

SERFF Tracking Number: CCGN-127839877 State: Arkansas
 Filing Company: Life Insurance Company of North America State Tracking Number: 50347
 Company Tracking Number: 11-8001
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness Benefits
 Project Name/Number: GCI/11-8001

Filing at a Glance

Company: Life Insurance Company of North America

Product Name: Group Critical Illness Benefits SERFF Tr Num: CCGN-127839877 State: Arkansas
 TOI: H07G Group Health - Specified Disease - SERFF Status: Closed-Approved- State Tr Num: 50347
 Limited Benefit Closed
 Sub-TOI: H07G.001 Critical Illness Co Tr Num: 11-8001 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Brian Smith, Chris Taylor, Disposition Date: 12/02/2011
 Kathy Forno, CCP, DCP, HIA, Rose
 Clark
 Date Submitted: 11/28/2011 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: GCI
 Project Number: 11-8001
 Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed
 Date Approved in Domicile:
 Domicile Status Comments: Our domiciliary state of Pennsylvania does not require the filing of forms intended for delivery outside Pennsylvania.

Explanation for Combination/Other:
 Submission Type: New Submission
 Group Market Type: Employer, Association
 Filing Status Changed: 12/02/2011
 State Status Changed: 12/02/2011
 Created By: Rose Clark
 Corresponding Filing Tracking Number: 11-8001
 Filing Description:

Market Type: Group
 Group Market Size: Small and Large
 Overall Rate Impact:
 Deemer Date:
 Submitted By: Rose Clark

We submit for your review and approval new Group Critical Illness Policy form GCI-00-1000.00 series, and Certificate form GCI-00-CE1000.00 series, for use with Life Insurance Company of North America. These forms are new, and are not intended to replace any forms currently on file. The forms have not been filed with our state of domicile, since

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Issuance of the policy on a group basis results in the economies of administration and acquisition. The uniformity of plan design and rating technique provided by marketing in multiple jurisdictions under a group policy form significantly reduces the cost of product marketing and product support administration, i.e., billing, claims adjudication, product delivery, etc. Group enrollment methods result in lower acquisition cost than is customary for comparable individual policies.

The enclosed rate manual and actuarial memorandum demonstrate the benefits provided are reasonable in relation to the premium charged. Your required certification(s) are also enclosed.

The referenced forms have been written in readable language and are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, positioning and format. However, printing standards will never be less than that required under your law.

Optional material is indicated by hard brackets ([]) and will be included or excluded as requested by the policyholder. Variable material indicated by soft brackets ({ }) will be included, with modifications as indicated, but will never be more restrictive than that permitted by law. A description of variability is also enclosed. Additionally, variations may result from negotiations between us and the policyholder or participating subscriber.

We appreciate your taking the time to review these forms. We trust that you will find everything in order. If you should have any questions or need additional information, please do not hesitate to e-mail me at rose.clark@cigna.com, or call me collect at 215-761-4110.

Company and Contact

Filing Contact Information

Rose Clark,
1601 Chestnut St -Two Liberty
Philadelphia, PA 19192

Rose.Clark@CIGNA.com
215-761-4101 [Phone]

Filing Company Information

Life Insurance Company of North America
1601 Chestnut Street
TL16D
Philadelphia, PA 19192
(215) 761-8442 ext. [Phone]

CoCode: 65498
Group Code: 901
Group Name:
FEIN Number: 23-1503749

State of Domicile: Pennsylvania
Company Type:
State ID Number:

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Filing Fees

Fee Required? Yes
Fee Amount: \$950.00
Retaliatory? No
Fee Explanation: \$50. per filing form to total \$950.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Life Insurance Company of North America	\$950.00	11/28/2011	54080611

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/02/2011	12/02/2011

SERFF Tracking Number: CCGN-127839877 State: Arkansas
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Disposition

Disposition Date: 12/02/2011

Implementation Date:

Status: Approved-Closed

Comment:

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

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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	Forms List	Approved-Closed	Yes
Supporting Document	Description of Variability	Approved-Closed	Yes
Supporting Document	Readability Certification	Approved-Closed	Yes
Form	Policy Face, Table of Contents, Schedule of Affiliates	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	General Definitions	Approved-Closed	Yes
Form	Description of Benefits	Approved-Closed	Yes
Form	Eligibility, Enrollment, Effective Date, Deferred Effective Date, Termination of Insurance, Continuation of Insurance, Portability Provisions	Approved-Closed	Yes
Form	Exclusions and Limitations	Approved-Closed	Yes
Form	Conversion Privilege	Approved-Closed	Yes
Form	Claim Provisions	Approved-Closed	Yes
Form	Administrative Provisions	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes
Form	Certificate Face Page	Approved-Closed	Yes
Form	Claim Provisions	Approved-Closed	Yes
Form	Administrative Provisions	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes
Form	Health Screening Benefit Rider	Approved-Closed	Yes
Form	Modifying Provisions Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Additional Benefit Rider	Approved-Closed	Yes
Form	Application/Evidence of Insurability/Enrollment/Change Form	Approved-Closed	Yes
Rate	Rate Manual	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GCI-00-1000.00

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/02/2011	GCI-00-1000.00	Policy/Cont	Policy Face, Table of Initial ract/Fratern Contents, Schedule al of Affiliates Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51.900	Policy, form GCI-00- 1000.00, final.pdf
Approved-Closed 12/02/2011	GCI-00-1100.00	Policy/Cont	Schedule of Benefits Initial ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51.900	Policy, form GCI-00- 1100.00, final.pdf
Approved-Closed 12/02/2011	GCI-00-1200.AR	Policy/Cont	General Definitions ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		51.900	Policy, form GCI-00- 1200.AR.pdf
Approved-Closed 12/02/2011	GCI-00-1300.00	Policy/Cont	Description of ract/Fratern Benefits al	Initial		51.900	Policy, form GCI-00- 1300.00,

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 Product Name: Group Critical Illness Benefits
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Certificate: final.pdf

Amendmen
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Approved- GCI-00- Policy/Cont Eligibility, Enrollment, Initial 51.900 Policy, form
 Closed 1400.AR ract/Fratern Effective Date, GCI-00-
 12/02/2011 al Deferred Effective 1400.AR.pdf
 Certificate: Date, Termination of

Amendmen Insurance,
 t, Insert Continuation of
 Page, Insurance, Portability
 Endorseme Provisions
 nt or Rider

Approved- GCI-00- Policy/Cont Exclusions and Initial 51.900 Policy, form
 Closed 1500.00 ract/Fratern Limitations GCI-00-
 12/02/2011 al Certificate: final.pdf
 Amendmen

t, Insert
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 Endorseme
 nt or Rider

Approved- GCI-00- Policy/Cont Conversion Privilege Initial 51.900 Policy, form
 Closed 1600.00 ract/Fratern GCI-00-
 12/02/2011 al Certificate: final.pdf
 Amendmen

t, Insert
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Approved- GCI-00- Policy/Cont Claim Provisions Initial 51.900 Policy, form
 Closed 1700.00 ract/Fratern GCI-00-
 12/02/2011 al Certificate: final.pdf

Certificate:

<i>SERFF Tracking Number:</i>	CCGN-127839877	<i>State:</i>	Arkansas		
<i>Filing Company:</i>	Life Insurance Company of North America	<i>State Tracking Number:</i>	50347		
<i>Company Tracking Number:</i>	11-8001				
<i>TOI:</i>	H07G Group Health - Specified Disease - Limited Benefit	<i>Sub-TOI:</i>	H07G.001 Critical Illness		
<i>Product Name:</i>	Group Critical Illness Benefits				
<i>Project Name/Number:</i>	GCI/11-8001				
	Amendmen t, Insert Page, Endorseme nt or Rider				
Approved- Closed 12/02/2011	GCI-00- 1800.00 Policy/Cont Administrative ract/Fratern Provisions al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	51.900	Policy, form GCI-00- 1800.00, final.pdf	
Approved- Closed 12/02/2011	GCI-00- 1900.AR Policy/Cont General Provisions ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	51.900	Policy, form GCI-00- 1900.AR.pdf	
Approved- Closed 12/02/2011	GCI-00- CE1000.00 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Certificate Face Page	Initial	51.900	Cert, form GCI-00- CE1000.00, final.pdf
Approved- Closed 12/02/2011	GCI-00- CE1700.00 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Claim Provisions	Initial	51.900	Cert, form GCI-00- CE1700.00, final.pdf
Approved- Closed	GCI-00- CE1800.00 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Administrative Provisions	Initial	51.900	Cert, form GCI-00-

<i>SERFF Tracking Number:</i>	CCGN-127839877	<i>State:</i>	Arkansas
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<i>Company Tracking Number:</i>	11-8001		
<i>TOI:</i>	H07G Group Health - Specified Disease - Limited Benefit	<i>Sub-TOI:</i>	H07G.001 Critical Illness
<i>Product Name:</i>	Group Critical Illness Benefits		
<i>Project Name/Number:</i>	GCI/11-8001		
12/02/2011	t, Insert Page, Endorsement or Rider		CE1800.00, final.pdf
Approved-Closed 12/02/2011	GCI-00-CE1900.AR Certificate General Provisions t, Insert Page, Endorsement or Rider	Initial 51.900	General Provisions - Cert, form GCI-00- CE1900.AR.pdf
Approved-Closed 12/02/2011	HSB-00-1000.00 Policy/Cont Health Screening ract/Fraternal Benefit Rider al Certificate: Amendment, t, Insert Page, Endorsement or Rider	Initial 51.900	HSB-00- 1000.00, final.pdf
Approved-Closed 12/02/2011	GCI-00-3000.00 Policy/Cont Modifying Provisions ract/Fraternal Amendment al Certificate: Amendment, t, Insert Page, Endorsement or Rider	Initial	GCI-00- 3000.00, 11-3 final.pdf
Approved-Closed 12/02/2011	GCI-00-4000.00 Policy/Cont Amendment ract/Fraternal al Certificate: Amendment, t, Insert Page, Endorsement or Rider	Initial	GCI-00- 4000.00, final.pdf

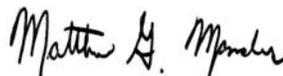
Life Insurance Company of North America
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235
A Stock Insurance Company

GROUP CRITICAL ILLNESS POLICY

POLICYHOLDER: {ABC Company, Inc.}
POLICY NUMBER: {Specimen}
POLICY EFFECTIVE DATE: {January 1, 2011}
POLICY ANNIVERSARY DATE: {January 1}
STATE OF ISSUE: {Any State}

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 AM on the Policy Effective Date shown above at the Policyholder's address. The laws of the State of Issue shown above govern this Policy.

[We and the Policyholder agree to all of the terms of this Policy.]



President

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

THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.

[The {Policyholder} should seek advice of its tax advisors if any part of the cost of this insurance is paid for with amounts not subject to Federal Income Tax. We can not provide such advice nor offer any opinions on taxation or tax status of any contributions toward the cost of insurance.]

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DESCRIPTION OF BENEFITS	[]
ELIGIBILITY	[]
[ENROLLMENT]	[]
EFFECTIVE DATE PROVISIONS	[]
[DEFERRED EFFECTIVE DATE PROVISIONS]	[]
TERMINATION OF INSURANCE	[]
[CONTINUATION OF INSURANCE PROVISIONS]	[]
[PORTABILITY PROVISIONS]	[]
EXCLUSIONS [AND LIMITATIONS]	[]
[CONVERSION PRIVILEGE]	[]
CLAIM PROVISIONS	[]
ADMINISTRATIVE PROVISIONS	[]
GENERAL PROVISIONS	[]

[SCHEDULE OF AFFILIATES

The following affiliates are insured under this Policy on the effective dates listed below.

<u>AFFILIATE NAME</u>	<u>LOCATION</u>	<u>EFFECTIVE DATE</u>
{ABC Company}	{your city, your state}	{January 1, 2011}

SCHEDULE OF BENEFITS

The Schedule of Benefits provides a brief outline of the coverage and benefits including the maximum benefit amount, benefit periods, and any limitations applicable to benefits provided in this Policy for each {Covered Person}, unless otherwise indicated.

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Policy provisions carefully.

Covered Class(es):

{Class {1}} All active full-time {Employees} of the {Policyholder} who [regularly work a minimum of {20} hours per week] [are Members in good standing].}

The following pages contain a Schedule of Benefits for each class of eligible {Employees}. For an explanation of these benefits, please see the *Description of Benefits* section.

SCHEDULE OF BENEFITS FOR CLASS {1}

[Subscriber: {Subscriber} Name]

Effective Date of {Subscriber}: {January 1, 2012}

[Minimum {Subscriber} Participation Requirements:

{20%} of eligible {Employees} [or] [{50} enrolled {Employees}] [, whichever is greater]]

[Eligibility Waiting Period:

For {Employees} [hired] [{31} days or more before the Policy Effective Date, {0} days]

For {Employees} [hired] [less than {31} days before the Policy Effective Date, {30} days]

For {Employees} [hired] after the Policy Effective Date, [{30} days] [next scheduled enrollment period]]

[Rehire:

If {the Employee's} employment ends and {He} is rehired within {3 months}, His previous work in an eligible group will apply toward the Eligibility Waiting Period. All other Policy provisions apply.]

[Credit for Prior Service:

The Insurance Company will apply any period of work with {the Employee's} {Employer} [within {12 months} of rehire] toward the Eligibility Waiting Period to determine His eligibility date.]

[Waiting Period: {30} days]

BENEFITS FOR COVERED PERSONS

{EMPLOYEE} BENEFITS

Critical Illness Benefit

[Basic Benefit:

Benefit Amount { \$5,000 - \$50,000 }

[Additional Benefit Amount [{ \$5,000 - \$50,000 }] [The Benefit Amount shown, available after {100%} of the Benefit Amount has been paid.]]]

[Voluntary Benefit:

Units of { \$1,000 }

Benefit Amount { \$5,000 - \$300,000 }

[Guaranteed Issue { \$5,000 - \$50,000 }]

[Maximum Benefit { \$300,000 }]

[Additional Benefit Amount [{ \$5,000 - \$300,000 }] [The Benefit Amount shown, available after {100%} of the Benefit Amount has been paid.]]]

[Continuation Option(s)

Applicable Coverage(s) Critical Illness Benefits for the {Employee} [, his Spouse] [, Dependent Child]

[For Furlough
[Maximum Benefit Period { up to {30 days} }]]]

[For Temporary Layoff
[Maximum Benefit Period { up to {30 days} }]]]

[For Family Medical Leave
[Maximum Benefit Period { up to {12 weeks} }]]

[For Leave of Absence
[Maximum Benefit Period { up to {12 weeks} }]]

[Disability [for {Employees} over Age {60}]
[Maximum Benefit Period { up to {26 weeks} }]]

[Military Service]]

[Portability

Portable Period {{5} years, to age {70}}
Amount of Portable Insurance {100%}
Coverage(s) that may be ported {{Employee}, Spouse, Dependent Child}
Benefit(s) that may be ported {all except...}
Maximum Age {70}}

[Age Based Reductions

Critical Illness Benefit(s) for the {Employee} will reduce to:
{65%} at Age {70}
[{{50%} at Age {75}}]
[{{30%} at Age {80}}]

[Health Screening Benefit Rider

Benefit Amount: {\$25, \$50, \$75, \$100}}

[SPOUSE BENEFITS

Critical Illness Benefit

[Basic Benefit:

Benefit Amount [{{5,000 - \$50,000}}] [{{50%} of {Employee} Benefit Amount]
[Additional Benefit Amount [{{5,000 - \$50,000}}] [The Benefit Amount shown, available after {100%} of the Benefit Amount has been paid.]]]

[Voluntary Benefit:

Benefit Amount [{{5,000 - \$300,000}}] [{{50%} of {Employee} Benefit Amount]
[Guaranteed Issue {\$5,000 - \$50,000}]
[Maximum Benefit {\$300,000}]
[Additional Benefit Amount [{{5,000 - \$300,000}}] [The Benefit Amount shown, available after {100%} of the Benefit Amount has been paid.]]]

[Portability

Portable Period {{5} years, to age {70}}
Amount of Portable Insurance {100%}
Coverage(s) that may be ported {Spouse, Dependent Child}
Benefit(s) that may be ported {all except...}
Maximum Age {70}}

[Age Based Reductions

Critical Illness Benefit(s) for the Spouse will reduce to:

- {65% } at Age {70}
- [[{50% } at Age {75}]
- [[{30% } at Age {80}]]

[Health Screening Benefit Rider

Benefit Amount: {\$25, \$50, \$75, \$100}]]

[DEPENDENT CHILD BENEFITS

Critical Illness Benefit

[Basic Benefit:

Benefit Amount [{\$5,000 - \$300,000}] [25%] of {Employee} Benefit Amount

[Additional Benefit Amount [{\$5,000 - \$50,000}] [The Benefit Amount shown, available after {100% } of the Benefit Amount has been paid.]]]

[Voluntary Benefit:

Benefit Amount [{\$5,000 - \$300,000}] [25%] of {Employee} Benefit Amount

[Guaranteed Issue: {\$5,000 - \$50,000}]

[Maximum Benefit: {\$300,000}]]

[Additional Benefit Amount [{\$5,000 - \$300,000}] [The Benefit Amount shown, available after {100% } of the Benefit Amount has been paid.]]]

[Portability

Portable Period {{5} years, to age {70} }

Amount of Portable Insurance {100% }

Coverage(s) that may be ported Dependent Child

Benefit(s) that may be ported {all except... }

[Maximum Age {70}]]

[Age Based Reductions

Critical Illness Benefit(s) for the Dependent Child will reduce to:

- {65% } at Age {70}
- [[{50% } at Age {75}]
- [[{30% } at Age {80}]]

[Health Screening Benefit Rider

Benefit Amount: {\$25, \$50, \$75, \$100}]]

COVERED CONDITIONS

Critical Illness(es)

Percentage of Benefit Amount

[Cancer Diagnosis {100%}]

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

[Each definition is optional and variable, depending on the type of group and benefits and options elected]

[Active Service

[Include when eligibility is based on employment status, for employer, trade or professional association or multiple employer groups.]

[{An Employee} will be considered in Active Service with His {Employer} on any day that is either:

1. one of {the Employer's} scheduled work days on which {the Employee} is performing His regular duties on a full-time basis, either at one of the {Employer's} usual places of business or at some other location to which the {Employer's} business requires {the Employee} to travel; or
2. a scheduled holiday, vacation day or period of {Employer}-approved paid leave of absence, other than disability or sick leave after {7 days}, only if {the Employee} was in Active Service on the preceding scheduled workday.]

[{A Covered Person} is not considered in Active Service if He is:

1. an Inpatient in a Hospital, {hospice} [or receiving Outpatient care for chemotherapy or radiation therapy];
2. confined at home under the care of Physician for Sickness or Injury;
- [3. Totally Disabled;]
- [4. receiving disability benefits from any source due to His Sickness, Injury or Total Disability;]
- [5. unable to perform any of the activities of daily living including eating, transferring, dressing, toileting, bathing and continence, without human supervision or assistance.]]

[Age

{A Covered Person's} Age, for purposes of initial premium calculations, is His Age attained on the date insurance becomes effective for Him under this Policy. [Thereafter, it is His Age attained on [the last Policy anniversary] [His last birthday.]]]

[Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)

A motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.]

[Blindness

Clinically proven irreversible reduction of sight in both eyes, with either:

1. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or
2. visual field restriction to 20° or less in both eyes.]

[Cancer

A disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. The term Cancer does not include:

1. pre-malignant conditions or conditions with malignant potential;
2. Carcinoma in Situ;
3. basal cell carcinoma and squamous cell carcinoma of the skin, unless metastatic disease develops; or
4. melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm, or melanoma in situ.]

[Carcinoma in Situ

A malignant tumor which has not yet become invasive but is confined only to the superficial layer of cells from which it arose. The term Carcinoma in Situ does not include:

1. pre-malignant conditions or conditions with malignant potential;

2. basal cell carcinoma and squamous cell carcinoma of the skin; or
3. melanoma or melanoma in situ.]

[Certificate

The Certificate, including the Certificate Schedule, amendments, riders and supplements, if any, is a written statement prepared by Us to set forth a summary of:

1. benefits to which the {Covered Person} is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.]

[Clinical Diagnosis

A diagnosis that is based on the study of symptoms. This type of diagnosis applies only when:

1. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
2. there is medical evidence to support the diagnosis; and
3. a Physician is treating the {Covered Person} for Cancer and/or Carcinoma in Situ.]

[Coronary Artery Disease

Heart disease or angina that has been clinically diagnosed and requires the {Covered Person} to undergo Coronary Artery Bypass Surgery, which is a surgical procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts. Angiographic evidence to support the necessity for this surgical procedure will be required. Coronary Artery Bypass Surgery does not include percutaneous coronary intervention (balloon angioplasty, stent implantation or related procedures to increase the flow of blood through the coronary arteries).]

[Covered Loss

A loss that is:

1. the result, directly and independently of all other causes; and
2. one of the Covered Conditions specified in the *Schedule of Benefits*; and
3. suffered by the {Covered Person} within the applicable time period described in this Policy.]

[Covered Person

An eligible person, as defined in the *Schedule of Benefits*, who is enrolled and for whom Evidence of Insurability, where required, has been accepted by Us, required premium has been paid when due and coverage under this Policy remains in force.]

[Critical Illness

[ALS,] [Blindness,] [Cancer and Carcinoma in Situ,] [Coronary ArteryDisease,] [End Stage Renal (Kidney) Failure,] [Heart Attack,] [Major Organ Transplant,] [Occupational HIV,] [Paralysis,] [and] [Stroke].]

[Date of Diagnosis

For:

[Amyotrophic Lateral Sclerosis (ALS), the date a Physician makes a diagnosis based on generally accepted principles of medicine in the United States at the time of the diagnosis is made.]

[Blindness, the date the ophthalmologist makes an accurate certification of Blindness.]

[Cancer or Carcinoma in Situ, the date the tissue specimen, blood samples and/or titer(s) are taken on which the diagnosis of Cancer or Carcinoma in Situ is based. If a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening, We will accept a Clinical Diagnosis.]

[Coronary Artery Disease, the date the Coronary Artery Bypass Surgery occurs.]

[End Stage Renal (Kidney) Failure, the date on which a Physician recommends that the {Covered Person} begin renal dialysis.]

[Heart Attack, the date that the ischemic death of a portion of the heart muscle occurred based on the criteria listed in the Heart Attack definition.]

[Major Organ Transplant, the date the transplant surgery occurs.]

[Occupational HIV, the date of a positive antibody HIV test, as described in the Occupational HIV definition.]

[Paralysis, the date a Physician makes a diagnosis based on clinical and/or laboratory findings as supported by the {Covered Person's} medical records.]

[Stroke, the date a Stroke occurred, based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic study, and the presence of neurological deficits persisting for a period of 30 days or greater.]

[Dependent Child

{An Employee's} [unmarried] child who meets the following requirements:

1. A child {from live birth to 19} years old;
2. [A child who is {19} or more years old but less than {26} years old, [enrolled in a school [as a full-time student]] and primarily supported by {the Employee}];]
3. A child who is {19} or more years old, [primarily supported by the {Employee}] and incapable of self-sustaining employment by reason of mental or physical handicap. [Proof of the child's condition and dependence must be submitted to Us within {31 days} after the date the child ceases to qualify as a Dependent Child for the reasons listed above.] [During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.]]

A child, for purposes of this provision, includes {an Employee's}:

1. natural child;
2. In the case of minor children under an {Employee's} charge, care and control for whom the {Employee} has filed a petition to adopt, coverage will be effective:
 - a. From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
 - b. On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.

Coverage shall terminate upon the dismissal of a petition for adoption.

3. An unmarried dependent child who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of age 19 years and who is chiefly dependent on the {Employee} for support and maintenance. Coverage shall continue so long as the coverage of the {Employee} remains in force and so long as the dependent remains in such condition. At Our request and expense, proof of the incapacity or dependency must be furnished to Us by the {Employee}, except in no event shall this requirement preclude eligible dependents, regardless of age. If the incapacity or dependency is thereafter removed or terminated, the {Employee} shall so notify Us.
4. {child, grandchild} for whom {the Employee} is the court-appointed legal guardian[, as long as the child resides with {the Employee}] and [primarily] depends on {the Employee} for financial support. [Financial support means that {the Employee} is eligible to claim the dependent for purposes of Federal and State income tax returns.]]

[If {an Employee} who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with {the Employee} for at least [six consecutive months] and intend to reside with {the Employee} for an indefinite period of time.]

5. a child of the {Employee's} domestic partner [/Partner to a Civil Union,] [provided the

child is living with, and is financially dependent upon {the Employee}];]
[6. legally placed ward who permanently resides with {the Employee}].

[Employee

For eligibility purposes, an Employee of {the Employer} who is in one of the Covered Classes.]

[Employer

{The Policyholder} and any affiliates, subsidiaries or divisions shown in the *Schedule of Affiliates* and which are covered under this Policy on the date of issue or subsequently agreed to by Us.]

[End Stage Renal (Kidney) Failure

Chronic irreversible failure of the function of both kidneys, such that regular hemodialysis or peritoneal dialysis is required to sustain life.]

[Full-time

Full-time means the number of hours set by the {Policyholder} as a regular work week for {Employees} in the {Employee's} eligibility class.]

[Furlough

A temporary suspension or alteration of Active Service initiated by the {Employer}, for a period of time specified in advance not to exceed {30 days} [at a time].]

[Heart Attack

An identifiable clinical event consistent with a heart attack:

1. which has at least two of the following three:
 - a. typical chest pain.
 - b. electrocardiographic (EKG) changes indicative of myocardial infarction. In the case of myocardial infarction associated with percutaneous coronary intervention (balloon angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria on establishing a diagnosis.
 - c. elevation of biochemical markers of myocardial necrosis.
2. and that results in some permanent functional loss of heart contraction detectable by a regional contraction abnormality study on an imaging study.

In the event of death, an autopsy confirmation and/or death certificate identifying myocardial infarction as the cause of death will be accepted.]

[He, His, Him, Himself

Refers to any individual, male or female.]

[Hospital

An institution that meets all of the following:

1. It is licensed as a Hospital pursuant to applicable law.
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons.
3. It is managed under the supervision of a staff of medical doctors.
4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.).
5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis.
6. It charges for its services.

[The term Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital, and the requirement that a patient must incur an expense as an Inpatient shall be waived.]

[The term Hospital shall include a military or veteran's hospital contracted for, or operated by, a national government or its agency where: (a) the services are rendered on an emergency basis; or (b) in the absence of insurance, a legal liability exists to pay the charges for the services given; or (c) the services are rendered for Outpatient Surgical Benefits as referenced in the *Schedule of Benefits*.]

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care; or
2. the aged, drug addicts or alcoholics.

[It also does not include a Veteran's Administration Hospital or Federal Government Hospitals unless the {Covered Person} incurs an expense.]]

[Initial Open Enrollment Period]	The period in the calendar year when an eligible {Employee} [who was hired] on or before the Policy may enroll for the first time for coverage under this Policy.]
[Injury]	A bodily injury which is the result of an accident.]
[Inpatient]	{A Covered Person} who is confined for at least one full day's Hospital room and board. [The requirement that a person be charged for room and board shall not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term Inpatient shall mean {a Covered Person} who is required to be confined for a period of at least a full day as determined by the Hospital.]]
[Insurability Requirement]	An eligible person will satisfy the insurability requirement for an amount of insurance on the day the Insurance Company agrees in writing to accept Him as insured for that amount. To determine an eligible person's acceptability for insurance, the Insurance Company will require evidence of good health and may require it be provided at the eligible person's expense.]
[Major Organ Transplant]	The first day of hospitalization for the surgical transplantation of a liver, lung or lungs, pancreas, kidney or heart. The transplanted organ must come from a human donor. If the {Covered Person} has a combination transplant (i.e. heart and lung), a single benefit amount will be payable.]
[Member]	For eligibility purposes, a Member is any one of the following: [1. An Employee of the Subscriber, not including a temporary or seasonal Employee;] 2. an Employee of a Member in good standing of a {Subscriber} [, not including a temporary or seasonal Employee]; 3. a person who meets all of the conditions of membership of a {Subscriber}; [4. a person who is eligible to participate in the Trust;] who is [a United States citizen or has a permanent Alien Registration Card] in one of the Covered Classes.]
[Nurse]	A licensed graduate registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.) who is not: 1. employed or retained by the {Policyholder}; 2. living in {the Covered Person's} household; or 3. a parent, sibling, spouse or child of {the Covered Person}.]
[Occupational Human Immunodeficiency Virus (Occupational HIV)]	Diagnosis of Human Immunodeficiency Virus (HIV) infection resulting from an accidental exposure to HIV-contaminated body fluids. The accidental exposure must occur during the normal course of duties for the occupation in which the {Covered Person} is regularly engaged. The HIV infection must result from accidental exposure to HIV-contaminated body fluids during the normal course of performing an occupation for which remuneration is earned. The contact with the HIV-contaminated body fluids must occur while the {Covered Person's} coverage under this Policy is in force. To qualify as Occupational HIV, these requirements apply:

1. within 5 days of the accidental exposure, a report or recording is provided to the appropriate person according to the legislation, regulations, standards or guidelines that apply to the {Covered Person's} occupation or profession;
2. the accidental exposure is investigated and a written investigation report is provided to Us by the {Covered Person's} {Employer};
3. a confirmatory antibody HIV test is taken within 5 days of the accidental exposure and HIV is not present;
4. all HIV tests are performed by a state certified and licensed laboratory; and
5. a follow-up confirmatory antibody HIV test is taken, between 90 days and 180 days after the accidental exposure, and the result is positive.

Occupational HIV does not include any HIV infection:

1. that results from intravenous drug use;
2. that results from sexual transmission; and
3. determined not to have been accidental.]

[Outpatient	{A Covered Person} who receives treatment, services and supplies while not an Inpatient in a Hospital.]
[Paralysis	The complete and permanent loss of the use of two or more limbs.]
[Pathological Diagnosis	A diagnosis that is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.]
[Pathologist	A Physician who is licensed to practice pathological anatomy by the American Board of Pathology. Pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.]
[Physician	A licensed health care provider practicing within the scope of His license and rendering care and treatment to {a Covered Person} that is appropriate for the condition and locality and who is not: <ol style="list-style-type: none"> 1. employed or retained by the {Policyholder}; 2. living in the {Covered Person's} household; or 3. a parent, sibling, spouse or child of the {Covered Person}.]
[Prior Plan	The plan of insurance, {former plan number, former insurance company name} providing similar coverage, sponsored by {the Employer} in effect immediately prior to this Policy's Effective Date.]
[Sickness	A physical or mental illness [, including pregnancy].]
[Spouse	{The Employee's} lawful spouse [who is at least Age {18} but not yet Age {70}] [and] [who is a United States citizen or has a permanent Alien Registration Card]. [Except for purposes of determining initial eligibility, the term includes a spouse who is widowed {or divorced or legally separated from} {an Employee}.]
[Stroke	A cerebrovascular incident qualifying as an infarction of brain tissue, a cerebral and subarachnoid hemorrhage, a cerebral embolism, or a cerebral thrombosis. The diagnosis must be supported by: <ol style="list-style-type: none"> 1. evidence of persistent neurological deficits confirmed by a neurologist at least {30} days after the event; and 2. confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

Stroke does not include:

1. transient ischemic attack;
2. brain Injury related to trauma or infection;
3. brain Injury associated with hypoxia, anoxia or hypotension;
4. vascular disease affecting the eye or optic nerve; and
5. ischemic disorders of the vestibular system.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.]

[Subscriber Any participating organization that subscribes to the Trust to which this Policy is issued.]

[Temporary Layoff A temporary suspension of Active Service for a period of time determined in advance by the {Employer}, other than a Furlough as defined. Temporary Layoff does not include the permanent termination of Active Service (including but not limited to a job elimination), which shall be treated as a termination of employment.]

[Totally Disabled or Total Disability Totally Disabled or Total Disability means either:
1. inability of the {Covered Person} who is currently employed to do any type of work for which He is or may become qualified by reason of education, training or experience; or
2. inability of the {Covered Person} who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.]

[Trust The {ABC Industry Insurance Trust} named on the face page of this Policy.]

[Waiting Period Waiting Period means the period of time, shown in the *Schedule of Benefits*, following the effective date of the {Covered Person's} insurance. No benefits will be paid for a Covered Loss which occurs during the Waiting Period.]

[We, Us, Our, Insurance Company Life Insurance Company of North America.]

[For use with Certificate]
[You, Your The person to whom the Certificate is issued.]

DESCRIPTION OF BENEFITS

We will pay the following Critical Illness Benefits to a {Covered Person} for those Critical Illnesses shown in the *Schedule of Benefits* that are diagnosed while coverage is in force, subject to the conditions and limitations set forth below, and the terms, conditions, limitations and exclusions applicable to all coverage under the Policy.

Conditions for All Benefit Payments

The Critical Illness Benefit for a Critical Illness will only be payable if:

1. the Date of Diagnosis occurs after the Waiting Period, if applicable;
2. the Date of Diagnosis occurs while the {Covered Person's} coverage under this Policy is in force;
3. the Critical Illness satisfies the definition for that condition; and
4. payment is not precluded by any general or specific exclusion or limitation set forth in the Certificate, or by any failure to meet any condition set forth in the Policy.

[If the Date of Diagnosis of a Critical Illness occurs during the Waiting Period, the Certificate may be returned to Us for a full refund of premium paid.]

CRITICAL ILLNESS BENEFIT

We will pay a Critical Illness Benefit to a {Covered Person} for the Diagnosis of those Critical Illnesses, shown in the *Schedule of Benefits*, that are diagnosed while coverage is in force, subject to the Conditions for All Benefit Payments and the Benefit Limitations provisions.

Critical Illness Benefit Amount

The amount of the Critical Illness Benefit is the Benefit Amount multiplied by the applicable Percentage of the Benefit Amount for the Diagnosis of the Critical Illness shown in the *Schedule of Benefits*.

The Benefit Amount is the sum shown in the *Schedule of Benefits* used to determine the amount payable for a Critical Illness Benefit.

If a payable Critical Illness Benefit is less than 100% of the Benefit Amount for one Critical Illness shown in the *Schedule of Benefits*, the remaining Benefit Amount is available for payment for a subsequent and different diagnosed Critical Illness shown in the *Schedule of Benefits*. The amount payable for a subsequent and different Critical Illness is the Benefit Amount multiplied by the Percentage of Benefit Amount for the Diagnosis of that Critical Illness subtracted from the remaining Benefit Amount.

[Optional: Included at the option of the Policyholder]

[ADDITIONAL CRITICAL ILLNESS BENEFIT

We will pay an Additional Critical Illness Benefit to a {Covered Person} for the Diagnosis of those Critical Illnesses, shown in the *Schedule of Benefits*, that are diagnosed while coverage is in force, subject to the Conditions for All Benefit Payments, the Conditions for Additional Critical Illness Benefit, and the Benefit Limitations provisions.

Additional Critical Illness Benefit Amount

The Additional Critical Illness Benefit Amount is the Additional Benefit Amount multiplied by the Percentage of Benefit Amount for the Diagnosis of the Critical Illness shown in the *Schedule of Benefits*.

The Additional Benefit Amount is the sum shown in the *Schedule of Benefits* used to determine the amount payable for an Additional Critical Illness Benefit.

Conditions for Additional Critical Illness Benefit

The Additional Critical Illness Benefit for a Critical Illness will only be payable if:

1. 100% of the Benefit Amount has been paid;

2. the diagnosed Critical Illness is subsequent and different from those Critical Illnesses for which a Critical Illness Benefit has already been paid; and
3. the subsequent and different Critical Illness is diagnosed after {180} days from the Date of Diagnosis of the last Critical Illness payable under the Benefit Amount.]

BENEFIT LIMITATIONS

These limitations apply to Our payments under the Critical Illness Benefit [and Additional Critical Illness Benefit]:

1. No more than one Benefit Amount [and one Additional Benefit Amount] will ever be paid per {Covered Person}.
2. We will pay the benefit for [Coronary Artery Disease] [and Carcinoma in Situ] only once per lifetime per {Covered Person}.

[Optional: Included at the option of the Policyholder]

[CRITICAL ILLNESS BENEFIT FOR RECURRENCE

We will pay a Critical Illness Benefit to a {Covered Person} for the Recurrence Diagnosis of those Critical Illnesses, shown in the *Schedule of Benefits*, that are diagnosed as a recurrence while coverage is in force, subject to the Conditions for All Benefit Payments and the Conditions for Critical Illness Benefit for Recurrence provisions.

Critical Illness Benefit Amount for Recurrence

The amount of the Critical Illness Benefit for a recurrence is the Benefit Amount multiplied by the applicable Percentage of the Benefit Amount for [each] Recurrence Diagnosis of the Critical Illness shown in the *Schedule of Benefits*.

Conditions for Critical Illness Benefit for Recurrence

The Critical Illness Benefit for recurrence of a Critical Illness will only be payable if:

1. the {Covered Person} is subsequently diagnosed with the same Critical Illness, for which a Critical Illness Benefit for the same diagnosis has been paid previously;
2. the subsequent and same Critical Illness is diagnosed more than {12} months after the previous diagnosis for that same Critical Illness; and
3. the {Covered Person} has not received treatment during the {12} month period between the two diagnoses. As used herein, "treatment" does not include [medications and] follow-up visits to the {Covered Person's} Physician.

["Medications" means any form of pharmacotherapy which is primarily used is to improve or maintain general physical condition or health, or which is used for routine, long term, or maintenance care that is provided after the resolution of the acute medical problem and where the pharmacotherapy is not expected itself to provide significant therapeutic improvement.]

[No more than one Critical Illness Benefit for Recurrence will be paid per Critical Illness per {Covered Person}.]

[BENEFIT REDUCTION

Any Critical Illness Benefit in force prior to the {Covered Person's} {70th} birthday will be reduced by the Age Based Reductions schedule, shown in the *Schedule of Benefits*, on the Policy Anniversary Date following the {Covered Person's} birthday.]

ELIGIBILITY

{An Employee} becomes eligible for insurance under this Policy on the date He meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits* [and is insured under the {Employer's} comprehensive health or major medical plan]. [A Spouse and Dependent Children of an eligible {Employee} become eligible for any dependent insurance provided by this Policy on the later of the date the {Employee} becomes eligible or the date the Spouse or Dependent Child meets the applicable definition shown in the *General Definitions* section of this Policy.] [An eligible person may be insured only once as of any given date under the Policy as a {Covered Person}, even though He may be eligible under more than one class of insureds.]

ENROLLMENT

An eligible {Employee} may apply for insurance, subject to the *Deferred Effective Date Provisions* section of this Policy, for Himself [or any eligible Spouse or Dependent Child] or to increase coverage for any {Covered Person} under this Policy during the Initial Open Enrollment Period [or] [the [Annual Re-Enrollment] [scheduled enrollment period]] as agreed to by Us and the {Policyholder}.

[Included for a policy which: (a) provides coverage for dependents and (b) does not allow the purchase on dependents on a stand-alone basis]

[An eligible {Employee} must [apply for Himself] [be insured] for coverage for which He is required to contribute to the cost of insurance in order to apply for coverage for an eligible Spouse or Dependent Child.]

During the Initial Open Enrollment Period, {an Employee}, [His eligible Spouse or Dependent Child] may become insured under the coverage provided by this Policy [for a benefit up to this Policy's Guaranteed Issue amount, as shown in the *Schedule of Benefits*, without satisfying any Evidence of Insurability]. [Any {Employee} who is not in Active Service on the date His coverage would otherwise become effective under this Policy, may not become covered under this Policy until He returns to Active Service.]

If {an Employee's} eligible dependent is (a) an Inpatient in a Hospital, hospice, rehabilitation or convalescent center, or custodial care facility; or (b) confined to His home under the care of a Physician, on the date insurance would otherwise be effective, it will be effective on the date the dependent is no longer an Inpatient in these facilities or confined at home.]

[This [open] [scheduled] enrollment excludes those {Covered Persons} whose Evidence of Insurability was disapproved within the {12} month period preceding the beginning of this [open] [scheduled] enrollment.]

EFFECTIVE DATE PROVISIONS

[Policy Effective Date

The Insurance Company agrees to provide the insurance described in this Policy in consideration of the {Policyholder's} application and payment of the initial premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page [as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied].]

[Optional: Include when policy is not issued directly to an eligible employer-employee group]

[Subscriber Effective Date

Insurance becomes effective for each Subscriber in consideration of the Subscriber's application, Subscription Agreement and payment of the initial premium when due. Insurance for the Subscriber becomes effective on the Effective date of Subscriber Participation [as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied].]

Effective Date for Individuals

[Included for a policy when Employees are not required to contribute to the cost of coverage for themselves. Plan will have 100% Employer-paid Basic Benefit with or without 100% Employee-paid Voluntary (“buy-up”) available (use in combination with options under “Employees are required to contribute to coverage for themselves”)]

[Basic Benefit]

[Insurance for an eligible {Employee} [who applies within {31 days} after the date He becomes eligible] [and] [,] [subject to the *Deferred Effective Date Provisions* section below,] becomes effective on the later of:

1. the effective date of [the Subscriber’s participation under] this Policy;
2. {the date} {the Employee} becomes eligible;
3. {the date} We or {the Employer} receive {the Employee’s} completed enrollment form during His lifetime;
4. the first of the month following {the date} We or the {the Employer} receive {the Employee’s} completed enrollment form] [.]

[Included for a policy which: (a) provides dependent coverage and (b) Employees are not required contribute to the cost of coverage for their dependents]

[Insurance for {an Employee’s} eligible Spouse [if {the Employee} applies within {31 days} after the date the Spouse becomes eligible] [and] [,] [subject to the *Deferred Effective Date Provisions* section below,] becomes effective on the later of:

1. the effective date of [the Subscriber’s participation under] this Policy;
2. {the date} {the Employee} becomes eligible;
3. {the date} {the Employee’s} insurance becomes effective;]
4. {the date} the dependent meets the definition of Spouse, as applicable;
5. {the date} We or {the Employer} receive the completed enrollment form for Spouse coverage;
6. the first of the month following {the date} We or the {the Employer} receive the completed enrollment form for Spouse coverage] [.]

[Insurance for {an Employee’s} eligible Dependent Child [if {the Employee} applies within {31 days} after the date the Dependent Child becomes eligible] [and] [,] [subject to the *Deferred Effective Date Provisions* section below,] becomes effective on the later of:

1. the effective date of [the Subscriber’s participation under] this Policy;
2. {the date} {the Employee} becomes eligible;
3. {the date} {the Employee’s} insurance becomes effective;]
4. {the date} the dependent meets the definition of Dependent Child, as applicable;
5. {the date} We or {the Employer} receive the completed enrollment form for Dependent Child coverage;
6. the first of the month following {the date} We or the {the Employer} receive the completed enrollment form for Dependent Child coverage] [.]

The {Employee} must give Us notice of any newborn children within ninety (90) days of the birth of before the next premium due date, whichever is later.

[Included for a policy when Employees are required to contribute to the cost of coverage for themselves. Plan may include: (a) Guaranteed Issue only, (b) Evidence of Insurability only or (c) both Guaranteed Issue and Evidence of Insurability]

[Voluntary Benefit]

[For all {Employee} coverage [up to the Guaranteed Issue amount], Evidence of Insurability is not required.] [For all {Employee} coverage [in excess of the [Guaranteed Issue] [and] [Basic Benefit] amount], Evidence of Insurability is required.]

[If {the Employee} [is eligible for Guaranteed Issue coverage,] applies for coverage [within the Guaranteed Issue amount] and agrees to make required contributions [within {31 days} after the date He becomes eligible] [and] [,] [subject to the *Deferred Effective Date Provisions* section below,] insurance becomes effective on the later of:

1. the effective date of [the Subscriber’s participation under] this Policy;
2. {the date} We receive {the Employee’s} completed enrollment form and the required first premium;

- [3. the first of the month following {the date} We receive {the Employee's} completed enrollment form and the required first premium;]
- [4. {the date} the first {payroll deduction} is authorized] [;]
- [5. {the date} the first {payroll deduction} occurs] [;]
- [6. {the date} the first premium payment is received.] [.]

[If {the Employee} is eligible for coverage [in excess of the [Guaranteed Issue amount] [and] [Basic Benefit],] applies for coverage [that exceeds the Guaranteed Issue amount] [and] [Basic Benefit] and agrees to make required contributions [within {31 days} after the date He becomes eligible] [and] [,] [subject to the *Deferred Effective Date Provisions* section,] insurance becomes effective on the later of:

1. the effective date of [the Subscriber's participation under] this Policy, if {the Employee's} Evidence of Insurability is approved by Us prior to the effective date of this Policy;
2. {the date} We agree to insure {the Employee} upon satisfaction of the Insurability Requirement, and receive the required first premium;
- [3. the first of the month following {the date} We agree to insure {the Employee} upon satisfaction of the Insurability Requirement, and receive the required first premium] [;]
- [4. {the date} the first {payroll deduction} is authorized] [;]
- [5. {the date} the first {payroll deduction} occurs] [;]
- [6. {the date} the first premium payment is received] [.]

[Included for a policy which: (a) provides dependent coverage and (b) Employees are required to contribute to the cost of coverage for their dependents:]

[For all Spouse coverage [up to the Guaranteed Issue amount], Evidence of Insurability is not required.] [For all Spouse coverage [in excess of the [Guaranteed Issue] [and] [Basic Benefit] amount], Evidence of Insurability is required.]

[If the Spouse is eligible [for Guaranteed Issue coverage,] and {the Employee} applies for coverage [within the Guaranteed Issue amount] and agrees to make required contributions [within {31 days} after the date the Spouse becomes eligible] [and] [,] [subject to the *Deferred Effective Date Provisions* section below,] insurance becomes effective on the later of:

1. the effective date of [the Subscriber's participation under] this Policy;
- [2. {the date} {the Employee} becomes eligible;]
- [3. {the date} {the Employee's} insurance becomes effective;]
4. {the date} the dependent meets the definition of Spouse as applicable;
5. {the date} We receive the completed enrollment form and the required first premium for Spouse coverage;
- [6. the first of the month following {the date} We receive the completed enrollment form and the required first premium for Spouse coverage;]
- [7. {the date} the first {payroll deduction} is authorized] [;]
- [8. {the date} the first {payroll deduction} occurs] [;]
- [9. {the date} the first premium payment is received.] [.]

[If the Spouse is eligible for coverage [in excess of the [Guaranteed Issue amount] [and] [Basic Benefit],] and the {Employee} applies for coverage [that exceeds the Guaranteed Issue amount] [and] [Basic Benefit] and agrees to make required contributions [within {31 days} after the date the Spouse becomes eligible] and [,] [subject to the *Deferred Effective Date Provisions* section,] insurance becomes effective on the later of:

1. the effective date of [the Subscriber's participation under] this Policy, if the Spouse's Evidence of Insurability is approved by Us prior to the effective date of this Policy;
- [2. {the date} {the Employee} becomes eligible;]
- [3. {the date} {the Employee's} insurance becomes effective;]
4. {the date} the dependent meets the definition of Spouse as applicable;
5. {the date} We agree to insure the Spouse upon satisfaction of the Insurability Requirement, and receive the required first premium for Spouse coverage] [;]
- [6. the first of the month following {the date} We agree to insure the Spouse upon satisfaction of the Insurability Requirement, and receive the required first premium for Spouse coverage] [;]

- [7. {the date} the first {payroll deduction} is authorized] [;]
- [8. {the date} the first {payroll deduction} occurs] [;]
- [9. {the date} the first premium payment is received] [.]

[For all Dependent Child coverage [up to the Guaranteed Issue amount], Evidence of Insurability is not required.] [For all Dependent Child coverage [in excess of the [Guaranteed Issue] [and] [Basic Benefit] amount], Evidence of Insurability is required.]

[If the Dependent Child is eligible [for Guaranteed Issue coverage,] and {the Employee} applies for coverage [within the Guaranteed Issue amount] and agrees to make required contributions [within {31 days} after the date the Dependent Child becomes eligible] [and] [,] [subject to the *Deferred Effective Date Provisions* section below,] insurance becomes effective on the later of:

1. the effective date of [the Subscriber's participation under] this Policy;
- [2. {the date} {the Employee} becomes eligible;]
- [3. {the date} {the Employee's} insurance becomes effective;]
4. {the date} the dependent meets the definition of Dependent Child as applicable;
5. {the date} We receive the completed enrollment form and the required first premium for Dependent Child coverage;
- [6. the first of the month following {the date} We receive the completed enrollment form and the required first premium for Dependent Child coverage;]
- [7. {the date} the first {payroll deduction} is authorized] [;]
- [8. {the date} the first {payroll deduction} occurs] [;]
- [9. {the date} the first premium payment is received.] [.]

[If the Dependent Child is eligible for coverage [in excess of the [Guaranteed Issue amount] [and] [Basic Benefit],] and the {Employee} applies for coverage [that exceeds the Guaranteed Issue amount] [and] [Basic Benefit] and agrees to make required contributions [within {31 days} after the date the Dependent Child becomes eligible] and] [,] [subject to the *Deferred Effective Date Provisions* section,] insurance becomes effective on the later of:

1. the effective date of [the Subscriber's participation under] this Policy, if the Dependent Child's Evidence of Insurability is approved by Us prior to the effective date of this Policy;
- [2. {the date} {the Employee} becomes eligible;]
- [3. {the date} {the Employee's} insurance becomes effective;]
4. {the date} the dependent meets the definition of Dependent Child as applicable;
5. {the date} We agree to insure the Dependent Child upon satisfaction of the Insurability Requirement, and receive the required first premium for Dependent Child coverage] [;]
- [6. the first of the month following {the date} We agree to insure the Dependent Child upon satisfaction of the Insurability Requirement, and receive the required first premium for Dependent Child coverage] [;]
- [7. {the date} the first {payroll deduction} is authorized] [;]
- [8. {the date} the first {payroll deduction} occurs] [;]
- [9. {the date} the first premium payment is received] [.]

Effective Date of Changes

Any increase or decrease in the amount of insurance for {the Covered Person} resulting from:

1. a change in benefits provided by this Policy; or
 2. a change in {the Employee's} Covered Class,
- will take effect on the date of such change. Increases will take effect subject to any Active Service requirement.

Benefit Reduction

{An Employee} may reduce benefits on Himself [,] [Spouse or Dependent Child] under this Policy at any time. A benefit reduction [,] [other than requested at an Annual Re-enrollment] will be effective on the date the Insurance Company receives the completed change form. [A request for a benefit reduction received during an Annual Re-enrollment will become effective on the Policy anniversary following the enrollment period.]

DEFERRED EFFECTIVE DATE PROVISIONS

[Active Service

The effective date of insurance will be deferred for any {Employee} [or any eligible Spouse or Dependent Child] who is not in Active Service on the date insurance would otherwise become effective. Insurance will become effective on the later of the date He returns to Active Service, or the date insurance would otherwise have become effective.]

[Optional: Included when evidence of insurability may be required for late entrants]

[Late Enrollment

If application for insurance is not made within {31 days} of the date a person is first eligible for insurance [or a Life Status Change] [or during an Annual Re-Enrollment], {the Covered Person} will be considered a late enrollee. Insurance for any late enrollee will become effective on the later of the date We approve the required evidence of insurability and receive required premium, or the date insurance would otherwise have become effective.]

[Replacement Coverage

{An Employee} [and any Spouse and Dependent Children] who [was] [were] insured under a Prior Plan and who [is] [are] not in Active Service on the effective date of [the Subscriber's participation under] this Policy will be insured on that date for the lesser of:

1. the amount of coverage in effect under the Prior Plan on the date it terminated; or
2. the amount of coverage provided under this Policy, without regard to the Active Service provision.

If the amount of coverage otherwise provided by this Policy is greater than the amount provided under the Prior Plan, the greater amount will become effective on the [first day of the month on or after the] [first day of the Policy year on or after the] date {the Employee}, [Spouse or Dependent Child] returns to Active Service.

Coverage under this provision will end on the earliest of the following dates:

1. the date the {Employee} meets the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the *Termination of Insurance* section;
3. {12} months after the Policy Effective Date; or
4. the last day the {Employee} would have been covered under the Prior Plan if that plan was still in force.

[The benefit amount will be reduced by any amount paid under the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.]

[Include this paragraph if contributions are required toward the cost of coverage]

[If {an Employee} is required to contribute to the cost of any portion of His [or His dependents'] coverage and is not in Active Service on the effective date of [the Subscriber's participation under] this Policy, coverage will terminate {31 days} after {the Employee} returns to Active Service unless He submits an enrollment form and the required initial premium. If {the Employee} selects the amount of benefit for which He is required to pay premium for Himself [or any dependents], the amount in effect under this provision will be the lesser of the amount provided under the Prior Plan and the smallest amount He may select under this Policy.]]

[Included for a policy when an employer requests these options or when sold to align with employer core medical plan]

[Annual Re-Enrollment] [and] [Life Status Change]

[An Annual Re-Enrollment is a period of time once a year as agreed to by Us and {the Policyholder} when {an Employee} can apply [for coverage] [or] [to increase coverage] on Himself [,] [Spouse or Dependent Child] under this Policy.]

[A Life Status Change is an event that the {Employer} has determined qualifies {an Employee} to apply [for coverage] [or] [to increase coverage] on Himself [,] [His Spouse or Dependent Child] due to a Life Status Change] under this Policy.

[Include specific life status changes only upon Policyholder request]

Life Status Changes that qualify {an Employee} to [apply] [or] [increase coverage] for Himself include:

- [1. marriage;]
- [2. loss of a spouse; whether by death, divorce, annulment or legal separation;]
- [3. birth or adoption of a child, or acquiring a child through marriage;]
- [4. a change in the {group} benefit plan available to the {Employee's} Spouse;] [and]
- [5. a change in the {Employee's} employment status that affects eligibility for {group} benefits for either {the Employee} or His Spouse] [.]

[Life Status Changes that qualify {an Employee} to [apply] [or] [increase coverage] for His eligible Spouse and Dependent Child include:

- [1. marriage;]
- [2. birth or adoption of a child, or acquiring a child through marriage;]
- [3. a change in the {group} benefit plan available to the Spouse;] [and]
- [4. a change in the Spouse's employment status that affects eligibility for {group} benefits for either {the Employee} or His Spouse] [.]]

[For all {Employee} coverage [up to the Guaranteed Issue amount], Evidence of Insurability is not required.] [For all {Employee} coverage [in excess of the [Guaranteed Issue] [and] [Basic Benefit] amount], Evidence of Insurability is required.]

{An Employee} who [is eligible to apply, but did not previously enroll, may apply] [or] [is insured may apply for an increase] for coverage. Changes to coverage for {an Employee} who applies during the enrollment period and agrees to make required contributions {31} days after enrollment period ends are as follows:

[Included for a policy when plan includes: (a) Guaranteed Issue only, (b) Evidence of Insurability only, or (c) both Guaranteed Issue and Evidence of Insurability]

[Coverage [up to the Guaranteed Issue amount] [, for which {an Employee} is eligible,] will be effective on the effective date of this Policy's anniversary following the enrollment period.]

[Coverage [in excess of the Guaranteed Issue amount] will be effective on the later of:

1. the effective date of this Policy's anniversary following the enrollment period, if {the Employee's} Evidence of Insurability is approved by Us prior to the effective date of this Policy's anniversary;
2. {the date} We approve {the Employee's} completed Evidence of Insurability form;
3. the first of the month following {the date} We approve {the Employee's} Evidence of Insurability form;
4. {the date} the first {payroll deduction} is authorized, following the date We approve {the Employee's} Evidence of Insurability form] [;]
5. {the date} the first {payroll deduction} occurs, following the date We approve {the Employee's} Evidence of Insurability form] [;]
6. {the date} the first premium payment is received, following the date We approve {the Employee's} Evidence of Insurability form] [.]]]

[For all Spouse coverage [up to the Guaranteed Issue amount], Evidence of Insurability is not required.] [For all Spouse coverage [in excess of the [Guaranteed Issue] [and] [Basic Benefit] amount], Evidence of Insurability is required.]

[The Spouse who [is eligible to apply, but was not previously enrolled by {the Employee}, the {Employee} may apply] [or] [is insured {the Employee} may apply for an increase] for coverage. Changes to coverage for the Spouse who {the Employee} applied for and agrees to make required contributions {31} day after the enrollment period, are effective as follows:

Coverage [up to the Guaranteed Issue amount] [, for which the Spouse is eligible,] will be effective on the effective date of this Policy's anniversary following the enrollment period.

Coverage [in excess of the Guaranteed Issue amount] will be effective on the later of:

1. the effective date of this Policy's anniversary following the enrollment period, if the Spouse's Evidence of Insurability is approved by Us prior to the effective date of this Policy's anniversary;
2. {the date} We approve the completed Evidence of Insurability form for Spouse coverage;
3. the first of the month following {the date} We approve the completed Evidence of Insurability form for Spouse coverage;]
4. {the date} the first {payroll deduction} is authorized, following the date We approve the Spouse's Evidence of Insurability form] [;]
5. {the date} the first {payroll deduction} occurs, following the date We approve the Spouse's Evidence of Insurability form] [;]
6. {the date} the first premium payment is received, following the date We approve the Spouse's Evidence of Insurability form] [.]]]

[For all Dependent Child coverage [up to the Guaranteed Issue amount], Evidence of Insurability is not required.] [For all Dependent Child coverage [in excess of the [Guaranteed Issue] [and] [Basic Benefit] amount], Evidence of Insurability is required.]

[The Dependent Child who [is eligible to apply, but was not previously enrolled by {the Employee}, the {Employee} may apply] [or] [is insured {the Employee} may apply for an increase] for coverage. Changes to coverage for the Dependent Child who {the Employee} applied for and agrees to make required contributions {31} day after the enrollment period, are effective as follows:

Coverage [up to the Guaranteed Issue amount] [, for which the Dependent Child is eligible,] will be effective on the effective date of this Policy's anniversary following the enrollment period.

Coverage [in excess of the Guaranteed Issue amount] will be effective on the later of:

1. the effective date of this Policy's anniversary following the enrollment period, if the Dependent Child's Evidence of Insurability is approved by Us prior to the effective date of this Policy's anniversary;
2. {the date} We approve the completed Evidence of Insurability form for Dependent Child coverage;
3. the first of the month following {the date} We approve the completed Evidence of Insurability form for Dependent Child coverage;]
4. {the date} the first {payroll deduction} is authorized, following the date We approve the Evidence of Insurability for Dependent Child coverage] [;]
5. {the date} the first {payroll deduction} occurs, following the date We approve the Dependent Child's Evidence of Insurability form] [;]
6. {the date} the first premium payment is received, following the date We approve the Dependent Child's Evidence of Insurability form] [.]]]

TERMINATION OF INSURANCE

The insurance on {a Covered Person} will end on the earliest date below:

1. the date this Policy or insurance for a Covered Class is terminated;
2. the date the Subscriber's participation under this Policy ends;]
3. the date the {Employee} is no longer in Active Service;]
4. the [next premium due date after the] date {the Employee} is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
5. the last day of the last period for which premium is paid;
6. the [next premium due] date after {the Covered Person} attains the maximum Age for insurance under this Policy, as shown in the *Schedule of Benefits*;]

- [7. the [next premium due] date after the {Member} ceases to be a {Member} in good standing of {the Subscriber};]
- [8. with respect to a Spouse {or Dependent Child}, the date of the death of the covered {Employee} or the date of divorce from the covered {Employee}[, unless the Spouse elects to continue insurance, including insurance on any Dependent Child];]
- [9. the date that the plan of benefits under which {the Covered Person} is covered is terminated.]

Termination will not affect a claim that arises while coverage was in effect.

[Optional: Continuation selections included at the option of the Policyholder]

CONTINUATION OF INSURANCE PROVISIONS

If an {Employee} is no longer in Active Service, He may be eligible to continue insurance. The following provisions explain the continuation options available under this Policy. Please see the *Schedule of Benefits*, to determine the applicability of these benefits on a class level.

Notwithstanding any other provision of this Policy, if an {Employee's} Active Service ends due to termination of employment, or any other termination of the employment relationship, insurance will terminate and Continuation of Insurance under this section will not apply.

[Continuation for {Layoff, Leave of Absence or Family Medical Leave}]

[Optional: Continuation for FMLA with fixed durations included, at the option of the Policyholder]

[If an {Employee's} Active Service ends due to {an Employer}-approved leave pursuant to the Family and Medical Leave Act (FMLA), insurance will continue up to the later of the period of His approved FMLA leave or the leave period required by law in the state in which He is employed. Premiums are required for this insurance.]

[If an {Employee's} Active Service ends due to any other leave of absence approved in writing by the {Employer} prior to the date the {Employee} ceases work, insurance will continue [for up to {12 weeks}]. Premiums are required for this insurance. [An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.]

[Optional: Continuation for FMLA with specified durations included, at the option of the Policyholder]

[If an {Employee's} Active Service ends due to personal or family medical leave approved timely by the {Employer}, insurance will continue [for up to {12 weeks for family medical leave}] [and up to {26 weeks} for military family leave]. Premiums are required for this insurance.]

[Optional: Continuation for Furlough included, at the option of the Policyholder]

[If an {Employee's} Active Service ends due to Furlough, insurance will continue [for up to {30 days}]. Premiums are required for this insurance.]

[Optional: Continuation for Temporary Layoff included, at the option of the Policyholder]

[If an {Employee's} Active Service ends due to Temporary Layoff, insurance will continue [for up to {30 days}]. Premiums are required for this insurance.]

[If an {Employee's} Active Service ends due to any other excused short term absence from work that is reported to the {Employer} timely in accordance with the {Employer's} reporting requirements for such short term absence, insurance will continue until the earlier of:

- [1. the date the {Employee's} employment relationship with the {Employer} terminates;]
- [2. the date premiums are not paid when due;]
- [3. the end of the {30 day} period that begins with the first day of such excused absence;]
- [4. the end of the period for which such short term absence is excused by the {Employer};]
- [5. the date the Policy is terminated by the Insurance Company.]

[Optional: Continuation for Disability included, at the option of the Policyholder]

[Continuation for Disability for {Employees}]

If an {Employee} [is over Age {60} and] becomes Disabled, as defined below, the benefits shown in the *Schedule of Benefits* will be continued, provided premiums are paid, until the earlier of the following dates:

1. The date {the Employee} is no longer Disabled.
2. The date following the Maximum Benefit Period shown in the *Schedule of Benefits*.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated by the Insurance Company.

[If {an Employee} incurs a Covered Loss while Disabled and benefits are continued under this provision, the Insurance Company will pay the benefits shown in the *Schedule of Benefits* equal to the amount in effect on the date {the Employee} became Disabled. [Automatic increases in benefits as outlined in the Policy will end while benefits are continued under this provision.] [However, the benefit will be subject to the provisions of the Policy that reduce the benefit amount because of Age, retirement, payment of any other benefits or a change in class.]

“Disability”/“Disabled” means because of Injury or Sickness {the Employee} is unable to perform the material duties of His Regular Occupation, as defined below, or is receiving disability benefits under the {Employer’s} plan.

“Regular Occupation” means the occupation {the Employee} routinely performs at the time the Disability begins. The Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.]

[Optional: Continuation for Military Service included, at the option of the Policyholder]

[Continuation for Military Service]

If {an Employee’s} Active Service ends due to entry into the armed forces, insurance will continue until the earliest of the following dates, if the required premium is paid:

1. 18 months;
2. the day {the Employee} fails to return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when insurance is continued under this provision:

1. [any change in benefits that occurs during the period of continuation will apply on the effective date of the change;]
2. [any Active Service requirement will be waived;]
3. {The Employee} will be given credit for the time He was covered under this Policy prior to the leave.

If {an Employee} does not continue insurance during such leave and returns to work:

1. {the Employee} and His enrolled Spouse and Dependent Children will be covered on the date {the Employee} returns to work from the leave. {The Employee} must return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994;
2. any portion of an eligibility waiting period that has not been completed will not be credited during {the Employee’s} leave.]

[Optional: Included at the option of the Policyholder]

[PORTABILITY PROVISIONS]

Insurance provided by this Policy is portable, for {an Employee} [for whom all eligibility ends under this Policy] [who would otherwise cease to be a member of one of the Covered Classes] as shown in the *Schedule of Benefits* and satisfies all of the conditions below.

Whose Insurance is Portable

A covered {Employee} who:

- [1. has been covered under this Policy for at least {12 months};]

[2. has not attained the Maximum Age for Portability shown in the *Schedule of Benefits*];
[3.] applies and agrees to pay required premiums,
may remain covered under this Policy [while it remains in force] [for the Portable Period shown in the *Schedule of Benefits*].
[Any Spouse or Dependent Child insurance provided under the covered {Employee's} Certificate is portable when {the Employee} ports His coverage.]

[A covered Spouse who:

[1. has been covered under this Policy for at least {12 months};]
[2. has not attained the Maximum Age for Portability shown in the *Schedule of Benefits*];
[3.] applies and agrees to pay required premiums,
may remain covered under a Certificate issued to Him [while this Policy remains in force] [for the Portable Period shown in the *Schedule of Benefits*].]
[Any Dependent Child insurance provided under the Spouse's Certificate is portable when the Spouse ports His coverage.]]

[A covered Dependent Child who:

[1. has been covered under this Policy for at least {12 months};]
[2. has been covered under {the Employee's}[or Spouse's] Certificate that remains in force;]
[3.] applies and agrees to pay required premiums,
may remain covered under a Certificate issued to Him [while this Policy remains in force] [for the Portable Period shown in the *Schedule of Benefits*].]

Amount of Portable Insurance

[The amount of portable insurance is shown in the *Schedule of Benefits*. [Portable insurance will be reduced by any amount for which {the Covered Person} becomes eligible, [and enrolls] under a group policy providing similar insurance benefits, within {31 days} of the date His insurance under this Policy becomes portable]. [Any additional coverages and benefits for which {the Covered Person} was insured are portable only if shown in the *Schedule of Benefits*.]]

Effective Date of Ported Insurance

Ported insurance will become effective under this section on the date {the Covered Person's} insurance under the Policy would otherwise have terminated, as described above, if {the Covered Person} has applied and agreed to pay required premiums within {31 days} of the date He would otherwise have ceased to be eligible. {The Covered Person} need not show Us that He is insurable.

Termination of Ported Insurance

Insurance will end on the earliest of the following dates:

- [1. the date [the Policy] [or] [the Subscriber's participation under this Policy] or insurance for a Covered Class is terminated;]
2. the day after the end of the last period for which premiums are paid;
- [3. the end of the Portable Period;]
- [4. {three years} after the date [the Policy] or [the Subscriber's participation under this Policy] or insurance for a Covered Class is terminated];
- [5. the date {the Covered Person} becomes eligible for similar insurance under a group policy.]]

EXCLUSIONS [AND LIMITATIONS]

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* section:

[Optional: Each of the following Exclusions will be included or deleted, at the option of the Policyholder/Subscriber, and numbers will be adjusted accordingly]

- [1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane];
- [2. commission or attempt to commit a felony [or an assault]];
- [3. commission of or active participation in a riot, insurrection, rebellion or police action];
- [4. declared or undeclared war or act of war];
- [5. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days];
- [6. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage];
- [7. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. [“Under the influence of alcohol”, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred.]]

[Pre-Existing Condition Limitation

We will not pay benefits for a Covered Loss caused or contributed to by, or resulting from, a Pre-existing Condition. The term “Pre-existing Condition” means any Sickness or Injury for which a {Covered Person} received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines [or for which a reasonable person would have consulted a Physician] within {12} months before the {Covered Person’s} most recent effective date of insurance, and the most recent effective date of any added or increased amount of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Loss for which the Date of Diagnosis occurs after the {Covered Person} is insured under this Policy for at least {12} [continuous] months after the {Covered Person’s} most recent effective date of insurance, and effective date of any added or increased amount of insurance.]

CONVERSION PRIVILEGE

Whose Insurance May Be Converted

Each {Covered Person's} insurance [or any portion of it] may be converted if it ends for any of the following reasons:

1. employment or membership ends;
2. all eligibility ends [(except for Age for the {Employee} or {Covered Spouse})] under the Policy;
3. termination of the Policy;
4. termination of membership in an eligible class under the Policy.

[The {Covered Person} must be under Age {70} to be eligible for a converted policy.]

If {the Covered Person's} insurance or any portion of it ends for non-payment of premium, He may not convert. [If {the Covered Person's} insurance ends for a reason described in the Amount of Conversion Insurance provision below, conversion is subject to that section.]

{The Covered Person} need not show Us that He is insurable. The converted insurance will be an individual policy or certificate under another group policy, designated by Us at the time of the conversion.

[If {the Covered Person} has converted His group insurance and later becomes insured under the same group plan as before, He may not convert a second time unless He provides, at His own expense, proof of insurability or proof the prior converted policy is no longer in force.]

Amount of Conversion Insurance

{The Covered Person} may apply for an amount of insurance that is:

- [1. {in \$1,000 increments};]
- [2. not less than {\$5,000}, regardless of the amount of insurance under the Policy; and]
- [3. not more than the amount of insurance He had under the Policy, except as provided above, up to a maximum amount of {\$100,000}.]

[If {the Covered Person's} insurance ends because this Policy is terminated or is amended to terminate insurance for {the Covered Person's} class, and He has been covered under this Policy [or, any group insurance with similar benefits issued to the {Employer} which this Policy replaced,] for at least {one year}, {the Covered Person} may have Us issue an individual policy or certificate of insurance subject to the same terms, conditions and limitations listed above. However, the amount of insurance He may apply for will be limited to the lesser of the following:

1. insurance under this Policy less any amount of similar group insurance for which He is eligible on the date this Policy is terminated or for which He became eligible within {31 days} of such termination; or
2. {\$10,000}.]

[The conversion insurance may contain different benefits, limitations and exclusions.]

Effective Date of Conversion Insurance

The conversion insurance will take effect on the later of the following dates:

1. the date insurance under this Policy ended; or
2. [the {31st} day after the date insurance under this Policy ends] [the date application and required premium is [received by][submitted to] the Insurance Company, if [received][submitted] within the period required under this Policy].

{The Covered Person} must apply for the conversion insurance within {31 days} [after His insurance under this Policy ends] and pay the required premium, based on Our table of rates for such policies, His Age and class of risk. [If {the Covered Person} has assigned ownership of His group insurance, the owner/assignee must apply for the conversion insurance.]

[If {the Covered Person} [suffers a Covered Loss or] dies during this {31-day} period, We will pay a claim under this Policy for the amount of insurance that {the Covered Person} was entitled to convert, regardless of whether {the Covered Person} applied for the conversion insurance. If such conversion insurance is issued, it will be in exchange for any other benefits under this Policy.

If {the Covered Person} dies during the conversion period, benefits:

1. will not be paid under this Policy; and
2. will be payable under the conversion insurance, provided the {Covered Person's} application for conversion insurance and the required premium has been received by the Insurance Company.]

[Extension of Conversion Period

If {the Covered Person} is eligible to convert and is not notified of this right at least {15 days} prior to the end of the {31 day} conversion period, the conversion period will be extended. {The Covered Person} will have {15 days} from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond [60][90] days. "Notice", for the purpose of this section, means written notice presented to {the Covered Person} by {the Employer} or mailed to {the Covered Person's} last known address as reported by {the Employer}.

[If {the Covered Person} sustains a Covered Loss or dies during the extended conversion period, but more than {31 days} after His insurance under this Policy terminates, benefits will not be paid under this Policy. If {the Covered Person's} application for conversion insurance is received by Us and the required premium is paid, benefits may be payable under the converted insurance.]]

CLAIM PROVISIONS

Notice of Claim

Written [or authorized [electronic] [telephonic]] notice of claim must be given to Us within {31 days} after a Covered Loss occurs or begins or as soon as is reasonably possible. If written [or authorized [electronic] [telephonic]] notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written [or authorized [electronic] [telephonic]] notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include {the Policyholder's} name and Policy number and {the Covered Person's} name, address, Policy and Certificate number.

Claim Forms

We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written [or authorized electronic] proof of the nature and extent of the loss for which the claim is made.

[Claimant Cooperation Provision

Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.]

Proof of Loss

Written [or authorized electronic] proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within {90 days} after the termination of each period for which We are liable. If written [or authorized electronic] notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written [or authorized electronic] proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than {60} days after receipt of due written [or authorized electronic] proof of such loss. Subject to due written [or authorized electronic] proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the {Covered Person}, if living. If the {Covered Person} dies while any of these benefits remain unpaid, We may choose to make direct payment to any of the {Covered Person's} following living relatives: Spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of the {Covered Person's} estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay {\$1,000} to a relative by blood or marriage whom We believe is equitably entitled.

Any payment made by Us in good faith pursuant to this provision will fully discharge Us, and release Us from all liability, to the extent of such payment.

[Payment of Claims to Foreign Employees

{The Policyholder} may, in a fiduciary capacity, receive and hold any benefits payable to covered {Employees} whose place of employment is other than:

- {1. the United States of America;}
- {2. Puerto Rico; or}
- {3. the Dominion of Canada}.

We will not be responsible for the application or disposition by {the Policyholder} of any such benefits paid. Our payments to {the Policyholder} will constitute a full discharge of Our liability for those payments under this Policy.]

Physical Examination [and Autopsy]

We, at Our own expense, have the right and opportunity to examine {the Covered Person} when and as often as We may reasonably require while a claim is pending [and to make an autopsy in case of death where it is not forbidden by law].

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written [or authorized electronic] proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when {the Covered Person} dies, We may recover the overpayment from {the Covered Person's} estate.

ADMINISTRATIVE PROVISIONS

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates [set forth in the *Schedule of Benefits*] [determined by written agreement between the Policyholder and Us], the plan and amounts of insurance in effect. [If {a Covered Person's} insurance amounts are reduced due to Age, premium will be based on the amounts of insurance in force on the day [after] [before] the reduction took place.]

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least {31} days advance written notice. No change in rates will be made until {12} months after the Effective Date. An increase in rates will not be made more often than once in a {12} month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed, if any of the following events take place:

1. The Policy terms change.
- [2. The terms of the Subscriber's participation change.]
3. A division, subsidiary, eligible company, or class is added or deleted.
4. There is a change of more than {10%} in the number of [eligible] [insured] {Employees}.
5. Federal or state laws or regulations affecting benefit obligations change.
6. Other changes occur in the nature of the risk that would affect the Insurance Company's original risk assessment.
- [7. The Insurance Company determines the {Employer} fails to furnish necessary information.]

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

[The {Employer} must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.]

Payment of Premium

[Policyholder

The first premium is due on the Policy Effective Date. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Policyholder. If any premium is not paid on the Premium Due Date when due, this Policy will be cancelled as of such Premium Due Date, except as provided in the Policy Grace Period provision below.]

[Optional: Include when policy is not issued directly to an eligible employer-employee group]

[Subscriber

The first premium is due on the Subscriber's effective date of participation under this Policy. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Subscriber. If any premium is not paid when due, the Subscriber's participation under this Policy will be terminated as of the Premium Due Date on which premium was not paid, except as provided in the Subscriber Grace Period provision below.]

[Include when premiums payable directly to Insurance Company by the Employee]

[{Covered Person}

The {Covered Person} [shall] [may] be responsible for the payment of premium directly to Us, as determined by the {Employer} from the Policy Effective Date, or following the expiration of {60} days from the date insurance is continued for a {Covered Person} under the *Continuation of Insurance Provisions* section of the Policy. Premium shall be due [monthly] [quarterly] [semi-annually][annually], unless the {Covered Person} and the Insurance Company agree on some other period for premium payment. If premium is not paid when due, insurance will end as of the premium due date, except as provided in the {Covered Person} Grace Period provision below. [In addition to premium, We may assess a Monthly Administrative Charge, as appropriate to the Covered Class. In no event will the Monthly Administrative Charge exceed an amount equal to the sum of {\$10.00} and {2.5%} of the monthly premium due.]

Grace Period

[Policy

A Policy Grace Period of {31 days} will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time this Policy was in force.]

[Optional: Include when policy is not issued directly to an eligible employer-employee group]

[Subscriber

A Grace Period of {31 days} will be granted to each Subscriber for payment of its required premiums under this Policy. A Subscriber's participation under this Policy will remain in effect during the Grace Period. The Subscriber is liable to Us for any unpaid premium for the time its participation under this Policy was in force.]

[Include when premiums payable directly to the Insurance Company by Employee]

[[Covered Person]

A Grace Period of {31 days} will be granted for payment of required premiums under this Policy. {A Covered Person's} insurance under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.]

[Reinstatement of Insurance

[Optional: Include when neither the Family and Medical Leave provision, nor the Temporary Layoff provision, is included under the Continuation of Insurance Provisions section]

[[Insurance may be reinstated [without satisfying the Insurability Requirement,] if {an Employee's} insurance ends because He is on an approved unpaid leave of absence and He applies for reinstatement within 31 days of His return to Active Service.]

[After {an Employee's} insurance has ceased, it may be reinstated [without satisfying the Insurability Requirement,] at any date prior to {one year} after the date of termination.]

For reinstatement, the following conditions must be met:

1. The Policy is still in force.
2. The {Employee} is eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.]

[Optional: Include when Family Medical Leave provision is included under Continuation of Insurance Provisions]

[If {an Employee's} Active Service ended due to {an Employer}-approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, {an Employee's} insurance may be reinstated at the conclusion of the FMLA leave.

If {an Employee's} Active Service ends due to {the Employer}-approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only:

1. if the reinstatement occurs within {12 weeks} from the date insurance ends; or
2. when returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).]]

[Optional: Include when Temporary Layoff provision is included under Continuation of Insurance Provisions]

[[If {an Employee's} Active Service ends due to Temporary Layoff, insurance may be reinstated only if the reinstatement occurs within {31 days} from the date insurance ends.]

For insurance to be reinstated the following conditions must be met:

1. {An Employee} must be in a Class of Eligible Employees.
2. The required premium must be paid.
- [3. The Insurance Company must receive a written request for reinstatement within {31 days} from the date {an Employee} returns to Active Service.]

Reinstated insurance will be effective on the date {the Employee} returns to Active Service [if satisfaction of the Insurability Requirement is not required]. [If the Insurability Requirement must be satisfied, the reinstated insurance will be effective as provided in the *Effective Date Provisions* section.] If {the Employee} did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to [an approved unpaid leave of absence][, Temporary Layoff], credit will be given for any time that was satisfied.]

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

[Optional: Include when policy is not issued directly to an eligible employer-employee group]

[Subscriber Participation Under This Policy

An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by Us.]

Misstatement of Age [and Tobacco]

If {the Covered Person} has misstated His Age [or tobacco status], all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Certificates

Where required by law, We will provide a Certificate for delivery to {the Covered Person}. Each Certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

[[30 Day] Right To Examine Certificate

If {a Covered Person} does not like the Certificate for any reason, it may be returned to Us within {30 days} after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.]

[Multiple Certificates

[{The Covered Person} may have in force only one Certificate at a time under this Policy. If at any time {the Covered Person} has been issued more than one Certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one Certificate was issued.]

[{A Covered Person} is not eligible for insurance under more than one Certificate providing similar benefits for insurance under group policies issued by Us. If premium is being paid for more than one such Certificate, insurance will be in effect under the Certificate with the earliest effective date and premiums paid for Certificates which are not in effect will be refunded.]]

Assignment

[Option 1: Include if no rights and benefits are assignable]

[The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.]

[Option 2: Include when no assignment other than benefits that have become payable is permitted]

[The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Loss. Any other attempt to assign will be void.]

[Option 3: Include if assignment is permissible]

[We will be bound by an assignment of {a Covered Person's} insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by {the Covered Person} and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy and {the Covered Person's} Certificate remains in force.]

Incontestability**This Policy or Participation Under This Policy**

All statements made by {the Policyholder} to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to {the Policyholder}.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination

[We may terminate insurance on or after the first anniversary of the Policy Effective Date.] The {Policyholder} [or We] may terminate insurance on any Premium Due Date. Written notice by certified mail [or authorized electronic notice] must be given at least {31 days} prior to such Premium Due Date. [Failure by {the Policyholder} to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.]

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while insurance was in effect.

Agency

The {Employer} is acting as an agent of the {Employee} for transactions relating to insurance under the Policy. The actions of the {Employer} shall not be considered the actions of the Insurance Company, and the Insurance Company is not liable for any of their acts or omissions.

Clerical Error

{A Covered Person's} insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes

We may agree with {the Policyholder} to modify a plan of insurance without {the Covered Person's} consent.

Workers' Compensation Insurance

This Policy is not in place of and does not affect any requirements for insurance under any Workers' Compensation law.

Examination of the Policy

This Policy will be available for inspection at {the Policyholder's}[or Our] office during regular business hours.

Examination of Records

We will be permitted to examine all of {the Policyholder's} records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force. Examination may also occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all claims under this Policy.

[Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.]

New Entrants

To the group originally insured may be added from time to time eligible new {Employees} [or dependents, as the case may be,] in accordance with the terms of the Policy.

Life Insurance Company of North America
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235
A Stock Insurance Company

GROUP CRITICAL ILLNESS CERTIFICATE

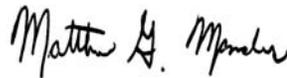
**THIS CERTIFICATE PROVIDES LIMITED COVERAGE.
PLEASE READ YOUR CERTIFICATE CAREFULLY.**

[We, the Life Insurance Company of North America, have issued a Group Policy, {001234} to {ABC Corporation}.]

[We certify that We insure all eligible persons [who are enrolled] according to the terms of the Group Policy. Your coverage will begin according to the terms set forth in the *Effective Date Provisions* section.]

This Certificate describes the benefits and basic provisions of Your coverage. It is not the insurance contract and does not waive or alter any terms of the Policy. If questions arise, the Policy language will govern. You may examine the Policy at the office of the Policyholder [or the Administrator].

This Certificate replaces all prior Certificates issued to You under the Group Policy.



Matthew G. Manders, President

[{30 DAY} RIGHT TO EXAMINE CERTIFICATE

Within {30 days} of receipt of this Certificate, You can return it to Us for any reason if not satisfied with the insurance provided under this Certificate. We will return any premium that has been paid and this Certificate will be void as if it had never been issued.]

**THIS IS A CRITICAL ILLNESS ONLY POLICY.
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

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CLAIM PROVISIONS

Notice of Claim

Written [or authorized [electronic] [telephonic]] notice of claim must be given to Us within {31 days} after a Covered Loss occurs or begins or as soon as is reasonably possible. If written [or authorized [electronic] [telephonic]] notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written [or authorized [electronic] [telephonic]] notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include {the Policyholder's} name and Policy number and Your name, address, Policy and Certificate number.

Claim Forms

We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written [or authorized electronic] proof of the nature and extent of the loss for which the claim is made.

[Claimant Cooperation Provision

Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.]

Proof of Loss

Written [or authorized electronic] proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within {90 days} after the termination of each period for which We are liable. If written [or authorized electronic] notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written [or authorized electronic] proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than {60} days after receipt of due written [or authorized electronic] proof of such loss. Subject to due written [or authorized electronic] proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the {Covered Person}, if living. If the {Covered Person} dies while any of these benefits remain unpaid, We may choose to make direct payment to any of the {Covered Person's} following living relatives: Spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of the {Covered Person's} estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay {\$1,000} to a relative by blood or marriage whom We believe is equitably entitled.

Any payment made by Us in good faith pursuant to this provision will fully discharge Us, and release Us from all liability, to the extent of such payment.

Physical Examination [and Autopsy]

We, at Our own expense, have the right and opportunity to examine { You, Your Spouse and/or Dependent Child } when and as often as We may reasonably require while a claim is pending [and to make an autopsy in case of death where it is not forbidden by law].

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written [or authorized electronic] proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when You {, Your Spouse, or Dependent Child} die, We may recover the overpayment from Your {, Your Spouse's, or Dependent Child's} estate.

ADMINISTRATIVE PROVISIONS

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. [If Your {, Your Spouse's and/or Dependent Child's} insurance amounts are reduced due to Age, premium will be based on the amounts of insurance in force on the day [after] [before] the reduction took place.]

[Include when premiums payable directly to Insurance Company by a Covered Person]

[Payment of Premium]

[Covered Person

You, {Your Spouse and/or Dependent Child} [shall] [may] be responsible for the payment of premium directly to Us, as determined by the {Employer} from the Policy Effective Date, or following the expiration of {60} days from the date insurance is continued for You, {Your Spouse and/or Dependent Child} under the *Continuation of Insurance Provisions* section of the Policy. Premium shall be due [monthly] [quarterly] [semi-annually][annually], unless You, {Your Spouse and/or Dependent Child} and the Insurance Company agree on some other period for premium payment. If premium is not paid when due, insurance will end as of the premium due date, except as provided in the Grace Period provision below. [In addition to premium, We may assess a Monthly Administrative Charge, as appropriate to the Covered Class. In no event will the Monthly Administrative Charge exceed an amount equal to the sum of {\$10.00} and {2.5%} of the monthly premium due.]]

[Include when premiums payable directly to the Insurance Company by a Covered Person]

[Grace Period]

[Covered Person

A Grace Period of {31 days} will be granted for payment of required premiums under this Policy. Your {, Your Spouse's, and/or Your Dependent Child's} insurance under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, insurance will end on the last day of the period for which premiums were paid.]

[Reinstatement of Insurance]

[Optional: Include when neither the Family and Medical Leave provision, nor the Temporary Layoff provision, is included under the Continuation of Insurance Provisions section]

[[Insurance may be reinstated [without satisfying the Insurability Requirement,] if Your insurance ends because You are on an approved unpaid leave of absence and You apply for reinstatement within 31 days of Your return to Active Service.]

[After Your insurance has ceased, it may be reinstated [without satisfying the Insurability Requirement,] at any date prior to {one year} after the date of termination.]

For reinstatement, the following conditions must be met:

1. The Policy is still in force.
2. You are eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.]

[Optional: Include when Family Medical Leave provision is included under Continuation of Insurance Provisions]

[If Your Active Service ended due to {an Employer}-approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, Your insurance may be reinstated at the conclusion of the FMLA leave.

If Your Active Service ends due to {the Employer}-approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only:

1. if the reinstatement occurs within { 12 weeks } from the date insurance ends; or
- [2. when returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).]

[Optional: Include when Temporary Layoff provision is included under Continuation of Insurance Provisions]

[[If Your Active Service ends due to Temporary Layoff, insurance may be reinstated only if the reinstatement occurs within {31 days} from the date insurance ends.]

For insurance to be reinstated the following conditions must be met:

1. You must be in a Class of Eligible Employees.
2. The required premium must be paid.
- [3. The Insurance Company must receive a written request for reinstatement within {31 days} from the date You return to Active Service.]

Reinstated insurance will be effective on the date You return to Active Service [if satisfaction of the Insurability Requirement is not required]. [If the Insurability Requirement must be satisfied, the reinstated insurance will be effective as provided in the *Effective Date Provisions* section.] If You did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to [an approved unpaid leave of absence][, Temporary Layoff], credit will be given for any time that was satisfied.]

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

[Optional: Include when policy is not issued directly to an eligible employer-employee group]

[Subscriber Participation Under This Policy

An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by Us.]

Misstatement of Age [and Tobacco]

If {the Covered Person} has misstated His Age [or tobacco status], all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Certificates

Where required by law, We will provide a Certificate for delivery to {the Covered Person}. Each Certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

[{30 Day} Right To Examine Certificate

If {a Covered Person} does not like the Certificate for any reason, it may be returned to Us within {30 days} after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.]

[Multiple Certificates

[{The Covered Person} may have in force only one Certificate at a time under this Policy. If at any time {the Covered Person} has been issued more than one Certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one Certificate was issued.]

[{A Covered Person} is not eligible for insurance under more than one Certificate providing similar benefits for insurance under group policies issued by Us. If premium is being paid for more than one such Certificate, insurance will be in effect under the Certificate with the earliest effective date and premiums paid for Certificates which are not in effect will be refunded.]]

Assignment

[Option 1: Include if no rights and benefits are assignable]

[The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.]

[Option 2: Include when no assignment other than benefits that have become payable is permitted]

[The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Loss. Any other attempt to assign will be void.]

[Option 3: Include if assignment is permissible]

[We will be bound by an assignment of {a Covered Person's} insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by {the Covered Person} and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy and {the Covered Person's} Certificate remains in force.]

IncontestabilityThis Policy or Participation Under This Policy

All statements made by {the Policyholder} to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to {the Policyholder}.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination

[We may terminate insurance on or after the first anniversary of the Policy Effective Date.] The {Policyholder} [or We] may terminate insurance on any Premium Due Date. Written notice by certified mail [or authorized electronic notice] must be given at least {31 days} prior to such Premium Due Date. [Failure by {the Policyholder} to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.]

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while insurance was in effect.

Agency

The {Employer} is acting as Your agent for transactions relating to insurance under the Policy. The actions of the {Employer} shall not be considered the actions of the Insurance Company, and the Insurance Company is not liable for any of their acts or omissions.

Clerical Error

{A Covered Person's} insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes

We may agree with {the Policyholder} to modify a plan of insurance without {the Covered Person's} consent.

Workers' Compensation Insurance

This Policy is not in place of and does not affect any requirements for insurance under any Workers' Compensation law.

Examination of the Policy

This Policy will be available for inspection at {the Policyholder's}[or Our] office during regular business hours.

Examination of Records

We will be permitted to examine all of {the Policyholder's} records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force. Examination may also occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all claims under this Policy.

[Ownership of Records

All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.]

New Entrants

To the group originally insured may be added from time to time eligible new {Employees} [or dependents, as the case may be,] in accordance with the terms of the Policy.

Comment [RC1]: Per Ark. Code Ann. 23-86-108(3). Language Added. Form number changed

**Life Insurance Company of North America
1601 Chestnut Street**

Philadelphia, Pennsylvania 19192-2235

HEALTH SCREENING BENEFIT RIDER

This Rider is attached to and made a part of your group insurance {policy}. It is subject to the terms, conditions, limitations and exclusions contained in the policy as well as those set forth in this Rider. These benefits are not subject to a Pre-Existing Condition Limitation.

Rider Effective Date: {January 1, 2012}

Health Screening Tests

The procedures that are eligible for benefits under this Rider are:

- Mammography
- Pap Smear for women over Age 18
- Flexible Sigmoidoscopy
- Hemocult Stool Specimen
- Colonoscopy
- Prostate Specific Antigen (for prostate cancer)
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine levels of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography

Waiting Period

The Waiting Period is the period of time following the Rider Effective Date, during which no benefits are available. The Waiting Period for this Rider is {30} days.

Benefit

We will pay the Health Screening Benefit Amount shown in the *Schedule of Benefits*, for a Health Screening Test taken by a {Covered Person}. The benefit is limited to payment of one Health Screening Test per calendar year for each {Covered Person}.

In order for this benefit to be payable, the Health Screening Test must occur after each of the following:

1. the Rider Effective Date;
2. the {Employee's} Certificate effective date; and
3. the expiration of the Waiting Period for this Rider.

Exclusion

This Rider provides benefits for only those tests named in the Health Screening Tests list.

[Renewability/Termination of Coverage

This Rider is renewable [at the {Employee's} option]. However, this Rider shall automatically terminate on the earliest of the following dates:

1. the date the {Covered Person's} coverage ends for any reason under the {policy} to which this Rider is attached;
2. the end of the period for which premium is paid for this Rider, subject to the {policy's} Grace Period provision;
3. the end of the period for which premium is paid for coverage under the {policy}, to which this Rider is attached, subject to the {policy's} Grace Period provision[; or
4. the premium due date on or following the date We receive the {Employee's, Covered Person's} written request to terminate coverage under this Rider].]

Reinstatement

If the {Employee} applies for reinstatement of insurance under the {Employee's} Certificate, the {Employee} may apply to reinstate this Rider at that time.

This Rider terminates at the same time as the {policy} to which it is attached unless terminated at an earlier date. Except for the above, this Rider does not change the {policy} in any way.

LIFE INSURANCE COMPANY OF NORTH AMERICA



Matthew G. Manders, President

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

MODIFYING PROVISIONS AMENDMENT

Policyholder:

Policy No.

[Subscriber:]

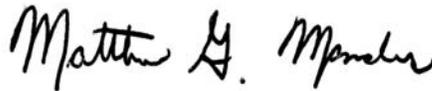
Amendment Effective Date:

This Amendment is attached to and made part of this Policy. Its provisions are intended to conform this Policy to the laws of the {state of Florida} and apply only to {Covered Persons} under this Policy who reside in {Florida}.

Policyholder and We hereby agree that the Policy [and any Certificates delivered under the Policy] [is] [are] amended as follows:

[This amendment form will be used to bring the policy into compliance with state laws that are applicable to residents of that state when the policy is issued in another state.]

Signed for the
Life Insurance Company of North America



Matthew G. Manders, President

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

AMENDMENT

Policyholder:

Policy No.

Amendment Effective Date:

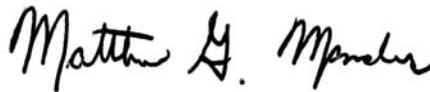
This Amendment is attached to and made part of this Policy. It is subject to all of the Policy provisions that do not conflict with its provisions. [Its provisions are intended to conform this Policy to the laws of the {state of } and apply only to Covered Persons under this Policy who reside in { }.]

[*Optional:* This Amendment will be in effect only for {Covered Employees/Members} in Active Service on {the Effective Date}. If {an Employee/Member} is not in Active Service on the date He would otherwise become eligible, He will become eligible on the date He returns to Active Service.]

Policyholder and We hereby agree that the Policy [and any Certificates delivered under the Policy] [is] [are] amended as follows:

[This form will be used to amend the terms of an in-force policy after its Effective Date. Changes included in any amendment will not be outside the scope of variability. This form may also be used to bring the policy into compliance with state laws that are applicable to residents of the {state of } when the policy is issued in that state.]

Signed for the
Life Insurance Company of North America



Matthew G. Manders, President

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

ADDITIONAL BENEFIT RIDER

[Policyholder] [or] [Subscriber]:

Policy No.

Rider Effective Date:

This Rider is attached to and made part of this Policy. The Benefits described below are added on the Rider Effective Date shown above and apply to all {Covered Persons} who are {*Optional: insured, in Active Service*} on that date. The provisions of this Rider apply to {Covered Persons} who become insured under this Policy after the Rider Effective Date, as of their Effective Dates of insurance.

The following section is added to the *Schedule of Benefits*.

[Here will be inserted the section in the Schedule of Benefits applicable to the benefit or coverage being added.]

The following Benefit Description is added to the *Description of Benefits* section.

[Here will be added the descriptive text, as filed and approved, applicable to the specific benefit or coverage being added.]

Signed for the
Life Insurance Company of North America



Matthew G. Manders, President

CRITICAL ILLNESS INSURANCE [APPLICATION] [EVIDENCE OF INSURABILITY] [ENROLLMENT] [CHANGE] FORM

Life Insurance Company of North America (LINA) a Cigna Company (herein called the Insurance Company)

[For info and customer service for Critical Illness Insurance, call {1-000-000-0000}.]

[• All info must be completed by the applicant.]

• The applicant, and spouse [/Domestic Partner] if coverage is requested, must sign and date this form.

• This form cannot be considered unless received within {30} days of the date it is dated.

[• The Insurance Company must approve your request for insurance before it becomes effective.]

Important: Please enter all dates in mm/dd/yyyy format.]

REASON FOR REQUEST

NEW HIRE INITIAL ENROLLMENT EVENT LATE ENTRANT
 LIFE STATUS CHANGE ONGOING ENROLLMENT EVENT REINSTATEMENT

[Please print (preferably in black ink)]

{EMPLOYEE} INFORMATION

Mr. Mrs. Ms. (Check one) Name: (First) _____ (Last) _____ (MI) _____
 Address _____ Apt. # _____ City _____ State _____ Zip _____
 Day Phone _____ Evening Phone _____ Social Security # _____ Date of Birth _____
 [Employer _____] [Policy # _____] [ID # _____] [Class _____]
 [Occupation _____] [Location _____] [Date of Hire _____] [Annual Salary _____]

[COMPLETE IF ELECTING SPOUSE [/DOMESTIC PARTNER] COVERAGE

I am currently married and my date of marriage is _____] I am currently eligible under the insurance as a Domestic Partner*]

Name: (First) _____ (Last) _____ (MI) _____ Social Security # _____ Date of Birth _____

[* In order to be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or any required Domestic Partner Affidavit on file with your employer, and accepted by the Insurance Company. If you do not currently have a state-registered Domestic Partnership, or an Domestic Partner Affidavit on file with your employer, an Affidavit should be requested from and will be made available to you through your employer.]]

CRITICAL ILLNESS INSURANCE [Policy Number _____]

[Have you smoked or used any form of tobacco in the last {12} months?

{Employee} Y N Spouse [/Domestic Partner] Y N]

[Employer-Paid
Basic Coverage

<u>Applicant</u> {Employee}	<u>[Amount]</u> [_____ times salary, to a maximum of \$_____]	<u>Guaranteed Issue Amount*</u> _____]
--------------------------------	--	--

Voluntary
{Employee}-Paid
Coverage

<u>Applicant</u>	<u>Decline</u>	<u>Amount Requested</u> [(check only one amount)] [(amount must be \${1,000} increments)]	<u>[Guaranteed Issue Amount*]</u>
{Employee}	<input type="checkbox"/>	<input type="checkbox"/> _____] <input type="checkbox"/> _____] <input type="checkbox"/> _____]	_____]
Spouse [/Domestic Partner]	<input type="checkbox"/>	<input type="checkbox"/> _____] <input type="checkbox"/> _____] <input type="checkbox"/> _____]	_____]
Child(ren)	<input type="checkbox"/>	<input type="checkbox"/> _____] <input type="checkbox"/> _____] <input type="checkbox"/> _____]	_____]

[* Guaranteed Issue Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.]

Health Screening Benefit]

_____]

[Premium Amount \$ _____]

[Applicant's Name **John Doe**] [[Social Security # **111-11-1111**] [ID# **3423**]]

I WISH TO MAKE THE FOLLOWING CHANGES TO MY CRITICAL ILLNESS COVERAGE

Consult with your employer for the coverage election options currently available. When selecting new coverage amounts, please ensure that your election(s) match the amounts[, salary multiples] or unit increments as currently available under your plan.

CHECK THE APPROPRIATE BOXES:

Increase, Decrease or Begin Coverage on the Following Individuals as Indicated Below

[(Complete the medical questions below if you are electing, or increasing, coverage for yourself or your spouse [/Domestic Partner])]

Applicant	Current Voluntary Coverage	New Voluntary Coverage	Total Voluntary Coverage
<input type="checkbox"/> {Employee}			
<input type="checkbox"/> Spouse [/Domestic Partner]			
<input type="checkbox"/> Child(ren)			

Life Status Change (check only one of the following boxes, and provide date of change)

Marriage] Divorce] Annulment] Legal Separation] Birth or Adoption of a Child] Death of Spouse [/Domestic Partner] or Child] Leave of Absence] Change in Spouse's [/Domestic Partner's] Employment] Return to or from Military Duty] Change from Full-time to Part-time (or vice-versa)]

Date of Life Status Change _____

Cancel Coverage on the Following Individuals (check all that apply)

{Employee} Spouse [/Domestic Partner] Dependent Child(ren)

Effective Date of Cancellation _____

Name Change (Current name / New Name)

{Employee} _____ / _____

Spouse [/Domestic Partner] _____ / _____]

ACCEPTANCE / DECLINATION

[I accept the insurance coverage(s) chosen above. I authorize my employer to {deduct the needed amounts from my earnings}. If I have not chosen coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability/good health at my own expense and that coverage is subject to the Insurance Company's approval.]

[I authorize the above changes to my {employee} paid coverage. I understand that certain changes may require medical information which will be requested by the Insurance Company if necessary. I authorize my employer to {make the appropriate payroll deductions} for changes noted above.]

Signature _____ Date _____

****You should read and sign the Agreements section that follows in this form****

[IMPORTANT]
Please complete the following section if needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Instructions for Evidence of Insurability Section

[Complete the employee info in this section if you (i.e., the {Employee}) are:

- applying for Insurance for yourself that is greater than the guaranteed coverage amount, or
- applying for Insurance for yourself [more than {31} days] after you were eligible for the insurance.]

[Complete the spouse [/Domestic Partner] info in this section if:

- applying for Insurance for your spouse [/Domestic Partner] that is greater than the guaranteed coverage amount, or
- applying for Insurance for your spouse [/Domestic Partner] [more than {31} days] after the spouse [/Domestic Partner] is eligible for the Insurance.]

Please indicate your answers for each question by checking the Yes or No box for the question.

	{Employee}	[Spouse [/Domestic Partner]
1. In the past 5 years has any proposed insured received medical advice or treatment for or had:		
• Cancer, carcinoma in situ, blood disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
• Stroke, transient ischemic attack, chronic obstructive lung or pulmonary disease, any disease or disorder of the heart, polycystic kidney disease, chronic renal failure, any liver disorder, diabetes, macular degeneration, retinitis pigmentosa, acquired immunodeficiency syndrome, HIV or organ transplant?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. In the past 6 months has any proposed insured:		
• Been recommended to have a diagnostic test related to cancer that has not been taken or for which results have not been received, or had a diagnostic or screening test related to cancer for which follow-up was recommended other than future routine screening?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
• Been treated with three or more medications for high blood pressure?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Indicate Height and Weight	Ht: ____ft. ____in. Wt: _____lbs	Ht: ____ft. ____in. Wt: _____lbs]]

[Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

SERFF Tracking Number: CCGN-127839877 State: Arkansas
 Filing Company: Life Insurance Company of North America State Tracking Number: 50347
 Company Tracking Number: 11-8001
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.001 Critical Illness
 Product Name: Group Critical Illness Benefits
 Project Name/Number: GCI/11-8001

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

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

SERFF Tracking Number: CCGN-127839877 State: Arkansas
 Filing Company: Life Insurance Company of North America State Tracking Number: 50347
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 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness Benefits
 Project Name/Number: GCI/11-8001

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 12/02/2011	Rate Manual	GCI-00-1000.00 et al	New		Rate Manual for GCI, final.pdf

LIFE INSURANCE COMPANY OF NORTH AMERICA
GROUP CRITICAL ILLNESS POLICY
Nationwide Rate Manual
Policy Form GCI-00-1000.00 et al

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Additional Benefit	
Recurrence Benefit	
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Rate Guarantee	
Waiting Period	
Pre-Existing Exclusion	
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Case Size	
Commission Level	

LIFE INSURANCE COMPANY OF NORTH AMERICA
GROUP CRITICAL ILLNESS POLICY
Nationwide Rate Manual
Policy Form GCI-00-1000.00 et al

ANNUAL BASE PREMIUM RATES PER \$1000 BENEFIT: Uni-Smoker

MALE with Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 1.91	\$ 2.83	\$ 2.27	\$ 3.19
25-29	\$ 2.26	\$ 3.58	\$ 2.62	\$ 3.94
30-34	\$ 3.36	\$ 5.48	\$ 3.71	\$ 5.84
35-39	\$ 5.16	\$ 8.43	\$ 5.52	\$ 8.79
40-44	\$ 8.75	\$ 14.09	\$ 9.11	\$ 14.45
45-49	\$ 16.52	\$ 24.53	\$ 16.88	\$ 24.88
50-54	\$ 27.03	\$ 37.88	\$ 27.39	\$ 38.23
55-59	\$ 42.11	\$ 57.28	\$ 42.47	\$ 57.64
60-64	\$ 63.07	\$ 83.35	\$ 63.42	\$ 83.70
65-69	\$ 87.86	\$ 116.19	\$ 88.22	\$ 116.55
70-74	\$ 114.98	\$ 152.93	\$ 115.34	\$ 153.29
75-79	\$ 159.30	\$ 204.35	\$ 159.66	\$ 204.71

FEMALE with Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 1.84	\$ 2.79	\$ 2.19	\$ 3.15
25-29	\$ 2.64	\$ 3.77	\$ 2.99	\$ 4.13
30-34	\$ 4.25	\$ 5.93	\$ 4.61	\$ 6.29
35-39	\$ 6.54	\$ 9.12	\$ 6.89	\$ 9.47
40-44	\$ 10.68	\$ 15.06	\$ 11.04	\$ 15.42
45-49	\$ 16.01	\$ 24.27	\$ 16.37	\$ 24.63
50-54	\$ 21.70	\$ 35.21	\$ 22.05	\$ 35.57
55-59	\$ 30.34	\$ 51.40	\$ 30.70	\$ 51.75
60-64	\$ 40.56	\$ 72.09	\$ 40.92	\$ 72.45
65-69	\$ 56.66	\$ 100.59	\$ 57.02	\$ 100.95
70-74	\$ 75.90	\$ 133.39	\$ 76.25	\$ 133.75
75-79	\$ 90.10	\$ 169.75	\$ 90.45	\$ 170.10

MALE without Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 1.14	\$ 1.59	\$ 1.50	\$ 1.94
25-29	\$ 1.20	\$ 1.78	\$ 1.56	\$ 2.14
30-34	\$ 1.93	\$ 2.77	\$ 2.29	\$ 3.13
35-39	\$ 3.13	\$ 4.26	\$ 3.48	\$ 4.61
40-44	\$ 5.35	\$ 7.07	\$ 5.70	\$ 7.43
45-49	\$ 10.26	\$ 12.83	\$ 10.61	\$ 13.19
50-54	\$ 14.90	\$ 18.46	\$ 15.26	\$ 18.82
55-59	\$ 20.91	\$ 26.67	\$ 21.26	\$ 27.03
60-64	\$ 29.46	\$ 37.24	\$ 29.81	\$ 37.60
65-69	\$ 38.50	\$ 50.82	\$ 38.85	\$ 51.18
70-74	\$ 54.91	\$ 74.27	\$ 55.26	\$ 74.62
75-79	\$ 90.92	\$ 114.89	\$ 91.28	\$ 115.24

FEMALE without Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 0.90	\$ 1.47	\$ 1.25	\$ 1.82
25-29	\$ 1.15	\$ 1.75	\$ 1.51	\$ 2.11
30-34	\$ 1.68	\$ 2.64	\$ 2.04	\$ 3.00
35-39	\$ 2.26	\$ 3.82	\$ 2.61	\$ 4.18
40-44	\$ 3.46	\$ 6.13	\$ 3.81	\$ 6.49
45-49	\$ 5.15	\$ 10.27	\$ 5.50	\$ 10.63
50-54	\$ 7.13	\$ 14.58	\$ 7.48	\$ 14.93
55-59	\$ 11.52	\$ 21.98	\$ 11.88	\$ 22.33
60-64	\$ 15.57	\$ 30.29	\$ 15.92	\$ 30.65
65-69	\$ 24.65	\$ 43.90	\$ 25.01	\$ 44.26
70-74	\$ 38.72	\$ 66.17	\$ 39.07	\$ 66.53
75-79	\$ 47.92	\$ 93.39	\$ 48.28	\$ 93.74

LIFE INSURANCE COMPANY OF NORTH AMERICA
GROUP CRITICAL ILLNESS POLICY
Nationwide Rate Manual
Policy Form GCI-00-1000.00 et al

ANNUAL BASE PREMIUM RATES PER \$1000 BENEFIT: Smoker

MALE with Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 2.43	\$ 3.59	\$ 2.79	\$ 3.94
25-29	\$ 3.13	\$ 4.94	\$ 3.49	\$ 5.30
30-34	\$ 5.09	\$ 8.20	\$ 5.44	\$ 8.56
35-39	\$ 8.72	\$ 14.00	\$ 9.07	\$ 14.36
40-44	\$ 15.16	\$ 24.11	\$ 15.51	\$ 24.47
45-49	\$ 29.91	\$ 43.84	\$ 30.27	\$ 44.19
50-54	\$ 46.36	\$ 65.57	\$ 46.71	\$ 65.93
55-59	\$ 70.65	\$ 97.08	\$ 71.01	\$ 97.43
60-64	\$ 101.88	\$ 135.90	\$ 102.24	\$ 136.26
65-69	\$ 130.37	\$ 177.30	\$ 130.73	\$ 177.66
70-74	\$ 165.70	\$ 224.96	\$ 166.06	\$ 225.32
75-79	\$ 205.79	\$ 273.39	\$ 206.15	\$ 273.75

FEMALE with Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 2.32	\$ 3.53	\$ 2.67	\$ 3.89
25-29	\$ 3.62	\$ 5.19	\$ 3.98	\$ 5.54
30-34	\$ 6.23	\$ 8.77	\$ 6.59	\$ 9.13
35-39	\$ 10.57	\$ 14.93	\$ 10.93	\$ 15.29
40-44	\$ 17.91	\$ 25.49	\$ 18.27	\$ 25.85
45-49	\$ 27.84	\$ 42.80	\$ 28.20	\$ 43.16
50-54	\$ 38.43	\$ 61.61	\$ 38.79	\$ 61.97
55-59	\$ 52.86	\$ 88.18	\$ 53.21	\$ 88.54
60-64	\$ 68.05	\$ 118.99	\$ 68.41	\$ 119.35
65-69	\$ 93.87	\$ 159.05	\$ 94.23	\$ 159.41
70-74	\$ 118.53	\$ 201.38	\$ 118.88	\$ 201.73
75-79	\$ 135.20	\$ 238.10	\$ 135.56	\$ 238.46

MALE without Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 1.45	\$ 2.01	\$ 1.80	\$ 2.37
25-29	\$ 1.66	\$ 2.45	\$ 2.02	\$ 2.81
30-34	\$ 2.93	\$ 4.15	\$ 3.28	\$ 4.51
35-39	\$ 5.28	\$ 7.11	\$ 5.64	\$ 7.46
40-44	\$ 9.26	\$ 12.15	\$ 9.62	\$ 12.51
45-49	\$ 18.57	\$ 23.04	\$ 18.93	\$ 23.40
50-54	\$ 25.56	\$ 31.87	\$ 25.91	\$ 32.22
55-59	\$ 35.08	\$ 45.12	\$ 35.44	\$ 45.47
60-64	\$ 47.58	\$ 60.64	\$ 47.94	\$ 61.00
65-69	\$ 57.12	\$ 77.54	\$ 57.48	\$ 77.90
70-74	\$ 79.13	\$ 109.36	\$ 79.48	\$ 109.71
75-79	\$ 117.46	\$ 153.42	\$ 117.82	\$ 153.77

FEMALE without Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 1.13	\$ 1.85	\$ 1.49	\$ 2.21
25-29	\$ 1.58	\$ 2.41	\$ 1.94	\$ 2.77
30-34	\$ 2.46	\$ 3.92	\$ 2.82	\$ 4.28
35-39	\$ 3.65	\$ 6.29	\$ 4.01	\$ 6.65
40-44	\$ 5.79	\$ 10.42	\$ 6.15	\$ 10.78
45-49	\$ 8.95	\$ 18.23	\$ 9.31	\$ 18.59
50-54	\$ 12.62	\$ 25.40	\$ 12.98	\$ 25.76
55-59	\$ 20.07	\$ 37.61	\$ 20.43	\$ 37.97
60-64	\$ 26.12	\$ 49.91	\$ 26.47	\$ 50.27
65-69	\$ 40.84	\$ 69.40	\$ 41.19	\$ 69.75
70-74	\$ 60.46	\$ 100.03	\$ 60.82	\$ 100.38
75-79	\$ 71.92	\$ 130.65	\$ 72.27	\$ 131.00

LIFE INSURANCE COMPANY OF NORTH AMERICA
GROUP CRITICAL ILLNESS POLICY
Nationwide Rate Manual
Policy Form GCI-00-1000.00 et al

ANNUAL BASE PREMIUM RATES PER \$1000 BENEFIT: Non-Smoker

MALE with Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 1.82	\$ 2.70	\$ 2.18	\$ 3.06
25-29	\$ 2.11	\$ 3.34	\$ 2.47	\$ 3.70
30-34	\$ 3.05	\$ 5.00	\$ 3.41	\$ 5.36
35-39	\$ 4.53	\$ 7.45	\$ 4.89	\$ 7.80
40-44	\$ 7.62	\$ 12.32	\$ 7.98	\$ 12.68
45-49	\$ 14.16	\$ 21.12	\$ 14.52	\$ 21.48
50-54	\$ 23.62	\$ 32.99	\$ 23.97	\$ 33.35
55-59	\$ 37.07	\$ 50.26	\$ 37.43	\$ 50.61
60-64	\$ 56.22	\$ 74.07	\$ 56.58	\$ 74.43
65-69	\$ 80.36	\$ 105.41	\$ 80.71	\$ 105.76
70-74	\$ 106.03	\$ 140.22	\$ 106.39	\$ 140.58
75-79	\$ 151.10	\$ 192.17	\$ 151.46	\$ 192.52

FEMALE with Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 1.75	\$ 2.66	\$ 2.11	\$ 3.02
25-29	\$ 2.46	\$ 3.52	\$ 2.82	\$ 3.88
30-34	\$ 3.90	\$ 5.43	\$ 4.26	\$ 5.79
35-39	\$ 5.83	\$ 8.09	\$ 6.18	\$ 8.45
40-44	\$ 9.41	\$ 13.22	\$ 9.77	\$ 13.58
45-49	\$ 13.92	\$ 21.00	\$ 14.28	\$ 21.36
50-54	\$ 18.74	\$ 30.55	\$ 19.10	\$ 30.91
55-59	\$ 26.37	\$ 44.91	\$ 26.73	\$ 45.26
60-64	\$ 35.71	\$ 63.82	\$ 36.07	\$ 64.18
65-69	\$ 50.10	\$ 90.28	\$ 50.46	\$ 90.63
70-74	\$ 68.38	\$ 121.39	\$ 68.73	\$ 121.75
75-79	\$ 82.13	\$ 157.68	\$ 82.49	\$ 158.04

MALE without Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 1.08	\$ 1.51	\$ 1.44	\$ 1.87
25-29	\$ 1.12	\$ 1.66	\$ 1.48	\$ 2.02
30-34	\$ 1.76	\$ 2.53	\$ 2.11	\$ 2.88
35-39	\$ 2.75	\$ 3.75	\$ 3.10	\$ 4.11
40-44	\$ 4.65	\$ 6.18	\$ 5.01	\$ 6.53
45-49	\$ 8.79	\$ 11.03	\$ 9.15	\$ 11.38
50-54	\$ 13.02	\$ 16.10	\$ 13.38	\$ 16.45
55-59	\$ 18.41	\$ 23.41	\$ 18.76	\$ 23.77
60-64	\$ 26.26	\$ 33.11	\$ 26.61	\$ 33.47
65-69	\$ 35.21	\$ 46.11	\$ 35.57	\$ 46.46
70-74	\$ 50.63	\$ 68.07	\$ 50.99	\$ 68.43
75-79	\$ 86.24	\$ 108.09	\$ 86.60	\$ 108.44

FEMALE without Cancer

Age	EE	EE+SP	EE+CH	EE+Fam
0-24	\$ 0.85	\$ 1.40	\$ 1.21	\$ 1.75
25-29	\$ 1.07	\$ 1.64	\$ 1.43	\$ 1.99
30-34	\$ 1.54	\$ 2.42	\$ 1.90	\$ 2.78
35-39	\$ 2.01	\$ 3.38	\$ 2.37	\$ 3.74
40-44	\$ 3.04	\$ 5.37	\$ 3.40	\$ 5.73
45-49	\$ 4.47	\$ 8.87	\$ 4.83	\$ 9.23
50-54	\$ 6.16	\$ 12.67	\$ 6.51	\$ 13.02
55-59	\$ 10.01	\$ 19.22	\$ 10.37	\$ 19.58
60-64	\$ 13.70	\$ 26.83	\$ 14.06	\$ 27.19
65-69	\$ 21.80	\$ 39.40	\$ 22.15	\$ 39.76
70-74	\$ 34.88	\$ 60.20	\$ 35.24	\$ 60.55
75-79	\$ 43.69	\$ 86.81	\$ 44.05	\$ 87.17

LIFE INSURANCE COMPANY OF NORTH AMERICA
GROUP CRITICAL ILLNESS POLICY
Nationwide Rate Manual
Policy Form GCI-00-1000.00 et al

ANNUAL HEALTH SCREENING RIDER PREMIUM RATES PER \$25 BENEFIT

EE	EE+SP	EE+CH	EE+Fam
\$ 13.64	\$ 27.27	\$ 14.14	\$ 27.77

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ADJUSTMENT FACTORS

Rates may vary based on changes to the benefit schedule outlined in the Actuarial Memorandum. Rates can also be adjusted by home or field office underwriters to reflect case-specific underwriting considerations. Base premium rates will also be adjusted for the following items:

Risk Management Factors

Part %	0% GI	25% GI	50% GI	75% GI	100% GI
[0,5%)	1.36	1.67	1.98	2.29	2.61
[5,10%)	1.11	1.36	1.61	1.86	2.11
[10,15%)	1.01	1.18	1.35	1.53	1.70
[15,20%)	0.96	1.09	1.22	1.34	1.47
[20,25%)	0.94	1.04	1.14	1.24	1.34
[25,30%)	0.92	1.01	1.09	1.18	1.26
[30,35%)	0.91	0.99	1.06	1.13	1.21
[35,40%)	0.90	0.97	1.03	1.10	1.17
[40,45%)	0.90	0.96	1.02	1.08	1.13
[45,50%)	0.89	0.95	1.00	1.06	1.11
[50,55%)	0.89	0.94	0.99	1.04	1.09
[55,60%)	0.88	0.93	0.98	1.03	1.07
[60,65%)	0.88	0.93	0.97	1.02	1.06
[65,70%)	0.88	0.92	0.96	1.01	1.05
[70,75%)	0.88	0.92	0.96	1.00	1.04
[75,80%)	0.88	0.91	0.95	0.99	1.03
[80,85%)	0.87	0.91	0.95	0.98	1.02
[85,90%)	0.87	0.91	0.94	0.98	1.01
[90,95%)	0.87	0.91	0.94	0.97	1.01
95%+	0.87	0.90	0.94	0.97	1.00

For a given GI% between those stated above the Risk Management Factor will be interpolated.

<u>Item</u>	<u>Factor Range</u>
Industry:	0.75 – 1.40
Area:	0.88 – 1.07
Additional Benefit Provision:	1.00 – 1.07
Recurrence Benefit Provision:	1.00 – 1.30
Portability:	1.00 – 1.11
Rate Guarantee:	1.00 – 1.10

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Waiting Period:	0.98 – 1.00
Pre-Existing Exclusion:	1.00 – 1.03
Occupational HIV:	1.00 – 1.01
Case Size:	0.90 – 1.10
Commission Level:	0.75 – 1.25

SERFF Tracking Number: CCGN-127839877 State: Arkansas
 Filing Company: Life Insurance Company of North America State Tracking Number: 50347
 Company Tracking Number: 11-8001
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Critical Illness Benefits
 Project Name/Number: GCI/11-8001

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment Attachment: Readability Certification.pdf	Approved-Closed	12/02/2011
Satisfied - Item: Application Comments: Attachment Attachment: Appl, EOI form GCI-009320.AR.pdf	Approved-Closed	12/02/2011
Satisfied - Item: Forms List Comments: Updated form list Attachment: Forms List, final.pdf	Approved-Closed	12/02/2011
Satisfied - Item: Description of Variability Comments: Attachment: Description of Variability, final.pdf	Approved-Closed	12/02/2011

SERFF Tracking Number: CCGN-127839877 State: Arkansas
Filing Company: Life Insurance Company of North America State Tracking Number: 50347
Company Tracking Number: 11-8001
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
Limited Benefit
Product Name: Group Critical Illness Benefits
Project Name/Number: GCI/11-8001

	Item Status:	Status
Satisfied - Item: Readability Certification	Approved-Closed	Date: 12/02/2011
Comments:		
Attachment: Readability Certification.pdf		

**Life Insurance Company of North America
1601 Chestnut Street
P.O. Box 7716
Philadelphia, PA 19192-2235**

READABILITY CERTIFICATION

We, the Life Insurance Company of North America, certify that we have carefully scored the forms listed below, using the Flesch Readability Test, in accordance with applicable readability standards. These forms were tested together, for a composite score.

Form Number	Description of Form	Score
GCI-00-1000.00 et al	Group Insurance Policy	51.9
GCI-00-CE1000.00 et al	Group Certificate	51.9
HSB-00-1000.00	Health Screening Benefit Rider	51.9

Signature: _____



Name: Edmund J. Skowronek

Title: Assistant Director

Date: November 11, 2011

CRITICAL ILLNESS INSURANCE [APPLICATION] [EVIDENCE OF INSURABILITY] [ENROLLMENT] [CHANGE] FORM

Life Insurance Company of North America (LINA) a Cigna Company (herein called the Insurance Company)

[For info and customer service for Critical Illness Insurance, call {1-000-000-0000}.]

[• All info must be completed by the applicant.]

• The applicant, and spouse [/Domestic Partner] if coverage is requested, must sign and date this form.

• This form cannot be considered unless received within {30} days of the date it is dated.

[• The Insurance Company must approve your request for insurance before it becomes effective.]

Important: Please enter all dates in mm/dd/yyyy format.]

REASON FOR REQUEST

NEW HIRE] INITIAL ENROLLMENT EVENT] LATE ENTRANT]
 LIFE STATUS CHANGE] ONGOING ENROLLMENT EVENT] REINSTATEMENT]

[Please print (preferably in black ink)]

{EMPLOYEE} INFORMATION

Mr. Mrs. Ms. (Check one) Name: (First) _____ (Last) _____ (MI) _____
 Address _____ Apt. # _____ City _____ State _____ Zip _____
 Day Phone _____ Evening Phone _____ Social Security # _____ Date of Birth _____
 [Employer _____] [Policy # _____] [ID # _____] [Class _____]
 [Occupation _____] [Location _____] [Date of Hire _____] [Annual Salary _____]

[COMPLETE IF ELECTING SPOUSE [/DOMESTIC PARTNER] COVERAGE

I am currently married and my date of marriage is _____] I am currently eligible under the insurance as a Domestic Partner*]

Name: (First) _____ (Last) _____ (MI) _____ Social Security # _____ Date of Birth _____

[* In order to be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or any required Domestic Partner Affidavit on file with your employer, and accepted by the Insurance Company. If you do not currently have a state-registered Domestic Partnership, or an Domestic Partner Affidavit on file with your employer, an Affidavit should be requested from and will be made available to you through your employer.]]

CRITICAL ILLNESS INSURANCE [Policy Number _____]

[Have you smoked or used any form of tobacco in the last {12} months?

{Employee} Y N Spouse [/Domestic Partner] Y N]

[Employer-Paid
Basic Coverage

<u>Applicant</u> {Employee}	<u>[Amount]</u> [_____ times salary, to a maximum of \$_____]	<u>Guaranteed Issue Amount*</u> _____]
--------------------------------	--	--

Voluntary
{Employee}-Paid
Coverage

<u>Applicant</u>	<u>Decline</u>	<u>Amount Requested</u> [(check only one amount)] [(amount must be \${1,000} increments)]	<u>[Guaranteed Issue Amount*</u>
{Employee}	<input type="checkbox"/>	<input type="checkbox"/> _____] <input type="checkbox"/> _____] <input type="checkbox"/> _____]	_____
Spouse [/Domestic Partner]	<input type="checkbox"/>	<input type="checkbox"/> _____] <input type="checkbox"/> _____] <input type="checkbox"/> _____]	_____
Child(ren)	<input type="checkbox"/>	<input type="checkbox"/> _____] <input type="checkbox"/> _____] <input type="checkbox"/> _____]	_____]

[* Guaranteed Issue Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.]

Health Screening Benefit]

_____]

[Premium Amount \$ _____]

GCI-009320.AR

[Applicant's Name **John Doe**] [[Social Security # **111-11-1111**] [ID# **3423**]]

I WISH TO MAKE THE FOLLOWING CHANGES TO MY CRITICAL ILLNESS COVERAGE

Consult with your employer for the coverage election options currently available. When selecting new coverage amounts, please ensure that your election(s) match the amounts[, salary multiples] or unit increments as currently available under your plan.

CHECK THE APPROPRIATE BOXES:

Increase, Decrease or Begin Coverage on the Following Individuals as Indicated Below

[(Complete the medical questions below if you are electing, or increasing, coverage for yourself or your spouse [/Domestic Partner])]

Applicant	Current Voluntary Coverage	New Voluntary Coverage	Total Voluntary Coverage
<input type="checkbox"/> {Employee}			
<input type="checkbox"/> Spouse [/Domestic Partner]			
<input type="checkbox"/> Child(ren)			

Life Status Change (check only one of the following boxes, and provide date of change)

Marriage] Divorce] Annulment] Legal Separation] Birth or Adoption of a Child] Death of Spouse [/Domestic Partner] or Child] Leave of Absence] Change in Spouse's [/Domestic Partner's] Employment] Return to or from Military Duty] Change from Full-time to Part-time (or vice-versa)]

Date of Life Status Change _____

Cancel Coverage on the Following Individuals (check all that apply)

{Employee} Spouse [/Domestic Partner] Dependent Child(ren)

Effective Date of Cancellation _____

Name Change (Current name / New Name)

{Employee} _____ / _____

Spouse [/Domestic Partner] _____ / _____]

ACCEPTANCE / DECLINATION

[I accept the insurance coverage(s) chosen above. I authorize my employer to {deduct the needed amounts from my earnings}. If I have not chosen coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability/good health at my own expense and that coverage is subject to the Insurance Company's approval.]

[I authorize the above changes to my {employee} paid coverage. I understand that certain changes may require medical information which will be requested by the Insurance Company if necessary. I authorize my employer to {make the appropriate payroll deductions} for changes noted above.]

Signature _____ Date _____

****You should read and sign the Agreements section that follows in this form****

[IMPORTANT]
Please complete the following section if needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Instructions for Evidence of Insurability Section

[Complete the employee info in this section if you (i.e., the {Employee}) are:

- applying for Insurance for yourself that is greater than the guaranteed coverage amount, or
- applying for Insurance for yourself [more than {31} days] after you were eligible for the insurance.]

[Complete the spouse [/Domestic Partner] info in this section if:

- applying for Insurance for your spouse [/Domestic Partner] that is greater than the guaranteed coverage amount, or
- applying for Insurance for your spouse [/Domestic Partner] [more than {31} days] after the spouse [/Domestic Partner] is eligible for the Insurance.]

Please indicate your answers for each question by checking the Yes or No box for the question.

	{Employee}	[Spouse [/Domestic Partner]
1. In the past 5 years has any proposed insured received medical advice or treatment for or had:		
• Cancer, carcinoma in situ, blood disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
• Stroke, transient ischemic attack, chronic obstructive lung or pulmonary disease, any disease or disorder of the heart, polycystic kidney disease, chronic renal failure, any liver disorder, diabetes, macular degeneration, retinitis pigmentosa, acquired immunodeficiency syndrome, HIV or organ transplant?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. In the past 6 months has any proposed insured:		
• Been recommended to have a diagnostic test related to cancer that has not been taken or for which results have not been received, or had a diagnostic or screening test related to cancer for which follow-up was recommended other than future routine screening?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
• Been treated with three or more medications for high blood pressure?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Indicate Height and Weight	Ht: ____ft. ____in. Wt: _____lbs	Ht: ____ft. ____in. Wt: _____lbs]]

[Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

LIFE INSURANCE COMPANY OF NORTH AMERICA

FORMS LIST

GROUP CRITICAL ILLNESS POLICY

FORM GCI-00-1000.00, et al

Form Number	Name
GCI-00-1000.00	Policy Face Page, Table of Contents, Schedule of Affiliates
GCI-00-1100.00	Schedule of Benefits
GCI-00-1200.AR	General Definitions
GCI-00-1300.00	Description of Benefits: Critical Illness Benefit, Recurrence Benefit, Benefit Reduction
GCI-00-1400.AR	Eligibility, Enrollment, Effective Date Provisions, Deferred Effective Date Provisions, Termination of Insurance, Continuation of Insurance Provisions, Portability Provisions
GCI-00-1500.00	Exclusions and Limitations
GCI-00-1600.00	Conversion Privilege
GCI-00-1700.00	Claim Provisions
GCI-00-1800.00	Administrative Provisions
GCI-00-1900.AR	General Provisions
Certificate	
GCI-00-CE1000.00	Certificate Face Page
GCI-00-CE1700.00	Claim Provisions
GCI-00-CE1800.00	Administrative Provisions
GCI-00-CE1900.AR	General Provisions
Miscellaneous Forms	
HSB-00-1000.00	Health Screening Benefit Rider
GCI-00-3000.00	Modifying Provisions Amendment
GCI-00-4000.00	Amendment
GCI-00-5000.00	Additional Benefit Rider
GCI-009320.AR	Application/Evidence of Insurability/Enrollment/Change Form

LIFE INSURANCE COMPANY OF NORTH AMERICA (LINA)

DESCRIPTION OF VARIABILITY

GROUP CRITICAL ILLNESS POLICY FORM GCI-00-1000.00, et al

Information that may be included/excluded based on case specifics is contained in brackets []. Illustrative information including class identifiers, benefit amounts, age ranges, time durations, references to optional benefits and provisions customized to fit the policyholder's benefit plan is bracketed using { }. In no event will the information contained in these bracketed areas be less favorable to an insured person than the minimum standards set forth in your law.

General Comments

Please note the following:

This policy form is designed to be issued (a) directly to an employer or other eligible group or (b) to a trust to which multiple employers or other eligible entities may subscribe. References to "Policyholder", "Employer" and "Subscriber" may be selected as applicable.

References to the Person(s) Insured

The terms "Employee", "Member", "Covered Person", etc., may be used as applicable to reflect policy/certificate issuance to employer/employee groups or other eligible groups under the law of your state. A term other than "Employee" or "Member" may be used if requested by the Policyholder for consistency with other policies or with personnel practices. Modifications may also be made to reflect coverage provided to a specific Covered Class.

References to Payroll Deduction

The term "payroll deduction" may be replaced with "ACH transaction", "credit card transaction", or "direct bill transaction", to reflect the applicable type of payment arrangement.

Gender Neutrality

The male pronoun is used throughout the forms, and is defined to include the female pronoun wherever referenced. These references may be changed to gender neutral terms upon issuance of the policy/certificate.

Combined Coverages

The policy/certificate pages may reflect the application of certain provisions to distinct coverages. For example, the description of classes may vary depending on the nature of the group, the coverages provided and the plan offered by the Policyholder. Different provisions may apply on a coverage distinct basis.

Issuance of Certificates

Certificates shall consist of text identical to the Policy, and may be personalized for specific certificateholders. Certificates will bear a different form number. The content, format and text of the certificates may vary in any of the following specific respects:

- a. Separate certificates may be issued for one or more Covered Classes under the policy. In that case, language not applicable to the rights of the Covered Person in that Covered Class may be omitted.
- b. Any language which reflects the rights and obligations of the Policyholder may be omitted.
- c. "You" may be substituted for the Covered Person, as described in the References to the Person(s) Insured section above, and the text may be written in a more conversational style.

- d. The order and grouping of provisions may be modified to better apply to the certificateholder.
- e. The print size, style, page size and layout may be modified to reflect 8 ½" x 11" pages, 5" x 7" pages, or other sizes subject to any requirements of the readability law of your state.
- f. The listing of Initial Premium Rates may be deleted, in which case a reference to the premium rates contained in the policy will be substituted.

Listed below is a description of variable text, by policy section, along with a corresponding explanation of the scope of variability.

Face Page

The second paragraph is deleted when the plan of insurance is not subject to ERISA.

Text informing the Policyholder to seek advice as to the tax implications will be included in policies when the premium for insurance is being paid on a before-tax basis.

Table of Contents

The Table of Contents illustrates all of the coverages and benefits that could be marketed. Upon issuance, the appropriate text will be selected to reflect case specifications. Variable text not chosen by the Policyholder for the benefit plan will be deleted.

Schedule of Affiliates

Variations in the text shown will reflect the name(s) of subsidiary or affiliate companies, or the name(s) of corporate divisions, their location(s) and the date on which coverage becomes effective.

Schedule of Benefits

The Schedule of Benefits illustrates all of the coverages and benefits that could be marketed. Variations in the text shown will be based primarily on the plan design elected by the Policyholder, the benefit amount for coverages and/or benefits elected, the covered classes, and the applicability of certain provisions at the case, coverage or class level.

The description of classes may vary depending on the type of group or plan offered by the Policyholder. The Schedule illustrates how the information may be presented on a class level.

Variable text not chosen by the Policyholder for the benefit plan will be deleted.

General Definitions

The text in this section will be appropriately included, excluded or modified according to the following:

1. the type of group covered (e.g., employer/employee, association, etc.);
2. the type of plan offered (e.g., employee only, employee and family, spouse only where permitted by law, flexible benefits plan, etc.);
3. the types of coverages and benefits elected; and
4. other case or plan specifications.

In the definition of Active Service, the term "hospice" may be used alone, or in combination with "rehabilitation or convalescence center" and/or "custodial care facility".

In the definition of Member, the term "Subscriber" is replaced with "Policyholder", when the policy is not issued to a trust.

Description of Benefits

Bracketed text will be included or deleted, according to the types of benefits elected, and plan specifications.

Eligibility

The appropriate text will be selected according to the type of group covered and the type of plan offered.

Enrollment

The appropriate text will be selected according to the type of group covered and the type of plan offered. The provision may be deleted in its entirety, at the request of the Policyholder, for a policy issued to an affinity group.

Effective Date Provisions

The appropriate text will be selected according to the type of group covered, the type of plan offered, and the premium contribution scheme set forth in the plan.

Additional modifications may be made to accurately reflect case specifications (e.g., coverage becoming effective on the first/fifteen/thirtieth day of the month next following the date the employee/member is eligible and enrolls for coverage; or the first/last day of the calendar month next following the date the dependent meets the definition of Spouse or Dependent Child).

Deferred Effective Date Provisions

Active Service

If case specifications include the use of an Active Service requirement, the text will be modified by including bracketed references to the Active Service requirement. If case specifications do not include this provision it will be deleted.

Late Enrollment

If case specifications include a provision for late enrollees, the text will be modified by including bracketed references to the Late Enrollment provisions. The time period shown represents the minimum time period that applies to this provision, and may be modified based on negotiations between the Policyholder and LINA. If case specifications do not include this provision it will be deleted.

Replacement Coverage

If case specifications involve the takeover of a benefit plan from a Policyholder's prior carrier, the text will be modified according to the type of group covered, the type of plan offered and the effective date of replacement coverage. Additional text will be included or excluded according to the premium contribution scheme set forth in the plan. If case specifications do not include this provision it will be deleted.

Annual Re-Enrollment and Life Status Changes

If case specifications indicate that the plan is a flexible benefits plan, or that the plan includes provisions for annual re-enrollment, the text will be modified according to the type of group covered, the type of plan offered and the premium contribution scheme set forth in the plan. Additional text will be modified according to whether dependent enrollment or increases in dependent coverage are permitted, and the effective date of the coverage elected during the annual re-enrollment period. If case specifications do not include this provision it will be deleted. References to "{group}" may be replaced with the actual full name of the group plan of insurance, at the election of the Policyholder.

If case specifications indicate that the plan is a flexible benefits plan, or that the plan includes provisions for life status changes, the text will be modified according to the type of group covered, the type of plan offered, whether life status changes may be elected or increased and the specific life status changes permitted. Additional text will be modified based on the effective date of the life status change.

If case specifications do not include this provision it will be deleted.

Termination of Insurance

The appropriate text will be selected according to the type of group covered, the type of plan offered, the contribution scheme set forth in the plan, the Covered Person's attainment of a specified age, and other specific provisions that apply to the Covered Person.

Continuation of Insurance Provisions

Unless otherwise noted, all continuation provisions are available as an option. These options may apply at the case or class level. Benefit amounts, durations, and in some cases applicability of the benefit on the class level are shown in the Schedule of Benefits.

Continuation for Layoff, Leave of Absence or Family Medical Leave

If elected by the Policyholder, variable text will be modified according to the type of group covered and type of leave designated. Time limits represent the minimum time limits that apply to this provision, and may be modified based on negotiations between the Policyholder and LINA. The bracketed references to time limits will be included when the Policyholder chooses to state the limits in the provision text instead of in the Schedule of Benefits.

Continuation for Disability

If elected by the Policyholder, the appropriate text will be selected according to the type of group covered, the type of plan offered, and the Policyholder's selection of automatic increases and the use of benefit reduction provisions. If case specifications do not include this provision it will be deleted. The bracketed reference "[is over Age {60} and]" will be included when the Policyholder chooses to state this limit in the provision text instead of in the Schedule of Benefits.

Continuation for Military Service

If elected by the Policyholder, variable text will be modified according to the type of group covered. Variable text referring to dependents and to the conditions that are applicable when coverage is continued will be included or excluded based on the type of plan offered.

Portability Provisions

If elected by the Policyholder, variable text will be included according to the type of group covered. References to "{12 months}" in the Whose Insurance is Portable provision may be completed using from 3 to 18 months, at the option of the Policyholder. Other time limits represent the minimum time limits that apply to this provision, and may be modified based on negotiations between the Policyholder and LINA. Variable text referring to dependents, and to the conditions that apply when coverage is ported, will be included or excluded based on the type of plan offered.

Exclusions and Limitations

Each exclusion, and the Pre-Existing Condition Limitation provision, will be included or excluded based on the plan specifications of the Policyholder.

Conversion Privilege

This provision will be included or excluded based on the plan specifications of the Policyholder. If included, the text will vary according to the type of group covered. Time limits and conversion amounts may be increased but will not be less than those shown.

Claim Provisions

The text will vary according to the type of group covered. References to electronic or telephonic notice for claims or for proof of loss may be used based on plan specifications. Time limits shown may be used, or increased, but will not be less than the minimums required by law.

On the variability of specific claim provisions:

Claimant Cooperation Provision

This provision will be included or excluded at the option of the Policyholder.

Time of Payment of Claims

The time limit shown may be used, or decreased, but will not be greater than the maximum allowed by law.

Payment of Claims

Variable text will be modified based on the type of group covered. The dollar amount may vary from \$1,000 to \$5,000.

Payment of Claims to Foreign Employees

This provision will be included or excluded at the option of the Policyholder. Variable text will be modified based on the type of group covered. The listing of geographic areas will also be modified to reflect the location(s) selected by the Policyholder.

Physical Examination and Autopsy

References to autopsy are deleted in jurisdictions where autopsies cannot legally be performed.

Administrative Provisions

Variable text will be included, excluded or modified according to the type of group covered. Time limits may be increased but will not be less than the minimums required by law. The Reinstatement of Insurance provision will be included or excluded at the option of the Policyholder and, if so elected, one or two of the three variable paragraphs will be included depending on the elected Continuation of Insurance provision(s).

General Provisions

Variable text will be included, excluded or modified according to the type of group covered. Time limits may be increased but will not be less than the minimums required by law. The Assignment provision will include one of the three variable paragraphs shown, as elected by the Policyholder. The Ownership of Records provision is included or excluded at LINA's option.

FORM GCI-009320.AR: Application/Evidence of Insurability/Enrollment/Change Form

This form is intended to support:

- initial requests for becoming insured for group critical illness insurance;
- requests for amounts of insurance in excess of the guaranteed amount of insurance;
- requests for changes in insurance that are subject to satisfaction of a medical evidence requirement;
- late enrollment for insurance; and
- reinstatement of insurance.

This form may be used as a combination application and evidence of insurability form, a combined enrollment and change form, or as another combination form of the four types of situations, or as a single situation form. This is for the purposes of obtaining information needed for the administration of the coverage for which the person is eligible (e.g., the person's name address, identification number, coverages accepted, elected, or declined and, if appropriate, the person's agreement to allow the Policyholder to deduct the person's premium contributions). Combining situations in the same document is done in response to the request of the Policyholder. The reasons for such a request involve reducing the need for completing repetitive information that is captured about the individual (e.g., name, address, social security number, age, sex, etc.) when accepting enrollment for, or requesting, insurance coverage; or the need to capture such information in a specific format for the purpose of "feeding" the Policyholder's human resources system or payroll system (again for the purpose of eliminating redundancy). The submitted form includes a demonstration of the type of information that would be captured on the enrollment form.

Despite the flexibility in situations, the medical questions shown in the third page will not vary in content. The questions section will be included or excluded based on the situation for which the form is designed for the Policyholder.

Items bracketed may be included or omitted.

We also want to make the Department aware that in the future, a bar code may be added to capture form number, Policyholder ID, state in which form is used, or routing within our business.

Variability details for form GCI-009320.AR in particular:

Page 1:

- The entire “For info...” section at top may be included or omitted. When included, the telephone number may change based on business needs of the insurer. When the form is provided in an electronic format, appropriate instructions for completing the on-line form will be provided.
- References to “Domestic Partner” throughout the form, and in the bracketed wording in the “Complete if Electing Spouse...” section, will only be included when the policy is issued in a state that mandates the inclusion of Domestic Partners when dependent coverage is included.
- Reference to “{12}” in the 1st line of the “Critical Illness” section may vary from 12 to 36.
- The blank checkbox shown below the “Health Screening Benefit” line may be used so that an employee may elect a future approved/authorized additional option.

Page 2:

- In “Acceptance/Declination”, the 1st paragraph is used when coverage is on a contributory basis, and the 2nd paragraph when the employee requests a change to the coverage that is in force, when such coverage is on a contributory basis. References to deductions may vary, to describe an alternate payment arrangement such as an ACH, credit card, or direct bill transaction.

Page 3:

- The “Important” section may be included or omitted. Directions to the applicant on how to complete the form may be modified to reflect requirements of the electronic format.
- The employee and spouse instruction paragraphs are used depending on the type of coverage elected. Reference to “{31}” may vary from 31 to 90. The “more than {31} days..” wording may be deleted if the requirements for becoming insured, including when first eligible, require proof of insurability. The eligibility requirements are applied at a policy or class level.
- The fraud warning may be moved to a separate page, and included with a list of fraud warnings that are mandated in various states, jurisdictions, and U.S. territories. This wording may be modified to comply with state mandates.

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- In “Agreements”, line 2, this item may be adjusted for use in the third person grammar (e.g. the employee is actively at work on the effective date), or this item may be omitted and replaced by the requirement that the person is not confined in a hospital or institution, or receiving certain medical treatment. The use of variability reflects eligibility requirements applied at a case or class level.
- In “Authorization”, “{30}” may be reduced, but in any event the period used will reflect the regulatory requirements of your state.
- In “Notice”, text may be modified to accommodate how the form is signed when the form is in electronic format.

**Life Insurance Company of North America
1601 Chestnut Street
P.O. Box 7716
Philadelphia, PA 19192-2235**

READABILITY CERTIFICATION

We, the Life Insurance Company of North America, certify that we have carefully scored the forms listed below, using the Flesch Readability Test, in accordance with applicable readability standards. These forms were tested together, for a composite score.

Form Number	Description of Form	Score
GCI-00-1000.00 et al	Group Insurance Policy	51.9
GCI-00-CE1000.00 et al	Group Certificate	51.9
HSB-00-1000.00	Health Screening Benefit Rider	51.9

Signature: _____



Name: Edmund J. Skowronek

Title: Assistant Director

Date: November 11, 2011