

SERFF Tracking Number: ICCI-127017751 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 47917  
 Company Tracking Number: HIC-ACC-POL 2/11  
 TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment  
 Product Name: Individual Accidental Death & Dismemberment  
 Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

## Filing at a Glance

Company: Humana Insurance Company

Product Name: Individual Accidental Death & Dismemberment SERFF Tr Num: ICCI-127017751 State: Arkansas

TOI: H03I Individual Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved-Closed State Tr Num: 47917

Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment Co Tr Num: HIC-ACC-POL 2/11 State Status: Approved-Closed

Filing Type: Form/Rate

Author: Brenda Dawson Reviewer(s): Rosalind Minor  
 Date Submitted: 02/07/2011 Disposition Date: 02/23/2011  
 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval  
 State Filing Description:

Implementation Date:

## General Information

Project Name: HIC-ACC-POL 2/11  
 Project Number: HIC-ACC-POL 2/11  
 Requested Filing Mode:  
 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: 02/23/2011  
 State Status Changed: 02/23/2011  
 Created By: Brenda Dawson  
 Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Brenda Dawson

Filing Description:

Enclosed for review and approval for use in your state are the above referenced forms. These forms are new and are not intended to replace any forms previously filed in your state.

Insurance Compliance Consultants, Inc., is making this filing on behalf of Humana Insurance Company, a Wisconsin domiciled company. A filing authorization letter is attached. All correspondence should be addressed to Insurance Compliance Consultants, Inc.

Individual Accidental Death and Dismemberment Policy form HIC-ACC-POL-AR 2/11 provides for Accidental Death and

SERFF Tracking Number: ICCI-127017751 State: Arkansas  
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Dismemberment Dismemberment  
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Dismemberment. Application form HIC-ACC-APP-AR 2/11 will be used to apply for the policy.

Total Disability Rider HIC-ACC-TDR-AR 2/11, Wellness Rider HIC-ACC-WBR-AR 2/11 and Additional Benefit Rider HIC-ACC-ABR-AR 2/11 are available for an additional premium.

Outline of Coverage HIC-ACC-OOC-AR 2/11 for the referenced policy is also enclosed.

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. These forms were prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the contract or to the general print size.

## Company and Contact

### Filing Contact Information

Brenda Dawson, Authorized Representative      Brendadawson@inscompliance.com  
3925 East State Street, Suite 200      815-316-6714 [Phone]  
Rockford, IL 61108      815-986-2355 [FAX]

### Filing Company Information

(This filing was made by a third party - insurancecomplianceconsultantsinc)

Humana Insurance Company      CoCode: 73288      State of Domicile: Wisconsin  
P.O Box 740036      Group Code: 119      Company Type: L&H  
500 West Main Street      Group Name: Humana Insurance      State ID Number:  
Company  
Louisville, KY 40201-7436      FEIN Number: 39-1263473  
(502) 580-2712 ext. [Phone]

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## Filing Fees

Fee Required?      Yes  
Fee Amount:      \$300.00  
Retaliatory?      No  
Fee Explanation:      \$50 per form

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Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	\$300.00	02/07/2011	44449271

SERFF Tracking Number: ICCL-127017751 State: Arkansas  
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 Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/23/2011	02/23/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	02/21/2011	02/21/2011	Brenda Dawson	02/22/2011	02/22/2011
Pending Industry Response	Rosalind Minor	02/21/2011	02/21/2011	Brenda Dawson	02/22/2011	02/22/2011

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 Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

## Disposition

Disposition Date: 02/23/2011

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):
Humana Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%
	<b>Percent Change Approved:</b>						
	<b>Minimum:</b>	%	<b>Maximum:</b>	%	<b>Weighted Average:</b>		%

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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	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Form (revised)	Accidental Death & Dismemberment Policy	Approved-Closed	Yes
Form	Accidental Death & Dismemberment Policy	Approved-Closed	Yes
Form	Total Disability Rider	Approved-Closed	Yes
Form	Additional Benefits Rider	Approved-Closed	Yes
Form	Accidental Death & Dismemberment Policy Amendment	Approved-Closed	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Rate	Rate sheet	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/21/2011  
Submitted Date 02/21/2011  
Respond By Date  
Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Accidental Death & Dismemberment Policy, HIC-ACC-POL-AR 2/11 (Form)

Comment: There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

SERFF Tracking Number: ICCI-127017751 State: Arkansas  
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Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/22/2011  
Submitted Date 02/22/2011

Dear Rosalind Minor,

### Comments:

thank you for your letter.

### Response 1

Comments: Page 4 of the policy was revised to include the refund of unearned premium provision.

### Related Objection 1

Applies To:

- Accidental Death & Dismemberment Policy, HIC-ACC-POL-AR 2/11 (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you

Sincerely,  
Brenda Dawson

SERFF Tracking Number: ICCI-127017751 State: Arkansas  
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Product Name: Individual Accidental Death & Dismemberment  
Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/21/2011  
Submitted Date 02/21/2011

Respond By Date

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Accidental Death & Dismemberment Policy, HIC-ACC-POL-AR 2/11 (Form)

Comment:

Under 'Change in Premiums', it is stated that...."We have the right, after the first Premium Due Date, to change the rate at which further premiums will be calculated....". Under 'Premium due Date', it is stated that the policy premium is payable on the policy effective date and the first day of each month thereafter....".

It has been our Department's policy for years that no insured will receive a rate increase prior to the annual anniversary date of the policy. After the first annual anniversary date of the policy, increase will not be given more frequently than once in a twelve (12) month period.

Please provide written certification that you would comply with our Department's policy.

### Objection 2

- Accidental Death & Dismemberment Policy, HIC-ACC-POL-AR 2/11 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

### Objection 3

- Accidental Death & Dismemberment Policy, HIC-ACC-POL-AR 2/11 (Form)

- Outline of Coverage, HIC-ACC-OOC-AE 2/11 (Form)

Comment: Hernia cannot be excluded nor can it have a waiting or probationary period. Refer to Rule and Regulation 18, Section 6A and Section 6F.

Please feel free to contact me if you have questions.

*SERFF Tracking Number:*      *ICCI-127017751*                      *State:*                      *Arkansas*  
*Filing Company:*              *Humana Insurance Company*                      *State Tracking Number:*      *47917*  
*Company Tracking Number:*      *HIC-ACC-POL 2/11*  
*TOI:*                      *H03I Individual Health - Accidental Death & Dismemberment*      *Sub-TOI:*                      *H03I.000 Health - Accidental Death & Dismemberment*  
*Product Name:*              *Individual Accidental Death & Dismemberment*  
*Project Name/Number:*      *HIC-ACC-POL 2/11/HIC-ACC-POL 2/11*

**Sincerely,**  
**Rosalind Minor**

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 Product Name: Individual Accidental Death & Dismemberment  
 Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 02/22/2011  
 Submitted Date 02/22/2011

Dear Rosalind Minor,

### Comments:

Thank you for your letter.

### Response 1

Comments: The incapacitated dependent provision was revised to remove the time limit.

### Related Objection 1

Applies To:

- Accidental Death & Dismemberment Policy, HIC-ACC-POL-AR 2/11 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Accidental Death & Dismemberment Policy	HIC-ACC-POL-AR	2/11	Policy/Contract/Fraternal Certificate	Initial			HIC ACC POL AR 2-11.pdf
<b>Previous Version</b>							
Accidental Death &	HIC-ACC-		Policy/Contract/Fraternal	Initial			HIC ACC

SERFF Tracking Number: ICCI-127017751 State: Arkansas  
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 Company Tracking Number: HIC-ACC-POL 2/11  
 TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment  
 Product Name: Individual Accidental Death & Dismemberment  
 Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11  
 Dismemberment Policy POL-AR Certificate POL AR  
 2/11 2-11.pdf

No Rate/Rule Schedule items changed.

**Response 2**

Comments: The exclusion for hernia was removed.

**Related Objection 1**

Applies To:

- Accidental Death & Dismemberment Policy, HIC-ACC-POL-AR 2/11 (Form)
- Outline of Coverage, HIC-ACC-OOC-AE 2/11 (Form)

Comment:

Hernia cannot be excluded nor can it have a waiting or probationary period. Refer to Rule and Regulation 18, Section 6A and Section 6F.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Accidental Death & Dismemberment Policy	HIC-ACC-POL-AR	2/11	Policy/Contract/Fraternal Certificate	Initial			HIC ACC POL AR 2-11.pdf
<b>Previous Version</b>							
Accidental Death & Dismemberment Policy	HIC-ACC-POL-AR	2/11	Policy/Contract/Fraternal Certificate	Initial			HIC ACC POL AR 2-11.pdf
Outline of Coverage	HIC-ACC-OOC-AE	2/11	Outline of Coverage	Initial			HIC-ACC-OOC-AR 2-11.pdf
<b>Previous Version</b>							

SERFF Tracking Number: ICCI-127017751 State: Arkansas  
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 Product Name: Individual Accidental Death & Dismemberment  
 Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11  
 Outline of Coverage HIC-ACC- OOC-AE 2/11 Outline of Coverage Initial HIC-ACC- OOC-AR 2-11.pdf

No Rate/Rule Schedule items changed.

**Response 3**

Comments: Page 4 of the policy was revised to include language that the premium will not change under the policy until the policy anniversary and not more frequently than annually thereafter.

**Related Objection 1**

Applies To:

- Accidental Death & Dismemberment Policy, HIC-ACC-POL-AR 2/11 (Form)

Comment:

Under 'Change in Premiums', it is stated that...."We have the right, after the first Premium Due Date, to change the rate at which further premiums will be calculated....". Under 'Premium due Date', it is stated that the policy premium is payable on the policy effective date and the first day of each month thereafter....".

It has been our Department's policy for years that no insured will receive a rate increase prior to the annual anniversary date of the policy. After the first annual anniversary date of the policy, increase will not be given more frequently than once in a twelve (12) month period.

Please provide written certification that you would comply with our Department's policy.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Accidental Death & Dismemberment Policy	HIC-ACC-POL-AR 2/11		Policy/Contract/Fraternal Certificate	Initial			HIC ACC POL AR 2-11.pdf

SERFF Tracking Number: ICCI-127017751 State: Arkansas  
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Product Name: Individual Accidental Death & Dismemberment  
Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

**Previous Version**

Accidental Death & Dismemberment Policy	HIC-ACC-POL-AR	2/11	Policy/Contract/Fraternal Certificate	Initial	HIC ACC POL AR 2-11.pdf
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No Rate/Rule Schedule items changed.

All appropriate revisions were made to the outline of coverage. Your continued review for approval is greatly appreciated. Thank you.

Sincerely,  
Brenda Dawson

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## Form Schedule

### Lead Form Number: Individual Accidental Death & Dismemberment

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/23/2011	HIC-ACC-POL-AR 2/11	Policy/Cont ract/Fratern al	Accidental Death & Dismemberment Policy Certificate	Initial			HIC ACC POL AR 2- 11.pdf
Approved-Closed 02/23/2011	HIC-ACC-TDR-AR 2/11	Policy/Cont ract/Fratern al	Total Disability Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			HIC ACC TDR AR 2- 11.pdf
Approved-Closed 02/23/2011	HIC-ACC-ABR-AR 2/11	Policy/Cont ract/Fratern al	Additional Benefits Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			HIC-ACC- ABR-AR 2-11 .pdf
Approved-Closed 02/23/2011	HIC-ACC-AMENDME NT	Policy/Cont ract/Fratern al	Accidental Death & Dismemberment Policy Amendment Certificate: Amendmen t, Insert Page, Endorseme	Initial			HIC-ACC- AMENDMEN T.pdf

<i>SERFF Tracking Number:</i>	<i>ICCI-127017751</i>	<i>State:</i>	<i>Arkansas</i>	
<i>Filing Company:</i>	<i>Humana Insurance Company</i>	<i>State Tracking Number:</i>	<i>47917</i>	
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<i>Product Name:</i>	<i>Individual Accidental Death &amp; Dismemberment</i>			
<i>Project Name/Number:</i>	<i>HIC-ACC-POL 2/11/HIC-ACC-POL 2/11</i>			
	<i>nt or Rider</i>			
Approved- Closed 02/23/2011	HIC-ACC- OOC-AE 2/11	Outline of Coverage	Outline of Coverage Initial	HIC-ACC- OOC-AR 2- 11.pdf
Approved- Closed 02/23/2011	HIC-ACC- APP-AR 2/11	Application/ Enrollment Form	Application Initial	HIC-ACC- APP-AR 2- 11.pdf

**Humana Insurance Company**  
**1100 Employers Boulevard**  
**Green Bay, Wisconsin 54344**  
**1-800-845-7519**

NAMED INSURED: [ADAM SMITH]

TYPE OF COVERAGE: [INDIVIDUAL]

POLICY EFFECTIVE DATE: [JULY 1, 2009]

PREMIUM: [\$00.00]

POLICY NUMBER: [00000001]

RENEWAL PREMIUM PERIOD: [MONTHLY]

**ACCIDENTAL DEATH AND DISMEMBERMENT POLICY**

**PREMIUMS SUBJECT TO CHANGE ON RENEWAL**

**IMPORTANT -- PLEASE READ**

Your application is attached to and forms a part of the Policy. PLEASE READ the copy of Your application. If anything in it is not correct, You must tell Us immediately. Your Policy was issued on the basis that all information in the application is correct and complete. If not, Your Policy may not be valid.

**30-DAY RIGHT TO EXAMINE POLICY**

WE URGE YOU TO EXAMINE THIS POLICY CLOSELY. If you are not satisfied, You may return it to us or to the agent from whom it was purchased within 30 days after that event; we will consider it void from the Policy Date and any premium paid will be returned.

**GUARANTEED RENEWABLE**

Your Policy is Guaranteed Renewable until age 70, by payment of premiums as they become due. This Policy will terminate on the last day of the period for which premium is paid unless continued in force during a Grace Period.

**PREMIUM CHANGE**

We have the right to change the table of premium rates for this Policy. The change in premium will apply to all policies of this form number issued to insureds in Your state of residence. Premiums will be charged in accordance with the table of premium rates using the original classification.

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

If You are eligible for Medicare, review the Medicare Supplement Buyers' Guide available from the Company.

**THIS IS AN ACCIDENT ONLY POLICY WHICH DOES NOT PAY BENEFITS FOR A LOSS FROM SICKNESS.**

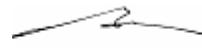
**This is a Non-Participating Policy.**

**Pre-Existing Conditions Not Paid - Subject to the Time Limit on Certain Defenses**

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

Signed for Humana Insurance Company at its Home Office on the Policy Effective Date.

  
Michael B. McCallister  
President

  
Gerald L. Ganoni  
Vice President

## TABLE OF CONTENTS

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**POLICY SPECIFICATIONS**

**INSURED** [ADAM SMITH]  
**POLICY EFFECTIVE DATE** [July 1, 2009]  
**POLICY NUMBER** [0000000001]  
**ISSUE AGE** [35]  
**INITIAL PREMIUM** [\$00.00]  
**TOTAL MONTHLY PREMIUM** [\$00.00]  
**TERMINATION DATE**

**POLICY AGE LIMIT: Insured Person - 70; Spouse - 70**

<u>DESCRIPTION OF BENEFITS</u> ACCIDENT PLAN	<u>NUMBER OF UNITS ELECTED</u> [1-3]	<u>MONTHLY PREMIUM AMOUNT</u> [\$00.00]		
		<u>INSURED</u>	<u>SPOUSE</u>	<u>CHILD</u>
<b>[ INDIVIDUAL COVERAGE ]</b>				
1. ACCIDENTAL DEATH OR DISMEMBERMENT: WITH COMMON CARRIER BENEFIT				
PRINCIPAL SUM		[20,000]	[10,000]	[5,000]
2. DISLOCATION OR FRACTURE: PRINCIPAL SUM		[2,000]	[1,000]	[500]
3. HOSPITAL CONFINEMENT: DAILY BENEFIT		[100]	[100]	[100]
4. AMBULANCE BENEFIT: REGULAR AIR		[100] [200]	[100] [200]	[100] [200]
5. EXPENSES - MAXIMUM BENEFIT		[250]	[250]	[250]

**ADDITIONAL BENEFIT (AS PROVIDED BY RIDER)**

HIC-ACC-TDR TOTAL DISABILITY RIDER	[\$0 Per Month]	[\$00.00]
HIC-ACC-ABR ADDITIONAL BENEFIT RIDER	[1 Unit]	[\$00.00]
HIC-ACC-WBR WELLNESS BENEFIT RIDER	[1 Unit]	[\$00.00]

## CONTRACT PROVISIONS

**Entire Contract:** The entire contract between You and Us consists of Your application, this Policy, and any riders or endorsements, copies of which are attached at issue.

**Policy Premiums:** The initial premium for this Policy is shown on page 3 under Policy Specifications.

**Change in Premiums:** We have the right, after the first Premium Due Date, to change the rate at which further premiums will be calculated for all insureds of Your rate class and same State of issue. No Insured Person will receive a rate increase prior to the annual anniversary date of the Policy. After the first annual anniversary date of the Policy, a premium increase will not be given more frequently than once in a 12 month period. We will give you notice of any change at least 60 days before the Premium Due Date on which it is to become effective.

**Premium Due Dates:** The Policy Premium is payable on the Policy Effective Date and the first day of each month thereafter. Each Policy Premium is due in advance of the date it becomes payable. This Policy will terminate on the last day of the period for which premium is paid unless continued in force during a grace period.

**Misstatement of Age:** If You have misstated your age, the premium amount due will be the amount necessary to purchase coverage for Your correct age.

**Changes:** No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of Our executive officers and attached to this Policy.

**Time Limit on Certain Defenses:** No misstatement in your application can be used to deny a claim or void this Policy unless:

- a) the misstatement was fraudulent; or
- b) your loss began within 2 years after You became an Insured Person.

We cannot deny or reduce a claim for Your loss commencing after 2 years from the date You became an Insured Person on the basis that a disease or physical condition existed before that date unless it is excluded by name or specific condition.

**Conformity with State Statutes.** On the Policy Effective Date, any part of this Policy in conflict with the statutes of the state in which it is delivered or issued for delivery is amended to agree with the statute's minimum requirements.

**Time Periods.** All periods begin and end at 12:01 A.M., Standard Time, at Your residence.

**Grace Period.** A grace period of 31 days is allowed after the due date for payment of each premium after the first premium payment. This Policy will continue in force during the grace period. If the premium is not paid during the grace period, this Policy will terminate at the end of the grace period.

**Reinstatement.** This Policy may be reinstated if it has terminated because the premium due was not paid before the end of the grace period. Reinstatement will only be allowed if:

- a) all past due premium is paid; and
- b) the reinstatement request is received together with one (1) month's premium within sixty (60) days of the end of the grace period.

The reinstated policy will cover only Injury occurring after the date of reinstatement.

If the period before reinstatement is more than 60 days after the end of the grace period, We will require the completion of a new application in addition to the required premium payment.

**Unpaid Premium.** Upon the payment of a claim under this Policy, any unpaid premium will be deducted.

**Refund of Unearned Premium.** If a Covered Person dies, any premium paid to Us on behalf of the deceased for a period after the date of such death will be refunded for any period beyond the end of the policy month in which the death occurred. Such refund will be made to the Covered Person's estate in a lump sum no later than thirty (30) days after proof of the insured Person's death has been furnished to Us. Notice of death should be sent to us within 12 months, or as soon as reasonably possible, after a Covered Person has died.

## DEFINITIONS

The terms, when used in this Policy, will have the following meanings:

**Actual Charges-** means charges for which a Covered Person is held liable. This includes charges that are solely Your responsibility, or charges that are a combination of insurance reimbursement and Your responsibility such as deductibles or co-payment. The fee negotiated between a managed care organization and medical providers would be considered the actual charge.

**Airworthiness Certificate** means the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Agency; or a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

**Civil or Public Aircraft** means an aircraft which has a current and valid Airworthiness Certificate, is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft, and is not operated by the militia or armed forces of any state, national government or international authority.

**Class** means any group of persons insured individually under this policy who have a common bond, such as age, sex, occupation, or geographic area.

**Common Carrier** means only regularly scheduled commercial airlines, passenger trains and intercity buses operating between definitely established terminals.

**Covered Person** means: a) you; and b) each person named as your Dependent in the Application.

**Dependent** means:

- a) your spouse, unless divorced or legally separated from you;
- b) your unmarried child(ren) who are less than age 21 and primarily dependent on you for support and maintenance; and
- c) your unmarried child(ren) who are at least age 21 but less than age 25 who:
  - 1) regularly attend an institution of learning; and
  - 2) are primarily dependent on You for support and maintenance.

A Child includes a stepchild residing with You, a child placed with you for adoption, a legally adopted child and a foster child. Child will also include a grandchild, if, at the time of his or her birth, one parent is Your dependent. If you give Us a Written Request, You may add Dependents to the Policy while it is in force.

**Incapacitated Children:** Coverage of a child who is: a) mentally or physically incapable of earning his or her own living; and b) over the age limit to qualify as a Dependent; and c) unmarried and primarily dependent on you for support and maintenance will not terminate solely due to age. But, you must give us notice of the incapacity. Coverage will continue as long as the incapacity continues and the required premium is paid. We may, from time to time, require proof of continued incapacity and dependency. After the first two years, we cannot require proof more than once each year.

**Injury** means bodily injury resulting directly from an accident which occurs while the person is insured under this Policy and independently of all other causes.

Loss resulting from:

- a) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
- b) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

**Military Transport Aircraft** means a transport aircraft operated by: a) the United States Air Mobility Command (AMC); or b) a national military air transport service of any country.

**Newborn Child Coverage:** If a child is born to the Named Insured or his or her Spouse while this Policy is in force as Family Coverage, the child will become covered by the Policy from the moment of birth.

**On**, when used with reference to any conveyance (land, water or air), means in or on, boarding or alighting from the conveyance.

**Pre-existing Condition** means a condition [a] which manifested itself prior to the effective date of coverage; or [b] for which medical advice or treatment was recommended by or received from a physician in the 5 years prior to the effective date of coverage.

**Total Disability** or **Totally Disabled** means, when the Insured Person is employed, the complete and continuous inability to perform the essential duties of his or her regular occupation. When the Insured Person is unemployed, his or her inability to engage in the normal and customary activities of a person of like age and in good health.

**We, Us** or **Our** means the insurance company named on the face page.

**Written Request** means any form provided by us for the particular coverage.

**You** and **Your** means the Insured Person named on the face page.

## PERIOD OF COVERAGE

**Effective Date of Covered Persons:** Your coverage becomes effective when:

- a) your application has been approved by Us;
- b) the required premium has been paid; and
- c) this Policy has been issued.

**Termination of Covered Persons:** Your coverage terminates on the earliest of:

- a) the date the Policy is terminated;
- b) the date of Your death;
- c) Your attainment of the Policy Age Limit, shown on page 3; or
- d) Your failure to pay the required premium, subject to the Grace Period.

Your spouse, if covered under the policy, becomes the new insured upon Your death or the date Your coverage terminates because You reached the Policy Age Limit.

Coverage for Your spouse will terminate on the first to occur of:

- a) the termination of this Policy;
- b) the date following your divorce, legal separation or annulment of marriage;
- c) your spouse's attainment of the Policy Age Limit, shown on page 3;
- d) the date of your spouse's death; or
- e) failure to pay the required premium, subject to the Grace Period.

Coverage for your dependent child(ren) will terminate on the first to occur of:

- a) the termination of this Policy;
- b) the policy anniversary date after he or she ceases to be a Dependent; or
- c) failure to pay the required premium, subject to the Grace Period.

Termination will be without prejudice to a claim that begins before termination.

## EXCLUSIONS AND LIMITATIONS

This Policy does not cover any loss resulting from:

- a) intentionally self-inflicted Injury;
- b) suicide or attempted suicide, whether sane or insane;
- c) injury incurred prior to the effective date of coverage;
- d) war or act of war, whether declared or undeclared;
- e) injury sustained while in the armed forces of any country or international authority;
- f) injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
- g) injury sustained while riding On any aircraft except as a fare paying passenger in an aircraft provided by a licensed Common Carrier;
- h) injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
- i) injury sustained while committing or attempting to commit a felony;
- j) injury sustained while the Covered Person is operating any motor vehicle while legally intoxicated from the use of alcohol;
- k) injury sustained by a dependent child while practicing for or participating in organized competitive football games;
- l) driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
- m) voluntarily taking poison;
- n) asphyxiation from voluntary inhaling gas or fumes.

## PRE-EXISTING CONDITION LIMITATION

If a Covered Person has a pre-existing condition, We will not pay benefits for such condition during the 2-year period beginning on the policy date, if the condition:

- a) was disclosed without material misrepresentation in answer to questions in the application for this Policy; and
- b) is not excluded by name or specific description.

## BENEFITS

AMOUNT(S) PAYABLE PER UNIT (1 UNIT)
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### ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If a Covered Person's Injury results in any of the following losses within 180 days after the date of accident, we will pay the sum shown opposite the loss.

We will not pay more than the Principal Sum for all losses due to the same accident.

The amount of the Principal Sum is shown on page 3.

For Loss of:	Primary Insured	Spouse	Child
Life	\$20,000	\$10,000	\$5,000
Both Hands or Both Feet or Sight of Both Eyes	\$20,000	\$10,000	\$5,000
Both Arms or Both Legs	\$20,000	\$10,000	\$5,000
One Hand or Arm and One Foot or Leg	\$20,000	\$10,000	\$5,000
Sight of One Eye	\$10,000	\$ 5,000	\$2,500
One Hand or One Arm	\$10,000	\$ 5,000	\$2,500
One Foot or One Leg	\$10,000	\$ 5,000	\$2,500
One or More Entire Toes	\$ 1,000	\$ 500	\$ 250
One or More Entire Fingers	\$ 800	\$ 400	\$ 200

**Loss** means with regard to:

- hands and feet, actual severance through or above wrist or ankle joints;
- sight, entire and irrecoverable loss thereof;
- toes and fingers, actual severance through or above the metacarpophalangeal joints;

If loss is sustained by a Covered Person while riding as a fare-paying passenger on scheduled Common Carrier, the amount of Principal Sum payable under the Accidental Death and Dismemberment Benefit will be tripled.

### DISAPPEARANCE

A Covered Person will be presumed to have suffered loss of life if:

- his or her body has not been found within one year after the disappearance of a covered conveyance in which he or she was an occupant at the time of its disappearance;
- the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
- this Policy would have covered Injury resulting from the accident.

## DISLOCATION AND FRACTURE BENEFIT

If a Covered Person's Injury results in any of the following losses within 90 days after the date of accident, we will pay the sum shown opposite the loss. We will not pay more than the Principal Sum for all losses due to the same accident.

The amount of the Principal Sum for Dislocation and Fracture Benefit is shown on page 3.

<b>For Complete Dislocation of:</b>	Primary Insured	Spouse	Child
Hip Joint	\$ 2,000	\$1,000	\$ 500
Knee Joint (Except Patella)	\$ 800	\$ 400	\$ 200
Bone or Bones of the Foot, Other than Toes	\$ 800	\$ 400	\$ 200
Ankle Joint	\$ 800	\$ 400	\$ 200
Wrist Joint	\$ 700	\$ 350	\$ 175
Elbow Joint	\$ 600	\$ 300	\$ 150
Shoulder Joint	\$ 400	\$ 200	\$ 100
Bone or Bones of the Hand, Other Than Fingers	\$ 300	\$ 150	\$ 75
Collar Bone	\$ 300	\$ 150	\$ 75
Two or More Fingers	\$ 140	\$ 70	\$ 35
Two or More Toes	\$ 140	\$ 70	\$ 35
One Finger or One Toe	\$ 60	\$ 30	\$ 15

<b>For Fracture of Bone or Bones of:</b>			
Skull (except Bones of Face or Nose)	\$1,900	\$ 950	\$ 475
Hip, Thigh (Femur)	\$2,000	\$1,000	\$ 500
Pelvis (Except Coccyx)	\$2,000	\$1,000	\$ 500
Arm, Between Shoulder and Elbow (Shaft)	\$1,100	\$ 550	\$ 275
Shoulder Blade (Scapula)	\$1,100	\$ 550	\$ 275
Leg (Tibia or Fibula)	\$1,100	\$ 550	\$ 275
Ankle	\$ 800	\$ 400	\$ 200
Knee Cap (Patella)	\$ 800	\$ 400	\$ 200
Collar Bone Clavicle	\$ 800	\$ 400	\$ 200
Forearm (Radius or Ulna)	\$ 800	\$ 400	\$ 200
Foot (Except Toes)	\$ 700	\$ 350	\$ 175
Hand or Wrist (Except Fingers)	\$ 700	\$ 350	\$ 175
Lower Jaw (Except Alveolar Process)	\$ 400	\$ 200	\$ 100
Ribs, Fingers or Toes	\$ 300	\$ 150	\$ 75
Bones of Face or Nose	\$ 300	\$ 150	\$ 75
One Rib, Finger or Toe	\$ 140	\$ 70	\$ 35
Coccyx	\$ 140	\$ 70	\$ 35

## ACCIDENT HOSPITAL INDEMNITY BENEFIT

We will pay the Daily Benefit for each day a Covered Person is Confined during one or more periods of hospital Confinement if:

- a) the Confinement is due to Injury; and
- b) the first day of Confinement occurs within 90 days after the accident.

The Daily Benefit is shown on page 3.

**Confined and Confinement** means:

- a) being admitted to a Hospital for receiving inpatient hospital services; and
- b) the patient is charged for at least one day's room and board by the hospital each time he or she is admitted.

A period of Confinement consists of consecutive days of Confinement following the date he or she is admitted as an inpatient. The last calendar day of a period of Confinement is not counted as a day of Confinement unless a Hospital room and board charge is made for the last day. We will pay the daily amount shown on page 3 for Hospital Confinement up to a maximum of 90 days per accident.

## **AMBULANCE SERVICE BENEFIT**

If, as a result of Injury, a Covered Person requires ambulance service for transfer:

- a) to a Hospital; or
- b) from a Hospital;

we will pay the amount shown on page 3 for Ambulance Services. The amount payable for ambulance service will be doubled if the transfer is by air ambulance.

For purposes of the Accident Hospital Indemnity Benefit and the Ambulance Service Benefit, the following definition applies:

**Hospital** means an institution which:

- a) operates pursuant to law;
- b) primarily and continuously provides medical care and treatment of sick and injured persons on an inpatient basis;
- c) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
- d) provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean:

- a) any institution or part thereof which is used primarily as:
  - 1) a nursing home, convalescent home, or skilled nursing facility;
  - 2) a place for drug addicts or alcoholics; or
  - 3) a place for rest, custodial care, or for the aged; and
- b) any institution located outside the United States or its territories.

The Limitation regarding institutions located outside the United States or its territories does not apply if Confinement is due to an emergency.

## **ACCIDENT MEDICAL EXPENSE BENEFIT**

If, as a result of Injury, a Covered Person requires medical or surgical treatment, we will pay the Actual Charges incurred for such treatment up to the maximum benefit amount per Injury shown on page 3.

The expense:

- a) must be incurred within 90 days from the date of Injury; and
- b) incurred for physician fees, X-rays or emergency room treatment.

Repair to a sound natural tooth is also included, if diagnosed by a dentist to have been the result of an accidental injury.

Medical or surgical treatment must be:

- a) prescribed by a legally qualified physician; and
- b) for the sole purpose of treating the Injury.

## CLAIMS

**Notice of Claim:** The person who has the right to claim benefits (the claimant or beneficiary) must give us written notice of a claim within 60 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible, but in no event more than one (1) year after the date of the accident.

The notice should include Your name and the policy number. Send it to Our office, or give it to Our agent.

**Claim Forms:** When We receive the notice of claim, We will send forms to the claimant for giving Us proof of loss. The forms will be sent within 15 days after We receive the notice of claim. If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to Us.

**Proof of Loss:** Proof of loss must be sent to Us in writing within 90 days after:

- a) the end of a period of Our liability for periodic payment claims; or
- b) the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

**Time of Claim Payment:** We will pay any daily, weekly or monthly benefit due:

- a) on a monthly basis, after We receive the proof of loss, while the loss and Our liability continue; or
- b) immediately after We receive the proof of loss following the end of Our liability.

We will pay any other benefit due immediately after We receive the proof of loss.

**Payment of Claims:** We will pay any benefit due for loss of Your life:

- a) according to the beneficiary designation in effect at the time of Your death;
- b) otherwise to Your estate.

All other benefits due and not assigned will be paid to You, if living; otherwise, to Your estate.

If a benefit due is payable to:

- a) Your estate; or
- b) any person who is either a minor or not competent to give a valid release for the payment, we may pay up to \$1,000 of the amount to some other person. The other person will be someone related to the minor or incompetent person by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

**Physical Examinations and Autopsy:** While a claim is pending we have the right at our expense:

- a) to have the person who has a loss examined by a physician when and as often as we feel is necessary; and
- b) to have an autopsy performed in case of death where it is not forbidden by law.

**Legal Actions:** You cannot take legal action against us:

- a) before 60 days following the date proof of loss is sent to us;
- b) after 3 years following the date proof of loss is due.

**Naming a Beneficiary:** You may name a beneficiary or change a revocable named beneficiary by giving your written request to Us. Your request takes effect on the date you execute it, regardless of whether you are living when We receive it. We will be relieved of further responsibility to the extent of any payment we made in good faith before We receive Your request.

**Assignment:** We will recognize an assignment You make under this Policy, provided:

- a) it is duly executed; and
- b) a copy is on file with us.

We assume no responsibility for the validity or effect of an assignment.

# Humana Insurance Company

1100 Employers Boulevard  
Green Bay, Wisconsin 54344  
1-800-845-7519

## TOTAL DISABILITY RIDER - INJURY/SICKNESS

### HIC-ACC-TDR-AR 2/11

(APPLICABLE TO INSURED PERSON ONLY - NOT AVAILABLE TO DEPENDENTS)

In consideration of an additional premium, which is added to the premium for the Policy to which this rider is attached, We will pay the benefits listed on the schedule page of the policy.

### Definitions

**Elimination Period** means a period of consecutive days and Insured must be Totally Disabled in order to qualify for any disability benefit payments. The Elimination Period is shown in the Schedule and begins on the first day of Total Disability. Disability Income Benefits are not payable during the Elimination Period.

**Injury** means bodily injury resulting directly from an accident which occurs while the person is insured under this Policy and independently of all other causes.

Loss resulting from:

- a) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
- b) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

**Sickness** means illness or disease, totally unrelated to an accidental Injury, which:

- a) began after the Policy Effective Date; and
- b) has been medically diagnosed by a licensed physician.

**Total Disability** means, for purposes of this rider:

- a) when the Insured Person is employed, complete and continuous inability of the Insured Person to perform the essential duties of his or her regular occupation; and
- b) when the Insured Person is not employed, he or she must:
  - 1) be receiving regular and personal care from a licensed physician; and
  - 2) either be unable to perform two or more Activities of Daily Living without Stand-by Assistance or be Cognitively Impaired.

**Activities of Daily Living** are:

- a) Bathing - the ability to wash oneself, either in a tub or shower or by sponge bath, with or without equipment or adaptive devices.
- b) Continence - the ability to voluntarily control bowel and bladder function, or, in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.
- c) Dressing - the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn, and to fasten or unfasten them.
- d) Eating - the ability to get nourishment into the body by any means once it has been prepared and made available to you.
- e) Toileting - the ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene and to care for clothing.
- f) Transferring - the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.

**Cognitive Impairment** and **Cognitively Impaired** mean that the Insured Person has suffered a deterioration or loss in his or her intellectual capacity which requires another person's assistance or verbal cueing to protect the Insured Person or others as measured by clinical evidence and standardized tests which reliably measure his or her impairment. Such loss in intellectual capacity can result from Sickness, Alzheimer's Disease or similar forms of senility or irreversible dementia.

**Stand-By Assistance** means the Insured Person requires the presence of another human being to ensure that all or part of an Activity of Daily Living can be completed or to ensure his or her safety.

**Rider Date** is the effective date of coverage under this rider. The Rider Date is the policy date, unless this rider is applied for at a later date. If applied for at a later date, the Rider Date is the effective date assigned by our Home Office in accordance with our policy dating rules in effect at the time this rider is issued

If the Insured Person becomes Totally Disabled, we will pay the Monthly Benefit Amount shown on page 3.

The Accident Total Disability must:

- a) result from Injury;
- b) begin within 90 days of the accident;
- c) continue for three (3) full consecutive days; and
- d) require the regular care of a legally qualified physician other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition.

After the third day of disability, benefits are payable for the first three days and every additional day for up to 6 months.

We will not pay for more than one accident during any period of accident total disability.

The Sickness Total Disability must:

- a) result from a sickness;
- b) continue for past the elimination period selected; and
- c) require the regular care of a legally qualified physician other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition.

For Total Disability of less than one full month, one-thirtieth of the Monthly Benefit amount will be payable for each day of Total Disability.

### **Successive Periods of Disability**

Periods of disability:

- a) due to the same or related medical causes; and
- b) separated by less than 90 days;

will be considered one period of disability while covered under the Policy.

Periods of disability separated by at least 90 days will be considered separate periods of disability.

If the Insured Person becomes Totally Disabled due to Sickness, we will pay the Monthly Benefit Amount shown in the Schedule.

The Total Disability must:

- a) require the care of a legally qualified physician, other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition; and
- b) last at least the number of days indicated above as the Elimination Period.

We will not pay for more than one benefit during any one period of Total Disability, regardless of how many injuries or sicknesses occur.

We will not pay more for the Sickness Total Disability Benefit than the Maximum Benefit Amount shown on the schedule page.

For any period of disability less than a full month, 1/30th of the monthly amount will be paid for each day of Total Disability.

This benefit is subject to the Pre-existing Condition Limitation and the Successive Periods of Disability Limitation. All other general provisions of the Policy to which this rider is attached apply to this rider.

## RIDER RENEWAL PROVISION

This rider is renewable in the same manner as the Policy to which it is attached.

## TERMINATION

This rider terminates:

- a) when coverage terminates under the Policy to which this rider is attached;
- b) when the premium for this rider is not paid before the end of the Grace Period; or
- c) when the Insured Person gave Us Written Notice to terminate this rider.

## PREMIUMS

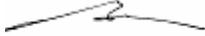
While this rider is in effect, premiums are due according to the terms of the Policy to which this rider is attached. If insufficient premiums are paid, premiums received will be applied first to the policy to which this rider is attached, and then to this rider

We reserve the right to change the premiums for this rider. If We decide to change the premiums, We will do so only:

- a) if We change the premiums for all riders of this same form in the Insured Person's State of residence;
- b) if such change is in accordance with the laws and regulations of the Insured Person's State of residence; and
- c) if We gave the Insured Person at least 60 days notice before such change becomes effective.

This rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Policy, except as stated herein.

Signed for Humana Insurance company

 Michael B. McCallister President	 Gerald L. Gani Vice President
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# Humana Insurance Company

1100 Employers Boulevard  
Green Bay, Wisconsin 54344  
1-800-845-7519

## ADDITIONAL BENEFITS RIDER

### HIC-ACC-ABR-AR 2/11

In consideration of an additional premium, which is added to the premium for the Policy to which this rider is attached, We will pay the benefits listed below.

### Definitions

**Coma** - means a continuous state of profound unconsciousness which lasts 5 or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movement, response to painful stimuli and vocalization. This condition requires intubation for respirator assistance. Medically induced comas are excluded.

**Continuous Hospital Intensive Care Confinement** means one continuous confinement or two or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days separation between confinements, they are considered separate confinements.

**Day** means a continuous 24-hour period.

**Hospital Confined or Confinement** means confinement as an inpatient in a hospital for which a full day's room and board charge is made by the hospital. It does not include confinement in an observation room or a fractional part of a day.

**Hospital Intensive Care Unit (ICU)** means a specifically designated portion of a Hospital that provides the highest level of medical care and is restricted to patients whose condition requires such level of care. The facilities must be apart from the surgical recovery room and from private or semi-private rooms. The ICU must be permanently equipped with special life-saving equipment for the care of the critically ill or injured. The patients must be under constant and continuous care of Nurses assigned just to the ICU. These units must be listed as Intensive Care Units in the current edition of the American Hospital Association Guide or be eligible to be listed therein. This guide lists three types of facilities that meet this definition:

- a) Intensive Care Unit;
- b) Cardiac Intensive Care Unit; and
- c) Infant (neonatal) Intensive Care Unit.

These do not include surgical recovery rooms, progressive care, intermediate care, private monitored rooms, observation units, telemetry units, or other facilities which do not meet the standards for a Intensive Care Unit as defined.

**Injury** means bodily injury resulting directly from an accident which occurs while the person is insured under this Rider and independently of all other causes.

Loss resulting from:

- a) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
- b) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

**Inpatient** means a covered person who is a resident patient using the room and board facilities of a hospital.

**Physical Therapist** means a licensed specialist in physical therapy. Physical Therapist does not include any covered person or any spouse, parent, brother, sister or child of a covered person.

**Rider Date** means the effective date of coverage under this rider. The Rider Date is the policy date, unless this rider is applied for at a later date. If applied for at a later date the Rider Date is the effective date assigned by Our Home Office in accordance with Our policy dating rules in effect at the time this rider is issued.

## Benefit Schedule

### 1 Unit

**Abdominal or Thoracic Surgery Benefit** - We will pay \$1,000 if a covered person undergoes abdominal or thoracic surgery to repair internal injuries as a result of a covered injury. The surgery must be performed within 3 days of the covered accident. For exploratory surgery done with no surgical repair we will pay \$100.

**Accident Follow-Up Treatment Benefit** - We will pay \$50 per day a covered person receives a follow-up treatment provided that a benefit has been paid under the Medical Expense Benefit of the policy. This benefit is limited to 2 treatments per covered accident per covered person. Treatments must be administered by a physician in the physician's office or a hospital on an outpatient basis. Follow-up treatments must begin within 90 days of the covered accident and not take place longer than 6 months after the covered accident. This Benefit is not payable at the same time a benefit is payable under the Physical Therapy Benefit.

**Appliance Benefit** - We will pay \$125 for prescribed medical appliances that aid in personal mobility including wheelchair, crutches or walker. Use of these devices must begin within 90 days after a covered accident and the Benefit is payable only once per covered person per covered accident.

**Blood and Plasma Benefit** - We will pay \$300 for blood or plasma for a transfusion required for a covered accident. The transfusion must be within 3 days of the covered accident and is payable only once per covered person per accident.

**Brain Injury Diagnosis Benefit** - We will pay \$150 for the first diagnosis of the following traumatic brain injuries: cerebral contusion; cerebral laceration; concussion; or intercranial hemorrhage. The covered person must be treated within 3 days of a covered accident; and diagnosis made by computed tomography (CT) scan, electroencephalogram (EEG), magnetic resonance imaging (MRI), positron emission tomography (PET) scan or X-ray must occur within 30 days of the accident. This benefit is payable only once per covered person.

**Burn Benefit** - We will pay \$100 if burns cover less than 15% of the body surface and \$500 if burns cover more than 15% of the body surface for one or more second or third degree burns other than sun burn. Treatment must be within 3 days of the covered accident and the benefit is payable only once per covered person per covered accident.

**Coma Benefit** - We will pay \$15,000 if a covered person is in a coma as defined in this rider which lasts 5 or more consecutive days as a result of a covered accident. This benefit is payable only once per covered person.

**Eye Injury Benefit** - We will pay \$100 for surgery or the removal of a foreign object from the eye. Treatment must be performed by a physician and occur within 90 days of the accident. An examination without anesthesia is not considered a surgery. This benefit is payable only once per covered person per covered accident.

**Family Member Lodging Benefit** - We will pay \$100 per day for lodging of one adult member of a covered person's family when a covered person is confined in a non-local hospital or speciality free standing treatment center undergoing treatment for a covered accident. This benefit is payable for 30 days for each covered accident. This benefit is payable only if the Non-local Transportation Benefit is payable under the covered accident. This benefit will not be paid if the family member lives within 60 miles of the treatment facility.

**Hospital Intensive Care Confinement Benefit** - We will pay \$400 per day that a covered person is confined to a hospital Intensive Care Unit. Confinement must begin within 3 days after a covered accident and is payable for up to 60 days of continuous confinement in the Intensive Care Unit. For a partial day confinement, the daily benefit will be pro-rated based on the number of hours confined divided by 24 hours.

**Immediate Hospitalization Benefit** - We will pay \$1,000 upon the first confinement to a hospital during a calendar year for a covered accident providing that a benefit is payable under the Hospital Confinement Benefit of the policy. The covered person must be confined to the hospital within 3 days of a covered accident and is payable only once per covered person per hospital confinement and only once per calendar year.

**Laceration Benefit** - We will pay \$50 for lacerations or cuts treated by a physician within 3 days of a covered accident. This benefit is only payable once per covered person per calendar year.

**Non Local Transportation Benefit** - We will pay \$300 per trip for non local treatment at a hospital or speciality free standing treatment center nearest the covered person's home. Treatment must be prescribed by a physician and the same treatment or care cannot be obtained locally. Non-local is treatment that is 60 miles or more one way from the covered person's home. We do not pay for visits to a physician's office or clinic or for services other than actual treatment. This benefit is payable 3 times per covered accident. This benefit does not cover ground or air ambulance.

**Paralysis Benefit** - We will pay \$10,000 for paraplegia and \$20,000 for quadriplegia if a covered person receives a spinal cord injury resulting in complete and permanent loss of use of two or more limbs. An attending physician must confirm the paralysis within 3 days of a covered accident and the paralysis must last for at least 90 consecutive days. This benefit is payable only once per covered person.

**Physical Therapy Benefit** - We will pay \$30 per day a covered person receives physical therapy treatment. This benefit is only payable if a benefit has been paid under the Medical Expense Benefit of the policy. We will pay for a maximum of one treatment per day with a maximum of 6 treatments per covered accident per covered person. This benefit is only payable for injuries resulting from a covered accident where benefits begin within 90 days of the covered accident. Treatments after 6 months after a covered accident are not covered. This benefit is not payable for a same visit for which a benefit is payable under the Accident Follow-Up Treatment Benefit.

**Prosthesis Benefit** - We will pay \$500 for one device and \$1,000 for 2 or more devices for a prosthetic hand, foot, or eye that is prescribed by a physician. This benefit is payable if a benefit is paid for the loss of hand, foot, or eye under the Accidental Dismemberment benefit of the policy. The device or devices must be received within 180 days of a covered accident. This benefit is payable only once per covered person per covered accident.

**Ruptured Disc Benefit** - We will pay \$500 for a ruptured disc of the spine. The ruptured disc must be diagnosed as a result of a covered accident and surgically repaired by a physician within 180 days of the date of the covered accident.

**Skin Graft Benefit** - We will pay 50% of the Burn Benefit under this rider if a covered person receives a skin graft for a burn for which a benefit is paid under the Burn Benefit. The skin graft must be performed by a physician to treat a covered burn within 90 days of a covered accident. This benefit is payable only once per covered person per covered accident.

**Tendon, Ligament, Rotator Cuff or Knee Cartilage Benefit** - We will pay \$500 per injury for an injured tendon, ligament, rotator cuff or knee cartilage. The injury site must be torn, ruptured, or severed and surgically repaired by a physician within 180 days of a covered accident. If exploratory surgery using arthroscopy is done and no surgical repair is done, we will pay \$150 for the exploratory surgery. This benefit is not paid if a benefit is paid under the Ruptured Disc Benefit of the rider for the same covered accident.

The benefits under this rider are subject to the Pre-existing Condition Limitation of the policy. All other general provisions of the Policy to which this rider is attached apply to this rider.

## RIDER RENEWAL PROVISION

This rider is renewable in the same manner as the Policy to which it is attached.

## TERMINATION

This rider terminates:

- a) when coverage terminates under the Policy to which this rider is attached;
- b) when the premium for this rider is not paid before the end of the Grace Period; or
- c) when the Insured Person gave Us Written Notice to terminate this rider.

## PREMIUMS

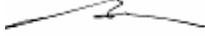
While this rider is in effect, premiums are due according to the terms of the Policy to which this rider is attached. If insufficient premiums are paid, premiums received will be applied first to the policy to which this rider is attached, and then to this rider.

We reserve the right to change the premiums for this rider. If We decide to change the premiums, We will do so only:

- a) if We change the premiums for all riders of this same form in the Insured Person's state of residence;
- b) if such change is in accordance with the laws and regulations of the Insured Person's state of residence; and
- c) if We gave the Insured Person at least 60 days notice before such change becomes effective.

This rider does not vary, waive, alter or extend any of the terms, conditions, or provisions of the Policy, except as stated herein.

Signed for Humana Insurance Company

 Michael B. McCallister President	 Gerald L. Gani Vice President
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**Humana Insurance Company**  
1100 Employers Boulevard  
Green Bay, Wisconsin 54344  
1-800-845-7519

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Named Insured: [ \_\_\_\_\_ ]  
Policy Number: [XXXXXXX]

**ACCIDENTAL DEATH AND DISMEMBERMENT  
POLICY AMENDMENT**

This Policy Amendment is attached to and made part of the Policy effective [Month Day, Year] at 12:01 AM, Standard Time at Your place of residence. Any changes in coverage apply only with respect to covered losses that occur on or after that date. Any changes in premium apply as of the first premium due date on or after the effective date of this Policy Amendment.

In consideration of timely payment of the required premium, the Policy has been as follows:

[ The following Dependent(s) is (are) added/deleted as Covered Persons under the Policy

- John Doe (Spouse)
- Jane Doe (Daughter) ]

[The Total Disability Rider HIC-ACC-TDR is hereby attached to/deleted from the Policy.

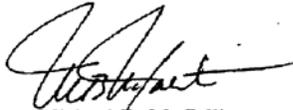
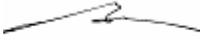
The Additional Benefits Rider HIC-ACC-ABR is hereby attached to/deleted from the Policy.

- The Wellness Benefit Rider HIC-ACC-WBR is hereby attached to/deleted from the Policy. ]

The Total Monthly Premium under the Policy is hereby changed to [\$xxx.xxx]

This Policy Amendment expires concurrently with the Policy and is subject to all of the provisions, limitations and conditions of the Policy except as they are specifically modified by this Policy Amendment.

Signed for by Humana Insurance Company at its Home Office on the Policy Effective Date.

 Michael B. McCallister President	 Gerald L. Ganoni Vice President
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**Humana Insurance Company**  
**1100 Employers Boulevard**  
**Green Bay, Wisconsin 54344**  
**1-800-845-7519**

**ACCIDENTAL DEATH AND DISMEMBERMENT POLICY**  
**REQUIRED OUTLINE OF COVERAGE FOR POLICY FORM HIC-ACC-POL-AR 2/11**  
**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

If you are eligible for Medicare, see the Medicare Supplement Buyers' Guide available from the Company.

**RETAIN THIS FOR YOUR RECORDS!**

- A. **Read Your Policy Carefully!** This outline of coverage provides a very brief description of some of the important policy features. This is not the insurance contract. The actual policy will control. The policy describes, in detail, the rights and obligations of both You and the insurance company. Therefore, it is important that you **READ YOUR POLICY CAREFULLY!**
- B. **ACCIDENTAL DEATH AND DISMEMBERMENT POLICY:** Coverage is provided for accidental death and dismemberment, dislocation or fractures, hospital confinement, ambulance and medical expense.

C. **BENEFITS.**

AMOUNT(S) PAYABLE PER UNIT (1 UNIT)

1. **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT** – We will pay the following amount shown:

<b>For Loss of:</b>	Primary Insured	Spouse	Child
Life	\$20,000	\$10,000	\$5,000
Both Hands or Both Feet or Sight of Both Eyes	\$20,000	\$10,000	\$5,000
Both Arms or Both Legs	\$20,000	\$10,000	\$5,000
One Hand or Arm and One Foot or Leg	\$20,000	\$10,000	\$5,000
Sight of One Eye	\$10,000	\$ 5,000	\$2,500
One Hand or One Arm	\$10,000	\$ 5,000	\$2,500
One Foot or One Leg	\$10,000	\$ 5,000	\$2,500
One or More Entire Toes	\$ 1,000	\$ 500	\$ 250
One or More Entire Fingers	\$ 800	\$ 400	\$ 200

**Loss** means with regard to: a) hands and feet, actual severance through or above wrist or ankle joints; b) sight, entire and irrecoverable loss thereof; c) toes and fingers, actual severance through or above the metacarpophalangeal joints.

**If loss is sustained by a Covered Person while riding as a fare-paying passenger on scheduled Common Carrier, We will pay three times the amount payable under the Accidental Death and Dismemberment Benefit.**

2. **DISLOCATION AND FRACTURE BENEFIT** – We will pay the following amount shown:

<b>For Complete Dislocation of:</b>	Primary Insured	Spouse	Child
Hip Joint	\$2,000	\$1,000	\$500
Knee Joint (Except Patella)	\$ 800	\$ 400	\$200
Bone or Bones of the Foot, Other than Toes	\$ 800	\$ 400	\$200
Ankle Joint	\$ 800	\$ 400	\$200
Wrist Joint	\$ 700	\$ 350	\$175
Elbow Joint	\$ 600	\$ 300	\$150
Shoulder Joint	\$ 400	\$ 200	\$100
Bone or Bones of the Hand, Other Than Fingers	\$ 300	\$ 150	\$ 75
Collar Bone	\$ 300	\$ 150	\$ 75
Two or More Fingers	\$ 140	\$ 70	\$ 35
Two or More Toes	\$ 140	\$ 70	\$ 35
One Finger or One Toe	\$ 60	\$ 30	\$ 15

**DISLOCATION AND FRACTURE BENEFIT (Continued)**

<b>For Fracture of Bone or Bones of:</b>	<b>Primary Insured</b>	<b>Spouse</b>	<b>Child/Children</b>
Skull (except Bones of Face or Nose)	\$1,900	\$ 950	\$ 475
Hip, Thigh (Femur)	\$2,000	\$1,000	\$ 500
Pelvis(Except Coccyx)	\$2,000	\$1,000	\$ 500
Arm, Between Shoulder and Elbow (Shaft)	\$1,100	\$ 550	\$ 275
Shoulder Blade (Scapula)	\$1,100	\$ 550	\$ 275
Leg (Tibia or Fibula)	\$1,100	\$ 550	\$ 275
Ankle	\$ 800	\$ 400	\$ 200
Knee Cap (Patella)	\$ 800	\$ 400	\$ 200
Collar Bone Clavicle	\$ 800	\$ 400	\$ 200
Forearm (Radius or Ulna)	\$ 800	\$ 400	\$ 200
Foot (Except Toes)	\$ 700	\$ 350	\$ 175
Hand or Wrist (Except Fingers)	\$ 700	\$ 350	\$ 175
Lower Jaw (Except Alveolar Process)	\$ 400	\$ 200	\$ 100
Two or More Ribs, Fingers or Toes	\$ 300	\$ 150	\$ 75
Bones of Face or Nose	\$ 300	\$ 150	\$ 75
One Rib, Finger or Toe	\$ 140	\$ 70	\$ 35
Coccyx	\$ 140	\$ 70	\$ 35

3. **ACCIDENT HOSPITAL INDEMNITY BENEFIT** – We will pay \$100 for each day a Covered Person is Confined during one or more periods of Hospital Confinement if: a) the Confinement is due to Injury; or b) the first day of Confinement occurs within 90 days after the accident.
4. **AMBULANCE SERVICE BENEFIT** –We will pay \$100 for regular ambulance and \$200 for air ambulance if as a result of a injury, a Covered Person requires ambulance service for transfer a) to a Hospital; or b) from a Hospital.
5. **ACCIDENT MEDICAL EXPENSE BENEFIT** – We will pay the Actual Charges incurred up to \$250 if, as a result of Injury, a Covered Person requires medical or surgical treatment.

**NUMBER OF UNITS SELECTED**       1 Unit       2 Units       3 Units

**For 2 Units of coverage, benefits are 2 times the amounts shown; and for 3 Units, benefits are 3 times the amounts shown.**

**Actual Charges-** means charges for which a Covered Person is held liable. This includes charges that are solely Your responsibility, or charges that are a combination of insurance reimbursement and Your responsibility such as deductibles or co-payment. The fee negotiated between a managed care organization and medical providers would be considered the actual charge.

**Pre-existing Condition** means a condition [a] which manifested itself prior to the effective date of coverage; or [b] for which medical advice or treatment was recommended by or received from a physician in the 5 years prior to the effective date of coverage.

**PRE-EXISTING CONDITION LIMITATION**

If a Covered Person has a pre-existing condition, We will not pay benefits for such condition during the 2 year period beginning on the policy date. Pre-existing Condition means a condition [a] which manifested itself prior to the effective date of coverage; or [b] for which medical advice or treatment was recommended by or received from a physician in the 5 years prior to the effective date of coverage.

**EXCLUSIONS AND LIMITATIONS**

This Policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury;
2. suicide or attempted suicide, whether sane or insane;
3. injury incurred prior to the effective date of coverage;
4. war or act of war, whether declared or undeclared;
5. injury sustained while in the armed forces of any country or international authority;
6. injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;

7. injury sustained while riding On any aircraft except as a fare paying passenger in an aircraft provided by a licensed Common Carrier;
8. injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
9. injury sustained while committing or attempting to commit a felony;
10. injury sustained while the Covered Person is operating any motor vehicle while legally intoxicated from the use of alcohol;
11. injury sustained by a dependent child while practicing for or participating in organized competitive football games;
12. driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
13. voluntarily taking poison;
14. asphyxiation from voluntary inhaling gas or fumes.

**ADDITIONAL BENEFITS (If Applied for and Approved)**

**TOTAL DISABILITY RIDER - INJURY/SICKNESS HIC-ACC-TDR-AR 2/11. Applied for:**  Yes  No

(APPLICABLE TO INSURED PERSON ONLY - NOT AVAILABLE TO DEPENDENTS)

If the Insured Person becomes Totally Disabled, we will pay the Monthly Benefit Amount as selected by you. You may select in \$100 increments from [\$300 to \$4000] per month benefit. Benefit selected cannot exceed 60% of monthly salary.

The Accident Total Disability must:

- a) result from Injury;
- b) must begin within 90 days of the accident;
- c) continue for three (3) full consecutive days; and
- d) require the regular care of a legally qualified physician other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition.

After the third day of disability, benefits are payable for the first three days and every additional day for up to 6 months. We will not pay for more than one accident during any period of accident total disability.

The Sickness Total Disability must:

- a) result from a sickness;
- b) continue for past the elimination period selected; and
- c) require the regular care of a legally qualified physician other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition.

For Total Disability of less than one full month, one-thirtieth of the Monthly Benefit amount will be payable for each day of Total Disability.

Amount of Monthly Benefit Selected: \$ \_\_\_\_\_

Elimination Period Selected for Sickness:  7 days  14 days  30 days

The benefits under this rider are subject to the Pre-existing Condition Limitation of the policy. All other general provisions of the Policy to which this rider is attached apply to this rider.

**RIDER RENEWAL PROVISION**

This rider is renewable in the same manner as the Policy to which it is attached.

**Successive Periods of Disability**

Periods of disability:

- a) due to the same or related medical causes; and
- b) separated by less than 90 days;

will be considered one period of disability while covered under the Policy.

Periods of disability separated by at least 90 days will be considered separate periods of disability.

If the Insured Person becomes Totally Disabled due to Sickness, we will pay the Monthly Benefit Amount shown in Schedule Page 4 of the policy. The Benefit will begin on the day following the elimination period selected.

The Total Disability must:

- a) require the care of a legally qualified physician, other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition; and
- b) last at least the number of days indicated above as the Elimination Period.

All other general provisions of the Policy to which this rider is attached apply to this rider.

### TERMINATION

This rider terminates:

- a) when coverage terminates under the Policy to which this rider is attached;
- b) when the premium for this rider is not paid before the end of the Grace Period; or
- c) when the Insured Person gave Us Written Notice to terminate this rider.

**ADDITIONAL BENEFITS RIDER - HIC-ACC-ABR-AR 2/11** Applied for:  Yes  No

### Benefit Schedule 1 Unit

**Abdominal or Thoracic Surgery Benefit** - We will pay \$1,000 if a covered person undergoes abdominal or thoracic surgery to repair internal injuries as a result of a covered injury. The surgery must be performed within 3 days of the covered accident. For exploratory surgery done with no surgical repair We will pay \$100.

**Accident Follow-Up Treatment Benefit** - We will pay \$50 per day a covered person receives a follow-up treatment provided that a benefit has been paid under the Medical Expense Benefit of the policy. This benefit is limited to 2 treatments per covered accident per covered person. Treatments must be administered by a physician in the physician's office or a hospital on an outpatient basis. Follow-up treatments must begin within 90 days of the covered accident and not take place longer than 6 months after the covered accident. This Benefit is not payable at the same time a benefit is payable under the Physical Therapy Benefit.

**Appliance Benefit** - We will pay \$125 for prescribed medical appliances that aid in personal mobility including wheelchair, crutches or walker. Use of these devices must begin within 90 days after a covered accident and the Benefit is payable only once per covered person per covered accident.

**Blood and Plasma Benefit** - We will pay \$300 for blood or plasma for a transfusion required for a covered accident. The transfusion must be within 3 days of the covered accident and is payable only once per covered person per accident.

**Brain Injury Diagnosis Benefit** - We will pay \$150 for the first diagnosis of the following traumatic brain injuries: cerebral contusion; cerebral laceration; concussion; or intercranial hemorrhage. The covered person must be treated within 3 days of a covered accident; and diagnosis made by computed tomography (CT) scan, electroencephalogram (EEG), magnetic resonance imaging (MRI), positron emission tomography (PET) scan or X-ray must occur within 30 days of the accident. This benefit is payable only once per covered person.

**Burn Benefit** - We will pay \$100 if burns cover less than 15% of the body surface and \$500 if burns cover more than 15% of the body surface for one or more second or third degree burns other than sunburn. Treatment must be within 3 days of the covered accident and the benefit is payable only once per covered person per covered accident.

**Coma Benefit** - We will pay \$15,000 if a covered person is in a Coma as defined in this rider which lasts 5 or more consecutive days as a result of a covered accident. This benefit is payable only once per covered person.

**Eye Injury Benefit** - We will pay \$100 for surgery or the removal of a foreign object from the eye. Treatment must be performed by a physician and occur within 90 days of the accident. An examination without anesthesia is not considered a surgery. This benefit is payable only once per covered person per covered accident.

**Family Member Lodging Benefit** - We will pay \$100 per day for lodging of one adult member of a covered person's family when a covered person is confined in a non-local hospital or speciality free standing treatment center while undergoing treatment for a covered accident. This benefit is payable for 30 days for each covered accident. This benefit is payable only if the Non-local Transportation Benefit is payable under the covered accident. This benefit will not be paid if the family member lives within 60 miles of the treatment facility.

**Hospital Intensive Care Confinement Benefit** - We will pay \$400 per day that a covered person is confined to a hospital Intensive Care Unit. Confinement must begin within 3 days after a covered accident and is payable for up to 60 days of continuous confinement in the Intensive Care Unit. For a partial day confinement, the daily benefit will be pro-rated based on the number of hours confined divided by 24 hours.

**Immediate Hospitalization Benefit** - We will pay \$1,000 upon the first confinement to a hospital during a calendar year for a covered accident providing that a benefit is payable under the Hospital Confinement Benefit of the policy. The covered person must be confined to the hospital within 3 days of a covered accident and is payable only once per covered person per hospital confinement and only once per calendar year.

**Laceration Benefit** - We will pay \$50 for lacerations or cuts treated by a physician within 3 days of a covered accident. This benefit is only payable once per covered person per calendar year.

**Non Local Transportation Benefit** - We will pay \$300 per trip for non local treatment at a hospital or specialty free standing treatment center nearest the covered person's home. Treatment must be prescribed by a physician and the same treatment or care cannot be obtained locally. Non-local is treatment that is 60 miles or more one way from the covered person's home. We do not pay for visits to a physician's office or clinic or for services other than actual treatment. This benefit is payable 3 times per covered accident. This benefit does not cover ground or air ambulance.

**Paralysis Benefit** - We will pay \$10,000 for paraplegia and \$20,000 for quadriplegia if a covered person receives a spinal cord injury resulting in complete and permanent loss of use of two or more limbs. An attending physician must confirm the paralysis within 3 days of a covered accident and the paralysis must last for at least 90 consecutive days. This benefit is payable only once per covered person.

**Physical Therapy Benefit** - We will pay \$30 per day a covered person receives physical therapy treatment. This benefit is only payable if a benefit has been paid under the Medical Expense Benefit of the policy. We will pay for a maximum of one treatment per day with a maximum of 6 treatments per covered accident per covered person. This benefit is only payable for injuries resulting from a covered accident where benefits begin within 90 days of the covered accident. Treatments after 6 months after a covered accident are not covered. This benefit is not payable for a same visit for which a benefit is payable under the Accident Follow-Up Treatment Benefit.

**Prosthesis Benefit** - We will pay \$500 for one device and \$1,000 for 2 or more devices for a prosthetic hand, foot, or eye that is prescribed by a physician. This benefit is payable if a benefit is paid for the loss of hand, foot, or eye under the Accidental Dismemberment benefit of the policy. The device or devices must be received within 180 days of a covered accident. This benefit is payable only once per covered person per covered accident.

**Ruptured Disc Benefit** - We will pay \$500 for a ruptured disc of the spine. The ruptured disc must be diagnosed as a result of a covered accident and surgically repaired by a physician within 180 days of the date of the covered accident.

**Skin Graft Benefit** - We will pay 50% of the Burn Benefit under this rider if a covered person receives a skin graft for a burn for which a benefit is paid under the Burn Benefit. The skin graft must be performed by a physician to treat a covered burn within 90 days of a covered accident. This benefit is payable only once per covered person per covered accident.

**Tendon, Ligament, Rotator Cuff or Knee Cartilage Benefit** - We will pay \$500 per injury for an injured tendon, ligament, rotator cuff or knee cartilage. The injury site must be torn, ruptured, or severed and surgically repaired by a physician within 180 days of a covered accident. If exploratory surgery using arthroscopy is done and no surgical repair is done, we will pay \$150 for the exploratory surgery. This benefit is not paid if a benefit is paid under the Ruptured Disc Benefit of the rider for the same covered accident.

The benefits under this rider are subject to the Pre-existing Condition Limitation of the policy. All other general provisions of the Policy to which this rider is attached apply to this rider.

The benefits under this rider are subject to the Pre-existing Condition Limitation of the policy. All other general provisions of the Policy to which this rider is attached apply to this rider.

**RIDER RENEWAL PROVISION**

This rider is renewable in the same manner as the Policy to which it is attached.

**TERMINATION**

This rider terminates:

- a) when coverage terminates under the Policy to which this rider is attached;
- b) when the premium for this rider is not paid before the end of the Grace Period; or
- c) when the Insured Person gave Us Written Notice to terminate this rider.

**WELLNESS BENEFIT RIDER HIC-ACC-WBR-AR 2/11. Applied for:**  Yes  No

**NUMBER OF UNITS SELECTED**  1 Unit  2 Units

For 2 Units of coverage, benefits are 2 times the amounts shown.

We will pay \$25 (twenty-five dollars) if You or any one eligible family member undergoes routine examinations or other preventive testing during the following Policy year. Services covered are: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings. The Benefit is limited to 2 visits per calendar year per Covered Person; and a maximum of 4 visits per calendar year if the policy is in force as family coverage. Eligible Family Members are Your Spouse and the Dependent Children of either You or Your Spouse. Service must be under the supervision of or recommended by a Physician, received while Your Policy is in force, and a charge must be incurred.

**D. RENEWAL AGREEMENT**

Except for fraud or material misrepresentation, you have the right to renew this policy to age 70 as long as premiums are paid on time. This policy will terminate on the last day of the period for which premium is paid unless continued in force during a grace period.

**E. TOTAL PREMIUM.** The annual premium is \$\_\_\_\_\_ ; if other than annual \$ «PREM\_TOTAL», mode monthly.

A grace period of 31 days will be granted for the payment of each premium after the first. Your policy remains in force during the grace period. Family plan coverage may include the following: you; your spouse; your unmarried dependent children under age 21 (25 if full-time student); grandchildren dependent upon you for income tax purposes; and children required to be insured under a medical support order by a court. Incapacitated children are covered in accordance with the incapacitated child continuation provision in the policy.

**Premium Change**

We have the right, after the first Premium Due Date, to change the rate at which further premiums will be calculated for all insureds of Your rate class and same State of issue. No Insured Person will receive a rate increase prior to the annual anniversary date of the Policy. After the first annual anniversary date of the Policy, a premium increase will not be given more frequently than once in a 12 month period. We will give you notice of any change at least 60 days before the Premium Due Date on which it is to become effective.

I hereby acknowledge that this outline of coverage was delivered to me on \_\_\_\_\_, 20\_\_\_\_\_.

This outline of coverage is not a contract. It is intended only as a general description of the policy provisions in the planning of your program. The benefits are determined by the terms and conditions of the policy alone. IN ALL CASES, CONSULT YOUR POLICY FOR FULL DETAILS.

**RETAIN FOR YOUR RECORDS.**

**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.  
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE  
GOVERNING CONTRACTUAL PROVISIONS**

**APPLICATION FOR  
ACCIDENT COVERAGE/TOTAL DISABILITY SICKNESS RIDER**  
Humana Insurance Company  
1100 Employers Boulevard, Green Bay, Wisconsin 54344

**ADMINISTERED BY:**  
Bay Bridge Administrators, LLC  
P.O. Box 161690 Austin, TX 78716  
(800) 845-7519

PROPOSED INSURED		LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH	AGE
STATE OF BIRTH	HEIGHT	WEIGHT	SOCIAL SECURITY NO.		MAILING ADDRESS		
CITY	STATE	ZIP	PHONE NO.		OCCUPATION	ANNUAL SALARY	

**Complete For Family Coverage:**

FIRST / LAST NAME	DOB	AGE	SEX	FIRST / LAST NAME	DOB	AGE	SEX
Spouse				Child			
Child				Child			
Child				Child			

**1. ACTIVELY AT WORK:** Is the proposed insured actively at work now and has she/he worked at least 17.5 hours a week for the last 6 months (except for minor illness or injury of one week or less or for normal pregnancy)?  Yes  No (If No, explain on reverse)

**2. SELECTION OF COVERAGE: [MONTHLY PAYROLL DEDUCTION]**

[ACCIDENT PLAN FORM HIC-ACC-POL-AR 2/11	ADDITIONAL BENEFIT RIDER FORM HIC-ACC-ABR-AR 2/11	WELLNESS BENEFIT RIDER FORM HIC-ACC-WBR-AR 2/11
<input type="checkbox"/> 1 Unit	<input type="checkbox"/> 1 Unit	<input type="checkbox"/> 1 Unit
<input type="checkbox"/> 2 Units		<input type="checkbox"/> 2 Units
<input type="checkbox"/> 3 Units		
<input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Individual & Child(ren) <input type="checkbox"/> Family              Monthly Rate \$ _____		

**[TOTAL DISABILITY RIDER (INDIVIDUAL ONLY)  
FORM HIC-ACC-TDR-AR 2/11**      MONTHLY DISABILITY BENEFIT \$ \_\_\_\_\_  
Elimination Period Sickness  7 days     14 days     30 days  
Monthly Rate \$ \_\_\_\_\_

I hereby authorize my Employer \_\_\_\_\_ to reduce my salary by the TOTAL DEDUCTION and forward this amount to Humana Insurance Company. The TOTAL DEDUCTION is calculated so as to produce the premium as shown herein.

3. COMPLETED BY AGENT	TOTAL DEDUCTION
Frequency of Deduction: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly	\$ _____

**4. REPRESENTATION AND AUTHORIZATION OF APPLICANT:**

**A. ACCIDENT PLAN, ACCIDENT BENEFIT RIDER AND WELLNESS BENEFIT RIDER PLAN**

- Do you have any other similar coverage in force or an application for similar insurance pending with this or any other company?  Yes  No
- Is the insurance applied for to replace or change any insurance in this or any other company?  Yes  No  
If "Yes" give Company Name and Policy Number \_\_\_\_\_

**B. TOTAL DISABILITY RIDER - SO FAR AS YOU KNOW AND BELIEVE:**

- Do you have any disease, disorder or impairment?  Yes  No
- Are you pregnant?  Yes  No
- Have you ever had or been told you had, or been treated for: Acquired Immune Deficiency Syndrome (AIDS), tuberculosis, disease of heart or circulatory system, high blood pressure, alcohol or drug dependency, ulcer or other disease of digestive system, epilepsy, nervous breakdown, psychiatric treatment, disease of urinary system, disease or disorder of the respiratory and reproductive system, cancer, diabetes, rupture, rheumatism, arthritis, or back, knee, bone, or joint condition?  Yes  No
- Have you consulted or been treated by any physician or practitioner in the past five years?  Yes  No
- Have you been advised to have an operation which has not been performed?  Yes  No
- Within the past two years have you lost time from work for sickness or accident for a period of four or more consecutive days?  Yes  No

If the answer is "Yes" to any question, explain fully on reverse

Agent's Signature \_\_\_\_\_

Signature of Proposed Insured \_\_\_\_\_

Agent's Number \_\_\_\_\_

Date of Signature \_\_\_\_\_

I acknowledge receipt of the outline of coverage for this plan? Yes No

I understand that death benefits are payable to the insured, if living, to the named beneficiary, if living, otherwise to the spouse of the insured, if living, otherwise to the estate of the deceased to whom benefits are payable.

Name and Relationship of Beneficiary: \_\_\_\_\_

I have read, or had read to me, the completed application and realize that any false statement or misrepresentation in this application may result in loss of coverage, subject to the Incontestability provision. I represent that the statements and answers given on this application are true, complete and correctly recorded. I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to Humana Insurance Company or its reinsurers any information. A copy of this Authorization is as valid as the original. This authorization applies to dependents on whom insurance is requested.

REMARKS:

Details of "Yes" answers to question B: \_\_\_\_\_

Details of "Yes" answers to question B4: (explain fully giving: 1) Name(s) and Address(s) of Doctor(s), 2) Dates of Treatment, 3) Ailment, 4) Degree of Recovery) \_\_\_\_\_

**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.**

<b>Agent Use Only</b>	
Case #: _____	Agent Split: _____
Date of First Deduction: _____	Agent II: _____%
Requested Effective Date: _____	Agent III: _____%

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance policy number \_\_\_\_\_, you have with \_\_\_\_\_ Insurance Company, and replace it with a policy to be **issued by Humana Insurance Company**. For your information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

\_\_\_\_\_ Insurance Company, and replace it with a policy to be **issued by Humana Insurance Company**. For your information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

Company, and replace it with a policy to be **issued by Humana Insurance Company**. For your information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(2) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your

medical/health history are truthfully and completely answered. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed, it should be carefully reviewed before being signed to be certain that all information has been properly recorded.

(3) New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

(4) This "Notice to Applicant" was delivered to me on:

(date) \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Signature of Witness / Agent \_\_\_\_\_

**COMPLETE THIS FORM IN DUPLICATE, ONE COPY TO BE LEFT WITH APPLICANT AND ONE COPY RETURNED TO THE HOME OFFICE.**

**PLAN ADMINISTERED BY  
BAY BRIDGE ADMINISTRATORS, LLC  
P.O. Box 161690  
Austin, Texas 78716  
(800) 845-7519**

SERFF Tracking Number: ICCL-127017751 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 47917  
 Company Tracking Number: HIC-ACC-POL 2/11  
 TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment  
 Product Name: Individual Accidental Death & Dismemberment  
 Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

**Rate Information**

Rate data applies to filing.

**Filing Method:** for approval  
**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:	Company Rate Change:	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):
Humana Insurance Company	N/A	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: *ICCI-127017751* State: *Arkansas*  
 Filing Company: *Humana Insurance Company* State Tracking Number: *47917*  
 Company Tracking Number: *HIC-ACC-POL 2/11*  
 TOI: *H03I Individual Health - Accidental Death & Dismemberment* Sub-TOI: *H03I.000 Health - Accidental Death & Dismemberment*  
 Product Name: *Individual Accidental Death & Dismemberment*  
 Project Name/Number: *HIC-ACC-POL 2/11/HIC-ACC-POL 2/11*

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 02/23/2011	Rate sheet	HIC-ACC-POL 2/11	New		Rates - Accident Policy.pdf

**Annual Premium Rates - Payroll Deduction Basis**

<u>Coverage Tier</u>	<u>Per Unit Base Policy</u>	<u>Per Unit Additional Benefit Rider</u>	<u>Per Unit Wellness Rider</u>	<u>Per \$100 7 -Day Elimination For Sickness Disability Rider</u>	<u>Per \$100 14 -Day Elimination For Sickness Disability Rider</u>	<u>Per \$100 30 -Day Elimination For Sickness Disability Rider</u>
Individual	112.74	39.44	42.34	63.72	56.34	42.23
Ind + Spouse	201.83	78.88	82.10			
Ind + Child(ren)	209.58	88.28	87.71			
Family	298.66	127.73	96.52			

**Annual Premium Rates - Direct Sales**

Ages	Per Unit		Per Unit		Per Unit		Per Unit		Per Unit		Per Unit		Per Unit									
	Base	Male	Base	Female	Additional	Benefit	Rider	Male	Additional	Benefit	Rider	Female	7 Day Sickness Elimination Period		14 Day Sickness Elimination Period		30 Day Sickness Elimination Period					
													Per \$100	Disability	Per \$100	Disability	Per \$100	Disability	Per \$100	Disability	Per \$100	Disability
Under 30	141.63		63.34		22.36		47.49		50.00		36.09		42.47		30.69		42.47		30.69		29.14	
30-34	132.36		79.48		28.78		44.79		62.98		39.27		54.23		32.54		54.23		32.54		36.29	
35-39	137.06		89.00		32.61		47.37		71.58		42.31		61.74		34.61		61.74		34.61		41.41	
40-44	120.63		93.66		34.47		41.27		76.77		46.64		66.50		37.74		66.50		37.74		45.46	
45-49	117.06		103.23		38.28		40.10		78.45		52.52		68.58		42.22		68.58		42.22		48.67	
50-54	119.71		114.03		42.67		40.77		78.99		60.23		69.91		48.42		69.91		48.42		52.32	
55-59	115.23		126.69		47.44		38.37		82.29		69.71		73.50		56.48		73.50		56.48		58.12	
60+	116.29		157.62		59.26		37.81		91.65		80.71		81.89		66.20		81.89		66.20		67.18	

G. P. MONNIN CONSULTING, INC.

Accident Policy - Blended Rates for Actuarial Memo.xls For Memo - Individual

## Annual Premium Rates - Direct Sales

### Spouse Rates

<u>Ages</u>	Per Unit		Per Unit	Per Unit
	Base	Base	Additional	Additional
	<u>Male</u>	<u>Female</u>	<u>Benefit</u>	<u>Benefit</u>
			<u>Rider</u>	<u>Rider</u>
			<u>Male</u>	<u>Female</u>
Under 30	110.20	50.21	47.49	22.36
30-34	103.33	63.61	44.79	28.78
35-39	107.81	71.54	47.37	32.61
40-44	94.54	75.42	41.27	34.47
45-49	91.79	83.36	40.10	38.28
50-54	93.67	92.41	40.77	42.67
55-59	89.43	102.69	38.37	47.44
60+	89.50	127.95	37.81	59.26

**Annual Premium Rates - Direct Sales**

**Child(ren) Rates**

Per Unit	Per Unit Additional Benefit
<u>Base</u>	<u>Rider</u>
96.83	48.84

**Annual Premium Rates - Direct Sales**

**Wellness Rider Rates per Unit**

One Unit = \$25 per visit benefit

	<u>Annual Rates</u>
Wellness Ind	42.34
Wellness Ind + SP	82.10
Wellness Ind + Ch	87.71
Wellness Ind + Fam	96.52

Note: Rates do not vary by age or sex

## **Appendix C**

### Projection of Loss Ratios

Policy Year	Premium	Claims	Loss Ratio
1	341.52	162.49	47.6%
2	209.67	100.86	48.1%
3	149.07	72.39	48.6%
4	116.76	57.44	49.2%
5	94.94	47.31	49.8%
6	78.99	39.86	50.5%
7	66.54	34.30	51.5%
8	56.03	29.49	52.6%
9	44.63	23.10	51.8%
10	37.59	19.80	52.7%
11	30.38	16.16	53.2%
12	25.48	14.14	55.5%
13	21.43	12.37	57.7%
14	16.64	9.22	55.4%
15	14.00	7.86	56.1%
16	11.30	6.36	56.2%
17	9.46	5.55	58.7%
18	7.94	4.85	61.1%
19	5.83	3.31	56.7%
20	4.90	2.83	57.7%
21	3.93	2.28	57.9%
22	3.30	2.01	60.9%
23	2.76	1.76	63.9%
24	1.94	1.11	57.4%
25	1.63	0.96	58.8%
26	1.36	0.82	60.3%
27	1.14	0.73	64.3%
28	0.96	0.65	68.3%
29	0.64	0.39	60.2%
30	0.54	0.33	61.9%
Present Value at 4.0%	1,361.28	680.73	50.0%

SERFF Tracking Number: ICCI-127017751 State: Arkansas  
 Filing Company: Humana Insurance Company State Tracking Number: 47917  
 Company Tracking Number: HIC-ACC-POL 2/11  
 TOI: H03I Individual Health - Accidental Death & Dismemberment Sub-TOI: H03I.000 Health - Accidental Death & Dismemberment  
 Product Name: Individual Accidental Death & Dismemberment  
 Project Name/Number: HIC-ACC-POL 2/11/HIC-ACC-POL 2/11

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> Cert of Comp. with Rule 19 Ind acc.pdf	Approved-Closed	02/23/2011
<b>Satisfied - Item:</b> Application <b>Comments:</b> See form schedule tab	Approved-Closed	02/23/2011
<b>Satisfied - Item:</b> Outline of Coverage <b>Comments:</b> see form schedule tab	Approved-Closed	02/23/2011
<b>Satisfied - Item:</b> Authorization Letter <b>Comments:</b> <b>Attachment:</b> Humana Insurance Company Authorization letter _2011_.pdf	Approved-Closed	02/23/2011

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: Humana Insurance Company

Form Number(s): HIC-ACC-POL-AR 2/11, HIC-ACC-TDR-AR 2/11, HIC-ACC-WBR-AR 2/11, HIC-ACC-ABR-AR 2/11, HIC-ACC-AMENDMENT, HIC-ACC-OCC-AR 2/11, HIC-ACC-APP-AR 2/11

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.



\_\_\_\_\_  
Signature of Company Officer

Gerald L. Ganoni Name

President  
Title

February 7, 2011  
Date



January 1, 2011

To: All State Insurance Departments

Humana Insurance Company hereby authorizes Insurance Compliance Consultants, Inc., to file the attached form(s) or a state specific variation of it, and to act on Our behalf regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Humana Insurance Company may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

Dave Vanden Heuvel  
Director of Business Services  
Humana Insurance Company

SERFF Tracking Number: *ICCI-127017751* State: *Arkansas*  
 Filing Company: *Humana Insurance Company* State Tracking Number: *47917*  
 Company Tracking Number: *HIC-ACC-POL 2/11*  
 TOI: *H03I Individual Health - Accidental Death & Dismemberment* Sub-TOI: *H03I.000 Health - Accidental Death & Dismemberment*  
 Product Name: *Individual Accidental Death & Dismemberment*  
 Project Name/Number: *HIC-ACC-POL 2/11/HIC-ACC-POL 2/11*

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
02/07/2011	Form	Accidental Death & Dismemberment Policy	02/22/2011	HIC ACC POL AR 2-11.pdf (Superseded)
02/07/2011	Form	Outline of Coverage	02/22/2011	HIC-ACC-OOC-AR 2-11.pdf (Superseded)

**Humana Insurance Company**  
**1100 Employers Boulevard**  
**Green Bay, Wisconsin 54344**  
**1-800-845-7519**

NAMED INSURED: [ADAM SMITH]

TYPE OF COVERAGE: [INDIVIDUAL]

POLICY EFFECTIVE DATE: [JULY 1, 2009]

PREMIUM: [\$00.00]

POLICY NUMBER: [00000001]

RENEWAL PREMIUM PERIOD: [MONTHLY]

**ACCIDENTAL DEATH AND DISMEMBERMENT POLICY**

**PREMIUMS SUBJECT TO CHANGE ON RENEWAL**

**IMPORTANT -- PLEASE READ**

Your application is attached to and forms a part of the Policy. PLEASE READ the copy of Your application. If anything in it is not correct, You must tell Us immediately. Your Policy was issued on the basis that all information in the application is correct and complete. If not, Your Policy may not be valid.

**30-DAY RIGHT TO EXAMINE POLICY**

WE URGE YOU TO EXAMINE THIS POLICY CLOSELY. If you are not satisfied, You may return it to us or to the agent from whom it was purchased within 30 days after that event; we will consider it void from the Policy Date and any premium paid will be returned.

**GUARANTEED RENEWABLE**

Your Policy is Guaranteed Renewable until age 70, by payment of premiums as they become due. This Policy will terminate on the last day of the period for which premium is paid unless continued in force during a Grace Period.

**PREMIUM CHANGE**

We have the right to change the table of premium rates for this Policy. The change in premium will apply to all policies of this form number issued to insureds in Your state of residence. Premiums will be charged in accordance with the table of premium rates using the original classification.

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

If You are eligible for Medicare, review the Medicare Supplement Buyers' Guide available from the Company.

**THIS IS AN ACCIDENT ONLY POLICY WHICH DOES NOT PAY BENEFITS FOR A LOSS FROM SICKNESS.**

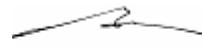
**This is a Non-Participating Policy.**

**Pre-Existing Conditions Not Paid - Subject to the Time Limit on Certain Defenses**

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

Signed for Humana Insurance Company at its Home Office on the Policy Effective Date.

  
Michael B. McCallister  
President

  
Gerald L. Ganoni  
Vice President

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**POLICY SPECIFICATIONS**

**INSURED** [ADAM SMITH]  
**POLICY EFFECTIVE DATE** [July 1, 2009]  
**POLICY NUMBER** [0000000001]  
**ISSUE AGE** [35]  
**INITIAL PREMIUM** [\$00.00]  
**TOTAL MONTHLY PREMIUM** [\$00.00]  
**TERMINATION DATE**

**POLICY AGE LIMIT: Insured Person - 70; Spouse - 70**

<u>DESCRIPTION OF BENEFITS</u> ACCIDENT PLAN	<u>NUMBER OF UNITS ELECTED</u> [1-3]	<u>MONTHLY PREMIUM AMOUNT</u> [\$00.00]		
		<u>INSURED</u>	<u>SPOUSE</u>	<u>CHILD</u>
<b>[ INDIVIDUAL COVERAGE ]</b>				
1. ACCIDENTAL DEATH OR DISMEMBERMENT: WITH COMMON CARRIER BENEFIT				
PRINCIPAL SUM		[20,000]	[10,000]	[5,000]
2. DISLOCATION OR FRACTURE: PRINCIPAL SUM		[2,000]	[1,000]	[500]
3. HOSPITAL CONFINEMENT: DAILY BENEFIT		[100]	[100]	[100]
4. AMBULANCE BENEFIT: REGULAR AIR		[100] [200]	[100] [200]	[100] [200]
5. EXPENSES - MAXIMUM BENEFIT		[250]	[250]	[250]

**ADDITIONAL BENEFIT (AS PROVIDED BY RIDER)**

HIC-ACC-TDR TOTAL DISABILITY RIDER	[\$0 Per Month]	[\$00.00]
HIC-ACC-ABR ADDITIONAL BENEFIT RIDER	[1 Unit]	[\$00.00]
HIC-ACC-WBR WELLNESS BENEFIT RIDER	[1 Unit]	[\$00.00]

## CONTRACT PROVISIONS

**Entire Contract:** The entire contract between You and Us consists of Your application, this Policy, and any riders or endorsements, copies of which are attached at issue.

**Policy Premiums:** The initial premium for this Policy is shown on page 3 under Policy Specifications.

**Change in Premiums:** We have the right, after the first Premium Due Date, to change the rate at which further premiums will be calculated for all insureds of Your rate class and same State of issue. We will give you notice of any change at least 60 days before the Premium Due Date on which it is to become effective.

**Premium Due Dates:** The Policy Premium is payable on the Policy Effective Date and the first day of each month thereafter. Each Policy Premium is due in advance of the date it becomes payable. This Policy will terminate on the last day of the period for which premium is paid unless continued in force during a grace period.

**Misstatement of Age:** If You have misstated your age, the premium amount due will be the amount necessary to purchase coverage for Your correct age.

**Changes:** No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of Our executive officers and attached to this Policy.

**Time Limit on Certain Defenses:** No misstatement in your application can be used to deny a claim or void this Policy unless:

- a) the misstatement was fraudulent; or
- b) your loss began within 2 years after You became an Insured Person.

We cannot deny or reduce a claim for Your loss commencing after 2 years from the date You became an Insured Person on the basis that a disease or physical condition existed before that date unless it is excluded by name or specific condition.

**Conformity with State Statutes.** On the Policy Effective Date, any part of this Policy in conflict with the statutes of the state in which it is delivered or issued for delivery is amended to agree with the statute's minimum requirements.

**Time Periods.** All periods begin and end at 12:01 A.M., Standard Time, at Your residence.

**Grace Period.** A grace period of 31 days is allowed after the due date for payment of each premium after the first premium payment. This Policy will continue in force during the grace period. If the premium is not paid during the grace period, this Policy will terminate at the end of the grace period.

**Reinstatement.** This Policy may be reinstated if it has terminated because the premium due was not paid before the end of the grace period. Reinstatement will only be allowed if:

- a) all past due premium is paid; and
- b) the reinstatement request is received together with one (1) month's premium within sixty (60) days of the end of the grace period.

The reinstated policy will cover only Injury occurring after the date of reinstatement.

If the period before reinstatement is more than 60 days after the end of the grace period, We will require the completion of a new application in addition to the required premium payment.

**Unpaid Premium.** Upon the payment of a claim under this Policy, any unpaid premium will be deducted.

## DEFINITIONS

The terms, when used in this Policy, will have the following meanings:

**Actual Charges-** means charges for which a Covered Person is held liable. This includes charges that are solely Your responsibility, or charges that are a combination of insurance reimbursement and Your responsibility such as deductibles or co-payment. The fee negotiated between a managed care organization and medical providers would be considered the actual charge.

**Airworthiness Certificate** means the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Agency; or a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

**Civil or Public Aircraft** means an aircraft which has a current and valid Airworthiness Certificate, is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft, and is not operated by the militia or armed forces of any state, national government or international authority.

**Class** means any group of persons insured individually under this policy who have a common bond, such as age, sex, occupation, or geographic area.

**Common Carrier** means only regularly scheduled commercial airlines, passenger trains and intercity buses operating between definitely established terminals.

**Covered Person** means: a) you; and b) each person named as your Dependent in the Application.

**Dependent** means:

- a) your spouse, unless divorced or legally separated from you;
- b) your unmarried child(ren) who are less than age 21 and primarily dependent on you for support and maintenance; and
- c) your unmarried child(ren) who are at least age 21 but less than age 25 who:
  - 1) regularly attend an institution of learning; and
  - 2) are primarily dependent on You for support and maintenance.

A Child includes a stepchild residing with You, a child placed with you for adoption, a legally adopted child and a foster child. Child will also include a grandchild, if, at the time of his or her birth, one parent is Your dependent. If you give Us a Written Request, You may add Dependents to the Policy while it is in force.

**Incapacitated Children:** Coverage of a child who is: a) mentally or physically incapable of earning his or her own living; and b) over the age limit to qualify as a Dependent; and c) unmarried and primarily dependent on you for support and maintenance will not terminate solely due to age. But, you must give us notice of the incapacity within 31 days of the termination date. Coverage will continue as long as the incapacity continues and the required premium is paid. We may, from time to time, require proof of continued incapacity and dependency. After the first two years, we cannot require proof more than once each year.

**Injury** means bodily injury resulting directly from an accident which occurs while the person is insured under this Policy and independently of all other causes.

Loss resulting from:

- a) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
- b) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

**Military Transport Aircraft** means a transport aircraft operated by: a) the United States Air Mobility Command (AMC); or b) a national military air transport service of any country.

**Newborn Child Coverage:** If a child is born to the Named Insured or his or her Spouse while this Policy is in force as Family Coverage, the child will become covered by the Policy from the moment of birth.

**On**, when used with reference to any conveyance (land, water or air), means in or on, boarding or alighting from the conveyance.

**Pre-existing Condition** means a condition [a] which manifested itself prior to the effective date of coverage; or [b] for which medical advice or treatment was recommended by or received from a physician in the 5 years prior to the effective date of coverage.

**Total Disability or Totally Disabled** means, when the Insured Person is employed, the complete and continuous inability to perform the essential duties of his or her regular occupation. When the Insured Person is unemployed, his or her inability to engage in the normal and customary activities of a person of like age and in good health.

**We, Us or Our** means the insurance company named on the face page.

**Written Request** means any form provided by us for the particular coverage.

**You and Your** means the Insured Person named on the face page.

## PERIOD OF COVERAGE

**Effective Date of Covered Persons:** Your coverage becomes effective when:

- a) your application has been approved by Us;
- b) the required premium has been paid; and
- c) this Policy has been issued.

**Termination of Covered Persons:** Your coverage terminates on the earliest of:

- a) the date the Policy is terminated;
- b) the date of Your death;
- c) Your attainment of the Policy Age Limit, shown on page 3; or
- d) Your failure to pay the required premium, subject to the Grace Period.

Your spouse, if covered under the policy, becomes the new insured upon Your death or the date Your coverage terminates because You reached the Policy Age Limit.

Coverage for Your spouse will terminate on the first to occur of:

- a) the termination of this Policy;
- b) the date following your divorce, legal separation or annulment of marriage;
- c) your spouse's attainment of the Policy Age Limit, shown on page 3;
- d) the date of your spouse's death; or
- e) failure to pay the required premium, subject to the Grace Period.

Coverage for your dependent child(ren) will terminate on the first to occur of:

- a) the termination of this Policy;
- b) the policy anniversary date after he or she ceases to be a Dependent; or
- c) failure to pay the required premium, subject to the Grace Period.

Termination will be without prejudice to a claim that begins before termination.

## EXCLUSIONS AND LIMITATIONS

This Policy does not cover any loss resulting from:

- a) intentionally self-inflicted Injury;
- b) suicide or attempted suicide, whether sane or insane;
- c) injury incurred prior to the effective date of coverage;
- d) war or act of war, whether declared or undeclared;
- e) injury sustained while in the armed forces of any country or international authority;
- f) injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
- g) injury sustained while riding On any aircraft except as a fare paying passenger in an aircraft provided by a licensed Common Carrier;
- h) injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
- i) injury sustained while committing or attempting to commit a felony;
- j) injury sustained while the Covered Person is operating any motor vehicle while legally intoxicated from the use of alcohol;
- k) hernia, including complications due to hernia;
- l) injury sustained by a dependent child while practicing for or participating in organized competitive football games;
- m) driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
- n) voluntarily taking poison;
- o) asphyxiation from voluntary inhaling gas or fumes.

## PRE-EXISTING CONDITION LIMITATION

If a Covered Person has a pre-existing condition, We will not pay benefits for such condition during the 2-year period beginning on the policy date, if the condition:

- a) was disclosed without material misrepresentation in answer to questions in the application for this Policy; and
- b) is not excluded by name or specific description.

## BENEFITS

<b>AMOUNT(S) PAYABLE PER UNIT (1 UNIT)</b>
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### ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If a Covered Person's Injury results in any of the following losses within 180 days after the date of accident, we will pay the sum shown opposite the loss.

We will not pay more than the Principal Sum for all losses due to the same accident.

The amount of the Principal Sum is shown on page 3.

For Loss of:	Primary Insured	Spouse	Child
Life	\$20,000	\$10,000	\$5,000
Both Hands or Both Feet or Sight of Both Eyes	\$20,000	\$10,000	\$5,000
Both Arms or Both Legs	\$20,000	\$10,000	\$5,000
One Hand or Arm and One Foot or Leg	\$20,000	\$10,000	\$5,000
Sight of One Eye	\$10,000	\$ 5,000	\$2,500
One Hand or One Arm	\$10,000	\$ 5,000	\$2,500
One Foot or One Leg	\$10,000	\$ 5,000	\$2,500
One or More Entire Toes	\$ 1,000	\$ 500	\$ 250
One or More Entire Fingers	\$ 800	\$ 400	\$ 200

**Loss** means with regard to:

- a) hands and feet, actual severance through or above wrist or ankle joints;
- b) sight, entire and irrecoverable loss thereof;
- c) toes and fingers, actual severance through or above the metacarpophalangeal joints;

If loss is sustained by a Covered Person while riding as a fare-paying passenger on scheduled Common Carrier, the amount of Principal Sum payable under the Accidental Death and Dismemberment Benefit will be tripled.

### DISAPPEARANCE

A Covered Person will be presumed to have suffered loss of life if:

- a) his or her body has not been found within one year after the disappearance of a covered conveyance in which he or she was an occupant at the time of its disappearance;
- b) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
- c) this Policy would have covered Injury resulting from the accident.

## DISLOCATION AND FRACTURE BENEFIT

If a Covered Person's Injury results in any of the following losses within 90 days after the date of accident, we will pay the sum shown opposite the loss. We will not pay more than the Principal Sum for all losses due to the same accident.

The amount of the Principal Sum for Dislocation and Fracture Benefit is shown on page 3.

<b>For Complete Dislocation of:</b>	Primary Insured	Spouse	Child
Hip Joint	\$ 2,000	\$1,000	\$ 500
Knee Joint (Except Patella)	\$ 800	\$ 400	\$ 200
Bone or Bones of the Foot, Other than Toes	\$ 800	\$ 400	\$ 200
Ankle Joint	\$ 800	\$ 400	\$ 200
Wrist Joint	\$ 700	\$ 350	\$ 175
Elbow Joint	\$ 600	\$ 300	\$ 150
Shoulder Joint	\$ 400	\$ 200	\$ 100
Bone or Bones of the Hand, Other Than Fingers	\$ 300	\$ 150	\$ 75
Collar Bone	\$ 300	\$ 150	\$ 75
Two or More Fingers	\$ 140	\$ 70	\$ 35
Two or More Toes	\$ 140	\$ 70	\$ 35
One Finger or One Toe	\$ 60	\$ 30	\$ 15
<b>For Fracture of Bone or Bones of:</b>			
Skull (except Bones of Face or Nose)	\$1,900	\$ 950	\$ 475
Hip, Thigh (Femur)	\$2,000	\$1,000	\$ 500
Pelvis (Except Coccyx)	\$2,000	\$1,000	\$ 500
Arm, Between Shoulder and Elbow (Shaft)	\$1,100	\$ 550	\$ 275
Shoulder Blade (Scapula)	\$1,100	\$ 550	\$ 275
Leg (Tibia or Fibula)	\$1,100	\$ 550	\$ 275
Ankle	\$ 800	\$ 400	\$ 200
Knee Cap (Patella)	\$ 800	\$ 400	\$ 200
Collar Bone Clavicle	\$ 800	\$ 400	\$ 200
Forearm (Radius or Ulna)	\$ 800	\$ 400	\$ 200
Foot (Except Toes)	\$ 700	\$ 350	\$ 175
Hand or Wrist (Except Fingers)	\$ 700	\$ 350	\$ 175
Lower Jaw (Except Alveolar Process)	\$ 400	\$ 200	\$ 100
Ribs, Fingers or Toes	\$ 300	\$ 150	\$ 75
Bones of Face or Nose	\$ 300	\$ 150	\$ 75
One Rib, Finger or Toe	\$ 140	\$ 70	\$ 35
Coccyx	\$ 140	\$ 70	\$ 35

## ACCIDENT HOSPITAL INDEMNITY BENEFIT

We will pay the Daily Benefit for each day a Covered Person is Confined during one or more periods of hospital Confinement if:

- a) the Confinement is due to Injury; and
- b) the first day of Confinement occurs within 90 days after the accident.

The Daily Benefit is shown on page 3.

**Confined and Confinement** means:

- a) being admitted to a Hospital for receiving inpatient hospital services; and
- b) the patient is charged for at least one day's room and board by the hospital each time he or she is admitted.

A period of Confinement consists of consecutive days of Confinement following the date he or she is admitted as an inpatient. The last calendar day of a period of Confinement is not counted as a day of Confinement unless a Hospital room and board charge is made for the last day. We will pay the daily amount shown on page 3 for Hospital Confinement up to a maximum of 90 days per accident.

## **AMBULANCE SERVICE BENEFIT**

If, as a result of Injury, a Covered Person requires ambulance service for transfer:

- a) to a Hospital; or
- b) from a Hospital;

we will pay the amount shown on page 3 for Ambulance Services. The amount payable for ambulance service will be doubled if the transfer is by air ambulance.

For purposes of the Accident Hospital Indemnity Benefit and the Ambulance Service Benefit, the following definition applies:

**Hospital** means an institution which:

- a) operates pursuant to law;
- b) primarily and continuously provides medical care and treatment of sick and injured persons on an inpatient basis;
- c) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
- d) provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean:

- a) any institution or part thereof which is used primarily as:
  - 1) a nursing home, convalescent home, or skilled nursing facility;
  - 2) a place for drug addicts or alcoholics; or
  - 3) a place for rest, custodial care, or for the aged; and
- b) any institution located outside the United States or its territories.

The Limitation regarding institutions located outside the United States or its territories does not apply if Confinement is due to an emergency.

## **ACCIDENT MEDICAL EXPENSE BENEFIT**

If, as a result of Injury, a Covered Person requires medical or surgical treatment, we will pay the Actual Charges incurred for such treatment up to the maximum benefit amount per Injury shown on page 3.

The expense:

- a) must be incurred within 90 days from the date of Injury; and
- b) incurred for physician fees, X-rays or emergency room treatment.

Repair to a sound natural tooth is also included, if diagnosed by a dentist to have been the result of an accidental injury.

Medical or surgical treatment must be:

- a) prescribed by a legally qualified physician; and
- b) for the sole purpose of treating the Injury.

## CLAIMS

**Notice of Claim:** The person who has the right to claim benefits (the claimant or beneficiary) must give us written notice of a claim within 60 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible, but in no event more than one (1) year after the date of the accident.

The notice should include Your name and the policy number. Send it to Our office, or give it to Our agent.

**Claim Forms:** When We receive the notice of claim, We will send forms to the claimant for giving Us proof of loss. The forms will be sent within 15 days after We receive the notice of claim. If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to Us.

**Proof of Loss:** Proof of loss must be sent to Us in writing within 90 days after:

- a) the end of a period of Our liability for periodic payment claims; or
- b) the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

**Time of Claim Payment:** We will pay any daily, weekly or monthly benefit due:

- a) on a monthly basis, after We receive the proof of loss, while the loss and Our liability continue; or
- b) immediately after We receive the proof of loss following the end of Our liability.

We will pay any other benefit due immediately after We receive the proof of loss.

**Payment of Claims:** We will pay any benefit due for loss of Your life:

- a) according to the beneficiary designation in effect at the time of Your death;
- b) otherwise to Your estate.

All other benefits due and not assigned will be paid to You, if living; otherwise, to Your estate.

If a benefit due is payable to:

- a) Your estate; or
- b) any person who is either a minor or not competent to give a valid release for the payment, we may pay up to \$1,000 of the amount to some other person. The other person will be someone related to the minor or incompetent person by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

**Physical Examinations and Autopsy:** While a claim is pending we have the right at our expense:

- a) to have the person who has a loss examined by a physician when and as often as we feel is necessary; and
- b) to have an autopsy performed in case of death where it is not forbidden by law.

**Legal Actions:** You cannot take legal action against us:

- a) before 60 days following the date proof of loss is sent to us;
- b) after 3 years following the date proof of loss is due.

**Naming a Beneficiary:** You may name a beneficiary or change a revocable named beneficiary by giving your written request to Us. Your request takes effect on the date you execute it, regardless of whether you are living when We receive it. We will be relieved of further responsibility to the extent of any payment we made in good faith before We receive Your request.

**Assignment:** We will recognize an assignment You make under this Policy, provided:

- a) it is duly executed; and
- b) a copy is on file with us.

We assume no responsibility for the validity or effect of an assignment.

**Humana Insurance Company**  
**1100 Employers Boulevard**  
**Green Bay, Wisconsin 54344**  
**1-800-845-7519**

**ACCIDENTAL DEATH AND DISMEMBERMENT POLICY**  
**REQUIRED OUTLINE OF COVERAGE FOR POLICY FORM HIC-ACC-POL-AR 2/11**  
**THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

If you are eligible for Medicare, see the Medicare Supplement Buyers' Guide available from the Company.

**RETAIN THIS FOR YOUR RECORDS!**

- A. **Read Your Policy Carefully!** This outline of coverage provides a very brief description of some of the important policy features. This is not the insurance contract. The actual policy will control. The policy describes, in detail, the rights and obligations of both You and the insurance company. Therefore, it is important that you **READ YOUR POLICY CAREFULLY!**
- B. **ACCIDENTAL DEATH AND DISMEMBERMENT POLICY:** Coverage is provided for accidental death and dismemberment, dislocation or fractures, hospital confinement, ambulance and medical expense.

C. **BENEFITS.**

AMOUNT(S) PAYABLE PER UNIT (1 UNIT)

1. **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT** – We will pay the following amount shown:

<b>For Loss of:</b>	Primary Insured	Spouse	Child
Life	\$20,000	\$10,000	\$5,000
Both Hands or Both Feet or Sight of Both Eyes	\$20,000	\$10,000	\$5,000
Both Arms or Both Legs	\$20,000	\$10,000	\$5,000
One Hand or Arm and One Foot or Leg	\$20,000	\$10,000	\$5,000
Sight of One Eye	\$10,000	\$ 5,000	\$2,500
One Hand or One Arm	\$10,000	\$ 5,000	\$2,500
One Foot or One Leg	\$10,000	\$ 5,000	\$2,500
One or More Entire Toes	\$ 1,000	\$ 500	\$ 250
One or More Entire Fingers	\$ 800	\$ 400	\$ 200

**Loss** means with regard to: a) hands and feet, actual severance through or above wrist or ankle joints; b) sight, entire and irrecoverable loss thereof; c) toes and fingers, actual severance through or above the metacarpophalangeal joints.

**If loss is sustained by a Covered Person while riding as a fare-paying passenger on scheduled Common Carrier, We will pay three times the amount payable under the Accidental Death and Dismemberment Benefit.**

2. **DISLOCATION AND FRACTURE BENEFIT** – We will pay the following amount shown:

<b>For Complete Dislocation of:</b>	Primary Insured	Spouse	Child
Hip Joint	\$2,000	\$1,000	\$500
Knee Joint (Except Patella)	\$ 800	\$ 400	\$200
Bone or Bones of the Foot, Other than Toes	\$ 800	\$ 400	\$200
Ankle Joint	\$ 800	\$ 400	\$200
Wrist Joint	\$ 700	\$ 350	\$175
Elbow Joint	\$ 600	\$ 300	\$150
Shoulder Joint	\$ 400	\$ 200	\$100
Bone or Bones of the Hand, Other Than Fingers	\$ 300	\$ 150	\$ 75
Collar Bone	\$ 300	\$ 150	\$ 75
Two or More Fingers	\$ 140	\$ 70	\$ 35
Two or More Toes	\$ 140	\$ 70	\$ 35
One Finger or One Toe	\$ 60	\$ 30	\$ 15

**DISLOCATION AND FRACTURE BENEFIT (Continued)**

<b>For Fracture of Bone or Bones of:</b>	<b>Primary Insured</b>	<b>Spouse</b>	<b>Child/Children</b>
Skull (except Bones of Face or Nose)	\$1,900	\$ 950	\$ 475
Hip, Thigh (Femur)	\$2,000	\$1,000	\$ 500
Pelvis(Except Coccyx)	\$2,000	\$1,000	\$ 500
Arm, Between Shoulder and Elbow (Shaft)	\$1,100	\$ 550	\$ 275
Shoulder Blade (Scapula)	\$1,100	\$ 550	\$ 275
Leg (Tibia or Fibula)	\$1,100	\$ 550	\$ 275
Ankle	\$ 800	\$ 400	\$ 200
Knee Cap (Patella)	\$ 800	\$ 400	\$ 200
Collar Bone Clavicle	\$ 800	\$ 400	\$ 200
Forearm (Radius or Ulna)	\$ 800	\$ 400	\$ 200
Foot (Except Toes)	\$ 700	\$ 350	\$ 175
Hand or Wrist (Except Fingers)	\$ 700	\$ 350	\$ 175
Lower Jaw (Except Alveolar Process)	\$ 400	\$ 200	\$ 100
Two or More Ribs, Fingers or Toes	\$ 300	\$ 150	\$ 75
Bones of Face or Nose	\$ 300	\$ 150	\$ 75
One Rib, Finger or Toe	\$ 140	\$ 70	\$ 35
Coccyx	\$ 140	\$ 70	\$ 35

3. **ACCIDENT HOSPITAL INDEMNITY BENEFIT** – We will pay \$100 for each day a Covered Person is Confined during one or more periods of Hospital Confinement if: a) the Confinement is due to Injury; or b) the first day of Confinement occurs within 90 days after the accident.
4. **AMBULANCE SERVICE BENEFIT** –We will pay \$100 for regular ambulance and \$200 for air ambulance if as a result of a injury, a Covered Person requires ambulance service for transfer a) to a Hospital; or b) from a Hospital.
5. **ACCIDENT MEDICAL EXPENSE BENEFIT** – We will pay the Actual Charges incurred up to \$250 if, as a result of Injury, a Covered Person requires medical or surgical treatment.

**NUMBER OF UNITS SELECTED**       1 Unit       2 Units       3 Units

**For 2 Units of coverage, benefits are 2 times the amounts shown; and for 3 Units, benefits are 3 times the amounts shown.**

**Actual Charges-** means charges for which a Covered Person is held liable. This includes charges that are solely Your responsibility, or charges that are a combination of insurance reimbursement and Your responsibility such as deductibles or co-payment. The fee negotiated between a managed care organization and medical providers would be considered the actual charge.

**Pre-existing Condition** means a condition [a] which manifested itself prior to the effective date of coverage; or [b] for which medical advice or treatment was recommended by or received from a physician in the 5 years prior to the effective date of coverage.

**PRE-EXISTING CONDITION LIMITATION**

If a Covered Person has a pre-existing condition, We will not pay benefits for such condition during the 2 year period beginning on the policy date. Pre-existing Condition means a condition [a] which manifested itself prior to the effective date of coverage; or [b] for which medical advice or treatment was recommended by or received from a physician in the 5 years prior to the effective date of coverage.

**EXCLUSIONS AND LIMITATIONS**

This Policy does not cover any loss resulting from:

1. intentionally self-inflicted Injury;
2. suicide or attempted suicide, whether sane or insane;
3. injury incurred prior to the effective date of coverage;
4. war or act of war, whether declared or undeclared;
5. injury sustained while in the armed forces of any country or international authority;
6. injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;

7. injury sustained while riding On any aircraft except as a fare paying passenger in an aircraft provided by a licensed Common Carrier;
8. injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
9. injury sustained while committing or attempting to commit a felony;
10. injury sustained while the Covered Person is operating any motor vehicle while legally intoxicated from the use of alcohol;
11. hernia, including complications due to hernia;
12. injury sustained by a dependent child while practicing for or participating in organized competitive football games;
13. driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway;
14. voluntarily taking poison;
15. asphyxiation from voluntary inhaling gas or fumes.

**ADDITIONAL BENEFITS (If Applied for and Approved)**

**TOTAL DISABILITY RIDER - INJURY/SICKNESS HIC-ACC-TDR-AR 2/11. Applied for:**  Yes  No

(APPLICABLE TO INSURED PERSON ONLY - NOT AVAILABLE TO DEPENDENTS)

If the Insured Person becomes Totally Disabled, we will pay the Monthly Benefit Amount as selected by you. You may select in \$100 increments from [\$300 to \$4000] per month benefit. Benefit selected cannot exceed 60% of monthly salary.

The Accident Total Disability must:

- a) result from Injury;
- b) must begin within 90 days of the accident;
- c) continue for three (3) full consecutive days; and
- d) require the regular care of a legally qualified physician other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition.

After the third day of disability, benefits are payable for the first three days and every additional day for up to 6 months. We will not pay for more than one accident during any period of accident total disability.

The Sickness Total Disability must:

- a) result from a sickness;
- b) continue for past the elimination period selected; and
- c) require the regular care of a legally qualified physician other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition.

For Total Disability of less than one full month, one-thirtieth of the Monthly Benefit amount will be payable for each day of Total Disability.

Amount of Monthly Benefit Selected: \$ \_\_\_\_\_

Elimination Period Selected for Sickness:  7 days  14 days  30 days

The benefits under this rider are subject to the Pre-existing Condition Limitation of the policy. All other general provisions of the Policy to which this rider is attached apply to this rider.

**RIDER RENEWAL PROVISION**

This rider is renewable in the same manner as the Policy to which it is attached.

**Successive Periods of Disability**

Periods of disability:

- a) due to the same or related medical causes; and
- b) separated by less than 90 days;

will be considered one period of disability while covered under the Policy.

Periods of disability separated by at least 90 days will be considered separate periods of disability.

If the Insured Person becomes Totally Disabled due to Sickness, we will pay the Monthly Benefit Amount shown in Schedule Page 4 of the policy. The Benefit will begin on the day following the elimination period selected.

The Total Disability must:

- a) require the care of a legally qualified physician, other than the Insured Person, unless the Insured Person's physician states that further treatment will not improve the Insured Person's condition; and
- b) last at least the number of days indicated above as the Elimination Period.

All other general provisions of the Policy to which this rider is attached apply to this rider.

### TERMINATION

This rider terminates:

- a) when coverage terminates under the Policy to which this rider is attached;
- b) when the premium for this rider is not paid before the end of the Grace Period; or
- c) when the Insured Person gave Us Written Notice to terminate this rider.

**ADDITIONAL BENEFITS RIDER - HIC-ACC-ABR-AR 2/11** Applied for:  Yes  No

### Benefit Schedule 1 Unit

**Abdominal or Thoracic Surgery Benefit** - We will pay \$1,000 if a covered person undergoes abdominal or thoracic surgery to repair internal injuries as a result of a covered injury. The surgery must be performed within 3 days of the covered accident. For exploratory surgery done with no surgical repair We will pay \$100.

**Accident Follow-Up Treatment Benefit** - We will pay \$50 per day a covered person receives a follow-up treatment provided that a benefit has been paid under the Medical Expense Benefit of the policy. This benefit is limited to 2 treatments per covered accident per covered person. Treatments must be administered by a physician in the physician's office or a hospital on an outpatient basis. Follow-up treatments must begin within 90 days of the covered accident and not take place longer than 6 months after the covered accident. This Benefit is not payable at the same time a benefit is payable under the Physical Therapy Benefit.

**Appliance Benefit** - We will pay \$125 for prescribed medical appliances that aid in personal mobility including wheelchair, crutches or walker. Use of these devices must begin within 90 days after a covered accident and the Benefit is payable only once per covered person per covered accident.

**Blood and Plasma Benefit** - We will pay \$300 for blood or plasma for a transfusion required for a covered accident. The transfusion must be within 3 days of the covered accident and is payable only once per covered person per accident.

**Brain Injury Diagnosis Benefit** - We will pay \$150 for the first diagnosis of the following traumatic brain injuries: cerebral contusion; cerebral laceration; concussion; or intercranial hemorrhage. The covered person must be treated within 3 days of a covered accident; and diagnosis made by computed tomography (CT) scan, electroencephalogram (EEG), magnetic resonance imaging (MRI), positron emission tomography (PET) scan or X-ray must occur within 30 days of the accident. This benefit is payable only once per covered person.

**Burn Benefit** - We will pay \$100 if burns cover less than 15% of the body surface and \$500 if burns cover more than 15% of the body surface for one or more second or third degree burns other than sunburn. Treatment must be within 3 days of the covered accident and the benefit is payable only once per covered person per covered accident.

**Coma Benefit** - We will pay \$15,000 if a covered person is in a Coma as defined in this rider which lasts 5 or more consecutive days as a result of a covered accident. This benefit is payable only once per covered person.

**Eye Injury Benefit** - We will pay \$100 for surgery or the removal of a foreign object from the eye. Treatment must be performed by a physician and occur within 90 days of the accident. An examination without anesthesia is not considered a surgery. This benefit is payable only once per covered person per covered accident.

**Family Member Lodging Benefit** - We will pay \$100 per day for lodging of one adult member of a covered person's family when a covered person is confined in a non-local hospital or speciality free standing treatment center while undergoing treatment for a covered accident. This benefit is payable for 30 days for each covered accident. This benefit is payable only if the Non-local Transportation Benefit is payable under the covered accident. This benefit will not be paid if the family member lives within 60 miles of the treatment facility.

**Hospital Intensive Care Confinement Benefit** - We will pay \$400 per day that a covered person is confined to a hospital Intensive Care Unit. Confinement must begin within 3 days after a covered accident and is payable for up to 60 days of continuous confinement in the Intensive Care Unit. For a partial day confinement, the daily benefit will be pro-rated based on the number of hours confined divided by 24 hours.

**Immediate Hospitalization Benefit** - We will pay \$1,000 upon the first confinement to a hospital during a calendar year for a covered accident providing that a benefit is payable under the Hospital Confinement Benefit of the policy. The covered person must be confined to the hospital within 3 days of a covered accident and is payable only once per covered person per hospital confinement and only once per calendar year.

**Laceration Benefit** - We will pay \$50 for lacerations or cuts treated by a physician within 3 days of a covered accident. This benefit is only payable once per covered person per calendar year.

**Non Local Transportation Benefit** - We will pay \$300 per trip for non local treatment at a hospital or specialty free standing treatment center nearest the covered person's home. Treatment must be prescribed by a physician and the same treatment or care cannot be obtained locally. Non-local is treatment that is 60 miles or more one way from the covered person's home. We do not pay for visits to a physician's office or clinic or for services other than actual treatment. This benefit is payable 3 times per covered accident. This benefit does not cover ground or air ambulance.

**Paralysis Benefit** - We will pay \$10,000 for paraplegia and \$20,000 for quadriplegia if a covered person receives a spinal cord injury resulting in complete and permanent loss of use of two or more limbs. An attending physician must confirm the paralysis within 3 days of a covered accident and the paralysis must last for at least 90 consecutive days. This benefit is payable only once per covered person.

**Physical Therapy Benefit** - We will pay \$30 per day a covered person receives physical therapy treatment. This benefit is only payable if a benefit has been paid under the Medical Expense Benefit of the policy. We will pay for a maximum of one treatment per day with a maximum of 6 treatments per covered accident per covered person. This benefit is only payable for injuries resulting from a covered accident where benefits begin within 90 days of the covered accident. Treatments after 6 months after a covered accident are not covered. This benefit is not payable for a same visit for which a benefit is payable under the Accident Follow-Up Treatment Benefit.

**Prosthesis Benefit** - We will pay \$500 for one device and \$1,000 for 2 or more devices for a prosthetic hand, foot, or eye that is prescribed by a physician. This benefit is payable if a benefit is paid for the loss of hand, foot, or eye under the Accidental Dismemberment benefit of the policy. The device or devices must be received within 180 days of a covered accident. This benefit is payable only once per covered person per covered accident.

**Ruptured Disc Benefit** - We will pay \$500 for a ruptured disc of the spine. The ruptured disc must be diagnosed as a result of a covered accident and surgically repaired by a physician within 180 days of the date of the covered accident.

**Skin Graft Benefit** - We will pay 50% of the Burn Benefit under this rider if a covered person receives a skin graft for a burn for which a benefit is paid under the Burn Benefit. The skin graft must be performed by a physician to treat a covered burn within 90 days of a covered accident. This benefit is payable only once per covered person per covered accident.

**Tendon, Ligament, Rotator Cuff or Knee Cartilage Benefit** - We will pay \$500 per injury for an injured tendon, ligament, rotator cuff or knee cartilage. The injury site must be torn, ruptured, or severed and surgically repaired by a physician within 180 days of a covered accident. If exploratory surgery using arthroscopy is done and no surgical repair is done, we will pay \$150 for the exploratory surgery. This benefit is not paid if a benefit is paid under the Ruptured Disc Benefit of the rider for the same covered accident.

The benefits under this rider are subject to the Pre-existing Condition Limitation of the policy. All other general provisions of the Policy to which this rider is attached apply to this rider.

The benefits under this rider are subject to the Pre-existing Condition Limitation of the policy. All other general provisions of the Policy to which this rider is attached apply to this rider.

**RIDER RENEWAL PROVISION**

This rider is renewable in the same manner as the Policy to which it is attached.

**TERMINATION**

This rider terminates:

- a) when coverage terminates under the Policy to which this rider is attached;
- b) when the premium for this rider is not paid before the end of the Grace Period; or
- c) when the Insured Person gave Us Written Notice to terminate this rider.

**WELLNESS BENEFIT RIDER HIC-ACC-WBR-AR 2/11. Applied for:**  Yes  No

**NUMBER OF UNITS SELECTED**  1 Unit  2 Units

For 2 Units of coverage, benefits are 2 times the amounts shown.

We will pay \$25 (twenty-five dollars) if You or any one eligible family member undergoes routine examinations or other preventive testing during the following Policy year. Services covered are: annual physical examinations, dental exams, mammograms, Pap smears, eye examinations, immunizations, flexible sigmoidoscopies, prostate-specific antigen tests (PSAs), ultrasounds, and blood screenings. The Benefit is limited to 2 visits per calendar year per Covered Person; and a maximum of 4 visits per calendar year if the policy is in force as family coverage. Eligible Family Members are Your Spouse and the Dependent Children of either You or Your Spouse. Service must be under the supervision of or recommended by a Physician, received while Your Policy is in force, and a charge must be incurred.

**D. RENEWAL AGREEMENT**

Except for fraud or material misrepresentation, you have the right to renew this policy to age 70 as long as premiums are paid on time. This policy will terminate on the last day of the period for which premium is paid unless continued in force during a grace period.

**E. TOTAL PREMIUM.** The annual premium is \$\_\_\_\_\_ ; if other than annual \$ «PREM\_TOTAL», mode monthly.

A grace period of 31 days will be granted for the payment of each premium after the first. Your policy remains in force during the grace period. Family plan coverage may include the following: you; your spouse; your unmarried dependent children under age 21 (25 if full-time student); grandchildren dependent upon you for income tax purposes; and children required to be insured under a medical support order by a court. Incapacitated children are covered in accordance with the incapacitated child continuation provision in the policy.

**Premium Change**

We have the right to change the table of premium rates for this policy. The change in premium will apply to all policies of this form number issued to insureds in your State of residence. Premiums will be charged in accordance with the table of premium rates using the original classification.

I hereby acknowledge that this outline of coverage was delivered to me on \_\_\_\_\_, 20\_\_\_\_\_.

This outline of coverage is not a contract. It is intended only as a general description of the policy provisions in the planning of your program. The benefits are determined by the terms and conditions of the policy alone. IN ALL CASES, CONSULT YOUR POLICY FOR FULL DETAILS.

**RETAIN FOR YOUR RECORDS.**

**THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.  
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE  
GOVERNING CONTRACTUAL PROVISIONS**