

SERFF Tracking Number: LSVX-G127900447 State: Arkansas
 Filing Company: USAbLe Life State Tracking Number: 50489
 Company Tracking Number: AR001460100020
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Hospital Indemnity, HIP2-R Revised Forms
 Project Name/Number: Hospital Indemnity, HIP2-R/AR001460100020

Filing at a Glance

Company: USAbLe Life

Product Name: Hospital Indemnity, HIP2-R Revised Forms SERFF Tr Num: LSVX-G127900447 State: Arkansas

TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved-Closed State Tr Num: 50489

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: AR001460100020 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI Life and Specialty Ventures Disposition Date: 12/15/2011

Date Submitted: 12/15/2011 Disposition Status: Approved-Closed

Implementation Date Requested: 01/15/2012

Implementation Date:

State Filing Description:

General Information

Project Name: Hospital Indemnity, HIP2-R
 Project Number: AR001460100020
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Individual Market Type:
 Filing Status Changed: 12/15/2011
 State Status Changed: 12/15/2011
 Created By: SPI Life and Specialty Ventures
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI Life and Specialty Ventures

Filing Description:

We are enclosing for your review and approval a revised Individual Hospital Confinement Indemnity application, and outline of coverage to be used with the Individual Hospital Indemnity Policy, HIP2-R (3-07), approved by your department on 10/20/2011. This application will replace the previously approved application, HIP2-RAPP (6-11). The difference in this application and the latter is the removal of the wellness benefit. The policy will be marketed to individuals by contracted agents and brokers.

The forms have been tested for readability and the certification is enclosed for your review.

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

APP-NOTICE (9-08) - Notice to Proposed Insured - 10/23/2008

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

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

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
USAbLe Life	\$100.00	12/15/2011	54577852

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/15/2011	12/15/2011

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Disposition

Disposition Date: 12/15/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Hospital Confinement Indemnity Application	Approved-Closed	Yes
Form	Hospital Confinement Indemnity Outline of Coverage	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/15/2011	HIP2-RAPP (6-11)	Application/ Hospital Enrollment Form	Confinement Indemnity Application	Revised	Replaced Form #: 49795 Previous Filing #:	47.700	HIP2-RAPP (6-11) rev.PDF
Approved-Closed 12/15/2011	HIP2-R-SOC (6-11)	Outline of Coverage	Hospital Confinement Indemnity Outline of Coverage	Revised	Replaced Form #: 49795 Previous Filing #:	47.700	HIP2-R-SOC (6-11) rev2.PDF



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

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

New Application Change Form Reinstatement Policy Replaces Policy No. _____

SECTION 1 - PERSONAL IDENTIFICATION

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

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

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

SECTION 2 - PLAN SELECTION New Applicant Application for Change

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

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

SECTION 3 - BENEFICIARY Name Beneficiary Change of Beneficiary

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

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

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

Social Security No.

SECTION 5 – AUTHORIZATION

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

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

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

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

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

I have read and understand the above statements and agreements.

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

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

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

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

Agent's Printed Name

Date Received Home Office



HOSPITAL CONFINEMENT INDEMNITY POLICY

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

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

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

BENEFITS	<input type="checkbox"/> PLAN I	<input type="checkbox"/> PLAN II	<input type="checkbox"/> PLAN III
<p>Daily Hospital Confinement Pays a daily benefit for inpatient hospital confinement due to a covered accident or sickness. <i>Maximum 180 days per confinement.</i></p>	\$50 per day	\$100 per day	\$200 per day
<p>Surgery and Anesthesia Pays according to the policy surgical schedule, up to the amount selected, for a surgical procedure, inpatient or outpatient, when surgery is due to a covered accident or sickness. Anesthesia pays 25% of the amount payable under the surgical benefit.</p>	Up to \$1,000 per operation	Up to \$1,500 per operation	Up to \$2,500 per operation
<p>Emergency Accident Pays the charges incurred, up to the maximum selected, if the covered person is injured in a covered accident and received treatment in a hospital emergency room, physician's office, or standalone emergency center within 72 hours after the accident. <i>Benefit is paid 2 times per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children combined is 2 visits per calendar year.</i></p>	Maximum \$100 per covered accident	Maximum \$250 per covered accident	Maximum \$500 per covered accident
<p>Outpatient Sickness Pays for treatment by a physician in a physician's office, clinic, urgent care facility, or emergency room for a covered sickness. <i>Benefits are limited to 5 visits per calendar year per covered person, except for dependent children. The maximum number of visits for all dependent children (combined) is 5 visits per calendar year.</i></p>	None	\$75 per visit	\$75 per visit
<p>Ambulance Pays for ground ambulance or air ambulance to or from a hospital or between medical facilities. <i>Pays only one benefit, whichever occurs first, per calendar year per person.</i></p>	Ground Ambulance \$250 Air Ambulance \$500	Ground Ambulance \$250 Air Ambulance \$500	Ground Ambulance \$500 Air Ambulance \$1,000

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

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

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

PRE-EXISTING CONDITIONS

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

EXCEPTIONS AND LIMITATIONS

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

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

RENEWABILITY AND CONTINUATION

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

COVERAGE EFFECTIVE DATE

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

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	12/15/2011
Comments:		
Attachment:		
AR - READABILITY CERTIFICATION.PDF		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	12/15/2011
Comments:		
Comply		

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification	Approved-Closed	12/15/2011
Bypass Reason: Not a rate filing.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	12/15/2011
Comments:		
Attached to Forms Tab.		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability	Approved-Closed	12/15/2011
Comments:		
Attachment:		
HIP2-R Statement of Variability rev.PDF		

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: USAble Life

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

Form Number	Score
HIP2-RAPP (6-11)	47.7
HIP2-R-SOC (6-11)	47.7

Signed: 
Name: Connie Phillips
Title: Assistant General Counsel & Assistant Secretary
Date: 12/15/2011

STATEMENT OF VARIABILITY

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

SPECIFIC VARIABLES HIP2-R (3-07)

Policy Face Page

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

Policy Schedule

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

Covered Person Definition

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

Specific Variables (continued)

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

Dependent Provisions

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

**SPECIFIC VARIABLES
HIP2-RAPP**

Section 1 – Personal Identification

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

Section 2 – Plan Selection

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

Section 5 – Authorization

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