnosis of a specified disease. This plan does not provide expense reimbursement for billed charges by a health care provider or coverage for health care services or supplies. Coverage will be offered by independent agents licensed in your state.

For your ease in reference, a listing of all submitted forms is enclosed. Please note that the form is numbered using a matrix format, where each section of the document has a unique form number. For example, the face page is numbered 8230.POL.AR, while the Exclusions section of the same document is numbered 8230.EXC.XX. The Company employs this form numbering style for administrative and tracking purposes. The form will always be issued in its entirety with all sections and form numbers included.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Christine R. Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168

Company and Contact

Filing Contact Information

Christine Fleming, Senior Contract Compliance Analyst	christine.fleming@assurant.com
501 W. Michigan St.	414-299-1306 [Phone] 1306 [Ext]
Milwaukee, WI 53203	414-299-6168 [FAX]

Filing Company Information

Time Insurance Company	CoCode: 69477	State of Domicile: Wisconsin
501 W. Michigan St.	Group Code: 19	Company Type:
Milwaukee, WI 53203	Group Name:	State ID Number:
(800) 800-1212 ext. [Phone]	FEIN Number: 39-0658730	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	$100.00	12/09/2011	54403295
Time Insurance Company	$100.00	12/12/2011	54430586

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/13/2011	12/13/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	12/12/2011	12/12/2011	SPI AssurantHealthandEmployeeBenef	12/12/2011	12/12/2011

Disposition

Disposition Date: 12/13/2011
Implementation Date:
Status: Approved-Closed
Comment:

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

SERFF Tracking Number:	*ASWX-G127862889*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*50444*
Company Tracking Number:	*AR01476FI00017*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*ASC (Voluntary Products)*		
Project Name/Number:	*ASC (Voluntary Products)/AR01476FI00017*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Variability Statement	Approved-Closed	Yes
Supporting Document	Form Listing	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Specified Disease Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Benefit Schedule	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes
Rate	Specified Disease RateSheet	Approved-Closed	Yes
Rate	Specified Disease Rate Lifetime Loss Ratio	Approved-Closed	No

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/12/2011
Submitted Date	12/12/2011
Respond By Date	

Dear Christine Fleming,

This will acknowledge receipt of the captioned filing.

Objection 1

- Specified Disease Policy, 8230.POL.AR (Form)
- Outline of Coverage, 8230.OOC.XX (Form)
- Benefit Schedule, 8230.BNS.XX (Form)
- Enrollment Form, 33000-AR (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $200.00. Please submit an additional $100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

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

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/12/2011
Submitted Date	12/12/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: Dear Rosalind, I have submitted an additional $100.00 filing fee.

Related Objection 1

Applies To:

- Specified Disease Policy, 8230.POL.AR (Form)
- Outline of Coverage, 8230.OOC.XX (Form)
- Benefit Schedule, 8230.BNS.XX (Form)
- Enrollment Form, 33000-AR (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $200.00. Please submit an additional $100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking Number:	*ASWX-G127862889*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*50444*
Company Tracking Number:	*AR01476FI00017*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.002 Dread Disease*
Product Name:	*ASC (Voluntary Products)*		
Project Name/Number:	*ASC (Voluntary Products)/AR01476FI00017*		

No Rate/Rule Schedule items changed.

Sincerely,
SPI AssurantHealthandEmployeeBenef

Form Schedule

Lead Form Number: 8230.POL.AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/13/2011	8230.POL.AR	Policy/Contract/Fraternal Certificate	Specified Disease Policy	Initial		50.200	ASC Specified Disease Policy - Variable (FINAL).PDF
Approved-Closed 12/13/2011	8230.OOC.XX	Outline of Coverage	Outline of Coverage	Initial		50.200	ASC Specified Disease Outline of Coverage - Variable (XX Benefits).PDF
Approved-Closed 12/13/2011	8230.BNS.XX	Schedule Pages	Benefit Schedule	Initial		52.100	ASC Specified Disease Benefit Schedule - Variable (XX Benefits).PDF
Approved-Closed 12/13/2011	33000-AR	Application/Enrollment Form	Enrollment Form	Initial		51.400	f 33000-AR.PDF

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

SPECIFIED DISEASE FIXED INDEMNITY INSURANCE POLICY
Limited [Cancer] [and] [Heart-Stroke] Fixed Indemnity Benefits

NOTICE: This is not a major medical insurance policy. This plan provides fixed indemnity benefits upon first ever Diagnosis of a Specified Disease. Fixed indemnity benefits are paid in the amount stated on the Benefit Schedule for the Specified Disease without regard to the cost of services rendered. This plan does not provide expense reimbursement for charges based on Your health care provider's bill.

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

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

RIGHT TO EXAMINE POLICY FOR [10-30] DAYS

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

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION/ENROLLMENT FORM FOR INSURANCE

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

[insert signature]	[insert signature]
Secretary	President

[Guaranteed Renewable except for stated reasons][Conditionally Renewable]: This Policy is [guaranteed][conditionally] renewable until attainment of age [65-85] years [except for stated reasons]. This Policy automatically renews except for as stated in the Effective Date and Termination Date provision section. Read Your Policy carefully to understand coverage limitations and termination provisions.

[THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.]

II. GUIDE TO YOUR COVERAGE

The sections of the Policy appear in the following order:

I. Signature Page

II. Guide To Your Coverage

III. Definitions

IV. Effective Date and Termination Date

V. Specified Disease Fixed Indemnity Benefits

[VI. Pre-Existing Conditions Limitation]

[VII.] Exclusions

[VIII.] Claim Provisions

[IX.] Premium Provisions

[X.] Other Provisions

III. DEFINITIONS

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

Accident or Accidental
Any event that meets all of the following requirements:
1. It causes harm to the physical structure of the body.
2. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
3. It is definite as to a single time and place.
4. It happens involuntarily.

An Accident does not include harm resulting, whether directly or indirectly, from Sickness, cerebral vascular accident (stroke), or exposure to Sickness, toxin, an infectious agent, or communicable disease.

Accidental Injury
Bodily damage occurring unexpectedly and unintentionally as the result of an Accident, independent of all other causes.

[Benefit Waiting Period
The period of consecutive days that must pass after the Effective Date before a Covered Person is eligible for Scheduled Benefits under the terms of this plan.

A Benefit Waiting Period only applies if it is shown in the Benefit Schedule. The Benefit Schedule will identify any applicable Benefit Waiting Periods along with the Scheduled Benefits to which they apply.]

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

[Cancer
1. A malignant tumor, including an in situ, and hematopoietic malignancy for which any of the following is recommended by Your Health Care Practitioner:
   a. Radiation;
   b. Chemotherapy[; or]
   c. Immunotherapy[; or]
   [d. Complete excision of an internal organ without need for further treatment]
2. Any metastatic cancer for which no therapy is recommended.

For purposes of this Policy, Cancer does not include:
1. Non-invasive dermatologic carcinomas (basal cell carcinoma (BCC), squamous cell carcinomas (SCC), melanoma in-situ), cervical carcinoma in situ or other premalignant conditions such as myelodysplastic and myeloproliferative disorders, leukoplakia, hyperplasia; or
2. An incidental pathological diagnosis found following surgical excision of an organ unless additional chemotherapy, radiation therapy and/or immunotherapy is recommended.]

[Cardiac Arrhythmia

Cardiac dysrhythmias, paroxysmal supraventricular tachycardia, paroxysmal ventricular tachycardia, atrial fibrillation and flutter, and ventricular fibrillation and flutter.]

[Cerebral Vascular Disease
Subarachnoid hemorrhage, intracerebral hemorrhage, occlusion and stenosis of precerebral arteries, and occlusion of cerebral arteries.]

[Coronary Angioplasty
An interventional procedure to widen or unblock the right coronary artery; left main stem; left anterior descending; or circumflex artery.]

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

[Coronary Artery Disease
Acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the heart, and coronary atherosclerosis due to lipid rich plaque.]

[Covered Dependent
A person who meets the definition of a Dependent and is eligible to receive benefits under this plan.]

Covered Person
A person who is eligible to receive benefits under this plan.

[**Dependent**
A Dependent is:

[1.] the Policyholder's lawful spouse or Domestic Partner; or

[2.] the Policyholder's or Domestic Partner's naturally born child, legally adopted child, a child that is placed for adoption with the Policyholder or Domestic Partner, a child for whom the Policyholder or Domestic Partner is the legal guardian, or the Policyholder's stepchild:

[a.] [who is unmarried or not a Domestic Partner; and]
[b.] [who is age [18-25] years or younger[.][;] and]
[c.] [who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student.]

[If Your unmarried child is age [19-26] years or older, the child will be considered a Dependent if You give Us proof that[:]

[1.] [the child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]

[2.] [the child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly

dependent on the Policyholder for financial support and be claimed as an exemption on Your most recent federal income tax return. You must give Us proof that the child meets these requirements after the child reaches the normal age for termination. .]]

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

[1.] [is no longer a full-time student; or]

[2.] [ceases to be claimed as an exemption on the Policyholder's federal income tax return, except for a Dependent child who is a full-time student; or]

[3.] [attains age [19-26]; or]

[4.] [marries or becomes a Domestic Partner; or]

[5.] [is over age [18-25] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.]

[If only Dependent children are covered under this plan, the youngest child will be considered the Policyholder. In this case, all siblings of the Policyholder will be considered Covered Dependents if they meet the requirements above[, except for the tax exemption status requirement].]]

Diagnosis/Diagnosed
Identification of a Specified Disease made during the Covered Person's life by a Health Care Practitioner that is supported by evaluations, clinical or laboratory tests, and observations documented in the Covered Person's medical records.

Domestic Partner
Two people of the same or opposite gender who reside together in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:
[1.] be at least [18] years of age.
[2.] be competent to enter into a contract.
[3.] not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

[[A Domestic Partner must provide Us with [an affidavit attesting that the domestic partnership has existed for a minimum period of [[0-24] months]] [or][evidence of state registry or license of the civil union/partnership] at the time of enrollment under this plan.] [Proof that the Domestic Partner relationship continues to exist may be requested by Us periodically.]]

Effective Date
The date coverage under this plan begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time at the Policyholder's state of residence.

[Family Plan
A plan of insurance covering the Policyholder and one or more of the Policyholder's Dependents, as shown on the Benefit Schedule.]

Health Care Practitioner

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

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

For the purposes of this Policy, Heart Attack does not include:
1. Any other disease or injury involving the cardiovascular system;
2. A cardiac arrest that is not caused by myocardial infarction.]

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

[**Maximum Benefit**
A Maximum Benefit is the amount of benefits, as shown in the Benefits Schedule, that We will pay for each Covered Person under this plan. This plan has varying types of Maximum Benefit limitations. Each Maximum Benefit limitation is stated on the Benefit Schedule corresponding to the applicable benefit provision. A particular Maximum Benefit only applies if it is shown on the Benefit Schedule.

[1.] [Maximum Lifetime Benefit: The maximum amount of all benefits combined that We will pay for each Covered Person under this plan over the lifetime of that Covered Person. This maximum will apply even if coverage with Us is interrupted. When the Maximum Lifetime Benefit has been paid by Us, no further benefits are payable for that Covered Person.]

[2.] [Maximum Benefit for Cancer: The maximum amount of benefits that We will pay for Cancer.]

[3.] [Maximum Benefit for Heart-Stroke: The maximum amount of benefits that We will pay combined for all Heart-Stroke Specified Diseases.]]

[Medicare
Any portion of Title XVIII of the United States Social Security Act of 1965, as amended.]

Policy
The contract issued by Us to the Policyholder providing benefits for Covered Persons.

Policyholder
The person to whom the Policy is issued as shown in the Benefit Schedule.

[Pre-Existing Condition
A Specified Disease:
1. For which medical advice, consultation, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the [6-24]-month period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or

2. That produced signs or symptoms during the [6-24]-month period immediately prior to the Covered Person's Effective Date.

   The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:
   a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
   b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.]

Scheduled Benefit
The fixed benefit amount payable upon the Diagnosis of a Specified Disease under the terms of this plan. The Scheduled Benefit for a Specified Disease is shown on the Benefit Schedule.

Sickness
A disease or an illness of a Covered Person. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness.

[Single Plan
A plan of insurance covering only the Policyholder.]

Specified Disease
Any disease identified as a Specified Disease on the Benefit Schedule. Diseases first ever Diagnosed anytime prior to the Covered Person's Effective Date under the Policy are not considered Specified Diseases for the purpose of this Policy.

[Stroke
Brain tissue infarction due to acute cerebrovascular incident, embolism, thrombosis or hemorrhage. The basis of the Diagnosis must include imaging documentation of new brain tissue infarction in association with acute onset of symptoms consistent with central nervous system neurological damage.

For the purposes of this Policy, Stroke does not include:
1. Transient Ischemic Attacks (TIAs).
2. Transient Global Amnesia (TGA).
3. External trauma causing Accidental Injury to the brain.
4. Brain damage due to infection, vasculitis, encephalopathy and inflammatory disease.
5. Ischemic disorders of the vestibular system.]

We, Us, Our, Our Company
Time Insurance Company or its administrator.

You, Your, Yours
The person listed on the Benefit Schedule as the Policyholder.

IV. EFFECTIVE DATE AND TERMINATION DATE

Eligibility and Effective Date of Policyholder
A person who is eligible may elect to be covered under this plan by completing the enrollment process and submitting any required premium. [You must be a resident of the state where this plan is issued.] [Evidence of insurability according to Our underwriting and eligibility criteria must also be provided.] Your coverage will take effect at 12:01 a.m. local time at the Policyholder's state of residence on Your Effective Date as shown on the Benefit Schedule.

[If the Policyholder moves out of the state where this plan is issued, We may replace this Policy with a similar fixed indemnity plan with the form number that is issued in the Policyholder's new state of residence. The new plan will be effective on the date the Policyholder becomes a resident of the new state. If the Policyholder moves to a state where We do not provide insurance under a fixed indemnity plan with the same plan design as this Policy, We reserve the right to terminate this plan[for You and any Covered Dependents].]

[This is a Single Plan. Dependents may not be added.]

[Eligibility and Effective Date of Dependents
The following information explains how You can obtain coverage for any Dependents that You want to add to Your plan:

[[1.] **Single Plan:** [If the Policyholder has a Single Plan, as shown in the Benefit Schedule, on the Effective Date of his or her plan, a Dependent cannot be added after the Policyholder's Effective Date.]

[If You have a Single Plan and want to add any Dependents after Your Effective Date, You may convert this plan to a Family Plan by completing an application/enrollment form and submitting any required premium for additional Dependents.] [Evidence of insurability will not be required for You but it must be provided for any Dependents.] Coverage under the new policy will take effect at 12:01 a.m. local time at the Policyholder's state of residence on the Effective Date for that Covered Person shown on the Benefit Schedule[, if such coverage is approved by Us]. The time during which a Pre-Existing Condition Limitation [and a Benefit Waiting Period apply][applies] to the Policyholder under the new policy will be reduced by the total number of consecutive days that the Policyholder was covered under this Policy immediately prior to termination. Covered Dependents will be subject to the full plan Pre-Existing Condition Limitation [and Benefit Waiting Period]. Benefits paid under the new policy cannot exceed the [Maximum Lifetime Benefit or any other] applicable Maximum Benefit that would have otherwise been paid under the terms of this Policy if coverage under this Policy would have remained in force.]

[[2.] **Family Plan:** If the Policyholder has a Family Plan, as shown in the Benefit Schedule, on the Effective Date of his or her plan, a Dependent can be added after the Policyholder's Effective Date. To be covered under this plan, a person must meet the Dependent definition in this plan and is subject to the additional requirements below:

a. **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth or the next premium due date, whichever is later. The Effective Date of coverage will be the time and date of birth on

the birth record. If these requirements are not met, Your newborn child will be covered for Specified Disease only for the first [31-60] days from birth.

b. **Adding an Adopted Child:** A newly adopted child can be added on the date the child is placed with the Policyholder in anticipation of legal adoption and the Policyholder assumes a legal obligation for support of the child or the date of legal adoption, whichever is earlier. You must call Our office or send Us written notice of the adoption or placement for adoption of the child and We must receive any required additional premium within [31-60] days of the adoption or placement for adoption, whichever is earlier. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the earlier of the date the child is adopted or placed for adoption. If these requirements are not met, Your newly adopted child will be covered for Specified Disease only for the first [31-60] days from placement for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.

c. **Adding a Child for Whom a Court Order Requires You to Provide Insurance**: A child for whom a court order requires the Policyholder or Covered Dependent spouse to provide this insurance can be added as of the date required by the order. You must call Our office or send Us written notice of the court order, provide a copy of the court order to Us, and We must receive any required additional premium within [31-60] days of the effective date of the order. The Effective Date of coverage for the child will be 12:01 a.m. local time at the Policyholder's state of residence on:

   I. the date the court order becomes effective, when the notice and premium payment requirements above are met; or

   II. the date You provide notice, including a copy of the court order, and any required premium to Us if received after the first [31-60] days following the date of the court order.

d. **Adding Any Other Dependent:** To add any other Dependents, an application/enrollment form must be completed and sent to Us along with any required premium. [Evidence of insurability must also be provided.] The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the Effective Date for that Covered Person shown on the Benefit Schedule.]]

Termination Date

The Policyholder may cancel this plan at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Policyholder's state of residence, minus any claims that were incurred after the termination date and paid by Us.

This Policy will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.

[2.] [The date We receive a request in writing [or by telephone] to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.]

[3.] The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.

[4.] The date there is fraud [or material misrepresentation] made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.

[5.] The date all plans the same as this one are terminated or non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.

[6.] [The date We terminate or nonrenew all individual market specified disease insurance plans in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.]

[7.] [The date the Policyholder moves to a state where We do not provide insurance under a plan with the same plan design as this Policy[, We reserve the right to terminate this coverage].

[8.] [For a Dependent, the date a Covered Dependent no longer meets the Dependent definition in this plan.]

[9.] [The date the Policyholder attains age [65-85] years.][The anniversary date of this Policy following the Policyholder's [65th-85th] birthday.]

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

[A Covered Person's coverage under this Policy will terminate:

[1.] [When benefit payments for that Covered Person equals the Maximum Lifetime Benefit shown in the Benefit Schedule.]

[2.] [If the Covered Person is Diagnosed with a Specified Disease within the applicable Benefit Waiting Period. We will refund the portion of the premium paid for that Covered Person's coverage.]

[3.] [If a Covered Person is not eligible for a benefit under this plan due to a Diagnosis of a Specified Disease prior the Effective Date of this plan. Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage.]

[Following such loss of coverage, if the Covered Person was the Policyholder and this is a Family Plan, the Covered Dependent spouse or Domestic Partner will be considered the Policyholder or, if only Dependent children are covered under this plan, the youngest child will be considered the Policyholder.] [The required premium will be reduced.][If this was a Family Plan and becomes a Single Plan based on the Covered Person's coverage termination, the required premium will be reduced to a Single Plan premium.]

[V]. SPECIFIED DISEASE FIXED INDEMNITY BENEFITS

WE WILL PAY SCHEDULED BENEFITS ONLY FOR THE SPECIFIED DISEASES LISTED IN THE BENEFIT SCHEDULE. THE SCHEDULED BENEFIT AMOUNT AND THE MAXIMUM BENEFIT FOR ELIGIBLE SPECIFIED DISEASES ARE SHOWN IN THE BENEFIT SCHEDULE. REFER TO THE EXCLUSIONS SECTION FOR EVENTS FOR WHICH BENEFITS ARE NOT PROVIDED UNDER THIS PLAN.

All benefits paid will be applied to [the Maximum Lifetime Benefit and are also subject to] any [other] applicable Maximum Benefit limitation provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.

[We will not pay benefits for Specified Diseases Diagnosed during a Covered Person's Benefit Waiting Period. A Benefit Waiting Period only applies if it is shown in the Benefit Schedule.]

Specified Disease Benefits
If a Covered Person has a first ever Diagnosis of a Specified Disease while insured under this Policy, We will pay the corresponding Scheduled Benefit shown in the Benefit Schedule.

We will not pay benefits for any Specified Disease if the Covered Person has received that Diagnosis at any time prior to the Covered Person's Effective Date of coverage under this Policy. [In the event a Covered Person has received a Diagnosis for any type of Cancer prior to the Effective Date, no benefit will be paid for any Cancer Diagnosis while this plan is in force. Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage.]

Amount of Benefit
Scheduled Benefits are payable according to the amount shown for each Specified Disease in the Benefit Schedule.

[Scheduled Benefits are payable no more than [one time for Cancer] [and] [one time for Heart-Stroke per Covered Person].]

[Upon attainment of age [65-85], the Schedule Benefits are reduced to [50-75%] of the original amount of the Scheduled Benefit that the Covered Person had on the Effective Date.]

[[VI]. PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Conditions Limitation
A Pre-Existing Condition is not eligible for benefits unless the first ever Diagnosis occurs after the Pre-Existing Condition limitation period has expired. We will not pay benefits for Specified Diseases that are, result from, or are related to a Pre-Existing Condition that is Diagnosed within the first [6-12] months this plan is in force.]

[VII]. EXCLUSIONS

This plan provides benefits only for Specified Diseases identified in the Benefit Schedule.

We will not pay benefits for claims resulting, whether directly or indirectly, from Specified Diseases that are related to, or are resulting from any of the following:

[1.] Any disease if the Covered Person was previously Diagnosed anytime prior to his or her Effective Date under this Policy.

[2.] [Any disease first Diagnosed within the applicable Benefit Waiting Period, as shown in the Benefit Schedule, immediately following the Policy Effective Date. [In such event, We will terminate the Covered Person's coverage under this Policy and refund the portion of the premium paid for that Covered Person's coverage.]]

[3.] [Arrhythmia resulting in Heart Attack occurred in association with use of an illegal drug or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]

[4.] [Any amount in excess of [the Maximum Lifetime Benefit or] any [other] Maximum Benefit for covered Scheduled Benefits.]

[5.] [Diseases or conditions that do not meet the definition of a Specified Disease in this plan.]

[6.] [Suicide or attempted suicide.]

[7.] [Self-inflicted Sickness, injury, or Accidental Injury.]

[VIII]. CLAIM PROVISIONS

Notice of Claim
You must notify Us of the claim within [20-90] calendar days after the date of Diagnosis, or as soon as reasonably possible[, by calling Our Home Office] [e-mailing Us at xxxxx@xxx.com][website at [www.abcdefg.com]] [or] [by mail to [Assurant Health P.O. Box [624], Milwaukee, WI 53201-[XXXX]]]. When providing notice of claim, You must provide Your name, address, and policy number.

Claim Forms
Within [15-30] calendar days after We receive Your notice of claim, We will provide claim forms to be used when submitting proof of loss. The forms must be completed and sent to Us or Our designee in accordance with the Proof of Loss provision below. If You do not receive the claim forms within [15-30] [calendar][business] days [or if We do not require a particular Proof of Loss to be submitted on a specified claim form], We will accept a written description of the exact nature and extent of the loss as proof of loss provided it meets the requirements, including the character and extent of the loss for which claim is made, and timeframes, for submitting proof of loss, as required on the claim form. [Call Us for a list of the requirements provided on the claim form.]

Proof of Loss
We must receive written [or electronic] proof of loss for which the claim is made. Proof of loss must be provided to Us within [90-180] calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date the Proof of Loss is otherwise required, unless You are declared incompetent by a court of law.

When We receive written [or electronic] proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us. If a Covered Person has other coverage with Us, We may use information received through such coverage when determining benefits under this plan.

[Assignment Prohibited
You may not assign benefits under this plan.]

[Assignment Not Prohibited
You may assign benefits under this plan. We will pay any claimant who produces evidence of assignment by You, payable in the order in which We receive such evidence of assignment and pursuant to proof of loss. If You assign benefits to a provider involved in the Diagnosis, the assigned amount paid will not be in excess of the amount shown on the provider's bill submitted as proof of loss. Any Scheduled Benefit amount in excess of the billed amount will be paid directly to You, unless otherwise expressly assigned by You.]

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

1. Authorize the release of all medical records to Us and other information We requested.
2. Provide Us with any medical records requested by Us.

3. Provide Us with information We requested about pending claims.
4. Provide Us with information that is accurate and complete.
5. Have any examination completed as requested by Us.
6. Provide reasonable cooperation to any requests made by Us.

Such Specified Diseases may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claim Provisions section.

Physical Examination and Autopsy
We have the right to have a Health Care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits. These exams will be paid by Us. We also have the right, in case of death, to have an autopsy done, at Our expense, where it is not prohibited by law.

Payment of Benefits
Benefits will be paid when We receive due written proof of loss, subject to any time period requirements under state law. Benefits for Specified Diseases will be paid to the Policyholder[unless they have been assigned to a provider]. [Benefit payments may be assigned to another person in whole or in part.] Any benefits unpaid at Your death will be paid at Our option to Your spouse, [Your Domestic Partner,] [or]Your estate[or the providers of the services].

We will base claim determinations according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for further benefits under this plan.

Overpayment
If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or the person or entity receiving the incorrect payment. We may offset any overpayment to You or a provider against future benefit payments.

[Rights of Administration
We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable, subject to applicable provisions of state and federal law.]

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

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

Claim Appeal
You have the right to request a review of all adverse claim decisions. A review must be requested in writing within [180 days] following Your receipt of the notice that the claim was denied or reduced.

[IX]. PREMIUM PROVISIONS

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

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

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your [geographic area,] [gender,] [age,] [class,] [trend,] [payment method] [and] [plan design.] All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You [add or delete Covered Dependents,] [change the payment method,] [move to another zip code] [or otherwise] change the coverage. [The mode of payment (monthly, quarterly or other) is subject to change,]You will be notified at least 60 days in advance of any such change.

Unearned Premium
Upon receipt of legal proof of a Covered Person's death We will return the unearned portion of any premium paid on a pro-rata basis in accordance with the laws in the Policyholder's state of residence.

Grace Period
There is a grace period of 31 days for the payment of each premium due after the initial premium during which period coverage will continue in-force. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the [date the grace period expires. If the premium is received during or by the end of the grace period, coverage will continue without interruption unless You call Our office or give Us written notice to cancel the coverage. [If a claim is payable during the grace period, any unpaid premiums due will be deducted from the claim payment.]

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

1. The lapse was not more than [45-180] days.
2. You submit a supplemental application/enrollment form for reinstatement to Us and remit the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
3. We approve Your application/enrollment form for reinstatement.

The coverage will be reinstated on the date We approve Your application/enrollment form for reinstatement. If We have not responded to Your application/enrollment form for reinstatement by the 45th day after We receive the application/enrollment form, the coverage will be reinstated on that date.

[If the coverage is reinstated, loss resulting from a Specified Disease will be covered only if the Diagnosis is made on or after the date of reinstatement.] [Loss due to a Specified Disease will be covered only if the Specified Disease begins more than 10 days after the date of reinstatement.] No benefits will be paid for such condition and related complications if during the time between the lapse date and the reinstatement date:

[1.] [Medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a provider [or prescription drugs were prescribed] regardless of whether the condition was diagnosed or not diagnosed; or]

[2.] [The condition produced signs or symptoms.]

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

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

This limitation will apply until coverage has been in force for [12 months] after the reinstatement date, unless the condition has been specifically excluded from coverage.

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

[Covered Dependent Conversion
A Covered Dependent may be eligible to convert to another similar specified disease plan that We issue in the Covered Dependent's state of residence at the time coverage terminates under this plan if:

1. The Covered Dependent's insurance terminates due to a valid decree of divorce or loss of Domestic Partner status between the Policyholder and the Covered Dependent; or
2. The Covered Dependent's insurance terminates due to the death of the Policyholder; or
3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.

To obtain conversion coverage, the Covered Dependent must submit a written application/enrollment form and the required premium to Us within 31 days after coverage under this plan terminates. Evidence of insurability will not be required. The conversion plan will be provided on the limited specified disease plan that We select for providing conversion coverage at that time. However, the conversion plan may provide different benefit levels, covered services and premium rates.

If written enrollment is not made within [31 days] following the termination of insurance under this plan, conversion coverage will not be available.

The conversion plan will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates. The time during which a Pre-Existing Condition Limitation [and a Benefit Waiting Period apply][applies] under the new plan will be reduced by the total number of consecutive days that You were covered under this Policy immediately prior to termination. Benefits paid under the new plan cannot

exceed the [Maximum Lifetime Benefit or any other] applicable Maximum Benefit that would have otherwise been paid under the terms of this Policy if coverage under this Policy would have remained in force.]

[X]. OTHER PROVISIONS

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

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

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

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

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

Entire Contract
This Policy is issued to the Policyholder. The entire contract of insurance includes the Policy, Benefit Schedule, a Covered Person's application/enrollment form and any riders and endorsements.

Representations Made on Application/Enrollment Form
All statements made on the application/enrollment form will be deemed representations and not warranties. No statement made in the application/enrollment form will be used in any suit or action at law or equity unless a copy of the application/enrollment form is furnished to the Policyholder, or in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's beneficiary or personal representative.

[Incentives, Rebates and Contributions
We may elect to furnish or participate in programs with other organizations that furnish [group applicants for coverage] [members of groups applying for coverage] [individual applicants for coverage] [Covered Persons] [individuals] [that meet common criteria or requirements determined by Us][, not to include health or claims history,] [with "premium holidays" or programs where premiums, fees or plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted] [or] [where other gifts or items of value may be offered or provided to You at no charge or at a discount] [at a time or times] [or] [for a period of time] determined by Us.]

[Electronic Delivery of Policy Documents
We may offer a discount to premium when You elect to receive Your Policy documents and related correspondence via electronic delivery. If applicable, the discount will be shown on Your billing statement. If You choose to discontinue electronic delivery the discount to premium will also terminate as of the date electronic delivery was terminated.]

[Administration Fee
We may charge a [one-time] Policy administration fee. We may waive this fee if, prior to issuance of the Policy, You elect to receive the Policy and related papers and correspondence via electronic delivery. Any applicable administration fee will be shown on Your [initial] billing statement.]

[Billing Method
If You elect to receive Your premium bill by manual and/or paper means, We may apply an additional fee for administration of the billing statement. We will waive the fee if You elect to receive the billing statement by electronic delivery[or by automatic payment method]. If You choose to discontinue electronic delivery, the fee will be applied to and payable for the next billing statement following the date electronic delivery[or automatic payment method] was terminated.]

[Discounted or Free Non-Insurance Programs We may elect to furnish or participate in programs with other organizations that furnish Policyholders that meet common criteria or requirements determined by Us with discount cards, vouchers, coupons, or other programs that may be offered or provided to Covered Persons at no charge or a reduced charge for a period of time determined by Us. We may provide You with access to discounts with certain health care providers and suppliers negotiated by Us.]

[Provider Access
We may provide Covered Persons with access to providers with whom We have a contracted rate for services or supplies. The Scheduled Benefit does not change whether We have a contracted rate with the provider from whom You obtain hospital, medical, surgical or prescription services or supplies. By using providers with whom We have a contracted rate to obtain Your medical services or supplies, You may obtain a lower cost of services or supplies. You must show Your plan ID card at the time services are rendered to obtain these contracted rates, if available.]

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

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

Legal Action
No suit or action at law or in equity may be brought to recover benefits under this plan prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No suit or action at law or in equity can be brought later than 3 years after the time written proof of loss is required to be furnished. [You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review process and exhaustion of administrative remedies.]

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

Modification of Your Coverage
The Policy may be changed at any time. We will give You [30 days] notice prior to any change.

We may modify the insurance plan [for You and any Covered Dependents]. This modification will be consistent with state law and will apply uniformly to all policies with Your plan of coverage. You will be notified of any change.

Severability
If any clause or portion this Policy is held invalid by a court or otherwise unenforceable, the remainder of the Policy shall not be affected.

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

Outline of Coverage
for
Specified Disease Insurance Policy Form 8230.POL.[XX]
Limited [Cancer] [and] [Heart-Stroke] Fixed Indemnity Benefits

Notice: The coverage applied for is a Specified Disease Policy. This plan provides fixed indemnity benefits upon first ever Diagnosis of a Specified Disease. The Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

To be eligible for any benefits under this Policy, the first ever Diagnosis of a Specified Disease must occur on or after the Covered Person's Effective Date, while this Policy is in effect, and not during any applicable Benefit Waiting Period.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE COVERAGE.

THE PLAN HAS LIMITED BENEFITS. PLEASE READ YOUR POLICY CAREFULLY TO UNDERSTAND PLAN LIMITATIONS.

[Guaranteed Renewable except for stated reasons][Conditionally Renewable] Plan: Read the Termination Date provision of Your Policy carefully. We reserve the right to change premiums by class upon any renewal date after the initial 12 months coverage is in force.

This outline of coverage provides a brief description of the important features of Your Policy. This is not the insurance contract. The Policy itself sets forth in detail the limits and conditions of coverage as well as the rights and obligations of both You and the insurance company. The Policy provides limited benefits only and contains Maximum Benefits. It is important that You READ YOUR POLICY AND BENEFIT SCHEDULE CAREFULLY.

SECTION 1: SCHEDULED BENEFITS

Specified Disease Fixed Indemnity Benefits We will pay the Scheduled Benefit shown below only for the Specified Diseases listed below. All benefits and limitations stated below are stated per Covered Person.	
[Maximum Lifetime Benefit:	[$XXX,XXX] – All benefit payments apply to the Maximum Lifetime Benefit.]
[Cancer Benefit	• [Benefit Waiting Period for Cancer: Cancer is eligible for benefits under this plan only if Diagnosed after the first [XXX] calendar days from the Effective Date.] • [All Cancer Benefits are limited to a Maximum Benefit of

	$[XXX,XXX].]
[Heart-Stroke Benefit	• [Benefit Waiting Period for Heart-Stroke: Heart-Stroke is eligible for benefits under this plan only if Diagnosed after the first [XXX] calendar days from the Effective Date.] • [All Heart-Stroke Benefits are limited to a Maximum Benefit of $[XXX,XXX].] • [Only one Scheduled Benefit is payable for Heart-Stroke.]]
[Upon attainment of age [65-85], the Schedule Benefits are reduced to [XX]% of the original amount of the Scheduled Benefit that the Covered Person had on the Effective Date.]	

Specified Disease	**Scheduled Benefit**
[Cancer	$[XXX,XXX]]
[Coronary Artery Disease or Cardiac Arrhythmia resulting in Heart Attack	$[XXX,XXX]]
[Coronary Artery Disease or Cardiac Arrhythmia resulting in Coronary Artery Bypass	$[XX,XXX]]
[Coronary Artery Disease resulting in Coronary Angioplasty	$[XX,XXX]]
[Cerebrolvascular Disease resulting in Stroke	$[XXX,XXX]]

SECTION 2: BENEFIT DESCRIPTION:

Specified Disease Benefits
If a Covered Person has a first ever Diagnosis of a Specified Disease while insured under this Policy, We will pay the corresponding Scheduled Benefit shown in the Benefit Schedule.

We will not pay benefits for any Specified Disease if the Covered Person has received that Diagnosis at any time prior to the Covered Person's Effective Date of coverage under this Policy. [In the event a Covered Person has received a Diagnosis for any type of Cancer prior to the Effective Date, no benefit will be paid for any Cancer Diagnosis while this plan is in force. Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage.]

Scheduled Benefits are payable according to the amount shown for each Specified Disease in the Benefit Schedule.

[Scheduled Benefits are payable no more than [one time for Cancer] [and] [one time for Heart-Stroke per Covered Person].]

[Upon attainment of age [65-85], the Schedule Benefits are reduced to [50-75%] of the original amount of the Scheduled Benefit that the Covered Person had on the Effective Date.]

SECTION 3: DEFINITIONS:
As used in this Outline of Coverage, capitalized terms (other than headings and titles) are defined as follows. Consult the Policy for a full list of all defined terms used in the Policy documents.

[Cancer

1. A malignant tumor, including an in situ, and hematopoietic malignancy for which any of the following is recommended by Your Health Care Practitioner:
   a. Radiation;
   b. Chemotherapy[; or]
   c. Immunotherapy[; or]
   [d. Complete excision of an internal organ without need for further treatment]
2. Any metastatic cancer for which no therapy is recommended.

For purposes of this Policy, Cancer does not include:
1. Non-invasive dermatologic carcinomas (basal cell carcinoma (BCC), squamous cell carcinomas (SCC), melanoma in-situ), cervical carcinoma in situ or other premalignant conditions such as myelodysplastic and myeloproliferative disorders, leukoplakia, hyperplasia; or
2. An incidental pathological diagnosis found following surgical excision of an organ unless additional chemotherapy, radiation therapy and/or immunotherapy is recommended.]

[Cardiac Arrhythmia
Cardiac dysrhythmias, paroxysmal supraventricular tachycardia, paroxysmal ventricular tachycardia, atrial fibrillation and flutter, and ventricular fibrillation and flutter.]

[Cerebral Vascular Disease
Subarachnoid hemorrhage, intracerebral hemorrhage, occlusion and stenosis of precerebral arteries, and occlusion of cerebral arteries.]

[Coronary Angioplasty
An interventional procedure to widen or unblock the right coronary artery; left main stem; left anterior descending; or circumflex artery.]

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

[Coronary Artery Disease
Acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the heart, and coronary atherosclerosis due to lipid rich plaque.]

Covered Person
A person who is enrolled and eligible to receive benefits under this plan, as shown on the Benefit Schedule.

Diagnosis/Diagnosed
Identification of a Specified Disease made during the Covered Person's life by a Health Care Practitioner that is supported by evaluations, clinical or laboratory tests, and observations documented in the Covered Person's medical records.

[Heart Attack

A myocardial infarction resulting in the death of an area of the heart muscle due to insufficient blood supply to that area. The basis of the Diagnosis must include:

1. serial measurements of cardiac biomarkers showing a pattern and level consistent with an acute myocardial infarction; and
2. new electrocardiographic changes consistent with acute myocardial infarction.

For the purposes of this Policy, Heart Attack does not include:

1. Any other disease or injury involving the cardiovascular system;
2. A cardiac arrest that is not caused by myocardial infarction.]

[**Maximum Benefit**

A Maximum Benefit is the amount of benefits, as shown in the Benefits Schedule, that We will pay for each Covered Person under this plan. This plan has varying types of Maximum Benefit limitations. Each Maximum Benefit limitation is stated on the Benefit Schedule corresponding to the applicable benefit provision. A particular Maximum Benefit only applies if it is shown on the Benefit Schedule.

[1.] [Maximum Lifetime Benefit: The maximum amount of all benefits combined that We will pay for each Covered Person under this plan over the lifetime of that Covered Person. This maximum will apply even if coverage with Us is interrupted. When the Maximum Lifetime Benefit has been paid by Us, no further benefits are payable for that Covered Person.]

[2.] [Maximum Benefit for Cancer: The maximum amount of benefits that We will pay for Cancer.]

[3.] [Maximum Benefit for Heart-Stroke: The maximum amount of benefits that We will pay combined for all Heart-Stroke Specified Diseases.]]

[Pre-Existing Condition

A Specified Disease:

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

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

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

Scheduled Benefit
The fixed benefit amount payable upon the Diagnosis of a Specified Disease under the terms of this plan. The Scheduled Benefit for a Specified Disease is shown on the Benefit Schedule.

Specified Disease
Any disease identified as a Specified Disease on the Benefit Schedule. Diseases first ever Diagnosed anytime prior to the Covered Person's Effective Date under the Policy are not considered Specified Diseases for the purpose of this Policy.

[Stroke
Brain tissue infarction due to acute cerebrovascular incident, embolism, thrombosis or hemorrhage. The basis of the Diagnosis must include imaging documentation of new brain tissue infarction in association with acute onset of symptoms consistent with central nervous system neurological damage.

For the purposes of this Policy, Stroke does not include:
1. Transient Ischemic Attacks (TIAs).
2. Transient Global Amnesia (TGA).
3. External trauma causing Accidental Injury to the brain.
4. Brain damage due to infection, vasculitis, encephalopathy and inflammatory disease.
5. Ischemic disorders of the vestibular system.]

SECTION 4: EXCLUSIONS AND LIMITATIONS

Pre-Existing Conditions Limitation
A Pre-Existing Condition is not eligible for benefits unless the first ever Diagnosis occurs after the Pre-Existing Condition limitation period has expired. We will not pay benefits for Specified Diseases that are, result from, or are related to a Pre-Existing Condition that is Diagnosed within the first [6-12] months this plan is in force.]

Exclusions
This plan provides benefits only for Specified Diseases identified in the Benefit Schedule.

We will not pay benefits for claims resulting, whether directly or indirectly, from Specified Diseases that are related to, or are resulting from any of the following:

[1.] Any disease if the Covered Person was previously Diagnosed anytime prior to his or her Effective Date under this Policy.

[2.] [Any disease first Diagnosed within the applicable Benefit Waiting Period, as shown in the Benefit Schedule, immediately following the Policy Effective Date. [In such event, We will terminate the Covered Person's coverage under this Policy and refund the portion of the premium paid for that Covered Person's coverage.]]

[3.] [Arrhythmia resulting in Heart Attack occurred in association with use of an illegal drug or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.]

[4.] [Any amount in excess of [the Maximum Lifetime Benefit or] any [other] Maximum Benefit for covered Scheduled Benefits.]

[5.] [Diseases or conditions that do not meet the definition of a Specified Disease in this plan.]

[6.] [Suicide or attempted suicide.]

[7.] [Self-inflicted Sickness, injury, or Accidental Injury.]

SECTION 5: RENEWABILITY PROVISIONS:
We will renew the coverage issued except that this coverage will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
[2.] [The date We receive a request in writing [or by telephone] to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.]
[3.] The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
[4.] The date there is fraud [or material misrepresentation] made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.
[5.] The date all plans the same as this one are terminated or non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.
[6.] [The date We terminate or nonrenew all individual market specified disease insurance plans in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.]
[7.] [The date the Policyholder moves to a state where We do not provide insurance under a plan with the same plan design as this Policy[, We reserve the right to terminate this coverage].
[8.] [For a Dependent, the date a Covered Dependent no longer meets the Dependent definition in this plan.]
[9.] [The date the Policyholder attains age [65-85] years.][The anniversary date of this Policy following the Policyholder's [65th-85th] birthday.]

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

SECTION 6: INITIAL PREMIUM INFORMATION: Premium is subject to change as provided in the Policy.
Initial Annual Premium: _____ Initial Premium Payment Mode: _____ INITIAL MODAL PREMIUM AMOUNT: $_____

Licensed Agent's Signature

Date

BENEFIT SCHEDULE
Limited Specified Disease Fixed Indemnity Benefits

Date of this Benefit Schedule: [XX/XX/XXXX]

THIS BENEFIT SCHEDULE CONTAINS LIMITED INFORMATION ABOUT YOUR PLAN. IN ADDITION, THE PLAN HAS LIMITED BENEFITS AND LIFETIME MAXIMUMS. PLEASE READ YOUR POLICY AND THE BENEFIT SCHEDULE CAREFULLY TO UNDERSTAND PLAN LIMITATIONS.

[Benefits will be paid for Specified Diseases first ever Diagnosed while this plan is in force.] Payment of benefits is subject to all the terms, limits and conditions in the plan.

Policyholder and Plan Information		
Policyholder:	[Name] [Address/City/State/Zip]	Effective Date: [XX/XX/XXXX]
[Plan Type:]	[Single Plan][Family Plan]	
[Covered Dependents:]	[[Spouse's][Domestic Partner's] Name] [Dependent Child's Name] [Dependent Child's Name]	[Effective Date: [XX/XX/XXXX]] [Effective Date: [XX/XX/XXXX]] [Effective Date: [XX/XX/XXXX]]
Policy Number:	[XXXXXXX]	
Initial Annual Premium:	[$XXX.XX]	
Initial Payment Option Mode:	[Monthly]	
Initial Modal Premium:	[$XXX.XX]	

Specified Disease Fixed Indemnity Benefits We will pay the Scheduled Benefit shown below only for the Specified Diseases listed below. All benefits and limitations stated below are stated per Covered Person.	
[Maximum Lifetime Benefit:	[$XXX,XXX] – All benefit payments apply to the Maximum Lifetime Benefit.]
[Cancer Benefit	• [Benefit Waiting Period for Cancer: Cancer is eligible for benefits under this plan only if Diagnosed after the first [XXX] calendar days from the Effective Date.] • [All Cancer Benefits are limited to a Maximum Benefit of $[XXX,XXX].]
[Heart-Stroke Benefit	• [Benefit Waiting Period for Heart-Stroke: Heart-Stroke is eligible for benefits under this plan only if Diagnosed after the first [XXX] calendar days from the Effective Date.] • [All Heart-Stroke Benefits are limited to a Maximum Benefit of $[XXX,XXX].]

	• [Only one Scheduled Benefit is payable for Heart-Stroke.]]
[Upon attainment of age [65-85], the Schedule Benefits are reduced to [XX]% of the original amount of the Scheduled Benefit that the Covered Person had on the Effective Date.]	
Specified Disease	**Scheduled Benefit**
[Cancer	$[XXX,XXX]]
[Coronary Artery Disease or Cardiac Arrhythmia resulting in Heart Attack	$[XXX,XXX]]
[Coronary Artery Disease or Cardiac Arrhythmia resulting in Coronary Artery Bypass	$[XX,XXX]]
[Coronary Artery Disease resulting in Coronary Angioplasty	$[X,XXX]]
[Cerebrolvascular Disease resulting in Stroke	$[XXX,XXX]]

[Application] [Enrollment Form] for [Assurant] [insert marketing name here] [Cancer] [and] [Heart-Stroke] [Specified Disease] [Fixed] [Indemnity] Insurance

PLEASE PRINT IN BLACK INK

PERSON[S] TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed.

	Name Last First M.I.	Sex	Birthdate (MM/DD/YY)	[Social Security Number]
[1.] [Primary] [Proposed] [Insured]				
	[Height _____ Weight _____]	[Used tobacco products in any form within the last year? ☐ Yes ☐ No]		
[2.] [Spouse] [/Domestic Partner]	Name Last First M.I.	Sex	Birthdate (MM/DD/YY)	[Social Security Number]
	[Height _____ Weight _____]	[Used tobacco products in any form within the last year? ☐ Yes ☐ No]		
[3.] [Dependents]	Name Last First M.I.	Sex	Birthdate (MM/DD/YY)	[Social Security Number]
[A.] [Dependents] *[list relationship below]*				
[B.] [Dependents] *[list relationship below]*				
[C.] [Dependents] *[list relationship below]*				
[D.] [Dependents] *[list relationship below]*				

[4.] Resident Address: _____
(No P.O. Boxes) (Street) (City) (State) (Zip)

[5.] Phone Number: (_____) _____ ☐ Home ☐ Business ☐ Cell

[Please list the phone number that would be the best to reach you during the day for any inquiries.]

[6.] E-mail Address: _____

[By providing your e-mail address you agree that you may receive your policy and/or certificate of issuance and other correspondence electronically.]

[7.] [Is the [Primary] [Proposed] [Insured] a U.S. citizen or Lawful Permanent Resident/ Green Card Holder? .....☐ Yes ☐ No]

REQUESTED EFFECTIVE DATE

Requested effective date: _____

A policy may not have an effective date of the 29th, 30th or 31st.]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]]

Assurant Health [501 West Michigan] [Milwaukee,] [WI] [53203] [Fax 414-299-6020]

[OTHER COVERAGE

[8.] [[Are any of] [Is] the [proposed] [persons to be] [insured] covered by, or has [application] been made for any type of [specified disease] [or] [medical] insurance? ..... ☐ Yes ☐ No]

[If "Yes," complete the section below.]

Insurance Company Name	Policy Number	Group or Individual	Type of Coverage	Phone Number (include area code)	Effective Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?
						☐ Yes ☐ No
						☐ Yes ☐ No

[MEDICAL QUESTION[S] FOR [CANCER] [PLAN]

[Complete question[s] [9] [and] [10] if applying for the [Cancer] [Plan]]

		Primary	[Spouse][/ Domestic Partner]]	[Enter dependent information in same order as page 1.] [A.]]	[B.]]	[C.]]	[D.]]
[9.] [Have you [or any person(s) to be insured] ever been: • diagnosed with a malignant condition or cancer other than non-invasive basal cell carcinoma (BCC) or non-invasive squamous cell carcinoma (SCC) • diagnosed with [Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)]?]	[Yes	☐	☐	☐	☐	☐	☐]
	[No	☐	☐	☐	☐	☐	☐]
[10.] [In the last [5] years, have you [or any person(s) to be insured] had any abnormal diagnostic tests (including, but not limited to, laboratory or blood tests, biopsy and imaging studies -- MRI, mammogram, etc.) for which additional laboratory or diagnostic studies are recommended but have not been completed?]	[Yes	☐	☐	☐	☐	☐	☐]
	[No	☐	☐	☐	☐	☐	☐]]

[MEDICAL QUESTION[S] FOR [HEART-STROKE] [PLAN]

[Complete question[s] [11] [-] [14] if applying for the [Heart-Stroke] [Plan]]

		Primary	[Spouse][/ Domestic Partner]]	[Enter dependent information in same order as page 1.] [A.]]	[B.]]	[C.]]	[D.]]	
[11.] [In the last [5] years, have you [or any person(s) to be insured] been diagnosed with, taken prescription medication for, or been treated for:	[Yes	☐	☐	☐	☐	☐	☐	]
	[No	☐	☐	☐	☐	☐	☐	]
[a.] [Heart attack or myocardial infarction (MI)]								
[b.] [Coronary Artery Disease (CAD)]								
[c.] [Angina Pectoris]								
[d.] [Transient Ischemic Attack (TIA)]								
[e.] [Stroke]								
[f.] [Carotid Artery Disease]								
[g.] [Peripheral Artery Disease (PAD)]]								
[12.] [Have you [or any person(s) to be insured,] been recommended or scheduled for but not completed or not yet received results of a cardiac stress test, carotid Doppler, or cardiac catheterization?]	[Yes	☐	☐	☐	☐	☐	☐	]
	[No	☐	☐	☐	☐	☐	☐	]
[13.] [Have you [or any person(s) to be insured] ever had or been recommended to have any of the following surgical interventions:	[Yes	☐	☐	☐	☐	☐	☐	]
	[No	☐	☐	☐	☐	☐	☐	]
[a.] [Angioplasty (PTCA)]								
[b.] [Coronary Artery Bypass Graft (CABG)]								
[c.] [Stent (heart or other artery)]								
[d.] [Carotid endarterectomy]]								
[14.] [Have you [or any person(s) to be insured] taken or been advised to take any prescription medication in the last [two] years for:								
[a.] [Hypertension (high blood pressure)]	[Yes	☐	☐	☐	☐	☐	☐	]
	[No	☐	☐	☐	☐	☐	☐	]
[b.] [Cholesterol/lipids]	[Yes	☐	☐	☐	☐	☐	☐	]
	[No	☐	☐	☐	☐	☐	☐	]
[c.] [Diabetes Mellitus]]	[Yes	☐	☐	☐	☐	☐	☐	]
	[No	☐	☐	☐	☐	☐	☐	]]

[AUTHORIZATION

[My [application] [enrollment form][,] [recorded Authorizations][,] [recorded personal health history] [and any amendments] shall be the basis for the contract.] [I agree that I must call Time Insurance Company and complete [the] [Authorization] [and] [personal health history] portion of the [application] [enrollment] process within [10] [day[s]] of commencement of the [application] [enrollment] process.]

[I understand the insurance plan is subject to underwriting.] [The insurance [, if approved by Time Insurance Company,] will be in force only when issued by Time Insurance Company.] [The effective date is assigned by Time Insurance Company.] [The first full premium must be paid.] [A change in the [eligibility] [health] of the proposed insured(s) after the completion of the [application] [enrollment form] and before the delivery of the contract may affect my eligibility for insurance with the company.] [I understand and agree that any information I provide through this [application] [enrollment] process may be shared with persons necessary to facilitate issuing this plan, including but not limited to my agent or broker.] [If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of this plan and the full extent of its liability shall be limited to the sum received.]

[I agree that a photocopy of this authorization shall be valid for [two] [year[s]] from the date signed.]

[[In order to determine my (our) eligibility for insurance,] [I hereby authorize any health care provider or medically related facility][, pharmacy] [, pharmacy benefit manager] [or pharmacy related facility,] [MIB, Inc.,] [("MIB")] [formerly known as the Medical Information Bureau][,] [consumer reporting agency,][insurance or reinsurance company] [or employer having information about me] [or my minor children] [to provide all such information] [including information regarding [employment,] [other insurance coverage,] [personal information,] [medical or pharmacy care, advice, treatment, or medication use]] [as may be requested to Time Insurance Company] [(or any consumer reporting agency authorized by Time Insurance Company)][, its legal representative or any medical records retrieval service Time Insurance Company may engage] [,][.] [including, but not limited to, [Examination Management Services, Inc.] [(EMSI),]] [and its agents][.]]

[[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, Human Immunodeficiency Virus (HIV) testing and treatment, sexually transmitted disease (STD) testing and treatment, sickle cell testing and treatment, prescription history, lab data and electrocardiograms (EKGs).] [This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents.] [Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.]]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or [application] [enrollment] determinations relating to me [and/or my minor children][.] [or for Time Insurance Company's underwriting or risk rating determinations.] If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application [for enrollment].]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, [P.O. Box 3050][,] [501 West Michigan][,] [Milwaukee, WI 5320[1][3][-3050]]. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. [But in no event will this authorization be in effect for longer than [24] months from the date signed.]]

[I acknowledge receiving the notification regarding [MIB, Inc.] [("MIB")] [and] [the Abbreviated Notice of Insurance Information Practices] [and] [the Outline of Coverage for this plan] [,] [if required].]

[I acknowledge that I have read the completed [application] [enrollment form].] [I attest that all statements and answers on this [application] [enrollment form] are complete, true and correct.] [I understand and acknowledge that any fraudulent statement [or material misrepresentation] [or omission] on the [application] [enrollment form] [,] [recorded] [Authorizations][,] [recorded] [personal health history] [and/or any amendments] may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

_____	_____	_____ a.m./p.m.	_____	_____
Signature of [Primary] [Proposed] [Insured] [or Legal Guardian]	Date Signed	Time Signed	City	State]

[_____]
[Signature of Spouse[/Domestic Partner] *(if proposed to be insured)]*

[_____]
[Signature(s) of Dependent(s) 18 or over *(if proposed to be insured)]*

[_____]
[Guardian's Signature]

[Premium Amount Sent: $_____]

[Processing Fee: $ _____[ ]_____]

[Attention: (Agent)
I have reviewed this [application] [enrollment form] to ensure that all required items have been completed.

I certify that:

☐ I personally saw the applicant. The applicant was asked each required question and the answer is truly and accurately recorded on the application in the respective response area. The answers are true to the best of my knowledge.

☐ The [application] [enrollment form] was completed by the applicant or applicant's representative and the answers are true to the best of my knowledge.

_____
Licensed Resident Agent's Signature

_____
Print Agent's Name

_____ Initial here if you witnessed the signing of this form by the [primary] [proposed] [insured] [or legal guardian].]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]]

AGENT/AGENCY INFORMATION

Agent Name: _____ Phone Number: _____

Agent Number: _____ E-mail Address: _____

Key Agency Contact: _____ Agency Name: _____

Fax Number: _____ Agency Number: _____

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

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

[☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** _____]	
[☐ Internal Replacement] [☐ Adding Dependent[s]] [☐ Adding a Spouse]	[☐ Conversion (over age dependent/divorce] [☐ Policy/Benefit Change To An Existing Policy] [List Type of Change Requested: _____] [☐ Reinstatement of Coverage]

]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]]

Assurant Health [501 West Michigan] [Milwaukee,] [WI] [53203] [Fax 414-299-6020]

[IMPORTANT NOTICES – LEAVE WITH CUSTOMER

[NOTIFICATION REGARDING [MIB, Inc.] [("MIB")] [formerly known as the Medical Information Bureau]

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

Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901 (TTY 866 346-3642)]. If you question the accuracy of the information in [MIB's] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB's] information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

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

[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

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

[FRAUD NOTICE

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

[PRIVACY

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

[FAIR CREDIT REPORTING ACT AND PRIVACY PRE-NOTIFICATION

Thank you for considering Time Insurance Company as your insurance carrier. Your [application] [enrollment form] will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this [application] [enrollment form] which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.]

LEAVE THIS PAGE WITH THE CUSTOMER – DO NOT FAX

[IMPORTANT NOTICE TO PERSONS ON MEDICARE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).]]

LEAVE THIS PAGE WITH THE CUSTOMER – DO NOT FAX

Rate Information

Rate data applies to filing.

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

Company Rate Information

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

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 12/13/2011	Specified Disease RateSheet	8230.POL.AR	New		2012_04_01 Cancer Heart Stroke - Rate Sheet 50% - 2011_12_01.PDF 2012_04_01 Cancer Heart Stroke - Rate Sheet 50% - 2011_12_01.XLS
Approved-Closed 12/13/2011	Specified Disease Rate Lifetime Loss Ratio	8230.POL.AR	New		2012_04_01 Cancer Heart Stroke - Lifetime Loss Ratio 50% - 2011_11_29.PDF 2012_04_01 Cancer Heart Stroke - Lifetime Loss Ratio 50% - 2011_11_29.XLS

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	12/13/2011

Comments:

Please see the Forms Schedule

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	12/13/2011

Comments:

Attachment:

ASC Specified Disease- Cover Letter.PDF

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	12/13/2011

Comments:

Attachment:

2012_04_01 Cancer Heart Stroke - Actuarial Memo 50% AR - 2011_11_29.PDF

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	12/13/2011

Comments:

Please the Forms Schedule

		Item Status:	Status Date:
Satisfied - Item:	Variability Statement	Approved-Closed	12/13/2011

Comments:

Attachment:

Statement of Variability.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	Form Listing	Approved-Closed	12/13/2011

Comments:

Attachment:

ASC Specified Disease Form Listing.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	12/13/2011

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

ASSURANT
Health

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

www.assurant.com

December 9, 2011

Arkansas Department of Insurance
1200 W Third Street
Little Rock, AR 72201

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Individual Specified Disease Indemnity forms: 8230.POL.AR et al.
Company Reference No.: ASWX-G127862889

Dear Sir/Madam:

The enclosed forms are hereby submitted for your review seeking approval along with the actuarial memorandum and rates. These forms are new and do not replace any forms currently on file with your office. These forms will be used to issue specified disease indemnity insurance in the individual market. This plan is designed to provide fixed indemnity benefits upon first ever diagnosis of a specified disease. This plan does not provide expense reimbursement for billed charges by a health care provider or coverage for health care services or supplies. Coverage will be offered by independent agents licensed in your state.

For your ease in reference, a listing of all submitted forms is enclosed. Please note that the form is numbered using a matrix format, where each section of the document has a unique form number. For example, the face page is numbered 8230.POL.AR, while the Exclusions section of the same document is numbered 8230.EXC.XX. The Company employs this form numbering style for administrative and tracking purposes. The form will always be issued in its entirety with all sections and form numbers included.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Best Regards,

Christine R. Fleming
Senior Contract Compliance Analyst
Legal Department
christine.fleming@assurant.com
T 414.299.1306 or 800.800.1212 ext. 1306
F 414.299.6168

ASSURANT
Health

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

www.assurant.com

STATEMENT OF VARIABILITY

- A number of benefit options and/or items which customarily vary according to the Policyholder's specific plan of insurance, which will allow us to deliver a customized contract to our customers reflecting all benefit options selected, helping to alleviate any ambiguity on the part of the customers as to what is covered and how it is covered.
- Flexibility in utilizing provisions when filing diverse products.
- Future flexibility to adjust to changing regulatory and market needs.

1. All bracketed numbers (excluding form numbers) are variable, subject to the confines of state and federal law. Bracketed benefit amounts, illustrated as a range, list of amounts or otherwise, are variable and can fluctuate to provide a richer benefit to the insured than what is represented in the approved document.

2. All bracketed text varies to the extent that such language may be:

   a. included as shown;
   b. omitted in its entirety;
   c. rearranged; or
   d. transferred to another provision, section or page.

3. All bracketed numbers and/or text will be varied only:

   a. within any statutory or regulatory requirements; and
   b. under the condition that the numerical value(s) and benefit language is within the intent and framework of the actual approved provision.

4. Bracketed addresses, locations, phone and fax numbers or other contact information may be changed to reflect the correct contact information.

We also reserve the right to amend the form(s) to correct any minor clerical or typographical errors we may have overlooked prior to approval, and to revise any phraseology to clarify the intent within the confines of the law.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

SPECIFIED DISEASE FIXED INDEMNITY FORMS LIST

FORM NUMBER	FORM TITLE AND/OR DESCRIPTION
8230.POL.AR	Specified Disease Fixed Indemnity Policy Cover Page
8230.TOC.XX	Matrix Insert Section: Table of Contents
8230.DEF.AR	Matrix Insert Section: Definitions
8230.EFF.AR	Matrix Insert Section: Effective Date and Termination Date
8230.BEN.XX	Matrix Insert Section: Specified Disease Fixed Indemnity Benefits
8230.EXC.XX	Matrix Insert Section: Exclusions and Limitations
8230.CLM.XX	Matrix Insert Section: Claim Provisions
8230.PRM.AR	Matrix Insert Section: Premium Provisions
8230.OTH.AR	Matrix Insert Section: Other Provisions
8230.BNS.XX	Benefit Schedule
33000-XX	Application/Enrollment Form for Specified Disease Fixed Indemnity Insurance
8230.OOC.XX	Specified Disease Fixed Indemnity Outline of Coverage

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Time Insurance Company**

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

Form Number	Score
8230.POL.AR	50.2
8230.OOC.XX	50.2
8230.BNS.XX	52.1
33000-AR	51.4

Signed: _____

Name: Julia M. Hix

Title: VP Regulatory Compliance& AH Compliance Officer

Date: 12/9/11