Filing at a Glance

Company: Unified Life Insurance Company

Product Name: ULIC XB Gp Acc Sick Assn	SERFF Tr Num: CMPL-127288307	State: Arkansas
TOI: H14G Group Health - Hospital Indemnity	SERFF Status: Closed-Approved-Closed	State Tr Num: 49112
Sub-TOI: H14G.000 Health - Hospital Indemnity	Co Tr Num: ULIC XB GP ACC SICK	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Nancy French	Disposition Date: 06/30/2011
	Date Submitted: 06/23/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: ULIC XB Gp Acc Sick Assn
Project Number: ULIC XB Gp Acc Sick Assn
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Association
Filing Status Changed: 06/30/2011
State Status Changed: 06/30/2011
Created By: Nancy French
Corresponding Filing Tracking Number:
Filing Description:
Dear Commissioner:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Deemer Date:
Submitted By: Nancy French

Compliance Research Services is pleased to submit the enclosed forms on behalf of Unified Life Insurance Company (Unified). A letter of filing authorization is enclosed.

The purpose of this submission is to allow Unified to provide group accident and sickness coverage to residents of your state who are members of the National Congress of Employers (NCE), an association based in the District of Columbia. Coverage will be provided to individual association members and their dependents. It will not be issued to employers

who are affiliated with the association.

The policy provides coverage for accidents, hospital confinement, hospital intensive care unit confinement, surgery, hospital admission, doctor office visit, preventive care, urgent care/emergency room, diagnostic tests, mental health, chemical dependency, critical illness and accidental death and dismemberment.

Variable areas of the certificate are set off in brackets. These include “John Doe” information, the ranges of benefits that will be offered, and benefit options.

The enclosed forms are new and do not replace any forms currently on file with your Department. We have included the association bylaws and any transmittals and certifications required by your Department.

The forms are in final format. Initially, the forms will be issued in paper format. Unified reserves the right to change the type style and paper size. We also request the right to make the forms available electronically, with enrollment available via the Internet or by telephonic means.

Regardless of the enrollment process used, Unified will adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via secured socket layer/secured line. Information contained in the enrollment form may be transmitted to Unified’s administrative office electronically as well as the electronic signature of the enrollee. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act.

The enrollment information will be collected and linked to the individual in such a manner that the electronic signature is invalidated if any of the data on the application is changed. Electronic signatures intended for use with this enrollment form will not be affixed to or duplicated on any other document.

If you have questions concerning this filing, please contact me at 513-984-6050 or at dsimon@crssolutionsgroup.com.

Sincerely,

J. David Simon
President

ULIC – Xchange Benefits
Generic Forms

Unified Life Insurance Company Forms Listing
NAIC #11121 FEIN #43-1917728

Form No.	Description
GRP 2011 FPM CERT	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage
GRP FP 2011 ENR	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form
GRP FPM 2011 POL	Group Accident and Sickness Hospital Indemnity Insurance Master Policy
GRP 2011 FPM APP	Policyholder Application for Group Accident and Sickness Hospital Indemnity Insurance
GRP 2011 FPM AE AR	Amendatory Endorsement

Company and Contact

Filing Contact Information

Nancy French, Product Manager
10921 Reed Hartman Highway
Suite 334
Cincinnati, OH 45242

nfrench@crssolutionsgroup.com
513-984-6050 [Phone]
513-984-7212 [FAX]

Filing Company Information

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

Unified Life Insurance Company	CoCode: 11121	State of Domicile: Texas
c/o 10921 Reed Hartman Highway	Group Code:	Company Type:
Suite 334	Group Name:	State ID Number:
Cincinnati, OH 45242	FEIN Number: 43-1917728	
(513) 984-6050 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	No
Fee Explanation:	5 forms
Per Company:	No

SERFF Tracking Number:	*CMPL-127288307*	*State:*	*Arkansas*
Filing Company:	*Unified Life Insurance Company*	*State Tracking Number:*	*49112*
Company Tracking Number:	*ULIC XB GP ACC SICK*		
TOI:	*H14G Group Health - Hospital Indemnity*	*Sub-TOI:*	*H14G.000 Health - Hospital Indemnity*
Product Name:	*ULIC XB Gp Acc Sick Assn*		
Project Name/Number:	*ULIC XB Gp Acc Sick Assn /ULIC XB Gp Acc Sick Assn*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unified Life Insurance Company	$250.00	06/23/2011	49027037

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2011	06/30/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Withdrawn	Nancy French	06/23/2011	06/23/2011
Form	Withdrawn	Nancy French	06/23/2011	06/23/2011
Supporting Document	Flesch Certification	Nancy French	06/23/2011	06/23/2011

Disposition

Disposition Date: 06/30/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-127288307*	*State:*	*Arkansas*
Filing Company:	*Unified Life Insurance Company*	*State Tracking Number:*	*49112*
Company Tracking Number:	*ULIC XB GP ACC SICK*		
TOI:	*H14G Group Health - Hospital Indemnity*	*Sub-TOI:*	*H14G.000 Health - Hospital Indemnity*
Product Name:	*ULIC XB Gp Acc Sick Assn*		
Project Name/Number:	*ULIC XB Gp Acc Sick Assn /ULIC XB Gp Acc Sick Assn*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document *(revised)*	Flesch Certification	Approved-Closed	Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Unified Authorization	Approved-Closed	Yes
Supporting Document	Statement of Variables	Approved-Closed	Yes
Supporting Document	By Laws	Approved-Closed	Yes
Form	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	Approved-Closed	Yes
Form	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	Approved-Closed	Yes
Form *(revised)*	Withdrawn	Approved-Closed	Yes
Form *(revised)*	Withdrawn	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Form	Group Accident and Sickness Hospital Indemnity Insurance Master Policy	Replaced	Yes
Form	Policyholder Application for Group Accident and Sickness Hospital Indemnity Insurance	Replaced	Yes

Amendment Letter

Submitted Date: 06/23/2011

Comments:

Please disregard our request for review of the policy and Policy application. we have also provided a revised readability certification. thank you

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Withdrawn	Policy/Contract/Fraternal Certificate	Withdrawn	Other	Withdrawn				
Withdrawn	Application/Enrollment Form	Withdrawn	Other	Withdrawn				

Supporting Document Schedule Item Changes:

Satisfied -Name: Flesch Certification

Comment:

READABILITY CERTIFICATION.pdf

Form Schedule

Lead Form Number: GRP 2011 FPM CERT

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/30/2011	GRP 2011 FPM CERT	Certificate	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	Initial		50.000	XB-ULI CERT.pdf
Approved-Closed 06/30/2011	GRP FP 2011 ENR	Application/Enrollment Form	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	Initial		59.000	XB-ULI ENRL Form.pdf
Approved-Closed 06/30/2011	Withdrawn	Policy/Contract/Fraternal Certificate	Withdrawn	Other	Other Explanation: Withdrawn		
Approved-Closed 06/30/2011	Withdrawn	Application/Enrollment Form	Withdrawn	Other	Other Explanation: Withdrawn		
Approved-Closed 06/30/2011	GRP 2011 FPM AE AR	Certificate Amendment, Insert Page, Endorsement or Rider	Amendatory Endorsement	Initial		45.000	AR Unified NCE AE 6-9-11-.pdf

Unified Life Insurance Company
[7201 West 129th Street, Suite 300, Overland Park, Kansas 66213]

GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE

THIS COVERAGE PROVIDES BENEFITS DUE TO ACCIDENT AND SICKNESS. THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER THE GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE POLICY. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

CERTIFICATE OF COVERAGE

Issued under the terms of
Group Insurance Policy Number: [12345]

Issued to: [ABC Association]
(herein called the Holder)

Policy Date: [June 1, 2011]

Unified Life Insurance Company hereby certifies that members of the class(es) eligible for insurance are insured under the above Policy as determined by the Eligibility and Effective Date provisions. Class is defined in the Certificate Schedule.

This Certificate is evidence of insurance provided under the Policy. All benefits are paid according to the terms of the Policy. This Certificate describes the essential features of the insurance coverage.

In this Certificate, the words “Named Insured” or “You” means a member of an eligible class as described on the Certificate Schedule, who is insured under the Policy and for whom premiums are remitted. The words “Covered Person” refer to any person covered under the Policy as described on the Certificate Schedule. The words “We”, “Us”, “Our” or “Company” refer to Unified Life Insurance Company. “Policy” means the Group Accident and Sickness Hospital Indemnity Insurance contract owned by the Holder and available for review by You. If the terms of Your Certificate of coverage and the Policy differ, the Policy will govern.

The Policy and this Certificate may be changed in whole or in part or cancelled as stated in the Policy. Such action may be taken without the consent of or notice to any Covered Person. Only an authorized officer at Our home office can approve a change. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an agent, may change the Policy or Certificate or waive any of its provisions. Premiums are subject to periodic changes.

The male pronoun includes the female whenever used.

This Policy is delivered in and governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

TO OBTAIN INFORMATION YOU MAY CALL OUR TOLL FREE NUMBER: [1-800-XXX-XXXX]

Signed for Unified Life Insurance Company:
[

President

Secretary

]

LIMITED BENEFIT - PLEASE READ THIS CERTIFICATE CAREFULLY.

THIS IS NOT COMPREHENSIVE MAJOR MEDICAL COVERAGE.
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

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CERTIFICATE SCHEDULE

1. POLICY INFORMATION

   "The Policyholder":
   Policy Effective Date:
   Policy Anniversary Date:

2. ELIGIBLE PERSONS: An Eligible Person is an individual who meets the requirements of [one of] the Covered Class[es] shown below:

[[Class 1]	All members [under age 65] of an association who have applied and have been approved to receive medical benefits.]
[[Class 2]	All eligible spouses under [65] years of age and dependent children of [Class 1-2] insureds for whom application and premium has been received.]

   [Dependent Coverage: ___ Yes _X_No]

3. COVERAGE YEAR: Begins on each [JANUARY 1ST] and continues for the next 12 consecutive months, and ends on [DECEMBER 31st] of the [same] year.

4. [SICKNESS BENEFIT WAITING PERIOD: [1-30] Days]

5. COVERAGE AND BENEFIT AMOUNTS:

Accident and Sickness Indemnity Benefit
Inpatient and Outpatient

Hospital Confinement Benefit

Hospital Confinement Benefit	[$50-3,000] Per Day of Confinement
Maximum Benefit	[3-100] Days Per Coverage Year
[Hospital Intensive Care Unit Confinement Benefit*	[$50--6,000] Per Day of Confinement
Maximum Benefit	[3-15] Days Per Coverage Year

*The Hospital Intensive Care Unit Confinement Benefit will only be payable if the Hospital Confinement Benefit is also payable. The Hospital Intensive Care Unit Confinement Benefit will be payable in addition to the Hospital Confinement Benefit.]

[Additional Hospital Admission Benefit

Hospital Admission Benefit	[$500 - 5,000] Per Admission
Maximum Benefit	[1-5] Admissions Per Coverage Year]

[Surgery Benefit

Surgery Benefit	[50-100] % of 2010 RBRVS
Maximum Benefit	[1-3] Surgeries per Coverage Year
Anesthesia Benefit	[20-25] % of Surgery Benefit]

[Surgery Benefit

Surgery Benefit	[$200 - $2,000] Per Inpatient Surgery
	[$100 - $1,500] Per Outpatient Surgery
Maximum Benefit	[1-3] Surgeries Per Coverage Year
Anesthesia Benefit	[20-25] % of Surgery Benefit]

[Outpatient Surgical Facility Benefit

Outpatient Surgical Facility Benefit	[$100-1,500] Per Day
Maximum Benefit	[1-3] Days Per Coverage Year]

[Doctors' Office Visit Benefits

Doctors' Office Visits Benefit – Primary Care Physician	[$25-300] Per Visit
Doctors' Office Visits Benefit – Specialty Care Physician	[$25-300] Per Visit
Maximum Benefit – Primary and Specialty Care Visits Combined	[1-5] Visits Per Coverage Year]

[Diagnostic X-ray & Laboratory Tests Benefits (including interpretation)

Basic Pathology	[$20 - $1,000] Per Day
Basic Radiology	[$20 - $1,000] Per Day
Advance Studies	[$50 - $2,500] Per Day
Maximum Benefit for all Diagnostic X-Ray and Laboratory Benefits	[1-5] Days Per Coverage Year]

[Emergency Room Visits Benefits

Emergency Room Benefit	[$50 – 1,000] Per Visit
Maximum Benefit	[1-5] Visits per Coverage Year]

[Ambulance Benefit

Land Ambulance Benefit	[$100-1,000] Per Covered Sickness/Accident
Air Ambulance Benefit	[$100 – 2,000] Per Covered Sickness/Accident
Maximum Benefit-Land and Air Ambulance Combined	[1-5] per Coverage Year]

[Other Covered Medical Services

[Skilled Nursing Facility Benefit	[$50 – 300] Per Day
Skilled Nursing Facility Maximum Benefit	[1 – 30] Days Per Coverage Year]
[Hospice Benefit	[$100 – 300] Per Day
Hospice Maximum Benefit	[10 – 180] Days]
[Rehabilitation Therapy Benefit	[$25 – 150] Per Visit
Rehabilitation Therapy Maximum Benefit	[1 - 10] Visits Per Coverage Year]

[Mental Health Benefits

Mental Health Inpatient Benefit	[$0 – 1,500] per day
Mental Health Inpatient Maximum Benefit	60 days per Coverage Year
Mental Health Outpatient Benefit	[$0 - 300] per treatment
Mental Health Outpatient Maximum Benefit	[$0 – 3,000] per Coverage Year]

[Chemical Abuse and Dependence Diagnosis and Treatment Benefit

Chemical Abuse and Dependence Diagnosis and Treatment Benefit	[$0 – 1,500] per day
Detoxification Maximum Benefit	12 Days of Active Treatment per Coverage Year
Inpatient Rehabilitation Maximum Benefit	60 Days per Coverage Year
Chemical Abuse and Dependence Outpatient Benefit	[$0 - 300] per treatment
Chemical Abuse and Dependence Outpatient Benefit Maximum Benefit	[$0 – 3,000] per Coverage Year]

[Wellness Benefit

Office Visit Benefit	[$25 – 500] per Visit
Maximum Benefit	[1-5] Visits per Coverage Year]
Diagnostic X-Ray and Laboratory Tests	[$20 – 500] per Visit
Maximum Benefit	[1 – 5] Days per Coverage Year

[Supplemental Accident Benefit

[Emergency Room Visit	[$50 – 1,000] per Covered Accident
Maximum Benefit	[1-5] Covered Accidents per Coverage Year]
[Inpatient Admission	[$50 – 2,000] per Covered Accident
Maximum Benefit	[1-5] Covered Admissions per Coverage Year]
[All Other	[$10 - 100] per Covered Accident
Maximum Benefit	[1-5] Covered Accidents per Coverage Year]

[Health Screening Services for Children Benefit

Health Screening Services for Children Benefit	[$0 – 100] per Visit]

[Habilitative Services For Children Benefit

Habilitative Services For Children Benefit	[$0 - 100] per Visit]

[HIV Screening Test Benefit

HIV Screening Test Benefit	[$0 – 100] per Visit]

[Cancer Screening Benefit

Cancer Screening Benefit	[$0 - 100] per Visit]

[Diabetes Supplies, Equipment and Self-Management Education Benefit

Diabetes Supplies, Equipment and Self-Management Education Benefit	[$0 - 100] per Coverage Year]

[Accidental Death Benefit

Accidental Death Principal Sum for Named Insured	[$1,000 - $25, 000]
Accidental Death Principal Sum for Spouse	50% of Named Insured Benefit
Accidental Death Principal Sum for Child(ren)	25% of Named Insured Benefit
Loss Period	Loss within [180-365] days from the date of the Accident]

GENERAL DEFINITIONS

Additional definitions may be contained in other Certificate benefit provisions or any endorsement or rider.

Accident

Accident means an unintended or unforeseen bodily injury sustained by a Covered Person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

[Ambulatory Surgical Center

An Ambulatory Surgical Center (ASC) means a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services. The Ambulatory Surgical Center must be certified with the Center for Medicare and Medicaid Services (CMS.) An ASC is either an independent facility or is operated by a hospital. A Hospital-operated facility must be a separately identifiable entity physically and administratively, and be financially independent and distinct from other operations of the Hospital. An Ambulatory Surgical Center is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, a place for treatment of mental disorders or a place for convalescent, custodial, educational or rehabilitory care.]

Ancillary Services

Ancillary services means standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient.

Confined or Confinement

Confined or *Confinement* means the assignment to a bed as a resident inpatient in a Hospital on the advice of a Physician or Confinement in an Observation Unit within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

Coverage Year

Coverage Year means a consecutive 12-month period or any part of such period, as shown on the Certificate Schedule.

Covered Accident

A *Covered Accident* is an Accident which:

- occurs after the effective date shown on the Certificate Schedule;
- occurs while this Certificate is in force; and
- is not excluded by name or specific description in this Certificate.

Covered Person(s). You and Your Dependents who are insured under the Group Policy.

Covered Sickness

A *Covered Sickness* means a Sickness which:

- occurs after the effective date shown on the Certificate Schedule;
- occurs while this Certificate is in force; and
- is not excluded by name or specific description in this Certificate.

Doctor or Physician

A *Doctor or Physician* means a legally qualified practitioner of the healing arts acting within the scope of his or her license and is not an Immediate Family Member.

For purposes of this definition, Immediate Family Member means a Covered Person's Spouse, son, daughter, mother, father, sister, or brother.

Emergency Room

Emergency Room means a portion of a Hospital where emergency diagnosis and treatment of a Sickness or Accident is provided.

Emergency Services

Emergency Services means:

- Health care services furnished in the emergency department of a hospital for the treatment of a medical emergency;
- Ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and
- Emergency medical services transportation.

Experimental/Investigational

A drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been give at the time the drug or device is furnished;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval; or

- Reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, medical care or treatment. Benefits will be considered in accordance with the drug or device at the time it is given or when medical care is received.

We will not limit or deny coverage, or impose additional conditions on the payment for the coverage, of routine patient care costs of items, drugs, and services furnished to a Covered Person in connection with participation in an approved clinical trial. We will not pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved clinical trial.

"Approved clinical trial" means:

- A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
  - (i) The National Institutes of Health;
  - (ii) The Centers for Disease Control and Prevention;
  - (iii) The Agency for Health Care Research and Quality;
  - (iv) The Centers for Medicare and Medicaid Services;
  - (v) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
  - (vi) The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
- A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or
- An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

[Hospice
Hospice means a facility operated by a Hospital or other licensed health care institution. It is not a convalescent home; a nursing home; a Skilled Nursing Facility; or a similar institution. Its purpose is to provide an alternative environment with palliative and supportive care for terminally ill patients either directly or on a consulting basis with the patient's Physician; or another community agency, such as a visiting nurses' association.

As used in this provision, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is less than 6 months.]

[Hospice Care
Hospice Care means care and supplies provided or coordinated by a Hospice to terminally ill patients with a life expectancy of 6 months or less.]

Hospital
A *Hospital* means a short-term, acute general hospital that is:

- primarily engaged in providing, by or under continuous supervision of physicians, to inpatients diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a physician or dentist;
- provides 24 hour nursing care by or under the supervision of RNs;
- has in effect a hospital review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of the United States Public Law 89-97 (42 USCA 1395x[k]);
- duly licensed by the agency responsible for licensing such hospitals; and
- not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, a place primarily for treatment of mental disorders or chemical dependency or a place for convalescent, custodial, educational or rehabilitory care.

Hospital Intensive Care Unit
A *Hospital Intensive Care Unit* means a place which:

- is a specifically designated area of the Hospital called an Intensive Care Unit that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;

- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24-hour basis; and
- has a Physician assigned to the Intensive Care Unit on a full-time basis.

A Hospital Intensive Care Unit that meets the definition above may include Hospital units with the following names:

- Intensive Care Unit;
- Coronary Care Unit;
- Neonatal Intensive Care Unit;
- Pulmonary Care Unit;
- Burn Unit;
- Transplant Unit.

A Hospital Intensive Care Unit is not any of the following step-down units:

- a progressive care unit;
- an intermediate care unit;
- a private monitored room;
- a sub-acute Intensive Care Unit;
- an Observation Unit; or
- any facility not meeting the definition of a Hospital Intensive Care Unit as defined in this Certificate.

Medical Emergency
Medical emergency means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Medically Necessary
Medically Necessary means a service or supply that is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Covered Person or provider;
- it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- it exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
- it is experimental/investigational treatment.

The fact that a Physician may prescribe, authorize, or direct a service does not, of itself, make it Medically Necessary or covered by the Policy.

Named Insured
A *Named Insured* is a person who is a member of an eligible class and holds a certificate of coverage.

Observation Unit
An *Observation Unit* is a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician; and which

- is under the direct supervision of a Physician or registered nurse; and
- is staffed by nurses assigned specifically to that unit; and
- provides care seven days per week, 24 hours per day.

[Pre-existing Condition
Pre-existing condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received from a physician within a [6-12] month period preceding the effective date of coverage of the Covered Person.]

[Resource Based Relative Value System, referred to as RBRVS.
The methodology used by the federal government to determine benefits payable under Medicare. Medicare assigns a "Relative Value Unit" or RVU to thousands of procedure codes used to bill physician and other services. The total RVU is the sum of three component RVUs including the Work RVU, the Practice Expense RVU and the Malpractice RVU. The Work RVU takes into account factors such as the amount of time required to perform the service and the degree of skill required to perform it. The Practice Expense RVU takes into account the location of the service, e.g., office setting, outpatient setting, etc. The Malpractice RVU takes into account the malpractice cost associated with a particular practice. We will base the surgery benefit on RBRVS.]

Sickness
Sickness means an illness, infection, disease or any other abnormal physical condition not caused by an Accident.

[Sickness Benefit Waiting Period
Sickness Benefit Waiting Period means the period of time during which benefits for Sickness are not paid. The Sickness Benefit Waiting Period is shown on the Certificate Schedule.]

[Skilled Nursing Facility
Skilled Nursing Facility means a facility that is operated pursuant to law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed Physician.]

ELIGIBILITY AND EFFECTIVE DATE

Effective Dates of Coverage
Your coverage under the Policy will start at 12:01 a.m. Standard Time on the effective date of coverage shown on Your Certificate Schedule.

Eligibility
To be eligible to enroll in the coverage, an individual must be a member of an eligible class as defined on the Certificate Schedule.

Enrollment
An individual who is a member of an eligible class may enroll for coverage on the date the individual first becomes a member of an eligible class.

Delayed Effective Date of Coverage
The effective date of any Named Insured's coverage will be delayed for any Named Insured if they are not a member of an eligible class on the effective date shown on the Certificate Schedule. The coverage will be effective on the date that the Named Insured returns to status as a member of an eligible class. If this is Named Insured and Spouse coverage or family coverage, coverage on the Spouse and/or Dependent children will be effective on the date that the Named Insured returns to status as a member of an eligible class.

Who is Covered By This Certificate
If this is Named Insured coverage as shown on the Certificate Schedule, We insure You, the Named Insured.

If this is Named Insured and Spouse coverage as shown on the Certificate Schedule, We insure You and Your Spouse.

If this is family coverage, as shown on the Certificate Schedule, We insure You, Your Spouse (if applicable), and Your Dependent children.

Spouse means the person married to You on the day We issue Your Certificate.

Dependent children means any unmarried natural children, step-children, legally adopted children or children placed into Your custody for adoption who is under the age of 26 years of age.

Adopted children and step children will be eligible for coverage on the same basis as natural children.

Coverage for the Named Insured's Newborn Children:

A child born to You or Your insured Spouse will automatically become insured as a Dependent. The child must be born to the Named Insured or to his Spouse while this Certificate is in force. We will cover each newborn child from the moment of live birth. Such coverage includes:

- the necessary care and treatment of medically diagnosed congenital defects;
- birth abnormalities;
- prematurity[.][;]
- [routine nursery care, provided the pregnancy originated while the Named Insured or Spouse was insured under the Policy.]

Coverage for the Named Insured's Adopted Children):
We will cover the Named Insured's adopted children from the moment of birth if You take physical custody of the infant upon the infant's release from the hospital and consent to the adoption has not been revoked. However, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

A child adopted by You or Your insured Spouse will automatically become insured as a dependent. The effective date of the coverage will be the earlier of:

- the date of placement for the purpose of adoption; or
- the date on which You assume a legal obligation for total or partial support of the child.

Coverage for adopted children will be to the same extent as provided for other covered dependent children and will include the necessary care and treatment of pre-existing medical conditions.

Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and

- the child is permanently removed from placement;
- the legal obligation terminates; or
- You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

For each newborn, step child and/or adopted child, You must:

- notify Us of his birth or placement in Your residence within 31 days of this occurrence;
- complete the required application for him; and
- pay the required premium for him, if any.

If a newborn is not enrolled within 31 days of birth coverage will be provided from the date that notice is given. Any additional premium required should be made to the Holder within 31 days of notification of birth or placement for the purposes of a step child and/or adoption.

DESCRIPTION OF BENEFITS

We will pay the benefits described below. Benefits will be paid, subject to any applicable benefit limitation [and the Sickness Benefit Waiting Period shown on the Certificate Schedule], when a Covered Person incurs charges while the Covered Person's coverage is in force. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for Covered Injury or Sickness.

HOSPITAL CONFINEMENT BENEFITS

We will pay the Hospital Confinement Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and is Confined in a Hospital due to injuries received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital must begin while the coverage is in force.

We will pay the amount shown on the Certificate Schedule for each day the Covered Person is confined, up to the Hospital Confinement Maximum Benefit shown on the Certificate Schedule.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or
- Confinement of less than 20 hours to an Observation Unit.

[We will not pay for any Hospital Confinement of a newborn child of a Covered Person following birth unless the child is injured or sick.]

Written proof of loss should include a Hospital bill verifying the patient's name, the dates of Hospital Confinement, the diagnosis and the charges incurred.

[HOSPITAL INTENSIVE CARE UNIT CONFINEMENT BENEFIT

We will pay the Hospital Intensive Care Unit Confinement Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and is Confined to a Hospital Intensive Care Unit as the result of injuries received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital Intensive Care Unit must begin while the coverage is in force. The Hospital Intensive Care Unit Confinement Benefit will only be payable if the Hospital Confinement Benefit is also payable. The Hospital Intensive Care Unit Confinement Benefit will be payable in addition to the Hospital Confinement Benefit.

We will pay the Hospital Intensive Care Unit Confinement Benefit amount shown on the Certificate Schedule for each day a Covered Person is Confined, up to the Hospital Intensive Care Unit Maximum Benefit shown on the Certificate Schedule.

If a Covered Person is Confined to a Hospital care unit that does not meet the definition of a Hospital Intensive Care Unit, We will pay the Hospital Confinement benefit up to the maximum benefit period shown on the Certificate Schedule.

Written proof of loss should include a Hospital bill verifying the patient's name, the dates of Hospital Confinement, the diagnosis and the charges incurred.]

[ADDITIONAL HOSPITAL ADMISSION BENEFIT

We will pay the Additional Hospital Admission Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and is Confined in a Hospital due to injuries received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital must begin while the coverage is in force. If admission is due to a Covered Accident, the Covered Person must be admitted within [six] months after the Covered Accident.

If a Covered Person is admitted to a Hospital and is discharged and admitted again for the same or related condition within 90 days, We will treat this later Hospital admission as a continuation of the previous Confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this later admission as a new and separate admission.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or
- A stay of less than 20 hours in an Observation Unit.

This benefit is subject to the Hospital Admission Benefit Maximum Benefit, shown on the Certificate Schedule.]

[SURGERY BENEFIT

We will pay the Surgery Benefit, shown on the Certificate Schedule, if any Covered Person undergoes a surgical procedure due to a Covered Accident or Covered Sickness. The procedure must be performed by a board certified surgeon in a Hospital or an Ambulatory Surgical Center. We will pay this benefit once per covered surgical procedure. If a Covered Person has more than one surgical procedure performed at the same time, We will pay only one surgical procedure benefit, even if caused by more than one Accident or Sickness. We will pay the benefit that has the highest dollar value. The surgical procedure must occur while the coverage is in force.

In the case of a Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, We will pay the Surgery Benefit, shown on the Certificate Schedule, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

If a Covered Person has more than one surgery for the same Covered Accident or Covered Sickness in a 90-day time period, We will pay the benefit that has the highest dollar value. If We have already paid a lower benefit amount for the same Covered Accident or Covered Sickness, We will deduct the amount paid from the higher benefit amount and pay the difference.

This benefit is subject to the Surgery Maximum Benefit shown on the Certificate Schedule

The Anesthesia Benefit is the surgery benefit times the percentage shown in the Certificate Schedule. Anesthesia must be administered by a licensed anesthesiologist or certified registered nurse anesthetist (CRNA).

Written proof of loss should include the surgeon's and the anesthesiologist's or certified registered nurse anesthetist's (CRNA's) itemized statement(s) verifying the patient's name, the surgical procedure code(s), the date of treatment, the diagnosis and the charges incurred.]

[OUTPATIENT SURGICAL FACILITY BENEFIT
We will pay the Outpatient Surgical Facility Benefit, shown on the Certificate Schedule, if a Coverage Person incurs charges for a surgical procedure performed in an Ambulatory Surgical Center or in a Hospital on an outpatient basis. The charges must be incurred as a result of injuries received in a Covered Accident or due to a Covered Sickness.

We will pay the amount shown on the Certificate Schedule for each day the Covered Person incurs charges, up to the Outpatient Surgical Facility Maximum Benefit shown on the Certificate Schedule.]

[DOCTOR'S OFFICE VISIT BENEFITS
We will pay the Doctor's Office Visit Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and requires a Doctor's office visit due to injuries received in a Covered Accident or due to a Covered Sickness. The visit must occur while the coverage is in force.

For a visit due to injuries received in a Covered Accident, the visit must occur within 72 hours after the date of the Covered Accident.

Services must be rendered by a licensed Physician acting within the scope of their license. A Primary Care Physician includes the Covered Person's:

- general practitioner;
- OB/GYN;
- osteopath; and
- internist.

We will pay the Doctor's Office Visit Benefit amount per visit shown on the Certificate Schedule, up to the Doctor's Office Visit Benefit Maximum Benefit, shown on the Certificate Schedule.

Written proof of loss should include bills verifying the patient name, the date of treatment, the diagnosis and the charges incurred.

The Doctor's Office Visit Benefit will not be payable for a doctor's visit that is payable under either the Mental Health Benefit or the Chemical Abuse and Dependency Diagnosis and Treatment Benefit.]

[DIAGNOSTIC X-RAY AND LABORATORY TESTS BENEFIT
We will pay the Diagnostic X-Ray and Laboratory Test Benefit shown on the Certificate Schedule when a Covered Person incurs charges for diagnostic x-ray and/or laboratory testing caused by a Covered Accident or Covered Sickness.

Benefits are payable on a per day basis and are subject to the definitions, limitations, exclusions and other provisions of the Policy.

The test must be performed:

- while the coverage is in force; and
- in a Hospital, Ambulatory Surgical Center or Doctor's office.

The test must be ordered by a Physician because of a Covered Accident or Covered Sickness.

We will pay the amount shown on the Certificate Schedule, up to the Maximum Benefit for all Diagnostic X-Ray and Laboratory Benefits.

[Basic Pathology
We will pay the Basic Pathology Benefit if a Covered Person incurs charges for laboratory tests performed for diagnostic purposes. The amount paid will be the amount shown on the Certificate Schedule for Basic Pathology.]

[Basic Radiology
We will pay the Basic Radiology Benefit if a Covered Person incurs charges for x-rays, ultrasounds and other medical imaging performed for diagnostic purposes. The amount paid will be the amount shown on the Certificate Schedule for Basic Radiology.]

[Advance Studies
We will pay the Advance Studies Benefit if a Covered Person incurs charges for: Angiogram; Arteriogram; Computer Tomography Scan (CT); Electroencephalogram (EEG); Magnetic Resonance Imaging (MRI); Myelogram; Positron Emission Tomography Scan (PET); and Thallium Stress Test. The amount paid will be the amount shown on the Certificate Schedule for Advance Studies. Procedures included in Advance Studies will not be payable as Basic Pathology or Basic Radiology.]

Written proof of loss should include a billing statement from the medical provider conducting the test, verifying the patient's name, the type of test performed, the diagnosis and the charges incurred and the date of treatment.]

[EMERGENCY ROOM VISIT BENEFIT
We will pay the Emergency Room Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and requires medical care from an emergency room due to injuries received in a Covered Accident or due to a Covered Sickness. The visit must occur while the coverage is in force.

For a visit due to injuries received in a Covered Accident, the visit must occur within 72 hours after the date of the Covered Accident.

Services must be rendered by a Physician.

We will pay the Emergency Room benefit amount shown on the Certificate Schedule, up to the Emergency Room Benefit Maximum Benefit, shown on the Certificate Schedule.

Written proof of loss should include bills verifying the patient name, the date of treatment, the diagnosis and the charges incurred.]

[AMBULANCE BENEFIT
We will pay the Land Ambulance Benefit or the Air Ambulance Benefit shown on the Certificate Schedule, if a licensed professional ambulance company transports a Covered Person by ground or air transportation to or from a Hospital or between medical facilities, where treatment is received as the result of a Covered Sickness or Accident. The Covered Person must incur charges while the coverage is in force for professional ambulance service to receive this benefit. The ambulance transportation must be within 90 days after a Covered Sickness or Accident. We will pay this amount once per Covered Sickness or Accident.

This benefit is subject to the Maximum Benefit – Land and Air Ambulance Combined, shown on the Certificate Schedule.]

[OTHER COVERED MEDICAL SERVICES
We will pay the Other Covered Medical Services Benefits is a Covered Person incurs charges for the services described below while the Covered Person's coverage is in force, up to the Maximum Benefit shown on the Certificate Schedule. The Covered Person must be under a Doctor's care, and the treatment must be Medically Necessary, for Covered Accident or Sickness.

[**Skilled Nursing Facility Care**
We will pay the Skilled Nursing Facility Benefit if a Covered Person incurs charges for and is Confined in a Skilled Nursing Facility due to injuries received in a Covered Accident or due to a Covered Sickness. Confinement must begin while the coverage is in force and immediately following a Hospital confinement of at least 3 days. Payment of this benefit will be in lieu of any Hospital Confinement benefit.

We will pay the Skilled Nursing Facility Benefit, shown on the Certificate Schedule, for each day a Covered Person is Confined, up to the Skilled Nursing Maximum Benefit shown on the Certificate Schedule.

We will not pay this benefit for:
- Emergency Room treatment;
- outpatient treatment; or
- Confinement of less than 20 hours to an Observation Unit.

We will not pay the Skilled Nursing Facility benefit, if the Covered Person is Hospital Confined.**]**

[Hospice Care
We will pay the Hospice Care Benefit if a Covered Person incurs charges for Hospice Care.

Coverage will consist of drugs and medical supplies for inpatient Hospice Care provided in a Hospice or in a Hospital and outpatient Hospice Care provided by a Hospice in the home.

Benefits for Hospice Care will end on the earliest of:
- the date the Covered Person dies;
- the date the Covered Person no longer qualifies for the Hospice Care program; or
- the date the Hospice Care Maximum Benefit has been paid.

We will pay the Hospice Care Benefit, shown on the Certificate Schedule, for each day a Covered Person receives Hospice Care benefits, up to the Hospice Care Maximum Benefit shown on the Certificate Schedule.]

[Rehabilitation Therapy
We will pay the Rehabilitation Therapy Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and requires physical therapy, speech therapy or occupational therapy due to injuries received in a Covered Accident or due to a Covered Sickness. The therapy must be for rehabilitation, must be Medically Necessary, and be prescribed by a Doctor.

We will pay the Rehabilitation Therapy amount per visit shown on the Certificate Schedule, up to the Rehabilitation Therapy Maximum Benefit, shown on the Certificate Schedule.]]

[MENTAL HEALTH BENEFITS
Inpatient Benefits

For Inpatient Benefits, We will pay the Mental Health Inpatient Benefit, shown on the Certificate Schedule, for each day of confinement if a Covered Person is confined to a Hospital or licensed institution to provide treatment for Mental Illness.

Benefits are subject to the Mental Health Inpatient Benefit Maximum Benefit shown on the Certificate Schedule.

Outpatient Benefits

For Outpatient Benefit, We will pay the Mental Health Outpatient Benefit, shown on the Certificate Schedule, for Covered Persons receiving treatment as a result of Mental Illness.

Benefits are subject to the Mental Health Outpatient Benefit Maximum shown on the Certificate Schedule.

Mental Illness means any mental condition including but not limited to affective disorders, neuroses, anxiety, stress, adjustment reactions, Alzheimer's disease and other organic senile dementias.

We will not pay any benefit for stays in a half-way house or other place that is not a licensed facility offering treatment for Mental Illness.]

[CHEMICAL ABUSE AND DEPENDENCY DIAGNOSIS AND TREATMENT BENEFIT
Inpatient Benefits

We will pay the Chemical Abuse and Dependency Diagnosis and Treatment Benefit, shown on the Certificate Schedule for Covered Persons receiving services provided in facilities which are accredited by the joint commission on accreditation of hospitals as alcoholism, substance abuse or chemical dependence treatment programs, for the treatment of Chemical Abuse and Chemical Dependency.

Benefits for detoxification services as a consequence of chemical dependence are subject to the Detoxification Maximum Benefit, shown on the Certificate Schedule, of 12 days of active treatment per Coverage Year per Family.

Benefits for rehabilitation services are subject to the Rehabilitation Maximum Benefit, shown on the Certificate Schedule, of 60 days of inpatient care per Coverage Year per Family.

Outpatient Benefits

For Outpatient Benefit, We will pay the Chemical Abuse and Dependence Outpatient Benefit, shown on the Certificate Schedule, for Covered Persons receiving outpatient services for Chemical Abuse and Dependency.

The term "chemical abuse" means alcohol and substance abuse.]

[WELLNESS VISIT BENEFIT
Upon receipt of due proof that a Covered Person incurred expenses for a Wellness Visit, we will pay a Wellness Visit Benefit up to the maximum as shown in the Certificate Schedule.

We will also pay the Wellness Visit Benefit – Diagnostic, X-ray and Laboratory Tests Benefit shown on the Certificate Schedule when a Covered Person incurs charges for diagnostic, x-ray and/or laboratory testing caused by a Wellness Visit.

Benefits are payable on a per day basis and are subject to the definitions, limitations, exclusions and other provisions of the Policy.

The Diagnostic Test must be performed:
- while the coverage is in force; and
- in a Hospital, Ambulatory Surgical Center or Doctor's office.

The Diagnostic Test must be ordered by a Physician because of a Wellness Visit.

We will pay the Diagnostic, X-ray and Laboratory Tests Benefit amount shown on the Certificate Schedule, up to the Diagnostic, X-ray and Laboratory Tests Benefit Maximum Benefit, shown on the Certificate Schedule.

Written proof of loss should include a billing statement from the medical provider conducting the Diagnostic Test, verifying the patient's name, the type of Diagnostic Test performed, the diagnosis and the charges incurred and the date of treatment.

We will not pay the Wellness Visit Benefit if the wellness examination or testing is considered a covered expense under any other benefit provision in the Description of Benefits section.

Additional Definitions – Whenever used in this benefit:
"Wellness Visit" means an office visit for routine examinations or other preventative testing, including a baseline mammogram, a screening mammogram, cervical cytologic screening, diagnostic radiology/imaging, colorectal cancer screening, prostate cancer screening, and physical examination.

"Baseline mammogram" means a screening mammogram that is used as a comparison for future examinations;

"Screening mammogram" means a low dose x-ray used to visualize the internal structure of the breast; and

"Cytologic screening" means a pap test to detect cervical cancer through the simple microscopic examination of cells scraped from the surface of the cervix.]

[SUPPLEMENTAL ACCIDENT BENEFIT
We will pay the Supplemental Accident Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges for Appropriate Treatment of an injury sustained in a Covered Accident received within [180 – 365] days of the Covered Accident. We will pay this Supplemental Accident Benefit in addition to any benefits payable under the Policy.

[Emergency Room
We will pay the Emergency Room benefit if a Covered Person incurs charges for Emergency Room services as a result of a Covered Accident. We will pay the amount shown on the Certificate Schedule up to the Emergency Room Maximum Benefit.

[Inpatient Admission
We will pay the Inpatient Admission benefit if a Covered Person incurs room and board charges for admission to a Hospital as a result of a Covered Accident. We will pay the amount shown on the Certificate Schedule up to the Inpatient Admission Maximum Benefit.]

[All Other
We will pay the All Other benefit if a Covered Person incurs charges, other than Emergency Room charges and Inpatient Admission charges, as a result of a Covered Accident. We will pay the amount shown on the Certificate Schedule up to the All Other Maximum Benefit.]

"Covered Accident" means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy.]

"Appropriate Treatment" means particularly adapted proper and suitable administration or application of remedies to a Covered Person for an injury sustained in a Covered Accident.

[**HEALTH SCREENING SERVICES FOR CHILDREN BENEFIT**
We will pay the Health Screening Services For Children Benefit, shown on the Certificate Schedule, for child health screening services for a Covered Person from birth to age 21. Services will be consistent with the standards and schedules of the American Academy of Pediatrics. Benefits for Health Screening Services will be payable if the charges incurred are not payable under another benefit.]

[HABILITATIVE SERVICES FOR CHILDREN BENEFIT
We will pay the Habilitative Services for Children Benefit shown on the Certificate Schedule if any Covered Person under the age of 21 years incurs charges for habilitative services. Benefits will not be provided for habilitative services actually delivered through early intervention or school services. Benefits for Habilitative Services for Children will be payable if the charges incurred are not payable under another benefit.

For the purposes of this provision, "habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.]

[HIV SCREENING TEST BENEFIT
We will pay the HIV Screening Test Benefit shown on the Certificate Schedule if any Covered Person incurs charges for a voluntary HIV screening test performed on a Covered Person while the Covered Person is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the Covered Person to seek Emergency Services. Benefits will be payable if the charges incurred are not payable under another benefit.]

[CANCER SCREENING BENEFIT
We will pay the Cancer Screening Benefit, shown on the Certificate Schedule, if a Covered Person incurs charges for and has one of the cancer screenings listed below while the coverage is in force:

- A baseline mammogram for women;
- An annual screening mammogram for women;
- An annual cervical cytologic screening for women;
- A cervical cytologic screening for women upon certification by an attending Physician that the test is Medically Necessary;
- A colorectal cancer screening that is in compliance with American Cancer Society colorectal cancer screening guidelines; and

- A prostate cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories, and frequencies referenced in such guidelines.

Cancer Screening Benefits will be payable if the charges incurred are not payable under another benefit.

For the purposes of this provision:

- "Baseline mammogram" means a screening mammogram that is used as a comparison for future examinations;
- "Screening mammogram" means a low dose x-ray used to visualize the internal structure of the breast; and
- "Cytologic screening" means a pap test to detect cervical cancer through the simple microscopic examination of cells scraped from the surface of the cervix.]

[DIABETES SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT EDUCATION BENEFIT

We will pay the Diabetes Supplies, Equipment and Self-Management Education Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Physician legally authorized to prescribe such item.]

[ACCIDENTAL DEATH BENEFIT

Accidental Death Benefit

We will pay the Accidental Death Benefit, shown on the Certificate Schedule if a Covered Person is injured as the result of a Covered Accident, and the injury causes the Covered Person to die within 90 days after the Covered Accident.

Proof of Loss

We must be given written proof of loss within 90 days after the covered loss occurs. If an authorized representative is not able to give Us written proof of loss within 90 days, it will not have a bearing on the claim if proof is given to Us as soon as it is reasonably possible except in the absence of legal capacity. Written proof of loss must include a claim form and if loss is due to death of a Covered Person, a certified copy of the death certificate.

Beneficiary

In the event of a benefit payable due to the Named Insured's death, the Accidental Death benefit will be paid to the Named Insured's beneficiary. The beneficiary is the person the Named Insured designated in the enrollment form as the beneficiary, unless it was changed at a later date. If a beneficiary was not named or if the person named is not living at the Named Insured's death, any Accidental Death benefit due will be paid in this order to:

The Insured's Spouse; or children; or parents; or brothers and sisters; or estate. In the event of a benefit payable due to the death of a Spouse or Dependent child, the Accidental Death benefit will be paid to the Named Insured, if living, otherwise to the estate of the insured Spouse or Dependent child.

If benefits are payable to a Covered Person's estate, We can pay benefits up to $1,000 to someone related to the Covered Person by blood or marriage who We feel is fairly entitled to them. If We do this, We will have no responsibility for this payment because We made it in good faith.

Change of Beneficiary

The Named Insured can ask Us to change their beneficiary at any time. The Insured should notify Us, and We will send him the form to complete. The request must be witnessed by someone other than his present beneficiary or his proposed beneficiary and returned to Us at Our home office. The change must be approved by Us. If approved, it will go into effect the day he signed the request. The change will not have a bearing on any payment We make before We receive it.]

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for treatment, services or supplies which:

- Are not Medically Necessary;
- Are not prescribed by a Doctor as necessary to treat Sickness or injury;
- Are experimental/investigational in nature, except as required by law;
- Are received without charge or legal obligation to pay; or
- Is provided by an immediate family member.

Additional Limitations and Exclusions

Except as specifically provided for in this Policy or any attached Riders, We will not pay benefits for Sickness or injuries that are caused by:

[Dental Procedures – Dental care or treatment except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.]

Elective Procedures and Cosmetic Surgery – Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

Felony or Illegal Occupation Commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

[Manipulations of the Musculoskeletal System –care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation or of or in the vertebral column.]

Suicide or Injuries Which Any Covered Person Intentionally Does to Himself- suicide, attempted suicide or intentionally self-inflicted injury.

War or Act of War. War or act of war (whether declared or undeclared; participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto. Losses as a result of acts of terrorism committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism.

Work-related Injury or Sickness. Work-related Injury or Sickness, whether or not benefits are payable under any state or federal Workers' Compensation, employer's liability or occupational disease law or similar law.

[Pregnancy]

[Pre-existing Condition Limitation
There is no coverage for a pre-existing condition for a continuous period of [6-12] months following the effective date of coverage under this Policy.

This limitation does not apply to:

- genetic information in the absence of a diagnosis of the condition related to such information; and
- a newborn child who is enrolled in the plan within 31 days after birth; nor to a child who is adopted or placed for adoption before attaining 18 years of age; and as of the last day of the 31-day period beginning on the date of birth, adoption or placement for adoption, is covered under creditable coverage.]

TERMINATION OF INSURANCE

Termination of a Named Insured's Coverage
The coverage on a Named Insured will terminate on the earliest of the following dates:

- the date the Policy terminates; or
- midnight on the last day, for which premium was paid, if premium is not paid by the end of the grace period, or
- 90 days after the date written notice was provided that the Named Insured is no longer in an eligible class; or
- the date the Named Insured's class is no longer included for insurance; or
- on the date the Named Insured asks Us to end their coverage.

If We discontinue offering this coverage to a particular class we will provide the class the option to purchase other coverage currently offered in such market without regard to the claims experience of the class or any health related status to any insureds covered or new insureds who may become eligible for such coverage.

Termination of coverage will not affect any Covered Accident or Covered Sickness that occurred while the coverage was in force.

When Coverage Ends on the Named Insured's Spouse and/or Dependents
If this is Named Insured and Spouse coverage or two-parent family coverage, coverage on the Named Insured's Spouse will end:

- if the Policy terminates;
- if the premiums are not paid for the Named Insured's Spouse when they are due;
- on the date the Named Insured asks Us to end their Spouse's coverage;
- on the date the Named Insured dies; or
- on the date the next premium is due after the Named Insured divorces their Spouse.

If this is family coverage, coverage on the Named Insured's dependents will end:

- if the Policy terminates;
- if the premium is not paid for the Named Insured's dependents when it is due;
- on the date the Named Insured asks Us to end their Dependent coverage; or
- on the date the Named Insured dies.

Coverage will end on each Dependent child when they no longer qualify as a Dependent as defined in the Certificate. It is the Named Insured's responsibility to notify Us if any Dependent no longer qualifies as an eligible Dependent. If this is family coverage and all of the dependents no longer qualify as eligible dependents and We are not notified, the extent of Our liability will be to refund premium for the time period for which they did not qualify. Coverage will not end on a Dependent child who reaches the limiting age if that child is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law or physical handicap and who became so incapable prior to the attainment of the age at which dependent coverage would otherwise terminate and who is dependent upon such Named Insured for support and maintenance. Proof of retardation or the disability and dependency must be furnished to Us within 31 days of the child's attainment of the limiting age and subsequently, as may be required by Us. However, proof may not be required more often than annually after the first 2 years following the child's attainment of the limiting age.

PREMIUMS

When and Where to Pay Premiums

The premiums for the coverage must be paid to Us at Our home office when they are due.

The premium due dates are based on:

- the effective date of the coverage shown on the Certificate Schedule; and
- the premium frequency.

The *premium frequency* is how often the premiums are due.

Grace Period (If Premiums Are Not Paid When Due)

After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. If the premium is not paid before the grace period ends, the coverage provided by the Policy will terminate at midnight on the last day for which premium was paid.

Our Right to Change Premiums

We have the right to change the premium We charge. If We plan to make a change, We will send You a notice at least 45 days before We make it.

We may change premium rates at any time for reasons which affect the risk assumed, including the reasons shown below:

- a change occurs in the plan design;
- the number of insureds changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this plan.

GENERAL PROVISIONS

Entire Contract; Changes

The Policy is a legal contract between the Holder and Us. The Policy is issued in consideration for the application(s) and payments, called premiums.

Whenever We use the word Policy, We mean the entire contract. The entire contract consists of:

- the Policy, the Certificate including the Certificate Schedule;
- the application(s), if any; and
- any attached riders or endorsements.

Riders and endorsements add provisions to or change the terms of the Policy.

Any changes made to the Policy must be attached in writing and signed by one of Our executive officers at [the address We have provided]. No agent or anyone else can change the coverage provided by the Policy or waive any of its provisions.

Incontestability

Any statement made by the Holder or a Named Insured, except for fraudulent misstatements, is considered a representation and not a warranty. A copy of the statement will be provided to the Holder or the Named Insured, whoever made the statement. No statement will be used to contest the Policy, the validity of coverage or reduce benefits unless it is in writing, signed by the Holder or Named Insured.

Coverage Provided by the Policy

We insure a Covered Person for loss according to the provisions of the Policy.

When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's eligibility for the benefits.

Conformity with State Statutes

If any provision of the Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

HOW TO FILE A CLAIM/CLAIM PROVISIONS

How to File a Claim

A claim form must be completed within 90 days after the covered loss begins or as soon as it is reasonably possible. The claim form, along with proof of loss, should be sent to Us at [the address We have provided.

If the Named Insured does not have a claim form, he must give Us a written statement describing the loss within 90 days after the covered loss begins or as soon as it is reasonably possible. The statement should include his name and Certificate Schedule Number as shown in the Certificate Schedule. It must also include proof of loss and how the loss occurred. The Named Insured should send the statement to Us at Our home office. When We receive the statement describing the loss, We will send him claim forms within 15 days. If he does not receive claim forms, his written statement along with the proof of loss will be used to process his claim.

Proof of Loss

The Named Insured must give Us a written proof of loss within 90 days after the covered loss begins. If he is not able to give Us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to Us as soon as it is reasonably possible, except in the absence of legal capacity.

Refer to the applicable benefit section(s) for written proof of loss requirement.

Payment of Claim

Benefits will be paid to the Named Insured or to the designated beneficiary on record. If no named beneficiary is on record with Us all or any part of the benefits owed will be paid to the estate. In lieu of paying benefits to the estate We may, at Our option, pay benefits to any one or more of the following surviving relatives:

- spouse;
- mother;

- father;
- child or children; and
- brothers or sisters.

If there are no survivors in any of these classes, We may pay benefits for expenses on account to a Hospital or Doctor's office or other person actually supporting him or her and who is deemed by Us to be entitled to payment. Any payments made in good faith will end Our liability to the extent of the payment.

Time of Payment of Claim
We will pay any benefits due immediately after We receive written proof of loss.

Physical Examinations
We can require that any Covered Person be examined by a Physician of Our choice at Our expense as often as it is reasonably necessary while his claim is pending.

Legal Action
We cannot be sued for benefits under the Policy until 60 days after written proof of loss has been given as required by the Policy or the expiration of 3 years from the time We receive written proof of loss.

Internal Appeals of Adverse Determinations
The Covered Person, their designee and the Covered Person's health care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing. The Covered Person has up to 180 calendar days after he or she receives notice of the adverse determination to file an appeal. We will acknowledge the Covered Person's request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and telephone number of the person handling the Covered Person's appeal and, if necessary, inform the Covered Person of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

We will decide internal appeals within 30 calendar days of receipt of the appeal request. Written notice of determination will be provided to the Covered Person or their designee (and the Covered Person's health care provider if he or she requested the review) within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

Reviews of services in which a provider requests an immediate review or any other urgent matter will be handled on an expedited basis.

For expedited appeals, the Covered Person's provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. The Covered Person's provider and clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of the appeal request.

If the Covered Person is not satisfied with resolution of his or her expedited appeal, he or she may file a standard internal appeal or an external appeal. Our failure to render a determination of the Covered Person's appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

Notice of Determination of Internal Appeal
The notice of determination of the Covered Person's internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for our decision. It will also explain the Covered Person's rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. We will send notices of determination to the Covered Person or their designee and to the Covered Person's health care provider.

Covered Person's Right To An External Appeal
Under certain circumstances, a Covered Person has a right to an external appeal of a denial of coverage. Specifically, if coverage is denied under the policy on the basis that the service is not Medically Necessary or is Experimental/Investigational treatment, a Covered Person or his representative may appeal the decision to an External Appeal Agent. An External Appeal Agent means an independent entity certified and licensed by the State to conduct such appeals.

Covered Person's Right To Appeal A Determination That A Service Is Not Medically Necessary
If coverage is denied under the policy on the basis that the service is not Medically Necessary, a Covered Person may appeal to an External Appeal Agent if the Covered Person satisfies the following two criteria:

- The service, procedure or treatment must otherwise be a covered expense under the policy; and
- The Covered Person must have received a final adverse determination through Our internal appeal process and We must have upheld the denial for the Covered Person and We must agree in writing to waive any internal appeal.

Covered Person's Rights To Appeal A Determination That A Service Is Experimental/Investigational Treatment

If coverage is denied under the Policy on the basis that the service is Experimental/Investigational treatment, a Covered Person may appeal to an External Appeal Agent if the Covered Person satisfies the following two criteria:

- The service must otherwise be a covered expense under the policy; and
- The Covered Person must have received a final adverse determination through Our internal appeal process and We must have upheld the denial for the Covered Person and We must agree in writing to waive any internal appeal.

In addition, the Covered Person's attending Physician must certify that the Covered Person has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the Covered Person's attending Physician has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders the Covered Person unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The Covered Person's attending Physician must also certify that the Covered Person's life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure -covered by the policy or one for which there exists a clinical trial (as defined by law).

In addition, the Covered Person's attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the Covered Person than any standard covered service. "Medical and scientific evidence" is defined as (1) peer-reviewed scientific studies published in, or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; (2) peer-reviewed medical literature, including literature related to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research; (3) peer-reviewed abstracts accepted for presentation at major medical association meetings; (4) peer-reviewed literature shall not include publications or supplements to publications sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer; (5) medical journals recognized by the secretary of Health and Human Services under section 1861(t)(2) of the federal Social Security Act; (6) the following standard reference compendia (A) the American Hospital Formulary Service-Drug Information; (B) the American Medical Association Drug Evaluation; (C) the American Dental Association Accepted Dental Therapeutics; and (D) the United States Pharmacopeia – Drug Information; and (7) findings studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institute of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
- A clinical trial for which the Covered Person is eligible. "Clinical trial" is defined as a peer-reviewed study plan which has been (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or an NIH center or the Food and Drug Administration in the form of an investigational new drug exemption, or the Federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

For purposes of this section, the Covered Person's attending Physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat the Covered Person's life threatening or disabling condition or disease.

District of Columbia Contact Information
If You are dissatisfied with the resolution reached through Our internal grievance system regarding Medical Necessity, You may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

District of Columbia Department of Health Care Finance Office of the Health Care Ombudsman and Bill of Rights
825 North Capital Street, N.E.
6th Floor
Washington, D.C. 20002

1 (877) 685-6391
Fax: (202) 478-1397

If You are dissatisfied with the resolution reached through Our internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

William P. White, Commissioner
Department of Insurance, Securities, and Banking
810 First Street N.E., 7th Floor
Washington, D.C. 20002
(202) 727-8000
Fax: (202) 354-1085

The External Appeal Process
If, through Our internal appeal process, the Covered Person has received a final adverse determination upholding a denial of coverage on the basis that the service is not Medically Necessary or is Experimental/Investigational treatment, the Covered Person has 45 days from receipt of such notice to file a written request for an external appeal. If the Covered Person and Us have agreed in writing to waive any internal appeal, the Covered Person has 45 days from receipt of such waiver to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through Our internal appeal process or Our written waiver of an internal appeal.

The Covered Person will have an opportunity to submit additional documentation with their request. If the External Appeal Agent determines the information the Covered Person submits represents a material change from the information on which We based the denial, the External Appeal Agent will share this information with Us in order for Us to exercise the right to reconsider the decision. If We choose to exercise this right, We will have three business days to amend or confirm the decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider the decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Covered Person's completed application. The External Appeal Agent may request additional information from the Covered Person, his physician or Us. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify the Covered Person in writing of its decision within two business days.

If the Covered Person's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Covered Person's health, the Covered Person may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the Covered Person and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify the Covered Person in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of Experimental/Investigational treatment, We will provide coverage subject to the other terms and conditions of the policy. Please note that if the External Appeal Agent approves coverage of Experimental/Investigational treatment that is part of a clinical trial, the policy will only cover the costs of services required to provide treatment to the Covered Person according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the Covered Person and Us. The External Appeal Agent's decision is admissible in any court proceeding.

Covered Person's Responsibilities

It is the Covered Person's Responsibility to initiate an external appeal process.

The Covered Person may initiate the external appeal process by filing a completed application with Us. A designee, including a health care provider, may be appointed by the Covered Person at any time in order to pursue an external appeal.

The Covered Person’s completed request for appeal must be filed within 45 days of the date upon which they receive written notification from Us that it has upheld a denial of coverage or the date upon which they receive a written waiver of any internal appeal.

Additionally, a health care provider has the right to pursue an external appeal of a retrospective adverse determination in his own right. Retrospective adverse determination means a determination for which utilization review was initiated after health care services have been provided.

Unified Life Insurance Company
[7201 West 129th Street, Suite 300, Overland Park, Kansas 66213]

ENROLLMENT FORM

TO BE COMPLETED BY MEMBER

Sponsor Member: Group #:

New Enrollment

☐ Change Date of Qualifying Event:

Please indicate the nature of change/qualifying event:

☐ Beneficiary Change

☐ Annual Enrollment Change

☐ Termination Date of Termination: Termination Reason:

NAME (Last) (First) (Middle Initial)	Social Security Number:

Home Address (Street):	City	State	Zip

Telephone Number:	Gender: ☐ Male ☐ Female	Birth Date:

Marital Status (check one): ☐ Married Date: ☐ Single ☐ Divorced ☐ Legally Separated

CHECK THE BOXES BELOW FOR COVERAGE ELECTED

Hospital Indemnity Coverage:	☐ Member Only ☐ Member/Spouse ☐ Member Plus One ☐ Member/Child(ren) ☐ Member/Family	☐ Decline Hospital Indemnity Coverage due to other coverage? ☐ Yes ☐ No

Covered Dependents Full Name	Social Security #	Sex	Birth Date
Spouse			
Dep			
Dep			

Do you or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete this section.
Insured: Date of Birth: Effective Date of Coverage:
Name of Health Carrier: Group/Policy #:
Covered Dependents:

Do you or your dependents have Medicare Coverage ☐ Yes ☐ No Name of Covered Person

☐ Medicare A ☐ Medicare B Medicare # (attach copy of card) Effective Date

ACCIDENTAL DEATH INSURANCE Amount Requested:	☐ Member ☐ Spouse ☐ Dependent $ $ $

ACCIDENTAL DEATH INSURANCE BENEFICIARY DESIGNATION

Primary: Name: Relationship:

(Last) (First) (Middle Initial)

Contingent: Name: Relationship:

(Last) (First) (Middle Initial)

DECLINING COVERAGE — Read and sign if you are declining any coverage offered above

Although I have been given the opportunity to apply for any group insurance offered to me through [ABC Association], I have decided not to participate in the coverages I have declined above. I understand that if I desire coverage at a later date, coverage may be subject to a waiting period and or evidence of insurability.

Member's Signature: _____ Date: _____

ACCEPTING COVERAGE — Read and sign if you are electing any coverage offered above

I request coverages under the group policies as selected above. For any coverage elected on a pre-tax basis, I understand that by signing this enrollment form I am making a binding election and it may only be changed for certain changes in family status as defined in the plan. I understand that participation in a health insurance plan may have an impact on my income tax and Social Security status, which may have a modest affect on my Social Security retirement benefit. I certify that I am a member in good standing of the [ABC Association], and all other information stated above is correct.

Member's Signature: _____ Date: _____

[Certain state insurance departments require that we advise you of the following statements:]

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

[Arkansas and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits 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.

California Residents: Any person who knowingly presents a false or fraudulent claim of payment of a loss is guilty of a crime and may be subject to civil fines and confinement in state prison.

District of Columbia Residents: **It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Mexico Residents: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

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

Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which may be a crime and subjects such person to criminal and civil penalties.

Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

Unified Life Insurance Company
[7201 West 129th Street, Suite 300, Overland Park, Kansas 66213]

ARKANSAS AMENDATORY ENDORSEMENT

This amendatory endorsement is made a part of the Policy or Certificate to which it is attached and is subject to all terms and provisions of such Policy or Certificate not inconsistent herewith. This amendatory endorsement is applicable only to Covered Persons who are **residents** of the State of Arkansas on the effective date of the Certificate.

1. The "Coverage for the Named Insured's Adopted Children" provision in the "Eligibility and Effective Date" section is deleted in its entirety. The following shall be substituted in its place:

   We will cover the Named Insured's adopted children from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the child. However, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

   A child adopted by You or Your insured Spouse will automatically become insured as a dependent. The effective date of the coverage will be the earlier of:
   - the date of placement for the purpose of adoption; or
   - the date on which You assume a legal obligation for total or partial support of the child.

   Coverage for adopted children will be to the same extent as provided for other covered dependent children and will include the necessary care and treatment of pre-existing medical conditions.

   Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and
   - the child is permanently removed from placement;
   - the legal obligation terminates; or
   - You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

   For each newborn, step child and/or adopted child, You must:
   - notify Us of his birth or placement in Your residence;
   - complete the required application for him; and
   - pay the required premium for him, if any.

   If a newborn is not enrolled within 90 days of birth, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of birth.

   If an adopted child is not enrolled within 90 days of adoption, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of placement for the purposes of adoption.

   If a step child is not enrolled within 90 days of placement in Your residence, coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of placement.

2. The last paragraph of the “When Coverage Ends on the Named Insured’s Spouse and/or Dependents” provision in the “Termination of Insurance” section is deleted in its entirety. The following is substituted in its place:

   Coverage will end on each Dependent child when they no longer qualify as a Dependent as defined in the Certificate. It is the Named Insured’s responsibility to notify Us if any Dependent no longer qualifies as an eligible Dependent. If this is family coverage and all of the dependents no longer qualify as eligible dependents and We are not notified, the extent of Our liability will be to refund premium for the time period for which they did not qualify. Coverage will not end on a Dependent child who reaches the limiting age if that child is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law or physical handicap and who became so incapable prior to the attainment of the age at which dependent coverage would otherwise terminate and who is dependent upon such Named Insured for support and maintenance. Upon Our request and at Our expense, the Named Insured must submit proof of incapacity or dependency to us for a Dependent whose coverage would otherwise terminate if not incapacitated or dependent.

3. The “Time of Payment of Claim” provision in the “How to File a Claim/Claim Provisions” section is deleted in its entirety. The following shall be substituted in its place:

   We will pay any benefits due not more than 30 days after We receive written proof of loss electronically or 45 days if the claim is submitted by other means.

This endorsement takes effect and expires concurrently with the Policy or Certificate to which it is attached, and is subject to all of the terms and conditions of the Policy not inconsistent therewith.

There are no other changes to the Policy or Certificate.

Signed for Unified Life Insurance Company:
[

President

Secretary

]

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	06/30/2011

Comments:

Attachment:

READABILITY CERTIFICATION.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	06/30/2011

Comments:

acknowledged

		Item Status:	Status Date:
Satisfied - Item:	Unified Authorization	Approved-Closed	06/30/2011

Comments:

Attachment:

Letter of Authorization for NCE to file rates etc.pdf

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables	Approved-Closed	06/30/2011

Comments:

Attachment:

ULI XB SOV Filing 6-14-11.pdf

		Item Status:	Status Date:
Satisfied - Item:	By Laws	Approved-Closed	06/30/2011

Comments:

Attachment:

NCE Constitution_and_By-Laws.pdf

READABILITY CERTIFICATION

RE: Unified Life Insurance Company

NAIC # 11121 **FEIN #** 43-1917728

This is to certify that form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

Group Accident and Sickness Benefit Forms:		Score
GRP 2011 FPM CERT	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	50
GRP FP 2011 ENR	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	59
GRP 2011 FPM AE AR	Amendatory Endorsement	45

William M. Buchanan
Chairman of the Board

June 20, 2011

UNIFIED LIFE INSURANCE COMPANY
P.O. Box 25326
Overland Park, KS 66225-5326
913-685-2233

March 15, 2011

RE: Unified Life Insurance Company (Unified)
Authorization to File Rates, Rules, and Forms

Dear Sir or Ma'am:

This letter authorizes Compliance Research Services, LLC (CRS) to make rate, rule, and form filings and their related riders and amendments or forms on behalf of Unified for the Xchange Benefits - NCE Program. Further, CRS is authorized to respond to all correspondence and inquiries from the departments or bureaus of insurance related to those filings. This authorization continues in effect until revoked or otherwise amended by an authorized representative of Unified.

Sincerely,

William M. Buchanan
Chairman of the Board

Statement of Variables
GRP 2011 FPM CERT
Group Accident and Sickness Hospital Indemnity Insurance

Coverage levels are chosen by the policyholder. Benefit amounts will change according to the level selected by the policyholder and/or the named insured. All numerical variable range levels will comply with the minimum statutory requirements and are provided in the Certificate Schedule.

GRP 2011 FPM CERT

1. On the Certificate face page, the Company Address is variable to accommodate any change in address.
2. On the Certificate face page, the Group Insurance Policy Number, the Holder and the Policy Date will be unique to each Policyholder.
3. The Phone number on the Certificate face page is variable to accommodate any new phone number.
4. The Officer Signatures on the Certificate face page are variable to accommodate any change in Officers.
5. The page numbers in the Table of Contents are variable and will be adjusted based on the number of benefits included.
6. Certificate Schedule Item 2
    - variables “one of” and “es” will be included if there are two Classes of members. The variables will not be included is there is only one Class of members.
    - the Class definitions may be included or omitted at the option of the Policyholder
    - variable “under age 65” may be included or omitted at the option of the Policyholder
    - variable “65” will be an age that is 65 or higher, for example 75.
    - variable “Class 1 - 2” will refer to the Class of members eligible
    - Dependent Coverage may be included or omitted at the option of the Policyholder
7. Certificate Schedule Item 3 – will include beginning and ending dates of the Coverage Year. The variable will be either “same” or “next”
8. Certificate Schedule Item 4 – may be included or omitted at the option of the Policyholder
9. Certificate Schedule Item 5 – the variable benefits may be included or omitted at the option of the Policyholder
10. General Definitions – the variable definitions will be included or omitted at the option of the Policyholder.
11. Coverage for the Named Insured’s Newborn Children – the last bulleted item regarding routine nursery care will be included if benefits for Pregnancy are not excluded
12. Description of Benefits – variable regarding Sickness Benefit Waiting Period will be included or omitted at the option of the Policyholder
13. Hospital Confinement Benefits – the variable paragraph regarding newborn children will be included if benefits for Pregnancy are excluded
14. Additional Hospital Admission Benefit - 30 days – 6 months
15. Limitations and Exclusions – variable limitations and exclusions may be included or omitted at the option of the policyholder
16. Entire Contract; Changes – will include the current company address
17. How to File a Claim - will include the current company address

GRP FP 2011 ENR

1. The Company Address is variable to accommodate any change in address.
2. The Holder name will be unique to each Policyholder.
3. All bracketed text in the Fraud Statement area will either be omitted or included but will not be changed

CONSTITUTION AND BY-LAWS OF
OF
NATIONAL CONGRESS OF EMPLOYERS, INC.

ARTICLE I
NAME & OFFICE

Section 1 - Name

The name of the association shall be the National Congress of Employers, Inc., hereinafter referred to as "NCE" or the "Association". NCE is a corporation incorporated in the State of Delaware with its principal place of business in the District of Columbia. NCE's By-Laws shall be governed and interpreted by the laws of the State of New York.

Section 2 - Office

The principal offices of the Association shall be located at 1101 Pennsylvania Avenue, Washington, D.C. and additional Chapter offices in New York and any other location the Board deems appropriate.

Section 3 - Registered Agent

The registered agent of the Association is National Registered Agent, Inc. located at 160 Greentree Drive, Suite 101, County of Kent, Dover, Delaware, 19904.

ARTICLE II
SEAL

Section 1 - Seal

The Association shall have a common seal consisting of a design to be determined by vote of the Board of Directors. The seal shall contain the name of the organization in a semi-circular fashion and the year of formal organization, 2006, surrounding or overwritten on an acceptable symbol embodying the purpose of the organization.

ARTICLE III
PURPOSE

Section 1 - Purpose

The purpose of NCE is to establish facilities and provide a forum for the exchange of ideas, opinions, technical know how and experiences among NCE's members as well as other national and international organizations and to engage in any other lawful purpose.

ARTICLE IV
MEMBERSHIP

Section 1 - Qualifications

NCE is a private, fraternal organization which neither seeks nor accepts public or corporate funding in any form. Membership is reserved for those individuals that embody the purposes and ideals of the NCE as defined by the Board of Directors. NCE, through its Board of Directors, shall not deny membership to any protected class of people set forth in Title VII of the Civil Rights Act of 1964, the Civil Rights Act of 1866, the Civil Rights Act of 1991, including, but not limited to, on the basis of race, religion, national origin, sexual orientation and/or gender or for any protected class of people as identified by the New York State Human Rights Laws or the Human Rights Laws of any other jurisdiction which NCE does business in.

Section 2 - Classification of Members

Membership into this organization shall be classified as follows:

1. Charter Members - These shall include the names of founding members: Hon. George F. Sabatella, Hon. Robert DiCarlo, Christopher G. Sabatella, Matthew D. Saronson, Andrea Ceretti and Michael DiFilippo.

2. Active Members - These shall include individuals operating sole proprietorships and other like situated individuals duly enrolled and in good standing, having been approved for full membership by the Board of Directors or their duly authorized delegated Membership Committee.

3. Associate Members - These shall include individuals that are members of the Association, but do not enjoy voting rights, cannot hold the position of committee chairman, nor have access to the other emollients of Full Membership.

4. Supporting Members - These shall include individuals who are conferred membership as such by the Board of Directors with rights as specified thereupon.

Section 3 - Rights and Privileges

1. Charter Member - They shall be entitled to all the privileges and services offered by the association and shall serve as permanent members of the Board of Directors.

2. Active Member - They shall be entitled to all the privileges and services offered by the Association. Each member may vote and be voted upon for office in the Association.

3. Associate Member - They shall include individuals that are members of the

Association, but do not enjoy voting rights, cannot head committee chairmanships nor have access to the other emollients of full membership.

4. Other Privileges - Other membership privileges include participation in various activities, programs and publications of the Association as may be designated from time to by the Board of Directors.

Section 4 - Fees and Dues

1. The Board of Directors may at any meeting of the Board adjust the membership dues applicable to the classes of members enumerated in these By-Laws without amending the By-Laws. Provided, however, that any dues increase which exceeds the cumulative increase of the Composite Consumer Price Index since the last dues increase must be confirmed by a supermajority of the Board of Directors. A supermajority shall be defined as 75% or more of the then sitting Board of Directors. Dues shall be payable in advance of the month due.

2. The Board of Directors shall determine the charges for all other fees associated with the meetings, publications, or other services provided by the Association.

3. Monthly membership dues will include fees for general membership meetings and publications.

Section 5 - Admission and Effectiveness of Membership

1. Applications for membership shall be made in writing. Applications shall be processed by the membership committee. The applicant will be advised of action taken on their application.

2. Effectiveness of membership shall start from the payment of entrance fees and membership dues of the applicant and after submission of other requirements that may be imposed by the membership committee and/or Board of Directors.

3. Fees shall be paid within thirty (30) days after official approval of application for membership.

Section 6 - Members in Good Standing

In order to be a member in good standing, a member shall have paid all dues and assessments within thirty (30) days after the same shall have become due and payable.

Section 7 - Liability of Members

Members who have not fully paid their annual dues and other obligations to the

Association shall be liable for any indebtedness of the Association to the extent of their unpaid accounts.

Section 8 - Termination of Membership

Any member may be separated from membership for any of the following causes:

1. Any member who shall have defaulted in the payment of dues and assessments for two (2) successive months shall be automatically suspended after dues notices had been given and will forfeit all rights and privileges in the Association; provided, however, that any member so suspended may be reinstated to full standing upon payment of all dues in arrears and upon the approval of the majority of the Board of Directors.

2. Any other cause or causes detrimental to the Association upon which, after due notice, investigation and hearing, the Board of Directors votes in favor of termination.

ARTICLE V
MEETINGS

Section 1 - Annual Meetings

The annual general membership meeting, for the purpose of election of the Board of Directors, shall be held on the third Friday of December of each year at the principal office of the Association or at any place in the State of New York or District of Columbia to be decided on by the Board of Directors.

The order of business shall be as follows:

- Reading of the Minutes and of the last Annual General Membership Meeting and approval thereof;
- Report of the Treasurer;
- Report of the President;
- General Annual Elections of the Board of Directors;
- Unfinished business;
- New and other business;
- Report of the election committee and announcement of the results of the election.

Section 2 - Special Meeting

Special meetings of the Association may be called anytime by the Executive Director or by a majority of the Board of Directors whenever either shall deem it necessary.

Section 3 - Notice of Meetings

The notice of the annual meetings or special meetings must be provided to all members in writing at least one (1) week before the meeting, either by letter, fax or electronic mail.

Section 4 - Quorum

A simple majority (50% + 1) of the Active members in good standing, including proxies, shall constitute a quorum for the election of the Directors or for the transaction of any other business except in those cases where the By-Laws require the affirmative vote of a greater proportion.

The final list of candidates, arranged alphabetically, will be circulated to all voting members not later than fifteen (15) days before the election. The list shall not indicate the number of nominations received by each candidate.

In the event that the number of candidates equal or would be less than the number of elective positions, the nomination shall be declared re-opened by the Election Committee on the floor during election day.

Section 5 - Voting of Members

Founding and Active Members in good standing (Voting Members) may vote at all meetings. Each Voting Member is entitled to one vote that may be cast either in person or with approval of the Board of Directors via telephonic participation. In voting for members of the Board of Directors, each Voting Member shall vote a maximum of nine (9) different candidates. If any voting member cannot attend the election, he may submit a written proxy to the committee on election before the election, which shall be used for quorum purposes only.

Section 6 - Certification

Prior to the elections, the Committee on Elections shall certify that the candidates are qualified and have been nominated in accordance with the Constitution and By-Laws of the NCE.

Section 7 - Election of Directors

The election of Directors shall be by secret ballot. Action on all other matters shall be by "aye" or "nay" vote or by other means as the majority present may decide.

Section 8 - Manner in Deciding Tie

Should there be a tie in the election for a Director, the same shall be decided by a flip of a coin by the candidates with an equal number of votes.

Section 9 - Campaign

Any candidate for election may campaign for his candidacy by sending personalized letters bearing only the name and address of the sender and not the official letterhead of the Association. Any other form of campaigning is disallowed and considered a violation of election rules. However, on the election floor, candidates may distribute personal business cards.

Section 10 - Violation of Rules

Any willful violation of election rules by any member of the Association shall disqualify them from running for office and/or voting during the election and will subject them to disciplinary action.

ARTICLE VII
BOARD OF DIRECTORS

Section 1 - Number and Term of Office

The management of the affairs of the Association shall be vested in the Board of Directors consisting of no fewer than four (4) and no greater than nine (9) members who shall be elected bi-annually by the voting members of the Association.

Section 2 - Quorum

The Directors shall act only as a Board. No individual Director shall have the power to act on behalf of the Board. An attendance of a quorum of Directors is necessary at all meetings for the transaction of any business and every decision of majority of those present shall be valid as an Association act. A Quorum shall consist of a simply majority of Directors (50% + 1).

Section 3 - Regular Meetings

The Board of Directors shall hold regular meetings every second Wednesday of the month at the office of the Association or at any date and place to be designated by the Board.

Section 4 - Special Meetings

Special meetings of the Board of Directors may be called by the Executive Director or at the written request of the majority of the Directors. Notice of special meetings shall be given at least one (1) week before the date of the meeting. Notice of such meetings shall be deemed waived if all members of the Board are present.

Section 5 - Powers

The Board of Directors shall exercise the following powers and such other powers as may be provided for by the laws of the State of New York:

1. To promulgate such rules and regulations not inconsistent with these By-Laws;

2. to manage the affairs of the Association within the context of the By-Laws and Articles of Incorporation;

3. To purchase or acquire or sell or dispose of assets for the Association on such terms and conditions as it shall be deemed proper;

4. To employ and fix the compensation of the administrative officer, employees and other officers of the Association;

5. To act on all matters as may be designated by the Association as a whole;

6. To alter, merge or subdivide the Association as the Board sees fit and to best serve the interests of the membership;

7. To perform any and all tasks necessary to further the interests of the Association, limited only by these By-Laws and the laws of the State of New York;

8. To enter into partnership agreements or strategic alliances with like intended Associations or groups;

9. Approves an annual budget and financial audit;

10. Approves the time and place for the annual meetings of the members and the Board of Directors and all business meetings of the Board.

11. Hire and dismiss staff as it deems necessary;

12. Approves all committees and organizational appointments;

13. Fills vacancies on the Board of Directors;

14. Serves as the primary strategic planning unit for the Association;

15. Establishes organizational policies and develops strategies and allocates resources to implement same; and

16. Allow telephonic meetings with a speaker system in place that allows all callers on the call to be heard and to be able to speak to all others present on the telephone call.

Section 6 - Resignation

Any Director or officer may resign his office in writing. Such resignation should take effect upon approval and clearance by the Board.

Section 7 - Vacancy

In the event of any vacancy in the Board of Directors by reason of resignation, termination, death, inability to discharge responsibilities, or for any other reason acceptable to the Board, said vacancy shall, with the approval of the remaining Board of Directors be filled by the surviving spouse of the Director, for the remainder of that Director's term of office. Subsequent vacancies shall likewise be filled in the same manner.

If the vacancy is in the ranks of principal officers of the Board, it shall be filled by election from among the members of the Board during the next regular or special meeting held for the propose.

ARTICLE VIII
OFFICERS

Section 1 - Principal Officers

Within the next fifteen (15) days after the election, as provided for in Article V, Section 1, the members of the Board of Directors shall elect from among themselves the Executive Director, President, Secretary and Treasurer.

Section 2 - Subordinate Officers

The Board, in its discretion, may create those new, subordinate offices they deem necessary. The subordinate officers shall be members of the Association, shall be appointed by the Board of Directors. The subordinate officers may be employed by the Board of Directors who shall determine the compensation of all subordinate officers.

Section 3 - Compensation of Officers

The President, Executive Director, Secretary, Treasurer and members of the Board of Directors shall receive no compensation. Salaries and compensation of other officers shall be fixed by the Board of Directors, provided that no member of the Association shall be appointed or elected to any position carrying with it compensation.

ARTICLE IX
DUTIES OF OFFICERS

Section 1 - Powers and Duties of the Executive Director

The Executive Director shall be the Chief Executive Officer of the Association and, as such, shall exercise all the powers and discharge all such duties regularly or continually inherent in his office under the law, and such others as may be required by resolutions of the Board of Directors and of the Association.

Section 2 - Powers and Duties of the President

The President shall act as Deputy Executive officer and shall exercise and discharge all the powers and the duties of the President in case of the disability or absence of a Deputy Executive Officer. The President shall have direction of the following standing committees:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee
4. Education Committee
5. Legal Committee
6. Charitable Works Committee
7. Other committees and functions as may be assigned to him.

Each committee shall be headed by a Chairperson.

Section 3 - Powers and Duties of the Secretary

The Secretary, who must be a member of the NCE, shall be the custodian of all corporate records and other minutes of all meetings of the Association and of the Board of Directors. He shall issue notices of meetings and prepare the Order of Business thereof. He shall keep in safe custody the seal of the Association and when authorized by the Board of Directors, shall affix such seal to any instrument requiring the same. The seal so affixed shall be attested by him. He shall perform such other duties as may be delegated to him by the Executive Director or the Board of Directors or as may be required of him.

Section 4 - Powers and Duties of Treasurer

The Treasurer shall be the finance officer of the Association and as such shall be the custodian of all funds and properties of the Association. He shall have charge of all the books of accounts of the Association. He shall be responsible for the collection of all the fees and dues from members. He shall make an annual financial report to the Association and such other reports as the Board of Directors may require.

ARTICLE X
COMMITTEES

Section 1 - Standing Committees

There shall be three major standing committees governed by a fourth, governed by the Executive Committee, namely:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee

All standing committees shall submit their master program for the fiscal year to the Board not later than the second regular Board meeting.

Section 2 - Executive Committee

It shall be composed of the Executive Director, the President, the Secretary, the Treasurer and the Chairman of each of the three standing committees.

The committee shall be responsible for the preparation of the annual budget for submission to the Board of Directors not later than the second regular meeting of the Board. It shall also formulate policies and procedures in furtherance of the objectives of the Association for submission to the Board, and direct the governance and running of the standing committees. It shall also perform such other duties as may be delegated by the Board of Directors.

ARTICLE XI
GENERAL PROVISIONS

Section 1 - Fiscal Year

The fiscal year shall begin on January 1 and end on December 31 of the same year.

Section 2 - Budget

The Board of Directors shall approve the annual budget of the Association within fifteen (15) days after receipt of the recommended budget from the Executive Committee. The approved budget shall be the appropriate measure of the Association. No expenditures in excess of the budget shall be authorized without the prior approval of the Board of Directors.

Section 3 - Signatories

All disbursements of funds of the Association shall be made by checks. Checks shall be signed by the Executive Director and countersigned by the President. The Board of Directors may authorize any officer or officers to sign in place of the duly authorized signatories.

ARTICLE XII
AMENDMENTS

Section 1 - Amendments

A two-thirds majority of the members of the Board of Directors may amend or repeal these By-Laws or adopt new By-Laws.

ARTICLE XIII
TRANSITORY PROVISIONS

Section 1 - Regular Members

All Charter, Active Associate and supporting members of the Association in good standing as of the approval of these amended By-Laws are ipso facto members of the Association, together with any other members approved by the Board.

ARTICLE XIV
ASSOCIATION RELATIONSHIPS

Section 1 - Affiliation With Other Professional Organizations

All members shall be encouraged to maintain active membership in local, national and international organizations. The Association may seek affiliation with like intended organizations as determined by the Board of Directors.

ARTICLE XV
LIQUIDATION

Section 1 - Dissolution

In the event of the liquidation and dissolution of the NCE, any properties, funds or monies, securities or other assets remaining in the treasury of, or to the account of, or otherwise belonging to, the NCE shall be disposed of as follows:

1. All liabilities and obligations of the NCE shall be paid and discharged, or adequate provision shall be made therefor.

2. Assets held by the NCE subject to legally valid requirements for their return, transfer or conveyance, upon dissolution and liquidation, shall be returned, transferred or conveyed in accordance with such requirements.

3. All remaining assets held by the NCE shall be transferred or conveyed, without obligation, to another association or foundation selected by the Board of Directors in office at the point dissolution as decided upon.

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.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/22/2011	Form	Group Accident and Sickness Hospital Indemnity Insurance Master Policy	06/23/2011	XB-ULI POLICY.pdf (Superceded)
06/22/2011	Form	Policyholder Application for Group Accident and Sickness Hospital Indemnity Insurance	06/23/2011	XB-ULI Master APP.pdf (Superceded)
06/22/2011	Supporting Document	Flesch Certification	06/23/2011	READABILITY CERTIFICATION.pdf (Superceded)

READABILITY CERTIFICATION

RE: Unified Life Insurance Company

NAIC # 11121 **FEIN #** 43-1917728

This is to certify that form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

Group Accident and Sickness Benefit Forms:		Score
GRP 2011 FPM CERT	Group Accident and Sickness Hospital Indemnity Insurance Certificate of Coverage	50
GRP FP 2011 ENR	Group Accident and Sickness Hospital Indemnity Insurance Enrollment Form	59
GRP FPM 2011 POL	Group Accident and Sickness Hospital Indemnity Insurance Master Policy	50
GRP 2011 FPM APP	Policyholder Application for Group Accident and Sickness Hospital Indemnity Insurance	47
GRP 2011 FPM AE AR	Amendatory Endorsement	45

William M. Buchanan
Chairman of the Board

June 20, 2011

Unified Life Insurance Company
[7201 West 129th Street, Suite 300, Overland Park, Kansas 66213]

GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE POLICY

THIS COVERAGE PROVIDES BENEFITS DUE TO ACCIDENT AND SICKNESS. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

GROUP POLICYHOLDER:	**[**ABC Company**]**
GROUP POLICY NUMBER:	**[**12345**]**
GROUP POLICY EFFECTIVE DATE:	**[**January 1, 2011**]**
STATE OF ISSUE	**[**XXXXX**]**

This Group Policy is issued and delivered in the State shown above and shall be governed by its laws. This policy will go into effect on the Group Policy Effective Date. All periods of insurance begin and end at 12:01 A.M. Standard Time at the Policyholder's address.

This Group Policy is the legal contract between the Group Policyholder and Unified Life Insurance Company. This Group Policy contains the terms under which we agree to insure eligible persons and pay benefits, subject to the terms and conditions herein. We and the Group Policyholder have agreed to all the terms and conditions of the Group Policy. The male pronoun includes the female whenever used.

This Group Policy is issued in consideration of statements made in the application and the payment of premium when due. A copy of the signed application will be attached and made a part of this Group Policy.

The provisions on the following pages and the terms in the Certificate, a copy of which is attached, are made a part of this Group Policy.

We agree to pay, in accordance with the terms of this Group Policy, the benefit amounts of the Group Policy to the Covered Persons. Details of the benefits are shown in the Certificate.

TO OBTAIN INFORMATION YOU MAY CALL OUR TOLL FREE NUMBER: [1-800-XXX-XXXX]

Signed for Unified Life Insurance Company By:

President

Secretary

LIMITED BENEFIT – PLEASE READ THIS GROUP POLICY CAREFULLY.

THE POLICY IS CANCELLABLE AT THE OPTION OF THE COMPANY.
PLEASE READ THE "TERMINATION OF THE GROUP POLICY" PROVISION.
THIS IS NOT COMPREHENSIVE MAJOR MEDICAL COVERAGE.
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

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GROUP POLICY PROVISIONS

Entire Contract: The entire contract consists of the Group Policy, the Certificate, the group application, the applications of Covered Persons and any other documents requested and accepted by us. No change in this Group Policy is valid unless approved by our executive officer. Such approval must be signed by our officer and attached to this Group Policy. No broker, agent or producer can change or waive any provision of this Group Policy.

Amendments: Any change in this Group Policy will be made by amendment approved by us and the Group Policyholder. Such amendment will not require the consent of any Covered Person. The effective time for any amendments shall be 12:01 A.M. Standard Time at the address of the Group Policyholder.

Certificates: We will provide each person insured under this Group Policy with a Certificate. The Certificate describes the main features of the Group Policy, to whom the benefits are payable, and the Limitations and Exclusions and other requirements of this Group Policy. The Group Policyholder must have the Group Policy available for inspection by such persons at all reasonable times.

Incontestability: The validity of the Group Policy shall not be contested except for nonpayment of premiums after it has been in force for 2 years from its date of issue. All statements made by a Covered Person will, in the absence of fraud, be deemed representations and not warranties. No such statement will be used in defense of any claim or in a contest unless the Covered Person has been given a copy. Any misstatement or omission of information made on the Covered Person's application form or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis for later rescission of coverage. After coverage for a Covered Person has been in force for 2 years during the Covered Person's lifetime, We do not have the right to contest coverage, except for fraud or non-payment of premium.

Legal Proceedings: No proceedings to obtain benefits may be brought against us until 60 days after we have received proper written proof of loss and any other documentation necessary to establish the benefits due. No proceedings may be brought more than 3 years after proof is required to be filed.

Required Data: The Group Policyholder or our authorized administrator must provide us with all data needed to carry out the terms of this Group Policy, including any information we may reasonably require. We may inspect the relevant records of the Group Policyholder at any time during regular business hours.

Conformity with State Statutes: If any provision of this Group Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

New Entrants. Any member of a Covered Class, as described in the Certificate Schedule, will become insured when they satisfy the requirements set forth in the Certificate.

Termination of the Group Policy: The Group Policy can be cancelled by the Policyholder or by Us.

If We cancel this Policy, a written notice will be delivered to the Policyholder at least 60 days prior to the cancellation date. Coverage will end at 12:00 midnight Standard Time on the cancellation date.

The Policyholder may cancel this Policy by written notice delivered to Us at least 31 days prior to the cancellation date. This Policy can be cancelled on an earlier date if we both agree. Coverage will end at 12:00 midnight Standard Time on the cancellation date.

Termination will be without prejudice to a claim for benefits for covered charges that were incurred while this Group Policy was in force.

THE REMAINDER OF THIS CONTRACT CONSISTS OF THE CERTIFICATE, WHICH IS ATTACHED TO, AND IS MADE A PART OF, THIS GROUP POLICY

THE CERTIFICATE

Unified Life Insurance Company
[7201 West 129th Street, Suite 300, Overland Park, Kansas 66213]

POLICYHOLDER APPLICATION
FOR GROUP ACCIDENT AND SICKNESS HOSPITAL INDEMNITY INSURANCE

1. Name of Association _____ Group #:_____

2. Address (Street) _____

City: _____ State: _____ Zip Code: _____

3. Phone Number: _____ 4. Plan Administrator: _____

5. Nature of Association: _____ 6. Effective Date of Coverage: _____

7. Sickness Waiting Period: _____ Days

8. Eligible Class

Association Group

All active members of [ABC Association] as determined by bylaws or charter of the Association

Number of eligible members: _____

Is there any association contribution? ☐ Yes ☐ No If yes, what percentage? _____ %

Named Insured Only: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Named Insured and Spouse: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Family: ☐ 100% ☐ 75% ☐ 50% ☐ _____ (other)

Plan Applied For:_____

Member Class:_____

9. Policy Benefits Selected: (See Rate Manual for Options)

Hospital Confinement Benefit

Hospital Confinement Benefit	[$50-3,000] Per Day of Confinement
Maximum Benefit	[3-100] Days Per Coverage Year
[Hospital Intensive Care Unit Confinement Benefit*	[$50--6,000] Per Day of Confinement
Maximum Benefit	[3-15] Days Per Coverage Year

*The Hospital Intensive Care Unit Confinement Benefit will only be payable if the Hospital Confinement Benefit is also payable. The Hospital Intensive Care Unit Confinement Benefit will be payable in addition to the Hospital Confinement Benefit.]

[Additional Hospital Admission Benefit

Hospital Admission Benefit	[$500 - 5,000] Per Admission
Maximum Benefit	[1-5] Admissions Per Coverage Year]

[Surgery Benefit

Surgery Benefit	[50-100] % of 2010 RBRVS
Maximum Benefit	[1-3] Surgeries per Coverage Year
Anesthesia Benefit	[20-25] % of Surgery Benefit]

[Surgery Benefit

Surgery Benefit	[$200 - $2,000] Per Inpatient Surgery [$100 - $1,500] Per Outpatient Surgery
Maximum Benefit	[1-3] Surgeries Per Coverage Year
Anesthesia Benefit	[20-25] % of Surgery Benefit]

[Outpatient Surgical Facility Benefit

Outpatient Surgical Facility Benefit	[$100-1,500] Per Day
Maximum Benefit	[1-3] Days Per Coverage Year]

[Doctors' Office Visit Benefits

Doctors' Office Visits Benefit – Primary Care Physician	[$25-300] Per Visit
Doctors' Office Visits Benefit – Specialty Care Physician	[$25-300] Per Visit
Maximum Benefit – Primary and Specialty Care Visits Combined	[1-5] Visits Per Coverage Year]

[Diagnostic X-ray & Laboratory Tests Benefits (including interpretation)

Basic Pathology	[$20 - $1,000] Per Day
Basic Radiology	[$20 - $1,000] Per Day
Advance Studies	[$50 - $2,500] Per Day
Maximum Benefit for all Diagnostic X-Ray and Laboratory Benefits	[1-5] Days Per Coverage Year]

[Emergency Room Visits Benefits

Emergency Room Benefit	[$50 – 1,000] Per Visit
Maximum Benefit	[1-5] Visits per Coverage Year]

[Ambulance Benefit

Land Ambulance Benefit	[$100-1,000] Per Covered Sickness/Accident
Air Ambulance Benefit	[$100 – 2,000] Per Covered Sickness/Accident
Maximum Benefit-Land and Air Ambulance Combined	[1-5] per Coverage Year]

[Other Covered Medical Services

[Skilled Nursing Facility Benefit	[$50 – 300] Per Day
Skilled Nursing Facility Maximum Benefit	[1 – 30] Days Per Coverage Year]
[Hospice Benefit	[$100 – 300] Per Day
Hospice Maximum Benefit	[10 – 180] Days]
[Rehabilitation Therapy Benefit	[$25 – 150] Per Visit
Rehabilitation Therapy Maximum Benefit	[1 - 10] Visits Per Coverage Year]

[Mental Health Benefits

Mental Health Inpatient Benefit	[$0 – 1,500] per day
Mental Health Inpatient Maximum Benefit	60 days per Coverage Year
Mental Health Outpatient Benefit	[$0 - 300] per treatment
Mental Health Outpatient Maximum Benefit	[$0 – 3,000] per Coverage Year]

[Chemical Abuse and Dependence Diagnosis and Treatment Benefit

Chemical Abuse and Dependence Diagnosis and Treatment Benefit	[$0 – 1,500] per day
Detoxification Maximum Benefit	12 Days of Active Treatment per Coverage Year
Inpatient Rehabilitation Maximum Benefit	60 Days per Coverage Year
Chemical Abuse and Dependence Outpatient Benefit	[$0 - 300] per treatment
Chemical Abuse and Dependence Outpatient Benefit Maximum Benefit	[$0 – 3,000] per Coverage Year]

[Wellness Benefit

Office Visit Benefit	[$25 – 500] per Visit
Maximum Benefit	[1-5] Visits per Coverage Year]
Diagnostic X-Ray and Laboratory Tests	[$20 – 500] per Visit
Maximum Benefit	[1 – 5] Days per Coverage Year

[Supplemental Accident Benefit

[Emergency Room Visit	[$50 – 1,000] per Covered Accident
Maximum Benefit	[1-5] Covered Accidents per Coverage Year]
[Inpatient Admission	[$50 – 2,000] per Covered Accident
Maximum Benefit	[1-5] Covered Admissions per Coverage Year]
[All Other	[$10 - 100] per Covered Accident
Maximum Benefit	[1-5] Covered Accidents per Coverage Year]

[Health Screening Services for Children Benefit

Health Screening Services for Children Benefit	[$0 – 100] per Visit]

[Habilitative Services For Children Benefit

Habilitative Services For Children Benefit	[$0 - 100] per Visit]

[HIV Screening Test Benefit

HIV Screening Test Benefit	[$0 – 100] per Visit]

[Cancer Screening Benefit

Cancer Screening Benefit	[$0 - 100] per Visit]

[Diabetes Supplies, Equipment and Self-Management Education Benefit

Diabetes Supplies, Equipment and Self-Management Education Benefit	[$0 - 100] per Coverage Year]

[Accidental Death Benefit

Accidental Death Principal Sum for Named Insured	[$1,000 - $25, 000]
Accidental Death Principal Sum for Spouse	50% of Named Insured Benefit
Accidental Death Principal Sum for Child(ren)	25% of Named Insured Benefit
Loss Period	Loss within [180-365] days from the date of the Accident]

10. Is this a replacement of similar coverage: ☐ Yes ☐ No
11. Previous Company: _____

    Termination Date of Prior Plan: _____

It is understood and agreed that this application shall be attached as a part of the Policy applied for, and that no Insurance shall be effective until approved by Unified Life Insurance Company at its home office.

I understand that Accident and Sickness Hospital Indemnity Plan covered persons are covered by group insurance benefits. The group insurance benefits vary depending on plan selected. These benefits are provided under a group insurance policy underwritten by Unified Life Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate which may include, but is not limited to, limitations for pre-existing conditions. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is an accident and sickness hospital indemnity plan that provides for limitations to the coverage for each benefit. The limitations are disclosed in the policy and certificate which are made available at the time of enrollment.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Dated at:_____ By: _____
(City, State) (Authorized Signature/Title)

On: _____ By: _____
Date (mm/dd/yyyy) (Printed Agent/Broker Name)

_____
(Signature of Agent/Broker)

To be Completed by Home Office

On _____ By _____ Plan Effective Date_____
Date (mm/dd/yyyy) Home Office