

SERFF Tracking Number: CAIC-127863751 State: Arkansas  
Filing Company: Continental American Insurance Company State Tracking Number: 50390  
Company Tracking Number: 8303  
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
Product Name: Accident 7800  
Project Name/Number: Accident 7800/8303

## Filing at a Glance

Company: Continental American Insurance Company

Product Name: Accident 7800

SERFF Tr Num: CAIC-127863751 State: Arkansas

TOI: H02G Group Health - Accident Only

SERFF Status: Closed-Approved-Closed  
State Tr Num: 50390

Sub-TOI: H02G.000 Health - Accident Only

Co Tr Num: 8303

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Sarah Thacker, David Kelly, Jennifer McLaughlin

Disposition Date: 12/05/2011

Date Submitted: 12/02/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Accident 7800

Status of Filing in Domicile: Authorized

Project Number: 8303

Date Approved in Domicile: 07/28/2011

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Other

Explanation for Other Group Market Type:

Union

Overall Rate Impact:

Filing Status Changed: 12/05/2011

Deemer Date:

State Status Changed: 12/05/2011

Submitted By: Jennifer McLaughlin

Created By: Jennifer McLaughlin

Filing Description:

Corresponding Filing Tracking Number: 8303

Please see submission letter under Supporting Documentation tab.

## Company and Contact

### Filing Contact Information

Sarah Thacker,

sthacker@caicworksite.com

2801 Devine Street

803-461-4512 [Phone]

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Columbia, SC 29205

**Filing Company Information**

Continental American Insurance Company CoCode: 71730 State of Domicile: South Carolina  
 2801 Devine Street Group Code: Company Type: LAH  
 Columbia, SC 29205 Group Name: Continental Amer Ins State ID Number:  
 Co  
 (803) 256-6265 ext. [Phone] FEIN Number: 57-0514130  
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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$450.00  
 Retaliatory? Yes  
 Fee Explanation: South Carolina's retaliatory fee is zero dollars; therefore, we are submitting the following:

One policy = \$50

One certificate = \$50

Two applications = \$100

Five riders = \$250

Total = \$450

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	\$450.00	12/02/2011	54216216

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/05/2011	12/05/2011

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## **Disposition**

Disposition Date: 12/05/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Submission Letter	Approved-Closed	Yes
Form	Master Policy	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form	Master Application	Approved-Closed	Yes
Form	Enrollment Application	Approved-Closed	Yes
Form	Dependent Rider	Approved-Closed	Yes
Form	Sickness Rider	Approved-Closed	Yes
Form	Gunshot Wound Rider	Approved-Closed	Yes
Form	Catastrophic Accident Rider	Approved-Closed	Yes
Form	Total Disability Rider	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: CAI7800AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 12/05/2011	CAI7800AR	Policy/Cont ract/Fratern al Certificate	Master Policy	Initial		47.100	CAI7800AR Policy 12022011.pdf
Approved- Closed 12/05/2011	CAI7801AR	Certificate	Certificate	Initial		47.800	CAI7801AR Certificate 120211.pdf
Approved- Closed 12/05/2011	CAI7810	Application/ Enrollment Form	Master Application	Initial		0.000	CAI7810 MasterApp 091411.pdf
Approved- Closed 12/05/2011	CAI7811	Application/ Enrollment Form	Enrollment Application	Initial		0.000	CAI7811 Enrollment Form 091411.pdf
Approved- Closed 12/05/2011	CAI7822	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Dependent Rider	Initial		52.100	CAI7822 Dependent Rider 070611.pdf
Approved- Closed 12/05/2011	CAI7823	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Sickness Rider	Initial		44.300	CAI7823 Sickness Rider 070611.pdf
Approved- Closed 12/05/2011	CAI7825	Certificate Amendmen t, Insert Page, Endorseme	Gunshot Wound Rider	Initial		59.300	CAI7825 Gunshot Wound Rider 070611.pdf

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<i>Product Name:</i>	Accident 7800		
<i>Project Name/Number:</i>	Accident 7800/8303		
	nt or Rider		
Approved- CAI7835	Certificate Catastrophic	Initial	45.900
Closed	Amendmen Accident Rider		
12/05/2011	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- CAI7849	Certificate Total Disability Rider	Initial	40.700
Closed	Amendmen		
12/05/2011	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
			CAI7835 Catastrophic Rider 070611.pdf
			CAI7849 Total Disability Rider 070611.pdf



# CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036]

## GROUP ACCIDENTAL INJURY INSURANCE POLICY

[ABC COMPANY, INC.] (“the Policyholder”) applied for coverage under this Group Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “we,” “us,” or “our”). Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as *he*, *him*, and *his*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of policy documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance policy.

### **This is a limited policy. Please read it carefully.**

This Plan becomes effective on the Effective Date at 12:01 a.m., as determined by the Policyholder's address. Plan Termination is governed by Section I. The Plan continues to be effective while premiums are paid, as provided in Section II.

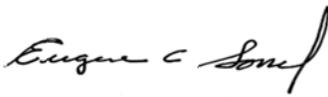
The Plan's first Anniversary Date appears below. Subsequent anniversaries will be the same date each following year.

The Policyholder may add new [Employees] or Dependents from time to time, according to the Plan's terms.

This Plan is a legal contract between the Company and the Policyholder. All matter printed or written by the Company on the following pages is part of this Plan. This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

[  ]

[Eugene Sorrel, President]

Group Policy Number [1234]

Effective Date [January 1, 2012]

Anniversary Date [January 1, 2013]

Jurisdiction [State Name]

Non-Participating

**ANY CERTIFICATES ISSUED IN THE STATE OF ARKANSAS ARE GOVERNED BY THE STATE OF ARKANSAS.**

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## **Section I – Eligibility, Effective Date, and Termination**

### **Eligibility**

A person is an eligible [Employee] under this Plan if he meets the following three requirements. He is:

1. [An Employee] of the Policyholder,
2. Engaged in [full; part]-time work, and
3. Included in the class of Employees eligible for coverage, as shown on the Application.

Dependents are eligible for coverage under this Plan. A *Dependent* is:

- The Spouse of [an Employee] **or**
- The Dependent Child of [an Employee]. *Dependent Children* are [an Employee's] or [an Employee's Spouse's] natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26 (details included in the **Definitions** section).

*Insureds* are defined as those who might be eligible for coverage in the following categories under this Plan:

- **[Employee] Coverage** – We insure only the [Employee].
- **[Employee] and Spouse Coverage** – We insure the [Employee] and Spouse.
- **[Employee] and Child Coverage** – We insure the [Employee] and any Dependent Children.
- **Family Coverage** – We insure the [Employee], Spouse, and any Dependent Children.

Any other additions to the Insured class must be added by Endorsement after applying to the Company.

### **Effective Date**

The Plan's Effective Date is shown on Page 1.

[An Employee's] Effective Date is the date his insurance takes effect. That date is either the date:

- Shown on the Certificate Schedule if the [Employee] is Actively at Work on that date, **or**
- The [Employee] returns to an Actively-at-Work status if he is not Actively at Work on the date shown on the Certificate Schedule.

### **Plan Termination**

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the first premium year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number mutually agreed upon by the Company and the Policyholder in the signed master Application.

The Policyholder has the sole responsibility to notify [Employees] of the Plan's termination.

If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address. If the Plan terminates, we will provide coverage for claims arising from Covered Accidents that occurred while the Plan was in force.

## **Termination of [An Employee's] Insurance**

[An Employee's] insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date he no longer meets the Plan's definition of [an Employee].
- The date he no longer belongs to an eligible class.

If the Plan terminates, we will provide coverage for claims arising from Covered Accidents that occurred while the Plan was in force.

## **Portability Privilege**

When [an Employee] [ends employment with the Employer] and his coverage would otherwise terminate, that [Employee] may elect to continue his coverage under this Plan. The [Employee] may continue the coverage that he had on the date his [employment] ended, including any in-force Spouse or Dependent Child coverage.

- To keep his Certificate in force, the [Employee] must:
  - Apply to the Company in writing within 31 days after the date his insurance would otherwise terminate; **and**
  - Pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- Insurance will end on the earlier of these dates:
  - 31 days after the date the [Employee] failed to pay any required premium
  - The date this Group Policy is terminated
- However, coverage may not be continued if:
  - The [Employee] failed to pay any required premium, **or**
  - This Group Policy terminates.

If [an Employee] qualifies for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.]

## **Section II – Premium Provisions**

### **Premium Calculations**

The Schedule of Premiums determines the premium amount payable on any premium due date. [The rates shown in this Schedule can be changed annually.] The Company will give the Policyholder written notice 31 days before any change in rates becomes effective.

### **Premium Payments**

The first premiums are due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

## **Grace Period**

This Plan has a 31-day Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

## **Section III – Definitions**

When the terms below are used in this Plan, the following definitions will apply:

***Accidental Injury*** or ***Injuries*** means bodily Injury or Injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of *Covered Accident*.

***Actively at Work*** is defined as an Insured's ability to perform his regular employment duties for a full normal workday. The Insured may perform these activities either at his employer's regular place of business or at a location where the Insured may be required to travel to perform the regular duties of his employment.

***Calendar Year*** is defined as January 1 through December 31 of the same year.

***Covered Accident*** means an unforeseen and unexpected traumatic event resulting in bodily Injury. An event meets the qualifications of Covered Accident if it:

- Occurs on or after the Plan's Effective Date,
- Occurs while coverage is in force, **and**
- Is not specifically excluded.

***Dependent*** means the Spouse of [an Employee] **or** the Dependent Child of [an Employee]. ***Dependent Children*** are [an Employee's] or [an Employee's Spouse's] natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. [The Employee] or [the Employee's] Spouse must furnish proof of this incapacity and dependency to the Company.

***Doctor*** is defined as a person who is:

- Legally qualified to practice medicine,
- Licensed as a physician by the state where Treatment is received, **and**
- Licensed to treat the type of condition for which a claim is made.

A Doctor does not include the Insured or an Insured's Family Member.

***[Employee]*** is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The [Employee] is the primary Insured under this Plan.

**Family Member** includes the Employee's **Spouse** (who is defined as an Employee's legal wife or husband) as well as the following members of the Insured's immediate family:

- son
- daughter
- mother
- father
- sister
- brother

This includes Step-Family Members and Family-Members-in-law.

**Full-time Work** means that an Insured spends at least [30 hours] per week performing his occupational duties.

**[Part-time Work** means that an Insured spends less than [16 hours] per week performing his occupational duties.]

**Hospital** refers to a place that:

- Is legally licensed and operated as a Hospital;
- Provides overnight care of injured and sick people;
- Is supervised by a Doctor;
- Has full-time nurses supervised by a registered nurse;
- Has on-site or pre-arranged use of X-ray equipment, laboratory, and surgical facilities; **and**
- Maintains permanent medical history records.

A Hospital is **not**:

- A nursing home;
- An extended-care facility;
- A convalescent home;
- A rest home or a home for the aged;
- A place for alcoholics or drug addicts; **or**
- A mental institution.

**Hospital Intensive Care Unit** refers to a specifically designed Hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be:

- Separate and apart from the surgical recovery room;
- Separate and apart from rooms, beds, and wards customarily used for patient confinement;
- Permanently equipped with special life-saving equipment to care for the critically ill or injured; **and**
- Under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

**[Psychiatrist** is a Doctor of medicine who specializes in the diagnosis and Treatment of mental disorders.]

**[Psychologist** is a clinical, mental health professional who works with patients. A Psychologist is not a Doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.]

**[Rehabilitation Unit** is a unit of a Hospital providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.]

*[Total Disability or Totally Disabled* means that due to an Accidental Injury the Insured is:

- Not able to perform the substantial and material duties of his occupation, **and**
- Receiving a Doctor's care that is appropriate for the condition causing the disability, **and**
- Not gainfully employed or occupied in any other occupation.]

*Treatment or Medical Treatment* is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

*Your Occupation* means the occupation in which the Insured is regularly engaged at the time he becomes disabled.

## **Section IV – Benefit Provisions**

The language in this provision matches that of the Certificate. As the Certificate is issued to the Insured, we included the use of "you" and "yours."

The benefit amounts payable under this section are shown in the Benefit Schedule.

### **Specific Injuries Benefits**

#### **Fracture Benefit**

*Fracture* is a break in a bone that can be seen by X-ray. If a bone is fractured in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the appropriate amount shown in the Benefit Schedule.

If the fracture requires open reduction, we will pay [200%] of the amount shown in the Benefit Schedule.

*Multiple fractures* refers to more than one fracture requiring either open or closed reduction. If these fractures occur in any one Covered Accident, we will pay the appropriate amounts shown in the Benefit Schedule for each fracture. However, we will pay no more than [200%] of the benefit amount for the bone fractured which has the highest dollar amount.

*Chip fracture* refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay [25%] of the amount shown in the Benefit Schedule for the affected bone.

#### **Dislocation Benefit**

*Dislocation* refers to a completely separated joint. If a joint is dislocated in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the amount shown in the Benefit Schedule.

If the dislocation requires open reduction, we will pay [200%] of the amount shown in the Benefit Schedule.

We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the Insured dislocated a joint before the Effective Date of his Certificate and then dislocates the same joint again, it will not be covered by this Plan.

*Multiple dislocations* refers to more than one dislocation requiring either open or closed reduction in anyone Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than [200%] of the benefit amount for the dislocated joint that has the higher dollar amount.

*Partial dislocation* is one in which the joint is not completely separated. If a Doctor diagnoses and treats the Accidental Injury as a partial dislocation, we will pay 25% of the amount shown in the Benefit Schedule for the affected joint.

If an Insured has **both** fracture and dislocation in the same accident, we will pay for both. However, we will pay no more than [200%] of the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

### **Laceration Benefit**

If an Insured receives a laceration in a Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule. The laceration must be repaired with stitches by a Doctor within 72 hours after the accident. The amount paid will be based on the length of the laceration.

The Insured may receive a laceration that does not require stitches. However, if that laceration is treated by a Doctor within 72 hours after the Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule.

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 72 hours after the accident, we will pay this benefit based on the largest single laceration which requires stitches, as shown in the Benefit Schedule.

### **Concussion Benefit**

A *concussion* or *Mild Traumatic Brain Injury (MTBI)* is defined as a disruption of brain function resulting from a traumatic blow to the head.(Note: *Concussion* and *MTBI* are used interchangeably.)

If the Insured has a concussion from a Covered Accident, we will pay the amount shown for this benefit in the Benefit Schedule. The concussion must be diagnosed by a Doctor.

### **Coma Benefit**

*Coma* means a state of profound unconsciousness caused by a Covered Accident. If the Insured is in a coma lasting 30 days or more as the result of a Covered Accident, we will pay this benefit as shown in the Benefit Schedule.

### **Emergency Dental Work Benefit**

We will pay this benefit if the Insured has an Injury to sound natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule.

### **Eye Injuries Benefit**

For eye injuries requiring surgical repair, we will pay the amount shown in the Benefit Schedule, if, because of a Covered Accident:

- The Insured injures an eye,
- A Doctor repairs the eye through surgery, **and**
- The eye surgery occurs within 90 days after the Accident.

For eye injuries requiring removal of a foreign body, we will pay the amount shown in the Benefit Schedule if a Doctor removes a foreign body from the eye, with or without anesthesia.

### **Tendons and Ligaments Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if a Covered Accident causes the Insured to:

- Tear, sever, or rupture a tendon or ligament;
- Receive Treatment from a Doctor within 60 days; **and**
- Have surgical repair within 90 days after the accident.

The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.

### **[Torn Rotator Cuff Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if a Covered Accident causes the Insured to:

- Suffer one or more torn rotator cuffs **and**
- Have surgical repair by a Doctor.

Surgical repair by a Doctor must occur within one year after the accident.]

### **Ruptured Disc Benefit**

We will pay the amount shown in the Benefit Schedule if a Covered Accident causes the Insured to:

- Rupture a disc in his spine,
- Receive Treatment from a Doctor within 60 days after the accident, **and**
- Have surgical repair by a Doctor within one year after the accident.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.

### **Torn Knee Cartilage Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured is injured in a Covered Accident and:

- Accidental injuries result in torn knee cartilage,
- This Injury requires Doctor Treatment within 60 days from the accident date, **and**
- This Injury requires surgical repair within one year from the accident date.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.

### **Internal Injuries Benefit**

We will pay the amount shown in the Benefit Schedule if:

- A Covered Accident causes the Insured to have internal Injuries, and
- Those internal Injuries require open abdominal or thoracic surgery.

### **Exploratory Surgery Benefit**

We will pay the amount shown in the Benefit Schedule if a Covered Accident causes the Insured to have exploratory surgery (without repair). The exploratory surgery must be required as the result of an Injury.

### **Paralysis Benefit**

*Paralysis* means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident:

- The Insured is injured,
- The Injury causes paralysis which lasts more than 90 days, **and**
- The paralysis is diagnosed by a Doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

### **Burns Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if the Insured has burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. The Insured must be treated for burns by a Doctor within 72 hours after the accident. First-degree burns are not covered.

### **[Hernia Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Suffers a hernia,
- Receives Treatment from a Doctor within 90 days after the accident, **and**
- Has surgical repair within one year after the accident date.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.]

### **[Ear Injuries Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Injures an ear, resulting in at least 60% hearing loss **and**
- Receives Treatment from a Doctor within 60 days after the accident.

We will pay this benefit only once for each injured ear during the Insured's lifetime. The amount paid will be based on when the accident occurred. Loss of hearing due to sickness or disease will not be covered. See the Benefit Schedule for details.]

### **Dismemberment Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Is injured **and**
- Loses a hand, a foot, or sight within 90 days after the accident as a result of the Injury.

If the Insured loses one hand, one foot, or the sight of one eye in a Covered Accident, we will pay the single loss benefit shown in the Benefit Schedule.

If the Insured loses both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double loss benefit shown in the Benefit Schedule.

If the Insured loses one or more fingers or toes in a Covered Accident, we will pay the finger/toe benefit shown in the Benefit Schedule.

*Dismemberment* means:

- **Loss of a hand** –The hand is removed at or above the wrist joint; **or**
- **Loss of a foot** –The foot is removed at or above the ankle; **or**
- **Loss of sight**–At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); **or**
- **Loss of a finger/toe**–The finger or toe is removed at or above the joint where it is attached to the hand or foot.

If the Insured does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown in the Benefit Schedule.

If the Dismemberment Benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

### **[Post-Traumatic Stress Disorder Benefit**

*Post-traumatic Stress Disorder (PTSD)* is a mental health condition triggered by a Covered Accident. We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. An Insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a Psychiatrist or Ph.D.-level Psychologist.

We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. This benefit is payable only once per Covered Accident.]

### **Services Benefits**

#### **Blood/Plasma Benefit**

We will pay the amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Is injured **and**
- Receives blood or plasma within 90 days after the accident.

#### **Ambulance Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Is injured **and**
- Requires transportation to a Hospital by a professional ambulance service. This transportation must occur within 90 days after the accident.

Ambulance service includes air ambulance service.

### **Transportation Benefit**

We will pay the applicable amount shown in the Benefit Schedule for train, plane, or bus transportation. This benefit is payable if, because of a Covered Accident, the Insured:

- Is injured **and**
- Requires Doctor-recommended Hospital Treatment or diagnostic study that is not available in the Insured's resident city.

Use of such transportation must begin within 90 days after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 50 miles from the Insured's residence.

### **Family Member Lodging Benefit**

We will pay this benefit in the amount and for the number of days shown in the Benefit Schedule. We will pay this benefit for each night's lodging in a motel/hotel room for an adult member of the Insured's immediate family. For this benefit to be payable, because of a Covered Accident:

- The Insured must be confined to a Hospital for Treatment of an Injury,
- The Hospital and motel/hotel must be more than 100 miles from the Insured's residence, **and**
- The Treatment must be prescribed by the Insured's local Doctor.

### **Medical Fees Benefit**

We will pay the amount shown in the Benefit Schedule for the following medical fees:

- X-rays
- Doctor services

For benefits to be payable, because of a Covered Accident, the Insured must:

- Be injured **and**
- Receive initial Treatment from a Doctor within 72 hours after the accident.

We will pay the Medical Fees Benefit:

- For Treatment received due to injuries from a Covered Accident **and**
- For each Covered Accident up to one year after the accident date.

[We will not pay the Medical Fees Benefit and the Accident Emergency Room Treatment Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.]

### **Prosthesis Benefit**

Prosthetic devices must be used as the result of Injury from a Covered Accident. For Covered Accidents, we will pay the amount shown in the Benefit Schedule for each prosthetic device the Insured uses.

Prosthetic devices **not** covered include:

- Hearing aids.
- Wigs.
- Dental aids (including, but not limited to, false teeth).

### **Appliances Benefit**

We will pay the amount shown in the Benefit Schedule if a Doctor advises the Insured to use a medical appliance. The medical appliance must be used as the result of an Injury received in a Covered Accident. It must be used as an aid in personal locomotion. *Medical appliance* means crutches, wheelchairs, leg braces, back braces, and walkers.

**Accident Follow-Up Treatment Benefit**

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 72 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.

We will pay for a maximum of 6 Treatments per Covered Accident.

**Physical Therapy Benefit**

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 72 hours after the Covered Accident.
- The Insured receives Doctor-prescribed physical therapy Treatment.
- The physical therapy Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.
- The physical therapy Treatment takes place within 6 months after the Covered Accident.

We will pay for a maximum of 6 physical therapy Treatments per Covered Accident. We will not pay this benefit for the same visit that the Accident Follow-up Treatment Benefit is paid.

**[Wellness Benefit**

We will pay the amount shown in the Benefit Schedule for the following:

- annual physical exams
- mammograms
- pap smears
- eye examinations
- immunizations
- flexible sigmoidoscopy
- PSA tests
- ultrasounds
- blood screening

[This benefit is payable after premiums have been paid for 12 months and while the Insured’s coverage is in force.]This benefit is payable [once] each 12-month period.]

**[Major Diagnostic Exams Benefit**

We will pay the amount shown in the Benefit Schedule if, because of Injuries sustained in a Covered Accident, the Insured requires one of the following exams, and a charge is incurred:

- computerized tomography (CT scan)
- magnetic resonance imaging (MRI)
- computerized axial tomography (CAT)
- electroencephalography (EEG)

These exams must be performed in a Hospital or a Doctor’s office. This benefit is limited to one payment per Covered Accident.]

**[Emergency Room Treatment Benefit**

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if the Insured:

- Receives Treatment in a Hospital emergency room **and**
- Receives initial Treatment within 72 hours after the Covered Accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.]

### **[Emergency Room Observation Benefit**

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if the Insured:

- Receives Treatment in a Hospital emergency room, **and**
- Is held in a Hospital for observation for at least 24 hours, **and**
- Receives initial Treatment within 72 hours after the accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. This benefit is paid in addition to [Accident Emergency Room Treatment Benefit or the Medical Fees Benefit.]

### **[Rehabilitation Unit Benefit**

We will pay the appropriate amount shown in the Benefit Schedule for injuries received in a Covered Accident if the Insured:

- Is admitted for a Hospital Confinement,
- Is transferred to a bed in a Rehabilitation Unit of a Hospital for Treatment, **and**
- Incurs a charge.

This benefit is limited to 30 days for each Insured per period of Hospital confinement. This benefit is also limited to a Calendar Year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Accident Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.]

## **Hospital Benefits**

### **Hospital Admission Benefit**

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will pay this benefit when, because of a Covered Accident, the Insured:

- Is injured,
- Requires Hospital confinement, **and**
- Is confined to a Hospital for at least [24 hours] within 6 months after the accident date.

[We will pay this benefit once per Calendar Year.] We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room Treatment or outpatient surgery or Treatment.

### **Hospital Confinement Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident:

- The Insured is injured, **and**
- Those injuries cause the Insured to be confined to a Hospital for at least [24 hours] within 90 days after the accident.

The Benefit Schedule shows the maximum period for which the Insured can collect the Hospital Confinement Benefit for the same Injury. This benefit is payable once per Hospital confinement even if the confinement is caused by more than one Accidental Injury.

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

### **Hospital Intensive Care Benefit**

We will pay the appropriate amount and number of days shown in the Benefit Schedule if, because of a Covered Accident:

- The Insured is injured, **and**
- Those injuries cause the Insured to be confined to a Hospital Intensive Care Unit.

This benefit is payable in addition to the Hospital Confinement Benefit.

### **[Accidental-Death Benefits**

#### **[Accidental-Death Benefit**

We will pay the amount shown in the Benefit Schedule if, because of a Covered Accident:

- The Insured is injured, **and**
- The Injury causes the Insured to die within 90 days after the accident.

We will pay the Accidental-Death Benefit in addition to the Accidental Common-Carrier Death Benefit.]

#### **[Accidental Common-Carrier Death Benefit**

We will pay the amount shown in the Benefit Schedule if the Insured:

- Is a fare-paying passenger on a common carrier, as defined below, **and**
- Is injured in a Covered Accident, **and**
- Dies within 90 days after the Covered Accident.

*Common carrier* means:

- An airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
- A railroad train that is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

We will pay the Accidental Common-Carrier Death Benefit in addition to the Accidental-Death Benefit.]]

### **[Waiver of Premium Benefit**

Injuries may result in more than [90] days of Total Disability for an Insured. If the Insured is disabled for [90] days, the Company will waive the premium payments for this coverage for up to [12 months] of Total Disability. At the end of the premium waiver period, the Insured must resume paying premiums to keep this coverage in force. Premiums waived will include those for in-force Dependents and Riders.

For premiums to be waived, the Insured must provide satisfactory proof of Total Disability.]

## **Section V – Exclusions**

We will not pay benefits for Injury, Total Disability, or death contributed to, caused by, or resulting from:

- **War** – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by his Certificate when the Insured is in such service.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Sickness** – having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical Treatment or diagnostic procedures for such illness.

- **Self-Inflicted Injuries** – injuring or attempting to injure yourself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- **Intoxication** – being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a Doctor. (*Legally intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred.)
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job.
- **Sports** – participating in any professional or semi-professional organized sport.
- **Cosmetic Surgery** – having cosmetic surgery or other elective procedures that are not medically necessary or having dental Treatment except as a result of a Covered Accident.
- **[Driving** – driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.]
- [An Injury arising from any employment.]
- [An Injury or sickness covered by Worker's Compensation.]

## **Section VI – Claim Provisions**

### **Notice of Claim**

The Insured must give written notice of claim:

- Within 60 days after a Covered Accident **or**
- As soon as reasonably possible.

Notice must include the Insured's name and the Certificate number. Notice can be mailed to the Company at:

**P.O. Box 427, Columbia, South Carolina, 29202**

### **Claim Forms**

When the Company receives notice of a claim, we will send the Insured forms so that he can file Proof of Loss (details included in the **Proof of Loss** section below). If the Company does not provide the forms within 15 working days, the Insured can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. The Insured will also need to provide a statement by the treating Doctor. The Insured must provide this information within the time limit stated in the **Proof of Loss** section.

### **Proof of Loss**

*Proof of Loss* refers to documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). The Insured must provide Proof of Loss to the Company at:

**P.O. Box 427, Columbia, South Carolina, 29202**

The Insured must provide Proof of Loss documentation within 90 days after the date of the Covered Accident. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for the Insured to provide this proof within the required time. The Insured must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after the Covered Accident, except in the absence of the Insured's legal mental capacity.

## **Claims Payment Timeframe**

Once we receive proper Proof of Loss, we will process the Insured's claim. If the claim can be paid, and a benefit provides for periodic payments, we will pay those benefits on a monthly basis. For other payable benefits, we will pay those claims after processing.

## **Payment of Claims**

We will pay all benefits to the Insured unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

1. To any approved assignee;
2. To the Insured's beneficiary;
3. To the Insured's surviving Spouse;
4. To the Insured's estate.

## **Changing Your Beneficiary**

The Insured can ask us to change his beneficiary at any time. The request must be in writing, and the change must be approved by us. If approved, it will go into effect the day the Insured signs the request. The change will not have any bearing on payments made before we approved the request.

## **Unpaid Premium**

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

## **Physical Examination and Autopsy**

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams and/or autopsy.

## **Legal Action**

The Insured cannot take legal action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

## **Section VII – General Provisions**

### **Entire Contract Changes**

The *Entire Contract of Insurance* is made up of:

- This Policy,
- The Application,
- Certificates,
- Endorsements,
- Benefit agreements, **and**
- Riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured have made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- The Policyholder, **or**
- The Insured, **or**
- The Insured's beneficiary.

This will ensure that Policyholders have an opportunity to review the information they have provided in their Applications. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Insured to be valid.

### **Misstatement of Age**

If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

### **Time Limit on Certain Defenses**

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Insured's Application. This does not apply to fraudulent misstatements.

### **Clerical Error**

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

### **Individual Certificate**

The Company will give the Policyholder a Certificate for each [Employee]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

### **Required Information**

The Policyholder will furnish all information and proofs which the Company may reasonably require with regard to the Plan.

### **Conformity With State Statutes**

Any Plan provision that conflicts with state statutes where this Plan was issued on its Effective Date is hereby amended to conform to the minimum requirements of those statutes.

## Section VIII – Benefit Schedule

	[Plan I]	[Plan II]
<b><u>Specific Injuries Benefits</u></b>		
<b>Fracture</b>		
Hip/thigh	[\$4,000]	[\$2,000]
Vertebrae	[3,600]	[1,800]
Pelvis	[3,200]	[1,600]
Skull (depressed)	[3,000]	[1,500]
Skull (simple)	[1,400]	[700]
Leg	[2,400]	[1,200]
Foot/ankle/knee cap	[2,000]	[1,000]
Forearm/hand	[2,000]	[1,000]
Lower jaw	[1,600]	[800]
Shoulder blade/collar bone	[1,600]	[800]
Upper arm/upper jaw	[1,400]	[700]
Facial bones (except teeth)	[1,200]	[600]
Vertebral processes	[800]	[400]
Coccyx/rib/finger/toe	[320]	[160]
<b>Dislocation</b>		
Hip	[2,700]	[1,350]
Knee (not knee cap)	[1,950]	[975]
Shoulder	[1,500]	[750]
Foot/ankle	[1,200]	[600]
Hand	[1,050]	[525]
Lower jaw	[900]	[450]
Wrist	[750]	[375]
Elbow	[600]	[300]
Finger/toe	[240]	[120]
<b>Laceration</b>		
Over 6"	[400]	[200]
2" to 6"	[200]	[100]
Under 2"	[50]	[25]
Lacerations not requiring stitches	[25]	[25]
<b>Concussion</b>		
	[200]	[100]
<b>Coma</b>		
	[10,000]	[5,000]
<b>Emergency Dental Work</b>		
Repair with crown	[150]	[75]
Extraction	[50]	[25]
<b>Eye Injuries</b>		
Requiring surgical repair	[250]	[125]
Removal of foreign body	[50]	[25]

<b>Tendons/Ligaments</b>		
Single	[400]	[200]
Multiple	[600]	[300]
<b>[Torn Rotator Cuff</b>		
Single	[250]	[125]
Multiple	[500]	[250]
<b>Ruptured Disc</b>		
Injury occurs during first Certificate year	[100]	[50]
Injury occurs after first Certificate year	[400]	[200]
<b>Torn Knee Cartilage</b>		
Injury occurs during first Certificate year	[100]	[50]
Injury occurs after first Certificate year	[400]	[200]
<b>Internal Injuries</b>	[1,000]	[500]
<b>Exploratory Surgery</b> (without repair)	[250]	[125]
<b>Paralysis</b>		
Four limbs (quadriplegia)	[10,000]	[5,000]
Two limbs (paraplegia)	[5,000]	[2,500]
<b>Burns</b>		
<b>Second Degree</b>		
Less than 10%	[100]	[100]
At least 10% but less than 25%	[200]	[200]
At least 25% but less than 35%	[500]	[500]
35% or more	[1,000]	[1,000]
<b>Third Degree</b>		
Less than 10%	[500]	[500]
At least 10% but less than 25%	[3,000]	[3,000]
At least 25% but less than 35%	[7,000]	[7,000]
35% or more	[10,000]	[10,000]
<b>[Hernia</b>		
First coverage year	[100]	[50]
Thereafter	[400]	[200]
<b>[Ear Injuries</b>		
First coverage year	[50]	[25]
Thereafter	[200]	[100]

**Dismemberment**

Loss of hand, foot, or sight		
Single loss	[6,250]	[3,125]
Double loss	[25,000]	[12,500]

Loss of one or more fingers or toes	[1,250]	[625]
Partial amputation of finger or toe	[100]	[100]

**[Post-Traumatic Stress Disorder]** [200] [100]]

**Services Benefits**

**Blood/Plasma** [100] [100]

**Ambulance** [300] [50]

**Air Ambulance** [1,000] [250]

**Transportation**

Train or Plane	[300]	[150]
Bus	[150]	[75]

**Family Member Lodging** [100]/per night [50]/per night

Maximum Benefit Period: 30 days

**Medical Fees** [125] [62.50]

**Prosthesis** [500] [250]

**Appliances** [100] [50]

**Accident Follow-Up Treatment** [25] [15]

Maximum of 6 Treatments per Covered Accident

**Physical Therapy** [25] [15]

Maximum of 6 Treatments per Covered Accident

**[Wellness]** [50] [25]]

[Once per] 12-month period

**[Major Diagnostic Exams]** [200] [100]]

Once per 12-month period

**[Emergency Room Treatment]** [100] [50]]

**[Emergency Room Observation]** [xx.xx] [xx.xx]]

**[Rehabilitation Unit]** [150]/day [75]/day]]

Maximum Benefit Period: 30 days per Hospital confinement

Limited to 60-day Calendar-Year maximum

**Hospital Benefits**

**Hospital Admission**

Payable once per Calendar Year

[1,000]

[500]

**Hospital Confinement**

Maximum Benefit Period: [365 days]

[200]/day

[100]/day

**Hospital Intensive Care**

Maximum Benefit Period: 30 days

[400]/day

[200]/day

**[Accidental-Death Benefits]**

**[Accidental Death**

[50,000]

[25,000]]

**[Accidental Common-Carrier Death**

[100,000]

50,000]]

**[Waiver of Premium**

[yes]

[yes]]

## **Section IX – Classifications and Schedule of Premiums**

### **[Section X – Incorporation of Rider Provisions**

The attached listed Certificate Riders are made a part of this Policy.

#### **Rider Name**

[Dependent Accident Rider  
[Sickness Rider  
[Gunshot Wound Rider  
[Catastrophic Accident Rider  
[Total Disability Rider

#### **Form Number**

CAI7822]  
CAI7823]  
CAI7825]  
CAI7835]  
CAI7849]]



# CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036]

## **CERTIFICATE OF INSURANCE FOR NON-PARTICIPATING GROUP ACCIDENTAL INJURY POLICY**

**This is accident-only coverage.  
It does not pay benefits for loss from sickness.**

**(Coverage for sickness may be included in a separate Rider,  
requiring additional premiums.)**

[ABC COMPANY, INC.] (“the Policyholder”) applied for coverage under this Group Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “we,” “us,” or “our”). Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. Your Application is maintained on a file and made part of this Certificate. (Please note that male pronouns—such as *he*, *him*, and *his*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of policy documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance policy.

### **Please read your certificate carefully.**

We certify that you are insured under the Group Accidental Injury Policy (the “Plan”). The Plan was issued to your [employer], the Policyholder. This coverage provides benefits for loss resulting from Accidental Injury. The Certificate is subject to the definitions, exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

**ANY CERTIFICATES ISSUED IN THE STATE OF ARKANSAS ARE  
GOVERNED BY THE STATE OF ARKANSAS.**

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<b>SECTION X</b>	-	Certificate Schedule

## **Section I – Eligibility, Effective Date, and Termination**

### **Eligibility**

You are an eligible [Employee] under this Plan if you meet the following three requirements. You are:

1. [An Employee] of the Policyholder,
2. Engaged in [full; part]-time work, and
3. Included in the class of Employees eligible for coverage, as shown on the Application.

Dependents are eligible for coverage under this Plan. A *Dependent* is:

- Your Spouse **or**
- The Dependent Child of your or your Spouse. *Dependent Children* are your or your Spouse's natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26 (details included in the **Definitions** section).

*Insureds* are defined as those who might be eligible for coverage in the following categories under this Plan:

- **[Employee] Coverage** – We insure only the [Employee].
- **[Employee] and Spouse Coverage** – We insure the [Employee] and Spouse.
- **[Employee] and Child Coverage** – We insure the [Employee] and any Dependent Children.
- **Family Coverage** – We insure the [Employee], Spouse, and any Dependent Children.

Any other additions to the Insured class must be added by Endorsement after applying to the Company.

### **Effective Date**

Your Certificate Effective Date is the date your insurance takes effect. That date is either the date:

- Shown on the Certificate Schedule if you are Actively at Work on that date, or
- You return to an Actively-at-Work status if you are not Actively at Work on the date shown on the Certificate Schedule.

### **Plan Termination**

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the first premium year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number mutually agreed upon by the Company and the Policyholder in the signed master Application.

The Policyholder has the sole responsibility to notify you of the Plan's termination. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address. If the Plan terminates, we will provide coverage for claims arising from Covered Accidents that occurred while the Plan was in force.

## **Termination of [An Employee's] Insurance**

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date you no longer meet the Plan's definition of [an Employee].
- The date you no longer belong to an eligible class.

If the Plan terminates, we will provide coverage for claims arising from Covered Accidents that occurred while the Plan was in force.

## **Portability Privilege**

When you [end employment with the Employer] and your coverage would otherwise terminate, you may elect to continue your coverage under this Plan. You may continue the coverage that you had on the date your [employment] ended, including any in-force Spouse or Dependent Child coverage.

- To keep your Certificate in force, you must:
  - Apply to the Company in writing within 31 days after the date his insurance would otherwise terminate; **and**
  - Pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- Insurance will end on the earlier of these dates:
  - 31 days after the date you failed to pay any required premium
  - The date this Group Policy is terminated
- However, coverage may not be continued if:
  - You failed to pay any required premium, **or**
  - This Group Policy terminates.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in your previously issued Certificate.]

## **Section II – Premium Provisions**

### **Premium Calculations**

The Schedule of Premiums determines the premium amount payable on any premium due date. [The rates shown in this Schedule can be changed annually.] The Company will give the Policyholder written notice 31 days before any change in rates becomes effective.

### **Premium Payments**

The first premium is due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan should be paid to the Company at its home office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

## **Grace Period**

This Plan has a 31-day Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

## **Section III – Definitions**

When the terms below are used in this Plan, the following definitions will apply:

***Accidental Injury*** or ***Injuries*** means bodily Injury or Injuries resulting from an unforeseen and unexpected traumatic event that meets the definition of *Covered Accident*.

***Actively at Work*** is defined as your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

***Calendar Year*** is defined as January 1 through December 31 of the same year.

***Covered Accident*** means an unforeseen and unexpected traumatic event resulting in bodily Injury. An event meets the qualifications of Covered Accident if it:

- Occurs on or after the Plan's Effective Date,
- Occurs while coverage is in force, **and**
- Is not specifically excluded.

***Dependent*** means your Spouse or your Dependent Child. ***Dependent Children*** are your or your Spouse's natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

However, there is an exception to the age-26 limit listed above. This limit will not apply to any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your Spouse must furnish proof of this incapacity and dependency to the Company.

***Doctor*** is defined as a person who is:

- Legally qualified to practice medicine,
- Licensed as a physician by the state where Treatment is received, **and**
- Licensed to treat the type of condition for which a claim is made.

A Doctor does not include you or your Family Member.

***[Employee]*** is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The **[Employee]** is the primary Insured under this Plan.

**Family Member** includes the Employee's **Spouse** (who is defined as an Employee's legal wife or husband) as well as the following members of the Insured's immediate family:

- son
- daughter
- mother
- father
- sister
- brother

This includes Step-Family Members and Family-Members-in-law.

**Full-time Work** means that you spend at least [30 hours] per week performing your occupational duties.

[**Part-time Work** means that you spend less than [16 hours] per week performing your occupational duties.]

**Hospital** refers to a place that:

- Is legally licensed and operated as a Hospital;
- Provides overnight care of injured and sick people;
- Is supervised by a Doctor;
- Has full-time nurses supervised by a registered nurse;
- Has on-site or pre-arranged use of X-ray equipment, laboratory, and surgical facilities; **and**
- Maintains permanent medical history records.

A Hospital is **not**:

- A nursing home;
- An extended-care facility;
- A convalescent home;
- A rest home or a home for the aged;
- A place for alcoholics or drug addicts; **or**
- A mental institution.

**Hospital Intensive Care Unit** refers to a specifically designed Hospital facility that provides the highest level of medical care and is restricted to patients who are critically ill or injured. Hospital Intensive Care Units must be:

- Separate and apart from the surgical recovery room;
- Separate and apart from rooms, beds, and wards customarily used for patient confinement;
- Permanently equipped with special life-saving equipment to care for the critically ill or injured; **and**
- Under constant and continuous observation by nursing staffs assigned to the Intensive Care Unit on an exclusive, full-time basis.

[**Psychiatrist** is a Doctor of medicine who specializes in the diagnosis and Treatment of mental disorders.]

[**Psychologist** is a clinical mental health professional who works with patients. Is not a Doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.]

[**Rehabilitation Unit** is a unit of a Hospital providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up and staffed in a unit specifically designated for this service.]

[*Total Disability or Totally Disabled* means that due to an Accidental Injury, you are:

- Not able to perform the substantial and material duties of your occupation, **and**
- Receiving a doctor's care that is appropriate for the condition causing the disability, **and**
- Not gainfully employed or occupied in any other occupation.]

*Treatment or Medical Treatment* is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

*Your Occupation* means the occupation in which you are regularly engaged at the time you become disabled.

## **Section IV – Benefit Provisions**

The language in this provision matches that of the Policy. As this Certificate is issued to you, the primary Insured, we included the use of "you" and "yours."

The benefit amounts payable under this section are shown in the Benefit Schedule.

### **Specific Injuries Benefits**

#### **Fracture Benefit**

*Fracture* is a break in a bone that can be seen by X-ray. If a bone is fractured in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the appropriate amount shown in the Benefit Schedule.

If the fracture requires open reduction, we will pay [200%] of the amount shown in the Benefit Schedule.

*Multiple fractures* refers to more than one fracture requiring either open or closed reduction. If these fractures occur in any one Covered Accident, we will pay the appropriate amounts shown in the Benefit Schedule for each fracture. However, we will pay no more than [200%] of the benefit amount for the bone fractured which has the highest dollar amount.

*Chip fracture* refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay [25%] of the amount shown in the Benefit Schedule for the affected bone.

#### **Dislocation Benefit**

*Dislocation* refers to a completely separated joint. If a joint is dislocated in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the amount shown in the Benefit Schedule.

If the dislocation requires open reduction, we will pay [200%] of the amount shown in the Benefit Schedule.

We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If you dislocated a joint before the Effective Date of your Certificate and then dislocate the same joint again, it will not be covered by this Certificate.

*Multiple dislocations* refers to more than one dislocation requiring either open or closed reduction in anyone Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than [200%] of the benefit amount for the dislocated joint that has the higher dollar amount.

*Partial dislocation* is one in which the joint is not completely separated. If a Doctor diagnoses and treats the Accidental Injury as a partial dislocation, we will pay 25% of the amount shown in the Benefit Schedule for the affected joint.

If you have **both** fracture and dislocation in the same Covered Accident, we will pay for both. However, we will pay no more than [200%] of the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

### **Laceration Benefit**

If you receive a laceration in a Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule. The laceration must be repaired with stitches by a Doctor within 72 hours after the accident. The amount paid will be based on the length of the laceration.

You may receive a laceration that does not require stitches. However, if that laceration is treated by a Doctor within 72 hours after the Covered Accident, we will pay the appropriate amount shown in the Benefit Schedule.

If you suffer multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 72 hours after the accident, we will pay this benefit based on the largest single laceration which requires stitches, as shown in the Benefit Schedule.

### **Concussion Benefit**

A *concussion* or *Mild Traumatic Brain Injury (MTBI)* is defined as a disruption of brain function resulting from a traumatic blow to the head. (Note: *Concussion* and *MTBI* are used interchangeably.)

If you have a concussion from a Covered Accident, we will pay the amount shown for this benefit in the Benefit Schedule. The concussion must be diagnosed by a Doctor.

### **Coma Benefit**

*Coma* means a state of profound unconsciousness caused by a Covered Accident. If you are in a coma lasting 30 days or more as the result of a Covered Accident, we will pay this benefit as shown in the Benefit Schedule.

### **Emergency Dental Work Benefit**

We will pay this benefit if you have an Injury to sound natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule.

### **Eye Injuries Benefit**

For eye injuries requiring surgical repair, we will pay the amount shown in the Benefit Schedule, if, because of a Covered Accident:

- You injure an eye,
- A Doctor repairs the eye through surgery, **and**
- The eye surgery occurs within 90 days after the Accident.

For eye injuries requiring removal of a foreign body, we will pay the amount shown in the Benefit Schedule if a Doctor removes a foreign body from the eye, with or without anesthesia.

### **Tendons and Ligaments Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if a Covered Accident causes you to:

- Tear, sever, or rupture a tendon or ligament;
- Receive Treatment from a Doctor within 60 days; **and**
- Have surgical repair within 90 days after the accident.

The amount paid will be based on the number (single or multiple) of tendons or ligaments repaired.

### **[Torn Rotator Cuff Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if a Covered Accident causes you to:

- Suffer one or more torn rotator cuffs **and**
- Have surgical repair by a Doctor.

Surgical repair by a Doctor must occur within one year after the accident.]

### **Ruptured Disc Benefit**

We will pay the amount shown in the Benefit Schedule if a Covered Accident causes you to:

- Rupture a disc in your spine,
- Receive Treatment from a Doctor within 60 days after the accident, **and**
- Have surgical repair by a Doctor within one year after the accident.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.

### **Torn Knee Cartilage Benefit**

We will pay the amount shown in the Benefit Schedule if you are injured in a Covered Accident and:

- Accidental injuries result in torn knee cartilage,
- This Injury requires Doctor Treatment within 60 days from the accident date, **and**
- This Injury requires surgical repair within one year from the accident date.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.

### **Internal Injuries Benefit**

We will pay the amount shown in the Benefit Schedule if:

- A Covered Accident causes you to have internal Injuries, and
- Those internal Injuries require open abdominal or thoracic surgery.

### **Exploratory Surgery Benefit**

We will pay the amount shown in the Benefit Schedule if a Covered Accident causes you to have exploratory surgery (without repair). The Exploratory Surgery must be required as the result of an Injury.

### **Paralysis Benefit**

*Paralysis* means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident:

- You are injured,
- The Injury causes paralysis which lasts more than 90 days, **and**
- The paralysis is diagnosed by a Doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and you later die as a result of the same Covered Accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

### **Burns Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if you have burns in a Covered Accident. We will pay the Burns Benefit according to the percentage of body surface burned. You must be treated for burns by a Doctor within 72 hours after the accident. First-degree burns are not covered.

### **[Hernia Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, you:

- Suffer a hernia,
- Receive Treatment from a Doctor within 90 days after the accident, **and**
- Have surgical repair within one year after the accident date.

The amount paid will be based on when the accident occurred. See the Benefit Schedule for details.]

### **[Ear Injuries Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, you:

- Injure an ear, resulting in at least 60% hearing loss **and**
- Receive Treatment from a Doctor within 60 days after the accident.

We will pay this benefit to you only once for each injured ear during your lifetime. The amount paid will be based on when the accident occurred. Loss of hearing due to sickness or disease will not be covered. See the Benefit Schedule for details.]

### **Dismemberment Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, you:

- Are injured **and**
- Lose a hand, a foot, or sight within 90 days after the accident as a result of the Injury.

If you lose one hand, one foot, or the sight of one eye in a Covered Accident, we will pay the single loss benefit shown in the Benefit Schedule.

If you lose both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double loss benefit shown in the Benefit Schedule.

If you lose one or more fingers or toes in a Covered Accident, we will pay the finger/toe benefit shown in the Benefit Schedule.

*Dismemberment* means:

- **Loss of a hand** – The hand is removed at or above the wrist joint; **or**
- **Loss of a foot** – The foot is removed at or above the ankle; **or**
- **Loss of sight** – At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); **or**
- **Loss of a finger/toe** – The finger or toe is removed at or above the joint where it is attached to the hand or foot.

If you do not qualify for the Dismemberment Benefit but lose at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown in the Benefit Schedule.

If the Dismemberment Benefit is paid and you later die as a result of the same Covered Accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

### **[Post-Traumatic Stress Disorder Benefit**

*Post-traumatic Stress Disorder (PTSD)* is a mental health condition triggered by a Covered Accident. We will pay the amount shown in the Benefit Schedule if you are diagnosed with Post-traumatic Stress Disorder. You must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a Psychiatrist or Ph.D.-level Psychologist.

We will pay the amount shown in the Benefit Schedule if you are diagnosed with Post-traumatic Stress Disorder. This benefit is payable only once per Covered Accident.]

### **Services Benefits**

#### **Blood/Plasma Benefit**

We will pay the amount shown in the Benefit Schedule if, because of a Covered Accident, you:

- Are injured **and**
- Receive blood or plasma within 90 days after the accident.

#### **Ambulance Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, you:

- Are injured **and**
- Require transportation to a Hospital by a professional ambulance service. This transportation must occur within 90 days after the accident.

Ambulance service includes air ambulance service.

#### **Transportation Benefit**

We will pay the applicable amount shown in the Benefit Schedule for train, plane, or bus transportation. This benefit is payable if, because of a Covered Accident, you:

- Are injured **and**
- Require Doctor-recommended Hospital Treatment or diagnostic study that is not available in your resident city.

Use of such transportation must begin within 90 days from the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 50 miles from your residence.

### **Family Member Lodging Benefit**

We will pay this benefit in the amount and for the number of days shown in the Benefit Schedule. We will pay this benefit for each night's lodging in a motel/hotel room for an adult member of your immediate family. For this benefit to be payable, because of a Covered Accident:

- You must be confined to a Hospital for Treatment of an Injury,
- The Hospital and motel/hotel must be more than 100 miles from your residence, **and**
- The Treatment must be prescribed by your local Doctor.

### **Medical Fees Benefit**

We will pay the amount shown in the Benefit Schedule for the following medical fees:

- X-rays
- Doctor services

For benefits to be payable, because of a Covered Accident, you must:

- Be injured **and**
- Receive initial Treatment from a Doctor within 72 hours after the accident.

We will pay the Medical Fees Benefit:

- For Treatment received due to injuries from a Covered Accident **and**
- For each Covered Accident up to one year after the accident date.

[We will not pay the Medical Fees Benefit and the Accident Emergency Room Treatment Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.]

### **Prosthesis Benefit**

Prosthetic devices must be used as the result of Injury from a Covered Accident. For Covered Accidents, we will pay the amount shown in the Benefit Schedule for each prosthetic device you use. Prosthetic devices **not** covered include:

- Hearing aids.
- Wigs.
- Dental aids (including, but not limited to, false teeth).

### **Appliances Benefit**

We will pay the amount shown in the Benefit Schedule if a Doctor advises you to use a medical appliance. The medical appliance must be used as the result of an Injury received in a Covered Accident. It must be used as an aid in personal locomotion. *Medical appliance* means crutches, wheelchairs, leg braces, back braces, and walkers.

### **Accident Follow-Up Treatment Benefit**

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- You receive initial Treatment within 72 hours after the Covered Accident.
- You receive Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.

We will pay for a maximum of 6 Treatments per Covered Accident.

### **Physical Therapy Benefit**

For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- You receive initial Treatment within 72 hours after the Covered Accident.
- You receive Doctor-prescribed physical therapy Treatment.
- The physical therapy Treatment begins within 30 days after the Covered Accident or discharge from the Hospital.
- The physical therapy Treatment takes place within 6 months after the Covered Accident.

We will pay for a maximum of 6 physical therapy Treatments per Covered Accident. We will not pay this benefit for the same visit that the Accident Follow-up Treatment Benefit is paid.

### **[Wellness Benefit**

We will pay the amount shown in the Benefit Schedule for the following:

- Annual physical exams
- mammograms
- pap smears
- eye examinations
- immunizations
- flexible sigmoidoscopy
- PSA tests
- ultrasounds
- blood screening

[This benefit is payable after premiums have been paid for 12 months and while your coverage is in force.] This benefit is payable [once] each 12-month period.]

### **[Major Diagnostic Exams Benefit**

We will pay the amount shown in the Benefit Schedule if, because of Injuries sustained in a Covered Accident, you require one of the following exams, and a charge is incurred:

- computerized tomography (CT scan)
- magnetic resonance imaging (MRI)
- computerized axial tomography (CAT)
- electroencephalography (EEG)

These exams must be performed in a Hospital or a Doctor's office. This benefit is limited to one payment per Covered Accident.]

### **[Emergency Room Treatment Benefit**

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if you:

- Receive Treatment in a Hospital emergency room **and**
- Receive initial Treatment within 72 hours after the Covered Accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same Covered Accident. We will pay the highest eligible benefit amount.]

### **[Emergency Room Observation Benefit**

We will pay the amount shown in the Benefit Schedule for injuries received in a Covered Accident if you:

- Receive Treatment in a Hospital emergency room, **and**
- Are held in a Hospital for observation for at least 24 hours, **and**
- Receive initial Treatment within 72 hours after the accident.

This benefit is payable only once per 24-hour period and only once per Covered Accident. This benefit is paid in addition to [Accident Emergency Room Treatment Benefit or the Medical Fees Benefit.]

### **[Rehabilitation Unit Benefit**

We will pay the appropriate amount shown in the Benefit Schedule for injuries received in a Covered Accident if you:

- Are admitted for a Hospital Confinement,
- Are transferred to a bed in a Rehabilitation Unit of a Hospital for Treatment, and
- Incur a charge.

This benefit is limited to 30 days per period of Hospital confinement. This benefit is also limited to a Calendar Year maximum of 60 days. We will not pay the Rehabilitation Unit Benefit for the same days that the Accident Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.]

### **Hospital Benefits**

#### **Hospital Admission Benefit**

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will pay this benefit when, because of a Covered Accident, you:

- Are injured,
- Require hospital confinement, **and**
- Are confined to a hospital for at least [24 hours] within 6 months after the accident date.

[We will pay this benefit once per Calendar Year.] We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room Treatment or outpatient surgery or Treatment.

#### **Hospital Confinement Benefit**

We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident:

- You are injured, **and**
- Those injuries cause you to be confined to a Hospital for at least [24 hours] within 90 days after the accident.

The Benefit Schedule shows the maximum period for which you can collect the Hospital Confinement Benefit for the same Injury.

This benefit is payable once per Hospital confinement even if the confinement is caused by more than one Accidental Injury.

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

#### **Hospital Intensive Care Benefit**

We will pay the appropriate amount and number of days shown in the Benefit Schedule if, because of a Covered Accident:

- You are injured, **and**
- Those injuries cause you to be confined to a hospital intensive care unit.

This benefit is payable in addition to the Hospital Confinement Benefit.

## **[Accidental-Death Benefits**

### **[Accidental-Death Benefit**

We will pay the amount shown in the Benefit Schedule if, because of a Covered Accident:

- You are injured, **and**
- The Injury causes you to die within 90 days after the accident.

We will pay the Accidental-Death Benefit in addition to the Accidental Common-Carrier Death Benefit.]]

### **[Accidental Common-Carrier Death Benefit**

We will pay the amount shown in the Benefit Schedule if you:

- Are a fare-paying passenger on a common carrier, as defined below, **and**
- Are injured in a covered accident, **and**
- Die within 90 days after the covered accident.

*Common carrier* means:

- An airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
- A railroad train that is licensed and operated for passenger service only; **or**
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

We will pay the Accidental Common-Carrier Death Benefit in addition to the Accidental-Death Benefit.]]

## **[Waiver of Premium Benefit**

Injuries may result in more than [90] days of Total Disability for you. If you are disabled for [90] days, the Company will waive the premium payments for this coverage for up to [12 months] of Total Disability. At the end of the premium waiver period, you must resume paying premiums to keep this coverage in force. Premiums waived will include those for in-force Dependents and Riders.

For premiums to be waived, you must provide satisfactory proof of Total Disability.]

## **Section V – Exclusions**

We will not pay benefits for Injury, Total Disability, or death contributed to, caused by, or resulting from:

- **War** –participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. We will return the prorated premium for any period not covered by this Certificate when you are in such service.
- **Suicide** –committing or attempting to commit suicide, while sane or insane.
- **Sickness** –having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical Treatment or diagnostic procedures for such illness.
- **Self-Inflicted Injuries** –injuring or attempting to injure yourself intentionally.
- **Racing** –riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- **Intoxication** –being legally intoxicated, or being under the influence of any narcotic, unless taken under the direction of a Doctor. *Legally intoxicated* means that condition as defined by the law of the jurisdiction in which the accident occurred.)
- **Illegal Acts** –participating or attempting to participate in an illegal activity, or working at an illegal job.

- **Sports** –participating in any organized sport –professional or semi-professional.
- **Cosmetic Surgery** –having cosmetic surgery or other elective procedures that are not medically necessary or having dental Treatment except as a result of a Covered Accident.
- **[Driving** –driving any taxi or intrastate or interstate long-distance vehicle for wage, compensation, or profit.]
- [An Injury arising from any employment.]
- [An Injury or sickness covered by Worker's Compensation.]

## **Section VI – Claim Provisions**

### **Notice of Claim**

You must give written notice of claim:

- Within 60 days after a Covered Accident **or**
- As soon as reasonably possible.

Notice must include your name and the Certificate number. Notice can be mailed to the Company at:

**P.O. Box 427, Columbia, South Carolina, 29202**

### **Claim Forms**

When the Company receives notice of a claim, we will send you forms so that you can file Proof of Loss (details included in the **Proof of Loss** section below). If the Company does not provide the forms within 15 working days, you can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. You will also need to provide a statement by the treating Doctor. You must provide this information within the time limit stated in the **Proof of Loss** section.

### **Proof of Loss**

*Proof of Loss* refers to documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). You must provide Proof of Loss to the Company at:

**P.O. Box 427, Columbia, South Carolina, 29202**

You must provide Proof of Loss documentation within 90 days after the date of the Covered Accident. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for you to provide this proof within the required time. You must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after the Covered Accident, except in the absence of your legal mental capacity.

### **Claims Payment Timeframe**

Once we receive proper Proof of Loss, we will process your claim. If the claim can be paid, and a benefit provides for periodic payments, we will pay those benefits on a monthly basis. For other payable benefits, we will pay those claims after processing.

## **Payment of Claims**

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

1. To any approved assignee;
2. To your beneficiary;
3. To your surviving spouse;
4. To your estate.

## **Changing Your Beneficiary**

You can ask us to change your beneficiary at any time. The request must be in writing and the change must be approved by us. If approved, it will go into effect the day you sign the request. The change will not have any bearing on payments made before we approved the request.

## **Unpaid Premium**

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

## **Physical Examination and Autopsy**

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams and/or autopsy.

## **Legal Action**

You cannot take legal action against us for benefits under this Plan:

- Within 60 days after you have sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

## **Section VII – General Provisions**

### **Entire Contract Changes**

The *Entire Contract of Insurance* is made up of:

- This Policy,
- The Application,
- Certificates,
- Endorsements,
- Benefit agreements, **and**
- Riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured have made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- The Policyholder, **or**
- The Insured, **or**
- The Insured's beneficiary.

This will ensure that Policyholders have an opportunity to review the information they have provided in their Applications. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Insured to be valid.

### **Misstatement of Age**

If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

### **Time Limit on Certain Defenses**

After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Application. This does not apply to fraudulent misstatements.

### **Clerical Error**

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

### **Individual Certificate**

The Company will give the Policyholder a Certificate for each [Employee; Member]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the plan.

### **Required Information**

The Policyholder will furnish all information and proofs which the Company may reasonably require with regard to the Plan.

### **Conformity With State Statutes**

Any Plan provision that conflicts with state statutes where this Plan was issued on its Effective Date is hereby amended to conform to the minimum requirements of those statutes.

## Section VIII – Benefit Schedule

	[Plan I]	[Plan II]
<b><u>Specific Injuries Benefits</u></b>		
<b>Fracture</b>		
Hip/thigh	[\$4,000]	[\$2,000]
Vertebrae	[3,600]	[1,800]
Pelvis	[3,200]	[1,600]
Skull (depressed)	[3,000]	[1,500]
Skull (simple)	[1,400]	[700]
Leg	[2,400]	[1,200]
Foot/ankle/knee cap	[2,000]	[1,000]
Forearm/hand	[2,000]	[1,000]
Lower jaw	[1,600]	[800]
Shoulder blade/collar bone	[1,600]	[800]
Upper arm/upper jaw	[1,400]	[700]
Facial bones (except teeth)	[1,200]	[600]
Vertebral processes	[800]	[400]
Coccyx/rib/finger/toe	[320]	[160]
<b>Dislocation</b>		
Hip	[2,700]	[1,350]
Knee (not knee cap)	[1,950]	[975]
Shoulder	[1,500]	[750]
Foot/ankle	[1,200]	[600]
Hand	[1,050]	[525]
Lower jaw	[900]	[450]
Wrist	[750]	[375]
Elbow	[600]	[300]
Finger/toe	[240]	[120]
<b>Laceration</b>		
Over 6"	[400]	[200]
2" to 6"	[200]	[100]
Under 2"	[50]	[25]
Lacerations not requiring stitches	[25]	[25]
<b>Concussion</b>		
	[200]	[100]
<b>Coma</b>		
	[10,000]	[5,000]
<b>Emergency Dental Work</b>		
Repair with crown	[150]	[75]
Extraction	[50]	[25]
<b>Eye Injuries</b>		
Requiring surgical repair	[250]	[125]
Removal of foreign body	[50]	[25]

<b>Tendons/Ligaments</b>		
Single	[400]	[200]
Multiple	[600]	[300]
<b>[Torn Rotator Cuff</b>		
Single	[250]	[125]
Multiple	[500]	[250]
<b>Ruptured Disc</b>		
Injury occurs during first Certificate year	[100]	[50]
Injury occurs after first Certificate year	[400]	[200]
<b>Torn Knee Cartilage</b>		
Injury occurs during first Certificate year	[100]	[50]
Injury occurs after first Certificate year	[400]	[200]
<b>Internal Injuries</b>	[1,000]	[500]
<b>Exploratory Surgery</b> (without repair)	[250]	[125]
<b>Paralysis</b>		
Four limbs (quadriplegia)	[10,000]	[5,000]
Two limbs (paraplegia)	[5,000]	[2,500]
<b>Burns</b>		
<b>Second Degree</b>		
Less than 10%	[100]	[100]
At least 10% but less than 25%	[200]	[200]
At least 25% but less than 35%	[500]	[500]
35% or more	[1,000]	[1,000]
<b>Third Degree</b>		
Less than 10%	[500]	[500]
At least 10% but less than 25%	[3,000]	[3,000]
At least 25% but less than 35%	[7,000]	[7,000]
35% or more	[10,000]	[10,000]
<b>[Hernia</b>		
First coverage year	[100]	[50]
Thereafter	[400]	[200]
<b>[Ear Injuries</b>		
First coverage year	[50]	[25]
Thereafter	[200]	[100]

**Dismemberment**

Loss of hand, foot, or sight		
Single loss	[6,250]	[3,125]
Double loss	[25,000]	[12,500]
Loss of one or more fingers or toes	[1,250]	[625]
Partial amputation of finger or toe	[100]	[100]

**[Post-Traumatic Stress Disorder]** [200] [100]]

**Services Benefits**

**Blood/Plasma** [100] [100]

**Ambulance** [300] [50]

**Air Ambulance** [1,000] [250]

**Transportation**

Train or Plane	[300]	[150]
Bus	[150]	[75]

**Family Member Lodging** [100]/per night [50]/per night  
Maximum Benefit Period: 30 days

**Medical Fees** [125] [62.50]

**Prosthesis** [500] [250]

**Appliances** [100] [50]

**Accident Follow-Up Treatment** [25] [15]  
Maximum of 6 Treatments per Covered Accident

**Physical Therapy** [25] [15]  
Maximum of 6 Treatments per Covered Accident

**[Wellness]** [50] [25]  
[Once per] 12-month period

**[Major Diagnostic Exams]** [200] [100]  
Once per 12-month period

**[Emergency Room Treatment]** [100] [50]

**[Emergency Room Observation]** [xx.xx] [xx.xx]]

**[Rehabilitation Unit]** [150]/day [75]/day]]  
Maximum Benefit Period: 30 days per Hospital confinement  
Limited to 60-day Calendar-Year maximum

**Hospital Benefits**

**Hospital Admission**

Payable once per Calendar Year

[1,000]

[500]

**Hospital Confinement**

Maximum Benefit Period: [365 days]

[200]/day

[100]/day

**Hospital Intensive Care**

Maximum Benefit Period: 30 days

[400]/day

[200]/day

**[Accidental-Death Benefits]**

**[Accidental Death**

[50,000]

[25,000]]

**[Accidental Common-Carrier Death**

[100,000]

50,000]]

**[Waiver of Premium**

[yes]

[yes]]

## **[Section IX — Incorporation of Rider Provisions**

The attached listed Certificate Riders are made a part of this Certificate.

### **Rider Name**

[Dependent Accident Rider  
[Sickness Rider  
[Gunshot Wound Rider  
[Catastrophic Accident Rider  
[Total Disability Rider

### **Form Number**

CAI7822]  
CAI7823]  
CAI7825]  
CAI7835]  
CAI7849]]

## Section XI – Certificate Schedule

INSURED [John A. Doe]	GROUP POLICY NUMBER [1234]
EFFECTIVE DATE [January 1, 2012]	CERTIFICATE NUMBER [56789]
INITIAL PREMIUM [\$109.75 Monthly]	FIRST RENEWAL DATE [February1, 2012]

\*Initial premium includes the premium for any riders purchased at the same time as the coverage provided by your certificate.





**CONTINENTAL AMERICAN  
INSURANCE COMPANY**

**ENROLLMENT FORM**

Please Mail: Post Office Box 427  
Columbia, South Carolina 29202  
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
<b>Accident</b>		
Endorsement:		

**EFFECTIVE DATE:**

[Employee] Name/Owner (First, MI, Last)		Social Security Number/ID Number	Gender	Date of Birth
Street Address		City	State	ZIP
[Employer]	Job Class	Location		Date of Hire
Hours Worked	Daytime Phone Number ( )	Beneficiary Name/Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)		Gender	Spouse's Date of Birth	
			[Employee]	Spouse
Are you actively at work?			<input type="checkbox"/> YES <input type="checkbox"/> NO	
Are you now hospitalized or unable to perform your normal duties and activities?				<input type="checkbox"/> YES <input type="checkbox"/> NO

**List all eligible children for whom you are proposing coverage (from Youngest to Oldest):**

Name	Gender	Date of Birth	Name	Gender	Date of Birth

**ACCIDENT**  24 Hour  Non-Occupational] Plan \_\_\_\_\_ [Section 125?  Yes  No]

Sickness Rider  Dependent Rider  Catastrophic Rider  Total Disability Rider  Gunshot Wound Rider

[Employee]  [Employee] & Spouse  [Employee] & Children  Family

**Cost per pay period: [Including any Riders] \$ \_\_\_\_\_**

**[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of \$[0.58].]**

To the best of my knowledge and belief, the answers to the questions on this Application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.

- Does this coverage replace or change any existing accident insurance?  YES  NO
- If "Yes," provide carrier and policy number: \_\_\_\_\_

[If this coverage will replace any existing Aflac individual policy please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy with Aflac via direct bill. You may contact Aflac for an explanation of your options for both continuation or cancellation of your existing coverage.]

CERTIFICATION: I have read the completed Application and I realize any false statement or misrepresentation in the Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Application is approved and the necessary premium is paid.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

I authorize [my employer] to deduct the appropriate dollar amount from my earnings and to deduct and pay Continental American Insurance Company the premium required thereafter each pay period for my insurance.

Deduction start date: \_\_\_\_\_

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

Date: \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Agent \_\_\_\_\_ Agent No.: \_\_\_\_\_ State of Enrollment: \_\_\_\_\_



# CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036]

## DEPENDENT ACCIDENT RIDER TO CERTIFICATE OF INSURANCE FOR ACCIDENTAL INJURY

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, **and**
- We have accepted your Application.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply.

### **Effective Date**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

### **Definitions**

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

*Dependent* means your Spouse or child (or children) who is:

- Named in the Application for this Rider, **and**
- For whom a premium is paid.

*Spouse* is your legal wife or husband.

This Rider will be issued to your spouse only if he or she is between ages 18 and 64. Coverage on your Spouse terminates when he or she attains age 70.

### **Benefits**

If a Dependent is injured in a Covered Accident, we will provide the benefits contained in the Certificate under the Benefits Section. We will pay the appropriate benefit amounts shown in the Dependent Benefit Schedule issued with this Rider.

## **General Provisions**

We will still pay benefits for any accident that occurred while your dependent was covered under this Rider, if:

- Your Spouse's coverage is terminated because of annulment or divorce, **or**
- A Dependent Child's coverage is terminated because he reaches age 26.

### **Time Limit on Certain Defenses**

After this Rider has been in force for a two-year period, we will not contest the statements made in the Application.

### **Contract**

This Rider is part of the Certificate. It will terminate when the Certificate terminates, or when premiums are no longer paid for this Rider.

This Rider is subject to all of the terms of the Certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,

[  ]

[Eugene Sorrel, President]

# Dependent Benefit Schedule

## Specific Injuries Benefits

### **Fracture**

Hip/thigh	[\$1,500]
Vertebrae	[1,350]
Pelvis	[1,200]
Skull (depressed)	[1,125]
Skull (simple)	[525]
Leg	[900]
Foot/ankle/knee cap	[750]
Forearm/hand	[750]
Lower jaw	[600]
Shoulder blade/collar bone	[600]
Upper arm/upper jaw	[525]
Facial bones (except teeth)	[450]
Vertebral processes	[300]
Coccyx/rib/finger/toe	[120]

### **Dislocation**

Hip	[1,350]
Knee (not knee cap)	[975]
Shoulder	[750]
Foot/ankle	[600]
Hand	[525]
Lower jaw	[450]
Wrist	[375]
Elbow	[300]
Finger/toe	[120]

### **Laceration**

Over 6"	[400]
2" to 6"	[200]
Under 2"	[50]

Lacerations not requiring stitches [25]

### **Concussion**

[200]

### **Coma**

[10,000]

### **Emergency Dental Work**

Repair with crown	[150]
Extraction	[50]

### **Eye Injuries**

Requiring surgical repair	[250]
Removal of foreign body	[50]

### **Tendons/Ligaments**

Single	[400]
Multiple	[600]

<b>[Torn Rotator Cuff</b>		
Single	[250]	
Multiple	[500]	
<b>Ruptured Disc</b>		
Injury occurs during first certificate year	[100]	
Injury occurs after first certificate year	[400]	
<b>Torn Knee Cartilage</b>		
Injury occurs during first certificate year	[100]	
Injury occurs after first certificate year	[400]	
<b>Internal Injuries</b>	[1,000]	
<b>Exploratory Surgery</b> (without repair)	[250]	
<b>Paralysis</b>		
Four limbs (quadriplegia)	[10,000]	
Two limbs (paraplegia)	[5,000]	
<b>Burns</b>		
<b>Second Degree</b>		
Less than 10%	[100]	
At least 10% but less than 25%	[200]	
At least 25% but less than 35%	[500]	
35% or more	[1,000]	
<b>Third Degree</b>		
Less than 10%	[500]	
At least 10% but less than 25%	[3,000]	
At least 25% but less than 35%	[7,000]	
35% or more	[10,000]	
<b>[Hernia</b>		
First coverage year	[100]	
Thereafter	[400]	
<b>[Ear Injuries</b>	[xx.xx]	
<b>Dismemberment</b>		
Loss of hand, foot or sight	<b>Spouse</b>	<b>Dependent Child</b>
Single loss	[2,500]	[1,250]
Double loss	[10,000]	[5,000]
Loss of one or more fingers or toes	[500]	[250]
Partial amputation of finger or toe	[100]	[100]
<b>[Post-Traumatic Stress Disorder</b>	[200]	[xx]

## **Services Benefits**

<b>Blood/Plasma</b>	[100]		
<b>Ambulance</b>	[100]		
<b>Air Ambulance</b>	[500]		
<b>Transportation</b>			
Train or Plane	[300]		
Bus	[150]		
<b>Family Member Lodging</b>	[100]/per night		
Maximum Benefit: 30 days			
<b>Medical Fees</b>	<b>Spouse</b>	<b>Dependent Child</b>	
Maximum per accident	[125]	[75]	
<b>Prosthesis</b>	[500]		
<b>Appliances</b>	[100]		
<b>Accident Follow-Up Treatment</b>	[25]		
Maximum of 6 treatments per Covered Accident			
<b>Physical Therapy</b>	[25]		
Maximum of 6 treatments per Covered Accident			
<b>[Wellness]</b>	[60]		
[Once] per 12-month period			
<b>[Major Diagnostic Exams]</b>	[xx]		
Once per 12-month period			
<b>[Emergency Room Treatment]</b>	[200] /day		
Payable once per 24-hour period			
<b>[Emergency Room Observation]</b>	<b>Spouse</b>	<b>Dependent Child</b>	
	[xx.xx]	[xx.xx]	
<b>[Rehabilitation Unit]</b>	[xx.xx]		
Maximum Benefit Period: 30 days per hospital confinement			
Limited to 60-day, calendar-year maximum			
<b><u>Hospital Benefits</u></b>			
<b>Hospital Admission</b>	[1,000]		
Payable once per calendar year			
<b>Hospital Confinement</b>	[200/day]		
Maximum Benefit: [365 days]			
<b>Hospital Intensive Care</b>	[400/day]		

Maximum Benefit: 30 days

**[Accidental Death Benefits]**

**[Accidental Death**

**Spouse**  
[10,000]

**Dependent Child**  
[5,000]

**[Accidental Common-Carrier Death**

[50,000]

[15,000]

**[Waiver of Premium**

[yes]

[yes]

## **Dependent Accident Rider Schedule**

INSURED [John A. Doe]	GROUP POLICY NUMBER [1234]
EFFECTIVE DATE [January 1, 2012]	RIDER NUMBER [0599]
INITIAL PREMIUM [\$10.25 Monthly]	CERTIFICATE NUMBER [56789]
FIRST RENEWAL DATE [February 1, 2012]	

**Benefits for Accidents – Dependent Accident Coverage  
(See Dependent Benefit Schedule)**



## CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036]

### **SICKNESS RIDER TO CERTIFICATE OF INSURANCE FOR ACCIDENTAL INJURY**

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, **and**
- We have accepted your Application.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply.

#### **Effective Date**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

#### **Definitions**

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

***Pre-existing Condition*** means a condition for which medical advice or treatment was recommended or received within the 12-month period before an Insured's Effective Date.

***Sickness*** means an illness, infection, disease, or any other abnormal condition, which is not:

- Caused solely by an injury, **or**
- The result of an injury.

***Covered Sickness*** includes the definition of Sickness above. Further, a Covered Sickness:

- Occurs while this Rider is in force; **and**
- [Is not a Pre-existing Condition; **and**]
- Is not excluded by name or specific description in this Rider.

***[Base Annual Pay*** refers to your base rate of annual pay from the Policyholder. Base Annual Pay excludes overtime pay, bonuses, or any other special pay.]

# **Benefits and Benefit Provisions**

## **Benefits**

### **Hospital Confinement Benefit**

If a Covered Sickness causes an Insured to be confined to a Hospital, we will pay the daily amount shown on the Rider Schedule, subject to the Elimination Period, if any, for that confinement. We will not pay benefits beyond the Maximum Benefit Period, which is also shown on the Rider Schedule.

We will pay this benefit only for Hospital Confinement due to, and limited to, the treatment of a Covered Sickness. We will pay this Benefit for only one Hospital Confinement at a time even if the confinement is caused by more than one Covered Sickness.

If we pay benefits for Hospital Confinement and an Insured becomes confined to a Hospital again within 6 months because of the same or related condition, we will treat the second confinement as a continuation of the first confinement.

### **Hospital Admission Benefit**

We will pay this benefit when an Insured is admitted to a Hospital and is confined as a resident bed patient because of a Covered Sickness.

We will pay the daily Hospital Admission Benefit in the amount shown in the Rider Schedule. We will not pay this Benefit for confinement to an observation unit or for emergency room treatment or for outpatient treatment.

We will pay this Benefit once for a period of confinement. We will pay this Benefit only once for each Covered Sickness. If an Insured is confined to the Hospital a second time because of the same or related Sickness, we will not pay this Benefit again.

### **[Hospital Intensive Care Benefit**

If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Sickness, we will pay the daily benefit amount shown on the Rider Schedule.

We will pay this amount for each day of such confinement, not to exceed the Maximum Benefit Period shown on the Rider Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Sickness or a Covered Accident and a Covered Sickness.

If we pay benefits for confinement in a Hospital's Intensive Care Unit and an Insured becomes confined to a Hospital's Intensive Care Unit again within 6 months because of the same or a related condition, we will treat the second confinement as a continuation of the first confinement.]

## **Benefit Provisions**

We will still pay benefits for any Covered Accident that occurred while your Dependent was covered under this Rider, if:

- Your Spouse's coverage is terminated because of annulment or divorce, **or**
- A Dependent Child's coverage is terminated because he reaches age 26.

## **Limitations and Exclusions**

### **Pre-existing Condition Limitation**

We will not pay benefits for loss starting within 12 months of an Insured's Effective Date if that loss is wholly or partly caused by or results from a Pre-existing Condition.]

[This Rider may have been issued as a replacement for a Rider previously issued to you under the Plan. If so, then the Pre-existing Condition Limitation Provision of this Rider applies only to any increase in benefits over the prior Rider. Any remaining period of Pre-existing Condition Limitation of the prior Rider would continue to apply to the prior level of Benefits.]

[Pregnancy is a "Pre-existing Condition" if conception was before an Insured's Effective Date.]

### **Exclusion[s]**

We will not pay benefits for a loss that is wholly or partly caused by or results from:

- [Mental or emotional disorders without demonstrable organic disease.]
- [Alcoholism, drug addiction, or chemical dependency.]

## **General Provisions**

### **Time Limit on Certain Defenses**

After this Rider has been in force for two years, we will not contest the statements made in the Application.

### **Contract**

This Rider is part of the Certificate and will terminate when the Certificate terminates, or when premiums are no longer paid for this Rider.

This Rider is subject to all of the terms of the Certificate to which it is attached unless any of those terms is inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,

[  ]

[Eugene Sorrel, President]

## Sickness Rider Schedule

INSURED [John A. Doe]	GROUP POLICY NUMBER [1234]
EFFECTIVE DATE [January 1, 2012]	RIDER NUMBER [0599]
INITIAL PREMIUM [\$41.25 Monthly]	CERTIFICATE NUMBER [56789]
FIRST RENEWAL DATE [February 1, 2012]	

[Plan – Employee only]

## Schedule for Sickness Rider Benefits

**Hospital Admission** [50] Per Period of Confinement

**Hospital Confinement**

Daily Benefit: [1500]  
Benefit Period: [365 Days]  
Elimination Period: [0 Days]

**[Hospital Intensive Care**

Daily Benefit: [200]  
Benefit Period: [30 Days]



## CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036]

### **GUNSHOT WOUND RIDER TO CERTIFICATE OF INSURANCE FOR ACCIDENTAL INJURY**

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, **and**
- We have accepted your Application.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply.

#### **Effective Date**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

#### **Definitions**

When the term below is used in this Rider, the following definition will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

A *Conventional Firearm* is a weapon that fires a shot (bullet) by gun powder or compressed gas.

#### **Gunshot Wound Benefit**

We will pay this benefit if you receive a gunshot wound in a Covered Accident and if:

- You did not intentionally shoot yourself, **and**
- The gunshot wound does not cause you to die.

We will pay the amount shown in the Benefit Schedule once per Covered Accident if:

- The gunshot wound is caused by a shot from a Conventional Firearm,
- The gunshot wound requires treatment by a Doctor within 24 hours after the Covered Accident, **and**
- The gunshot wound requires you to be admitted to a hospital.

If you are shot more than once in a 24-hour period, we will pay benefits only for the first wound.

[If, within 90 days, you lose a finger/toe, a hand/foot, or the sight of an eye or eyes, or die as the result of the same Covered Accident, we will pay only one benefit. We will pay the largest applicable benefit.]

[If you receive a fracture or a dislocation as the result of the same Covered Accident, we will pay the amount shown plus one-half of the Fracture Benefit or the Dislocation Benefit shown for the bone or joint involved. However, we will not pay more than [\$1,500] for each Covered Accident.]

The Gunshot Wound Benefit is not available for your Spouse and/or Dependent Children.

## **General Provisions**

### **Time Limit on Certain Defenses**

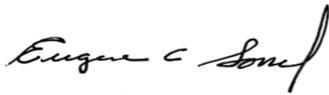
After this Rider has been in force for two years, we will not contest the statements made in the Application.

### **Contract**

This Rider and the Application for this Rider are part of the Policy and will terminate when the Policy terminates, or when premiums are no longer paid for this Rider.

This Rider is subject to all of the terms of the Policy to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,



[  
[Eugene Sorrel, President]

## Rider Benefit Schedule

INSURED [John A. Doe]	GROUP POLICY NUMBER [1234]
EFFECTIVE DATE [January 1, 2012]	RIDER NUMBER [0598]
INITIAL PREMIUM [\$0.45 Monthly]	CERTIFICATE NUMBER [56789]
FIRST RENEWAL DATE [February 1, 2012]	

## Benefit

**Gunshot Wound**

[\$1,000]



## CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036]

### **CATASTROPHIC ACCIDENT RIDER TO CERTIFICATE OF INSURANCE FOR ACCIDENTAL INJURY**

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, **and**
- We have accepted your Application.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply.

**The Benefits provided in this Rider are reduced by any benefits paid under the Certificate's Accidental Death, Dismemberment, or Paralysis Benefits.**

#### **Effective Date**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

#### **Definitions**

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

***Catastrophic Accident Elimination Period*** is the period of days after the date of a Covered Accident for which no benefits are payable under this rider. This period of days is shown on the Rider Schedule.

***Catastrophic Loss*** refers to an injury from a Covered Accident that causes total and irrecoverable:

- Loss of both hands or both feet; **or**
- Loss or loss of use of both arms or both legs; **or**
- Loss of one hand and one foot; **or**
- Loss of use of one arm and one leg; **or**
- Loss of sight of both eyes; **or**
- Loss of hearing in both ears; **or**
- Loss of the ability to speak.

Note:

- *The loss of use of an arm* means the functional loss of the entire arm from the shoulder to the hand.
- *The loss of use of a leg* means the functional loss of the entire leg from the hip to the foot.
- *The loss of sight* means both eyes are totally blind and that no sight can be restored.
- *The loss of hearing* means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid, or device.
- *The loss of the ability to speak* means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid, or device.

## Catastrophic Accident Benefit

We will pay the appropriate amount shown in the Rider Schedule at the end of the Catastrophic Accident Elimination Period if any Insured:

- Sustains a Catastrophic Loss as the result of a Covered Accident,
- Is under the appropriate care of a Doctor during the Catastrophic Accident Elimination Period, **and**
- Remains alive at the end of the Catastrophic Accident Elimination Period.

We will pay the Catastrophic Accident Benefit once per lifetime for each Covered Insured.

## Limitations and Exclusions

We will pay the Catastrophic Accident Benefit once per lifetime for each Insured covered under this Rider.

In addition to the exclusions listed in the **Exclusion** provision of your Certificate or any Dependent Riders, we will also not pay the Catastrophic Accident Benefit for injuries that are caused by or are the result of any Insured being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor.

## General Provisions

- This Rider is part of the Accident Certificate and will terminate when that Certificate terminates, or when premiums are no longer paid for this Rider.
- The premium for this Rider is shown in the Rider Schedule.
- This Rider is subject to all of the terms of the Accident Certificate to which it is attached unless any such items are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,

[  ]

[Eugene Sorrel, President]

## Rider Benefit Schedule

INSURED [John A. Doe]	GROUP POLICY NUMBER [1234]
EFFECTIVE DATE [January 1, 2012]	RIDER NUMBER [0599]
INITIAL PREMIUM [\$00.00 Monthly]	CERTIFICATE NUMBER [56789]
FIRST RENEWAL DATE [February 1, 2012]	

## Benefits

**Catastrophic Accident Elimination Period** [365] days

<b>Accident Occurs</b>		<b>Benefit Amount</b>
Before age 65	[Insured	\$100,000]
	[Spouse	50,000]
	[Child(ren)	50,000]
Age 65–70	[Insured	50,000]
	[Spouse	25,000]
	[Child(ren)	25,000]



## CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205  
800.433.3036]

### TOTAL DISABILITY RIDER TO CERTIFICATE OF INSURANCE FOR ACCIDENTAL INJURY

This Rider is a part of the Certificate to which it is attached. We have issued this Rider to you because:

- You paid the additional premium for this Rider; **and**
- We have accepted your Application.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply.

#### **Effective Date**

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider, provided that you are actively at work on that date.

#### **Definitions**

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

**Elimination Period** means the number of days of Total Disability that must elapse before benefits become payable. This number of days is shown in the Rider Schedule. Benefits are not payable, nor do they accrue, during an Elimination Period.

**Monthly Benefit for Total Disability** is shown in the Rider Schedule.

**Total Disability** or **Totally Disabled** means that due to an Accidental Injury:

- The Insured is not able to perform the substantial and material duties of his occupation; **and**
- The Insured is receiving care by a Doctor, which is appropriate for the condition causing the disability; **and**
- The Insured is not gainfully employed or occupied in any other occupation.

#### **Total Disability Benefit**

If the Insured is injured in a Covered [off-the-job] Accident and the Injury causes him to be Totally Disabled within 90 days after that accident, we will pay a monthly benefit for Total Disability as follows:

- Benefits start on the day following the Elimination Period shown in the Rider Schedule.
- Benefits will continue to be paid for days of Total Disability, but they will not be paid beyond the applicable Maximum Benefit Period shown in the Rider Schedule.

If the Insured becomes Totally Disabled again due to the same injury within 6 months, we will treat the second disability as a continuation of the first disability. This means that the length of time shown for Total Disability in the Rider Schedule is the maximum period for which the Insured can collect disability benefits resulting from the same injury. We will pay only one disability benefit at a time even if it is caused by more than one injury.

We will not pay the Total Disability Benefit for any period that the Insured is not under a Doctor's care and attendance, unless the Doctor tells us that regular care would be of no further benefit during his continuing disability.

Nothing in this definition extends the Maximum Benefit Period shown in the Rider Schedule.

## **General Provisions**

- This Rider is part of the Accident Certificate and will terminate when that Certificate terminates, or when premiums are no longer paid for this Rider.
- The premium for this Rider is shown in the Rider Schedule.
- This Rider is subject to all the terms of the Accident Certificate to which it is attached unless any such items are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,

[  ]

[Eugene Sorrel, President]

## Rider Benefit Schedule

INSURED [John A. Doe]	GROUP POLICY NUMBER [1234]
EFFECTIVE DATE [January 1, 2012]	RIDER NUMBER [0599]
INITIAL PREMIUM [\$00.00 Monthly]	CERTIFICATE NUMBER [56789]
FIRST RENEWAL DATE [February 1, 2012]	

## Benefit

### Total Disability

Monthly Benefit:	[\$1000]
Maximum Benefit Period:	[3, 6 or 12 months]
Elimination Period:	[0, 7, 14 or 30 days]

SERFF Tracking Number: CAIC-127863751 State: Arkansas  
 Filing Company: Continental American Insurance Company State Tracking Number: 50390  
 Company Tracking Number: 8303  
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only  
 Product Name: Accident 7800  
 Project Name/Number: Accident 7800/8303

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> CAIC Readability Certification.pdf	Approved-Closed	12/05/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application <b>Comments:</b> The applications to be used with this filing are included in the Form Schedule tab.	Approved-Closed	12/05/2011

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Submission Letter <b>Comments:</b> <b>Attachment:</b> Cover Letter 071111.pdf	Approved-Closed	12/05/2011



## READABILITY CERTIFICATION

I, James J. Hennessy, hereby certify that the following forms have the following readability score as calculated by the Flesch Reading Ease Test:

<u>Form</u>	<u>Readability Score</u>
CAI7800AR	47.1
CAI7801AR	47.8
CAI7822	52.1
CAI7823	44.3
CAI7825	59.3
CAI7835	45.9
CAI7849	40.7

  
Digitally signed by James J. Hennessy,  
AIRC, ACP, CCP  
DN: cn=James J. Hennessy, AIRC, ACP,  
CCP, o=CAIC, Aflac Group, ou=Vice  
President, Compliance,  
email=jhennessy@caicworksite.com,  
c=US  
Date: 2011.12.02 15:23:26 -05'00'

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James J. Hennessy, AIRC, ACP, CCP  
Vice President, Compliance  
Continental American Insurance Company

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December 2, 2011

Date



December 2, 2011

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-9134

**Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130**  
**TOI: H02G Group Health - Accident Only**  
**Sub-TOI: H02G.000 Health - Accident**  
**Proposed Effective Date: On Approval**  
**Domicile State Approval: SC 07/28/2011**  
**Forms:**  
**CAI7800SD Master Policy**  
**CAI7801SD Certificate**  
**CAI7810 Master Application**  
**CAI7811 Enrollment Application**  
**CAI7822 Dependent Rider**  
**CAI7823 Sickness Rider**  
**CAI7825 Gunshot Wound Rider**  
**CAI7835 Catastrophic Accident Rider**  
**CAI7849 Total Disability Rider**

Dear Sir or Madam:

The forms referenced above are being submitted for your review and approval. This is a new filing and will not replace any other forms on file with your department.

We are filing our Group Accidental Injury Insurance forms, which offer a rider for dependent coverage. We will be marketing this product to employer groups and union groups in accordance with your state guidelines. This product will be marketed on a voluntary, payroll-deduction basis.

The coverage provides hospital benefits, disability benefits, and accidental injury benefits for the employee when injured in a covered accident. We are also submitting sickness, gunshot wound, catastrophic, and total disability riders. These riders will not be optional at the employee level. They will be chosen at the group level.

Bracketed items in this filing indicate variable information and may be removed from some group plans. Any or all of the variables could be used in each plan, policy, or certificate, and the variable benefits will be selected according to the group's specifications.

Thank you for your consideration in this matter. If you have any questions please contact Jennifer McLaughlin at 1-888-730-2244, ext. 4322 or at [CompanyCompliance@aflac.com](mailto:CompanyCompliance@aflac.com).

Sincerely,

James J. Hennessy, AIRC, ACP, CCP  
Vice President, Compliance  
/jlm