

SERFF Tracking Number: RNIC-127212325 State: Arkansas
Filing Company: Reserve National Insurance Company State Tracking Number: 49078
Company Tracking Number:
TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002 Dread Disease
Limited Benefit
Product Name: SD-1 Specified Disease Policy
Project Name/Number: SD-1 Specified Disease Policy/

Filing at a Glance

Company: Reserve National Insurance Company

Product Name: SD-1 Specified Disease Policy SERFF Tr Num: RNIC-127212325 State: Arkansas

TOI: H071 Individual Health - Specified Disease SERFF Status: Closed-Approved- State Tr Num: 49078

- Limited Benefit Closed

Sub-TOI: H071.002 Dread Disease

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Kyle Conrad, Brenda
Ingram

Disposition Date: 06/29/2011

Date Submitted: 06/17/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: SD-1 Specified Disease Policy

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/29/2011

State Status Changed: 06/29/2011

Deemer Date:

Created By: Brenda Ingram

Submitted By: Brenda Ingram

Corresponding Filing Tracking Number:

Filing Description:

Ms. Rosalind D. Minor

Certified Rate and Form Analyst

Life and Health Division

Arkansas Insurance Department

1200 West Third Street

Little Rock, AR 72201-1904

RE: Reserve National Insurance Company - NAIC # 68462; FEIN# 73-0661453

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Form SD-1 – Specified Disease Policy
Form PEB-3 (7/89) – Existing Condition Benefit Endorsement
Form UAP-1 AR (8/11) - General A&H Application
Form OC SD-1 – Outline of Coverage
Form AR-INP (11/09) Important Notice
Form RP-A&H – Notice to Applicant Regarding Replacement of Health Insurance

Dear Ms. Minor:

We are submitting the above-referenced forms, which we request you consider for approval. This is a new filing not previously submitted. This filing is not subject to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 or any of the regulations thereunder (collectively referred to as the "PPACA").

Form SD-1 is an individual specified disease policy. This policy will be available to individuals age 0 through 64. It will not be issued to individuals who are 65 or older.

The possible "covered specified diseases" are: cancer, coronary artery/cardiovascular disease, diabetes, stroke, major organ transplant and end stage renal failure. Based on underwriting, one or more of those conditions may not be covered under a particular policy as issued.

Form SD-1 pays, for each "covered specified disease," 80% of the expense incurred up to stated maximum benefit amounts for each scheduled benefit. Each benefits for each "covered specified disease" renews 180 days after its stated maximum is reached for a particular "covered specified disease."

A deductible selected by the applicant must be satisfied by a covered person once in his/her lifetime for each covered specified disease before any benefits are payable for that covered specified disease. The deductibles are \$5,000, \$10,000 and \$20,000.

For each injury or sickness, Form SD-1 provides the following scheduled benefits that are calculated by multiplying 80% by the expense incurred but limited to the following maximum benefit amounts:

1. Daily Hospital Room and Board Benefit - \$500.
2. Miscellaneous Hospital Inpatient Benefit - \$100,000. On an optional basis, this maximum benefit amount may be increased to \$250,000 or \$500,000.

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3. Inpatient Doctor Visits Benefit - \$75 per visit, limited to 24 visits.

4. Inpatient Diagnostic Radiology Benefit - \$2,500.

5. Inpatient Pathology Benefit - \$2,500.

6. Surgeon's Benefit - As scheduled in the policy.

7. Anesthesia Benefit - 25% of the applicable surgery benefit.

8. Prosthesis Benefit - \$15,000.

9. Daily Skilled Nursing Facility/Rehabilitation Center Benefit - \$300.

10. Physical Therapy Benefit - \$50 per day, limited to \$2,500.

The following forms to be used with Form SD-1 are also being submitted:

A. Form PEB-3 (7/89) – Existing Condition Benefit Endorsement, which was previously approved by your office. In accordance with our underwriting guidelines, Form PEB-3 (7/89) may be selected by an applicant for coverage of a “covered specified disease,” which is a pre-existing condition, after a waiting period of 12 months.

B. Form UAP-1 AR (8/11) – General A&H Application, will be used as the application for Form SD-1. Form UAP-1 AR (8/11) will also be used as the application for our previously approved accident and health policies in your state, but not Medicare supplement policies, as applicable.

C. Form OC SD-1– Outline of Coverage, will be used in connection with Form SD-1.

D. Form AR-INP (11/09) - Important Notice, which was previously approved by your office, will be issued with each SD-1 Policy.

E. Form RP-A&H – Notice to Applicant Regarding Replacement of Health Insurance, which was previously approved by your office, will be used in replacement situations.

We are also submitting the applicable rates, and a supporting actuarial memorandum.

For the following reasons, Form SD-1 qualifies as “excepted benefits,” as defined by applicable law, and is not subject to

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the requirements of the PPACA: (a) the benefits are provided under a separate policy; (b) this is specified disease coverage; (c) there is no coordination of benefits with the benefits, exclusions or any other provision of any other health insurance coverage; and (d) each benefit is payable with respect to an event [as stated in Form SD-1] without regard to whether benefits are provided with respect to the same event under any other health insurance coverage.

If this filing meets with your approval, please furnish us with evidence thereof.

Thank you for your consideration in this matter. If there are any questions, you may contact me by telephone at (800) 874-1431, by fax at (405) 840-3426 or by e-mail at kconrad@unitrin.com.

Sincerely,

Kyle D. Conrad
Senior Vice President
and Associate Corporate Counsel
KDC:bdi

Company and Contact

Filing Contact Information

Kyle Conrad, Vice President & Associate Corporate Counsel
kconrad@unitrin.com
6100 N. W. Grand Blvd
800-874-1431 [Phone] 549 [Ext]
Oklahoma City, OK 73118

Filing Company Information

Reserve National Insurance Company
601 East Britton Road
Oklahoma City, OK 73114
(405) 848-7931 ext. 549[Phone]
CoCode: 68462
Group Code: 215
Group Name: Reserve National
FEIN Number: 73-0661453
State of Domicile: Oklahoma
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? No

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Fee Explanation: Policy & 2 Forms
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	\$150.00	06/17/2011	48817393

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/29/2011	06/29/2011

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Disposition

Disposition Date: 06/29/2011

Implementation Date:

Status: Approved-Closed

Comment:

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

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Certification	Approved-Closed	Yes
Supporting Document	Form RP-A&H	Approved-Closed	Yes
Supporting Document	AR-INP (11/09)	Approved-Closed	Yes
Form	Specified Disease Policy	Approved-Closed	Yes
Form	General A&H Application	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Rate	Rate Sheets	Approved-Closed	Yes

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Form Schedule

Lead Form Number: SD-1

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/29/2011	SD-1	Policy/Contract Certificate	Specified Disease Fraternal Policy	Initial		84.295	SD-1_POLICY_A RKANSAS.pdf
Approved-Closed 06/29/2011	UAP-1 AR (8/11)	Application/Enrollment Form	General A&H Application	Revised	Replaced Form #: UAP-1 AR (8/11) Previous Filing #: 47727		UAP-1 AR 8.11.pdf
Approved-Closed 06/29/2011	OC SD-1	Other	Outline of Coverage	Initial			OC SD-1 .pdf

THIS IS A SPECIFIED DISEASE POLICY THAT PAYS BENEFITS FOR ONLY THE SPECIFIED DISEASES SHOWN ON THE INSURED SCHEDULE. IT IS RENEWABLE AS PROVIDED IN THE RENEWAL SAFEGUARD PROVISION. PREMIUMS ARE BASED ON EACH COVERED PERSON'S ATTAINED AGE. WE HAVE THE RIGHT TO INCREASE PREMIUMS ON A CLASS BASIS BY STATE.



When we use "we," "us," "Company" or "our" we mean Reserve National Insurance Company. When we use "you" or "your" we mean the Insured or a Covered Person as defined in this Policy and as named on the Insured Schedule.

SPECIFIED DISEASE POLICY

INSURING AGREEMENT

We agree to indemnify each Covered Person as provided herein, for certain specified expenses, subject, however, to all the provisions, conditions, exclusions, limitations and other terms of this Policy.

In consideration of the payment of the premium in advance and in reliance upon the statements in the Insured's application, a copy of which is attached and which forms a part of this Policy, the Company hereby insures those persons named on the Insured Schedule, commencing at 12:01 A.M., Standard Time, at the place where the Insured resides, on the Effective Date shown on the Insured Schedule. Upon the expiration of the initial term, as shown on the Insured Schedule, this Policy, subject to the Renewability provision, may be continued in effect by the payment in advance, or within the grace period specified herein, of the premium in effect at the time of such renewal.

RENEWABILITY

Subject to the Termination provision, coverage under this Policy is renewable as provided in the **Renewal Safeguard** provision. Premiums are subject to change as provided in the Premium Payments provision.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to us at 601 East Britton Road, Oklahoma City, Oklahoma 73114-7710, within 10 days if any information shown on the application is not correct and complete, or if any past medical history has been left out of the application. The application is part of this Policy, which was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

RIGHT TO RETURN POLICY WITHIN 10 DAYS

If for any reason you are not satisfied with your Policy, you may return it to the Company or to the writing agent within 10 days of the date you received it and the premium you paid will be promptly refunded. Then this Policy will then be void from its beginning, and you and the Company will be in the same position as if it had never been issued.

THIS IS A LIMITED POLICY. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. SEE THE INSURED SCHEDULE FOR THE COVERED SPECIFIED DISEASES FOR WHICH BENEFITS ARE PAYABLE. NO BENEFITS ARE PAYABLE FOR ANY OTHER CONDITION, ACCIDENT OR SICKNESS.

READ THIS POLICY CAREFULLY WITH THE OUTLINE OF COVERAGE.

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INSURED SCHEDULE

		<u>Renewal Premium:</u>	Direct Bill	Bank Draft
Policy Number	00-H9-100000	Monthly	N/A	\$00.00
Effective Date	Sept. 1, 2011	Quarterly	\$00.00	\$00.00
Initial Term Expires	Sept. 1, 2011	Semi Annual	\$00.00	N/A
Initial Premium	\$00.00	Annual	\$00.00	N/A
Insured	JOHN DOE	Agent	RESERVE NATIONAL AGENT	

Dependents

JANE DOE
DEPENDENT 1
DEPENDENT 2
DEPENDENT 3

Policy Benefits and Limitations

Benefits payable for each Covered Specified Disease are the Benefit Percentage of the Expense Incurred, subject to the Deductible, but not to exceed the maximum benefit amounts shown below. Please note the limitations, and refer to the noted page numbers for details.

Deductible [page 4]

(Applies once in each Covered Person's lifetime for each Covered Specified Disease) \$10,000.00

Benefit Percentage [page 4]..... 80%

Benefits for each Covered Specified Disease:

Maximum Daily Hospital Room and Board Benefit [page 5]..... \$500.00

Maximum Miscellaneous Hospital Inpatient Benefit* [page 5]..... \$250,000.00

Maximum Inpatient Doctor Visits Benefit [page 5] \$75.00 Per Visit, Limited to 24 Visits

Maximum Inpatient Diagnostic Radiology Benefit [page 5] \$2,500.00

Maximum Inpatient Pathology Benefit [page 5] \$2,500.00

Maximum Surgeon's Benefit [page 6] See Schedule of Operations

Maximum Anesthesia Benefit [page 6].....25% of Surgeon's Benefit

Maximum Prosthesis Benefit [page 6] \$15,000.00

Maximum Daily Skilled Nursing Facility/Rehabilitation Center Benefit [page 6] \$300.00

Maximum Physical Therapy Benefit [page 6]..... \$50.00 Per Day, Limited to \$2,500.00

*Expenses Incurred for outpatient chemotherapy or radiation therapy will be covered as if such expenses were incurred on an inpatient basis, limited to a maximum aggregate benefit of \$2,500.00 per day for outpatient chemotherapy or radiation therapy.

Covered Specified Diseases

This Policy provides benefits for ONLY (a) the following Covered Specified Diseases and (b) any condition directly caused or aggravated by one or more of the following Covered Specified Diseases. Please refer to the definitions on page 3. No benefits are payable for any other condition, accident or sickness.

[Cancer]

[Coronary Artery/Cardiovascular Disease]

Diabetes

Stroke

Major Organ Transplant

End Stage Renal Failure

-See Endorsements and Riders on Reverse Side-

-HOME OFFICE-
 RESERVE NATIONAL INSURANCE COMPANY
 601 EAST BRITTON ROAD * OKLAHOMA CITY, OKLAHOMA 73114-7710

INSURED SCHEDULE

Endorsements and Riders

PEB-3 (7/89)

Applicable to JOHN DOE only, no benefits shall be paid or any loss or expense incurred or commencing prior to the expiration of 12 months from September 1, 2011, as a result of:

[Cancer, as defined in this Policy]

[Coronary Artery/Cardiovascular Disease, as defined in this Policy]

[Diabetes, as defined in this Policy]

[Stroke, as defined in this Policy]

[Major Organ Transplant, as defined in this Policy]

[End Stage Renal Failure, as defined in this Policy]

DEFINITIONS

The following terms in this Policy are defined as follows:

BENEFIT PERCENTAGE: "Benefit Percentage" means the percentage of covered Expenses Incurred for a Covered Specified Disease which is payable under each benefit provision of this Policy. The Benefit Percentage under this Policy is shown on the Insured Schedule.

CANCER: "Cancer" means only: (a) a malignant neoplasm characterized by the uncontrolled growth of malignant cells or (b) Hodgkin's disease or leukemia. Cancer shall be evidenced by:

- (1) microscopic examination of fixed tissue or preparations from the suspected area; and
- (2) criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Cancer may be evidenced by a clinical diagnosis when a pathological diagnosis cannot be made in accordance with accepted standards of medical practice; however, medical evidence must substantially support a clinical diagnosis of Cancer.

Cancer does not mean benign tumors or polyps, any pre-malignant condition or any condition with malignant potential. Skin cancer, other than malignant melanoma, is not a Covered Specified Disease and is not covered by this Policy.

CONFINED OR CONFINEMENT: "Confined" or "Confinement" means admission as a resident inpatient of a Hospital for at least a 24-hour period. No benefit is payable in connection with a period of Hospital Confinement less than 24 hours, except that if a Covered Person is confined in a Hospital solely for purposes of observation, the appropriate benefits under this Policy will be pro-rated based on the number of hours of observation.

CORONARY ARTERY/CARDIOVASCULAR DISEASE: "Coronary Artery/Cardiovascular Disease" means angina pectoris (stable angina), coronary insufficiency (unstable angina), myocardial infarction (heart attack), atherosclerosis, vessel spasms, clots, congestive heart failure or any other dysfunction of the cardiovascular system, including hypertension. Myocardial infarction shall be evidenced by: (a) angina with any EKG changes or (b) elevated Troponin.

COVERED PERSON: "Covered Person" means only (a) the Insured, (b) the Insured's spouse and (c) all of the Insured's dependent children, including adopted children; provided such Insured, spouse and dependent children are listed by name on the Insured Schedule and the applicable premium is paid.

COVERED SPECIFIED DISEASE: "Covered Specified Disease" means only a primary or principal diagnosis of one or more of the following, but only as shown on the Insured Schedule: (a) Cancer, (b) Coronary Artery/Cardiovascular Disease, (c) Diabetes, (d) Stroke, (e) Major Organ Transplant or (f) End Stage Renal Failure. Covered Specified Disease shall also be deemed to include all Covered Specified Diseases suffered concurrently.

This Policy provides benefits for ONLY (a) the Covered Specified Diseases shown on the Insured Schedule and (b) any condition directly caused or aggravated by one or more of the Covered Specified Diseases shown on the Insured Schedule. No benefits are payable under this Policy for any other condition, accident or sickness.

DEDUCTIBLE: "Deductible" means the amount of expenses that must be incurred for each Covered Specified Disease for covered medical treatment before any benefits provided by this Policy are payable. No benefits are payable for expenses making up the Deductible. A Covered Person must satisfy the Deductible **once** in his/her lifetime while this Policy is in force before any benefits provided by this Policy are payable for such Covered Specified Disease. The Deductible under this Policy is shown on the Insured Schedule.

DIABETES: "Diabetes" means diabetes mellitus, which is a group of metabolic disorders that result in hyperglycemia (high blood sugar), and any complications thereof, which include retinopathy, nephropathy, neuropathy and peripheral vascular disease. Diabetes shall be evidenced by elevated hemoglobin A1C (HB A1C).

END STAGE RENAL FAILURE: "End Stage Renal Failure" means only chronic irreversible failure of the function of both kidneys, which requires regular hemodialysis or peritoneal dialysis at least weekly.

DEFINITIONS (Continued)

EXPENSE INCURRED: "Expense Incurred" means the charges actually incurred by a Covered Person for covered medical treatment which is prescribed by a Physician. Expense is considered incurred on the date treatment is provided.

HOSPITAL: "Hospital" means only a legally constituted institution which operates pursuant to law having facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one or more licensed Physicians and which provides 24-hour nursing service by or under the supervision of registered nurses on duty. It does not mean convalescent, rehabilitation, nursing, rest, or extended care facilities, or facilities operated exclusively for treatment of the aged, or drug or alcohol abuse, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital. For purposes of outpatient surgery, "Hospital" includes an outpatient surgical facility licensed by the state in which the expense is incurred and operating pursuant to law or any other facility where outpatient surgery is performed as authorized by law. If a Covered Person incurs expense for covered treatment in connection with outpatient surgery, benefits under this Policy will be payable on an inpatient basis.

MAJOR ORGAN TRANSPLANT: "Major Organ Transplant" means only definitive evidence of the failure of the Covered Person's **liver, kidney, lung, entire heart or pancreas** which requires the malfunctioning organ to be replaced with an organ from a human donor under generally accepted medical procedures, **and surgery to transplant the replacement organ into the Covered Person is actually performed** in the United States. Major Organ Transplant shall be evidenced by: (a) the Covered Person's registration with the United Network of Organ Sharing (UNOS) or similar network and (b) surgery actually performed in the United States to transplant a human liver, kidney, lung, entire heart or pancreas into the Covered Person by a Physician who is board certified to perform such surgery.

Major Organ Transplant does not include transplantation of any other organ or tissue, or replacing any human organ with a mechanical device or with an organ or tissue from an animal. Major Organ Transplant does not include, with respect to the heart, the transplant of a heart valve or anything less than the entire heart. Major Organ Transplant does not include removal of any organ from any donor. No benefits are payable under this Policy for any Expense Incurred by or for a donor in connection with a Covered Person's Major Organ Transplant.

PHYSICIAN: "Physician" means any duly qualified individual (other than you, your spouse, your or your spouse's parent, grandparent, child, grandchild or sibling, or the spouse of any such individual, or anyone living at your residence) who is duly licensed and practicing the healing arts within the scope of his/her authority and license.

POLICY YEAR: "Policy Year" means each successive 12-month period extending from the Effective Date of this Policy so that each successive 12-month period constitutes a single Policy Year.

PRE-EXISTING CONDITION: "Pre-Existing Condition" means a condition which has been diagnosed, or has manifested itself to the Covered Person within the five-year period immediately preceding the Effective Date of this Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the two-year period following the Effective Date of this Policy.

REHABILITATION FACILITY: "Rehabilitation Facility" means a place licensed as such by the state in which it is located. A Rehabilitation Facility can also be a specifically designate area or part of a Hospital.

SKILLED NURSING FACILITY: "Skilled Nursing Facility" means a facility licensed to provide skilled nursing care by the proper authority of the state in which it is located. It must have a registered nurse (RN) on the premises 24 hours a day. A Skilled Nursing Facility does not include an assisted living facility.

STROKE: "Stroke" means only a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism or thrombosis. Stroke shall be evidenced by: (a) documented measurable neurological deficit that persists for at least 72 hours following the occurrence of the Stroke and (b) neuroimaging studies that confirm the diagnosis.

Stroke does not mean transient ischemic attack (TIA), reversible neurological deficit, migraine, cerebral injury resulting from trauma, or vascular disease affecting the eye, optic nerve or vestibular functions or other cerebral events.

LIMITATION

This Policy provides benefits for **ONLY (a) the Covered Specified Diseases shown on the Insured Schedule and (b) any condition directly caused or aggravated by one or more of the Covered Specified Diseases shown on the Insured Schedule. No benefits are payable under this Policy for any other condition, accident or sickness.**

BENEFITS

BENEFIT FOR DAILY HOSPITAL ROOM AND BOARD

If a Covered Person, while confined in a Hospital as a resident inpatient as a result of a Covered Specified Disease, while this Policy is in force, incurs expense for Daily Hospital Room and Board, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed the Maximum Daily Hospital Room and Board Benefit amount shown on the Insured Schedule. **This benefit for daily Hospital room and board is limited to 365 days for an adult or 60 days for a child under age 18 for any one Covered Specified Disease.**

BENEFIT FOR MISCELLANEOUS HOSPITAL EXPENSES

If a Covered Person, while confined in a Hospital as a resident inpatient as a result of a Covered Specified Disease, while this Policy is in force, incurs expense for the following miscellaneous Hospital inpatient services and supplies billed by the Hospital, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed the Maximum Miscellaneous Hospital Inpatient Benefit shown on the Insured Schedule **for any one Covered Specified Disease:**

Operating Room	Radiation Therapy	Oxygen
Recovery Room	Chemotherapy	Surgical Dressings
Emergency Room	Medicine	Medical & Surgical Supplies, but not including Prosthesis or Equipment
Anesthetics	Drugs	Laboratory
X-rays	I.V. Solution	Tissue Exam
Transfusions (Blood not included)	Antibiotics	Splints, Casts
CT Scan	Physiotherapy Service	
Electroencephalogram	Electrocardiogram	

Only the services and supplies shown above are covered under this benefit. Some examples of services and supplies not covered under this benefit include blood, convenience items, prosthesis and equipment.

Outpatient Radiation/Chemotherapy Therapy: If a Covered Person, while this Policy is in force, incurs expense for outpatient radiation therapy or outpatient chemotherapy administered by or under the supervision of a Physician for the treatment of Cancer, following a covered Hospital confinement or surgical procedure for which benefits for Miscellaneous Hospital Inpatient Expenses were payable for the treatment of such Cancer, benefits for such outpatient radiation therapy or outpatient chemotherapy will be payable, **subject to the Deductible provision**, as if incurred on an inpatient basis for such Cancer, but **not to exceed in the aggregate a maximum benefit of \$2,500.00 per day for such outpatient radiation therapy or outpatient chemotherapy.**

BENEFIT FOR INPATIENT DOCTOR VISITS

If a Covered Person, while confined in a Hospital as a resident inpatient as a result of any one Covered Specified Disease, while this Policy is in force, incurs expense for personal treatment by a Physician, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed a maximum benefit of \$75.00 for each treatment. This benefit is limited to one treatment per day, but not to exceed 24 treatments **for any one Covered Specified Disease.**

BENEFIT FOR INPATIENT DIAGNOSTIC RADIOLOGY

If a Covered Person, while confined in a Hospital as a resident inpatient as a result of a Covered Specified Disease, while this Policy is in force, incurs expense for the interpretation of X-rays, CT Scans or Magnetic Resonance Imaging by a radiologist, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed the Maximum Inpatient Diagnostic Radiology Benefit amount shown on the Insured Schedule **for any one Covered Specified Disease.**

BENEFITS (Continued)

BENEFIT FOR INPATIENT PATHOLOGY

If a Covered Person, while confined in a Hospital as a resident inpatient as a result of a Covered Specified Disease, while this Policy is in force, incurs expense for the services of a pathologist, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed the Maximum Inpatient Pathology Benefit amount shown on the Insured Schedule **for any one Covered Specified Disease**.

BENEFIT FOR SURGEON

If a Covered Person, as a result of a Covered Specified Disease, while this Policy is in force, incurs expense for a surgical operation performed by a Physician, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred for the primary surgeon for such operation, but not to exceed the applicable amount shown on the Schedule of Surgical Operations. The maximum aggregate benefit payable under this provision for all surgical operations shall be limited to \$8,000.00 **for any one Covered Specified Disease**. This benefit is payable for surgery performed either on an inpatient or outpatient basis. This benefit is not payable for any Expense Incurred for a Physician who assists the primary surgeon with a surgical operation.

BENEFIT FOR ANESTHESIOLOGIST

If a Covered Person, while this Policy is in force, incurs expense for the administration of anesthesia by a Physician for a surgical procedure covered by this Policy, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed 25% of the benefit payable under this Policy's Benefit for Surgeon for the primary surgeon for the surgical procedure.

BENEFIT FOR PROSTHESIS

If a Covered Person, as a result of a Covered Specified Disease, while this Policy is in force, incurs expense for a prosthesis (a replacement part or device, whether organic or inorganic, implanted in the body to perform or augment a bodily function, such as a pacemaker, a defibrillator, artificial limbs, joints or eyes, casts, splints, trusses or braces), **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed a Maximum Prosthesis Benefit amount shown on the Insured Schedule **for any one Covered Specified Disease**.

BENEFIT FOR DAILY SKILLED NURSING FACILITY/ REHABILITATION FACILITY CONFINEMENT

If a Covered Person, as a result of a Covered Specified Disease, while this Policy is in force, incurs expense for confinement in a Skilled Nursing Facility or Rehabilitation Facility, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, but not to exceed the Maximum Daily Skilled Nursing Facility/Rehabilitation Facility Benefit amount shown on the Insured Schedule for each full day of confinement. This benefit is limited in the aggregate to 30 days of such confinement **for any one Covered Specified Disease**.

BENEFIT FOR PHYSICAL THERAPY

If a Covered Person, as a result of a Covered Specified Disease, while this Policy is in force, incurs expense for physical therapy, **subject to the Deductible provision**, we will pay the Benefit Percentage of the Expense Incurred, limited to \$50.00 per day and not to exceed in the aggregate the Maximum Physical Therapy Benefit amount shown on the Insured Schedule **for any one Covered Specified Disease**.

SCHEDULE OF SURGICAL OPERATIONS

HEAD

Burr Holes hematoma	3920.00
Craniotomy hematoma	4760.00
Craniotomy skull tumor	8000.00
Intracranial aneurysm	6440.00

EAR

Mastoidectomy - radical	6000.00
Mastoidectomy - simple	2800.00
Tympanoplasty	3640.00
Tympanotomy	600.00

EYE

Blepharoplasty	2000.00
Enucleation of eyeball	1600.00
Foreign body removal	400.00
Iridectomy	2400.00
Keratotomy	2400.00
Lens implant	2400.00
Sclerotomy	2400.00
Vitrectomy	2400.00

NOSE

Antrum puncture for drainage	400.00
Ethmoidectomy	1800.00
Polypectomy	800.00
Septoplasty	2400.00
Submucous resection	1800.00

THROAT - NECK

Laryngoscopy	1000.00
Radical neck dissection for tumor	8000.00
Removal of larynx	5600.00
Removal of tumor larynx	2800.00
Removal of vocal cord	3200.00
Thyroidectomy	4000.00
Tonsillectomy adenoidectomy	1200.00

CHEST

Bronchoscopy	1600.00
Esophagoscopy	600.00
Esophagogastroduodenoscopy	1200.00
Lobectomy	4800.00
Mediastinoscopy	1600.00
Mediastinotomy	800.00
Lung needle biopsy	600.00
Pneumonectomy	5600.00
Thoracentesis	400.00
Thoracoplasty	5600.00
Thoracotomy with biopsy	2800.00
UGI endoscopy with biopsy	1600.00
UGI endoscopy diagnostic	1200.00

BREAST

Breast aspiration	400.00
Breast biopsy	640.00
Radical mastectomy	
Bilateral	6000.00
Reconstruction	6000.00
Unilateral	3200.00
Reconstruction	3200.00
Reduction mammoplasty	
Bilateral	2800.00
Unilateral	2000.00
Removal of tumor	1200.00
Simple mastectomy	
Bilateral	2400.00
Reconstruction	2400.00
Unilateral	2000.00
Reconstruction	2000.00

CARDIOVASCULAR

Ablation therapy - veins	2400.00
Aortic valve replacement	8000.00
Combined left and right heart catheterization	2400.00
Coronary angioplasty	7000.00
Coronary artery bypass	8000.00
Hemodialysis access	2400.00
Electrophysiologic evaluation, heart	4000.00
Embolectomy	2400.00
Endarterectomy	7000.00
Insertion venous access	1600.00
Left heart catheterization, coronary angiography	2400.00
Mitral valve replacement	8000.00
Pericardiectomy	4800.00
Pericardiotomy	3200.00
Permanent pacemaker insertion	3200.00
Popliteal artery bypass	4480.00
Repair of aneurysm	7000.00
Right heart catheterization, Swan-Ganz	2200.00
Thrombectomy	2400.00
Vascular injection	800.00

ABDOMEN

Appendectomy	2800.00
Biopsy of liver	1800.00
Biopsy of pancreas	2000.00
Cholecystectomy	2800.00
Colostomy	3200.00
Enterolysis	2600.00
Exploratory laparotomy	2800.00
Gastrectomy	
Sub Total	4800.00
Total	6000.00
Gastroenterostomy	4000.00
Intestinal resection	3200.00
Omentectomy	2400.00
Splenectomy	3200.00

GENITO-URINARY TRACT

Adrenalectomy	3600.00
Cystectomy	3200.00
Cystolithotomy	3400.00
Cystoscopy	1000.00
Epididymectomy	1800.00
Marshall Marchetti Krantz	3600.00
Nephrectomy	5600.00
Nephrolithotomy	3400.00
Orchiectomy	2000.00
Suprapubic prostatectomy	3600.00
TUR prostate	3600.00
Urethral dilation	400.00

GYNECOLOGY

Biopsy of cervix	800.00
Biopsy of endometrium	800.00
Cautery of cervix	800.00
Dilatation and curettage	1400.00
Hysterectomy, abdominal	4000.00
Hysterectomy, vaginal	3600.00
Hysterosalpingography	800.00
Hysteroscopy, biopsy	800.00
Hysteroscopy, ablation	1400.00
Laparoscopy	1600.00
Oophorectomy	2400.00
Salpingectomy	3200.00

Maximum Surgeon's Benefit for all surgical operations for a Covered Specified Disease: \$8000.00

SCHEDULE OF SURGICAL OPERATIONS

GYNECOLOGY (continued)

Vaginal fistula repair..... 1800.00

RECTUM

Colonoscopy fiberoptic..... 1200.00
 with biopsy 1600.00
 with removal of polyp 2000.00
 Fistulectomy 2000.00
 I&D abscess 400.00
 Proctectomy 5600.00
 Proctoperineoplasty 2400.00
 Proctoscopy 600.00
 Sigmoidoscopy..... 1200.00

AMPUTATIONS

Above elbow..... 2400.00
 Above knee 4000.00
 Below elbow 2400.00
 Below knee..... 3200.00
 Finger or Toe..... 1000.00
 Transmetatarsal 2000.00

ORTHOPEDIC

Arthrocentesis 400.00
 Arthroplasty, hip 4800.00
 Arthroplasty, knee 3200.00
 Arthroscopy, knee 1600.00
 Arthroscopy, shoulder 1600.00
 Arthrotomy, knee with meniscectomy..... 3200.00

FRACTURES

For pathologic fractures due to metastatic or
 primary bone cancer, the maximum benefit shall be:
 With prosthesis..... 8000.00
 Without prosthesis..... 3200.00

MISCELLANEOUS

Bone marrow – biopsy, aspiration 800.00
 Flap - tissue transfer 1000.00
 I&D abscess 400.00
 Mohs Surgery..... 2600.00
 Mohs Surgery, Chemo 1000.00
 Muscle, Skin Flap..... 1600.00
 Removal of tumors
 face, nose, ears..... 800.00
 scalp, neck, hand, foot 600.00
 trunk, arm, leg 400.00
 malignant - face, nose, ears 1000.00
 malignant - scalp, neck, hand, foot..... 800.00
 malignant - trunk, arm, leg..... 600.00
 Suturing of surface wounds
 face and mucous membrane..... 600.00
 scalp, neck, genitalia, trunk extremities..... 400.00

For surgical operations not otherwise specified in the Schedule of Operations, the Company will determine the amount to be included as a benefit on a basis commensurate to similar listed operations, but in no event shall the maximum benefit for operations not specified exceed Eight Thousand Dollars (\$8,000.00).

Maximum Surgeon's Benefit for all surgical operations for a Covered Specified Disease: \$8000.00

RENEWAL OF MAXIMUM BENEFIT LIMITS FOR ANY ONE COVERED SPECIFIED DISEASE

If a Covered Person, as a result of any one Covered Specified Disease, is paid the maximum benefit limit under any benefit provision of this Policy, then:

(a) Benefits under that benefit provision will not be payable for that same Covered Specified Disease during the 180-day period following the date the Covered Person incurred the expense that resulted in payment of the maximum benefit limit;

(b) The maximum benefit limit under that benefit provision will renew for that same Covered Specified Disease upon the expiration of the 180-day period following the date the Covered Person incurred the expense, while this Policy is in force, that resulted in payment of the maximum benefit limit; and

(c) For each Covered Specified Disease, the maximum benefit limit under each benefit provision of this Policy will continue to renew under this provision as long as such Covered Person's coverage under this Policy remains in force.

EXCLUSIONS

This Policy does not cover any loss caused or contributed to by: (a) any condition, accident or sickness that is not a Covered Specified Disease specifically named on the Insured Schedule or that is not caused or aggravated by a Covered Specified Disease specifically named on the Insured Schedule; (b) alcoholism or drug addiction; (c) dental care or treatment; (d) cosmetic or elective surgery, except that excluded cosmetic surgery shall not include breast reconstruction in connection with mastectomy, including reconstructive surgery on a nondiseased breast to establish symmetry with a diseased breast on which reconstructive surgery has been performed (e) a Covered Specified Disease covered by any worker's compensation act or occupational diseases law; (f) rest cures, custodial care, and routine physical examinations; (g) expenses incurred to the extent benefits are actually paid by Medicare; (h) charges that a Covered Person is not legally required to pay or that would not have been made if no insurance coverage had existed; (i) treatment received in a U.S. Government or Veterans hospital for which a Covered Person is not required to pay; (j) eye glasses, hearing aids and examination for the prescription or fitting thereof; (k) any expense incurred for the acquisition, purchase, harvesting or transportation of human or animal organs used in transplant procedures; (l) a Covered Specified Disease sustained while serving in the armed forces of any country or international authority at war, whether war is declared or not (we will return the pro-rata premium for any period not covered by this Policy while you are in such service).

PRE-EXISTING CONDITIONS LIMITATIONS

Any Covered Specified Disease which is a Pre-Existing Condition, as defined herein, is not covered under this Policy until this Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is not shown on this Policy's Insured Schedule on the date of the loss.

PREMIUM PAYMENTS

(a) All premiums are payable in advance to us at our Home Office. The payment of any premium shall not maintain the insurance under any Policy in force beyond the day immediately preceding the due date of the next premium except as hereinafter provided in the Grace Period provision.

(b) Premiums may be changed. Premiums for this Policy are based on the attained age of each Covered Person and each Covered Person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to sex, attained age, smoking status, date of issue and/or the Insured's state, county or ZIP code of residence. We will give you 31 days notice before any such premium change.

TERMINATION

A Covered Person's coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the earlier of: (a) the end of the 31-day grace period following the due date of any premium for that Covered Person which is not paid; or (b) the date the Covered Person enrolls in and becomes eligible to receive benefits under Medicare, in which case any unearned premium under this Policy will be refunded to the Covered Person.

COVERAGE FOR SPOUSE AND DEPENDENT CHILDREN

Coverage will be provided for the Insured's spouse and/or dependent children (including adopted children) who are listed by name on the Insured Schedule; provided the applicable premium is paid. If the Insured's spouse and/or dependent children are not covered by this Policy such individual(s) may be added after the Effective Date by submitting a written application and paying the correct premium for his/her coverage. We must approve the application for his/her coverage to be effective.

A newborn child of the Insured is automatically covered for 90 days from the moment of birth. We must receive notice of birth and payment of the applicable premium within 90 days after the child's date of birth or before the next premium due date, whichever is later, in order to have the newborn's coverage continue beyond such 90-day period.

A newborn child adopted by the Insured is automatically covered for 60 days from the moment of birth if the petition for adoption is filed within 60 days after the child's date of birth. We must receive written notice of birth and payment of the applicable premium within 60 days after the child's date of birth in order to have the newborn adopted child's coverage continue beyond such 60-day period.

A child adopted by the Insured more than 60 days after the date of birth is automatically covered for 60 days from the date the petition for adoption is filed. We must receive written notice of the filing of the petition for adoption and payment of the applicable premium within 60 days after the date of placement in order to have the adopted child's coverage continue beyond such 60-day period.

For purposes of this provision, an adopted child includes a minor child under the charge, care and control of the insured, and for whom the Insured has filed a petition to adopt. The coverage of an adopted child will terminate upon the dismissal or denial of the petition for adoption.

Upon the Insured's death, his/her surviving spouse shall become the Insured if such spouse is a Covered Person at the time of the Insured's death and the applicable premium is paid.

RENEWAL SAFEGUARD

This Policy is renewable as follows:

- (a) The Company may not decline to renew this Policy except for one or both of the following reasons:
 - (1) Renewal premiums are declined on all policies bearing the same form number as this Policy issued to persons in the same state in which the Insured resides; or
 - (2) Failure to correctly report matters inquired of in the application for this Policy.
- (b) While this Policy is in effect, the Company shall not have the right to place any restrictive amendment hereon with respect to any coverage in effect hereunder. **There shall be no change in rate classification on account of any physical impairment of a Covered Person or on account of any claims under this Policy.**
- (c) The Company's right to refuse renewal, which is expressly reserved as set forth in (a) above, may be exercised by giving written notice, at least thirty (30) days prior to the expiration of the term for which premium has been paid, to the Insured by either delivery or by mailing to his last address as shown by the records of the Company when, not less than thirty (30) days thereafter, such refusal of renewal shall be effective.

UNIFORM PROVISIONS

1. ENTIRE CONTRACT; CHANGES: This Policy together with the application, endorsements, benefit agreements, riders and attached papers, if any, is the entire contract of insurance. No change in the Policy shall be valid until approved in writing by a Vice President, the Secretary or the President of the Company, and signed at our Home Office. Such approval must be noted on or attached to this Policy. No agent may change this Policy, and no agent may waive any of its provisions.

2. TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the Effective Date of this Policy, no misstatement of a Covered Person, except a fraudulent misstatement made in the application, shall be used to void this Policy. After two years from the Effective Date of the coverage with respect to any claim which is made, no misstatement of any Covered Person eligible for coverage under this Policy, except a fraudulent misstatement contained in a written instrument signed by the Insured, shall be used to deny a claim for loss incurred commencing after expiration of such two years. (This provision is continued on the next page.)

UNIFORM PROVISIONS (Continued)

2. TIME LIMIT ON CERTAIN DEFENSES (Continued): (b) We shall not deny or reduce a claim for loss incurred after two years from the Effective Date of coverage of this Policy on the ground that a Covered Specified Disease on the date of loss had existed before the Effective Date of coverage of this Policy. This applies to only (1) the Covered Specified Diseases shown on the Insured Schedule and (2) any condition directly caused or aggravated by one or more of the Covered Specified Diseases shown on the Insured Schedule. It does not include those diseases or physical conditions excluded under the Exclusions provision of this Policy.

3. GRACE PERIOD: There will be a grace period of 31 days for payment of each premium falling due after the first premium. This Policy will stay in force during the grace period.

4. REINSTATEMENT: This Policy shall lapse if you do not pay the premium before the end of the grace period. If we or any agent authorized by us to accept premium later accepts premium and does not require an application for reinstatement, such acceptance shall reinstate this Policy. If we or such agent require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy shall be reinstated upon our approval of such application. This Policy shall be reinstated on the 45th day of such conditional receipt, unless we give you prior written notice of disapproval. The reinstated Policy shall cover only loss due to a Covered Specified Disease beginning more than 10 days from such date. In all other respects you and the Company shall have the same rights under this Policy as were in effect before it lapsed unless special conditions are added in connection with the reinstatement. Premium accepted in connection with this provision shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

5. NOTICE OF CLAIM: You must give us written notice of claim. It must be given within 20 days after a covered loss occurs or starts, or as soon as you reasonably can. You may give the notice or you may have someone do it for you. Such notice should give your name and Policy number. Notice should be mailed to us at our home office or to any authorized agent.

6. CLAIM FORMS: When we receive your notice, we will send you forms for filing proof of loss. If we do not send them within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. This statement should include the type of and extent of the loss you incurred. We must receive this statement within the time given for filing proof of loss.

7. PROOF OF LOSS: You must give us written proof of your loss within 90 days after the date of loss or as soon as you reasonably can. Proof must, however, be furnished within 12 months except in the absence of legal capacity.

8. TIME OF PAYMENT OF CLAIMS: We will pay you immediately upon receipt of due written proof of loss for benefits provided under this Policy. However, a benefit that is payable by periodic payments, subject to due written proof of loss, shall be paid monthly. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

9. PAYMENT OF CLAIMS: (a) Subject to the Direct Payment of Hospital, Medical Services provision, benefits will be paid to the Insured. Any benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or estate. (b) If benefits are payable to the Insured's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000.00 to someone related to the Insured or beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

10. PHYSICAL EXAMINATION AND AUTOPSY: We, at our expense, may have you or your dependent examined when and as often as we may reasonably require while a claim is pending. We may also have an autopsy performed at our expense unless prohibited by law.

11. LEGAL ACTIONS: No legal may be brought to recover on this Policy within 60 days after written proof of such loss has been given as required by this Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be given.

12. CHANGE OF BENEFICIARY: Unless you make an irrevocable designation of beneficiary, only you shall have the right to change the beneficiary. Consent of the beneficiary shall not be required to make any change in this Policy. Also, no such consent shall be required for surrender or assignment of this Policy.

13. CANCELLATION: This Policy may not be cancelled by the Company, nor by you, during a period for which premium has been paid and officially accepted by the Company. The Company may not decline to renew this Policy, except as provided in the Termination provision or the Renewal Safeguard provision.

POLICY PROVISIONS

1. MISSTATEMENT OF AGE: If the age of a covered person has been misstated, all benefits payable to that person shall be in the amount the premium paid would have bought at the correct age.

2. UNPAID PREMIUM: Any due and unpaid premium for this Policy may be deducted from its benefits then payable.

3. ILLEGAL OCCUPATION: We shall not be liable for any loss to which a contributing cause was your commission or attempt to commit a felony. We shall not be liable for a loss to which a contributing cause was your participation in an illegal job.

4. INTOXICANTS AND NARCOTICS: We shall not be liable for any loss sustained or contracted in consequence of a Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.

5. CONFORMITY WITH STATE STATUTES: The provisions of this Policy must conform with the laws of the state in which you reside on the date of issue. If any do not, they are hereby amended to conform.

6. ADDITIONAL PROVISIONS:

A. DIRECT PAYMENT OF HOSPITAL, MEDICAL SERVICES: Subject to any written direction of the Insured, all or any portion of any indemnities provided hereunder on account of hospital, nursing, medical or surgical services may, at our option, and unless the Insured requests otherwise, not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services.

B. ALTERNATIVE DISPUTE RESOLUTION: If a dispute arises between a Covered Person and the Company concerning the payment or non-payment of benefits under this Policy, either party may request that the dispute be referred to **mediation**. Such a request must be submitted to the other party in writing and must include a description of the issue(s) in dispute. The parties will then contact the American Arbitration Association, which will appoint a mediator who is experienced in resolving health insurance disputes.

If the decision of the mediator is in favor of the Covered Person, the Company will accept the decision and pay the cost of the mediator and any experts he/she consults with.

If the decision of the mediator is in favor of the Company, the Company will pay the cost of the mediator and any experts he/she consults with.

This provision will not affect any right of a Covered Person under the Legal Actions provision of this Policy or applicable law.

C. CONTINUATION OF COVERAG UPON DIVORCE: If a Covered Person ceases to be covered under this Policy by reason of divorce, such Covered Person may continue his/her coverage under a separate policy identical to this Policy, subject to the following: (a) such Covered Person must give written notice to the Company within 30 days of such divorce of his/her desire to continue coverage; (b) the continuation policy will be issued without evidence of insurability; (c) the premium for the continuation policy will be no more than the premium that would be charged such Covered Person had the divorce not occurred; and (d) any waiting periods will be considered satisfied under the continuation policy to the extent satisfied under this Policy.

D. INDEPENDENT, NONCOORDINATED BENEFITS: Each benefit under this Policy is independent of and is not coordinated with the benefits, exclusions or any other provision of any other health insurance coverage or health plan. Each benefit under this Policy is payable with respect to an event without regard to whether benefits are provided with respect to the same event under any other health insurance coverage or health plan. Benefits payable under this Policy will not be reduced on account of any other health insurance coverage or health plan.

E. REFUND OF UNEARNED PREMIUM UPON DEATH OF COVERED PERSON: In the event of a Covered Person's death, any benefits payable to his/her estate shall include any premium paid for any period beyond the date of such Covered Person's death. Said unearned premium shall be paid in a lump sum within 30 days following our receipt of due written proof of death.

IN WITNESS WHEREOF, Reserve National Insurance Company has caused this Policy to be issued as of the Effective Date, and to be executed by its President and Secretary at its Home Office at 601 East Britton Road, in the City of Oklahoma City, Oklahoma.


Secretary


President

RESERVE NATIONAL INSURANCE COMPANY

OKLAHOMA CITY, OKLAHOMA

EXISTING CONDITION BENEFIT ENDORSEMENT

Reserve National Insurance Company, in consideration of the payment of the additional premium which has been included in the premium shown in the schedule of the Policy to which this endorsement is attached, agrees to provide, subject to the hereafter described waiting period, the benefits set forth in the Policy for the following conditions which have manifested themselves to the Insured prior to the effective date hereof: September 1, 2011

Name of Insured: JOHN DOE

Condition(s): [Cancer, as defined in the Policy]
[Coronary Artery/Cardiovascular Disease, as defined in the Policy]
[Diabetes, as defined in the Policy]
[Stroke, as defined in the Policy]
[Major Organ Transplant, as defined in the Policy]
[End Stage Renal Failure, as defined in the Policy]

WAITING PERIODS: No benefit shall be paid for any loss or expense incurred or commencing prior to the expiration of 12 months from the effective date of this endorsement as a result of the above listed condition(s).

All the provisions, conditions and limitations of the Policy to which this endorsement is attached which are not modified hereby and which are not in conflict herewith shall be applicable to this endorsement.

IN WITNESS WHEREOF, RESERVE NATIONAL INSURANCE COMPANY has caused this Endorsement to be executed by its President to be effective on the date listed above.


Secretary


President

**ENDORSEMENT(S), IF ANY, AND PHOTOCOPY OF THE APPLICATION
ATTACHED HERETO CONSTITUTE PART OF THE CONTRACT**

THIS SPACE INTENTIONALLY LEFT BLANK



THIS IS A SPECIFIED DISEASE POLICY

The benefits provided by this Policy are limited. Read this Policy carefully with the outline of coverage.

SD-1

AGENT CODE _____
MGR CODE _____

POLICY NUMBER(S): _____

EFFECTIVE DATE
Month _____ Day _____ Year _____

1. Full Name of Each Applicant

1	2	3	4	First	Middle Initial	Last	Social Security No.	Relation To Proposed Insured	BIRTH DATE			Age	Ht.	Wt.	Sex
									Mo.	Day	Yr.				

Specified Disease Policy SD-1
 Scheduled Benefit Hospital, Medical, Surgical Expense Policy PS-1

Deductible \$	Daily Room Max. \$	Hospital Misc. Max. \$	Surgery Sch.*
Basic	List Endorsements & Rates	PEB Table	Total Monthly Premium
App't # Mthly. Rt.			
1			
2			
3			
4			
*See the Policy for details.			Total _____

Fixed Indemnity Policy ACS-1 Surgery Schedule* _____
Qualifying Period Before Daily Hospital Indemnity Payable: _____ Days
Daily Hospital Indemnity Amount First 5 Days _____

Scheduled Benefit Accident-Only Policy SA-1
Deductible \$ _____ Daily Room Max. \$ _____

Deductible \$	Daily Room Max. \$	Surgery Sch.*
Basic	List Endorsements & Rates	PEB Table
App't # Mthly. Rt.		
1		
2		
3		
4		
*See the Policy for details.		Total _____

Accident Policy
 AP-79 AP-02-79
 AP-91 AP-91-70

App't #	Total Monthly Prem.
1	
2	
3	
4	
Total	

Dental/Vision Expense Policy
Pol. Yr. Ded. \$ _____
Pol. Yr. Max. \$ _____

App't #	Total Monthly Prem.
1	
2	
3	
4	
Total	

First Diagnosis Heart Attack / First Major Heart Surgery Indemnity Policy HRT-98
First Diagnosis Heart Attack Benefit (after 30 days) \$ _____
First Major Heart Surgery Benefit (after 30 days) \$ _____

App't #	Total Monthly Prem.	PEB Table
1		
2		
3		
4		
Total		

Supplemental Outpatient Expense Policy
 OS-99 OP-2000 Deductible \$ _____

Basic	List Endorsements & Rates	PEB Table	Total Monthly Premium
App't # Mthly. Rt.			
1			
2			
3			
4			
Total			

Fixed Indemnity Policy SIP-1* Surgery Schedule** _____
 Hospital Indemnity Policy HDI **See the Policy for details.
Daily Indemnity Amount First 10 Days _____ Next 21 Days _____

Basic	List Endorsements & Rates	PEB Table	Total Monthly Premium
App't # Mthly. Rt.			
1			
2			
3			
4			
*Elimination Period Before Daily Indemnity is Payable: _____ Days			Total _____

Home Health Care Indemnity Policy HHC-95

Basic	List Endorsements & Rates	Total Monthly Premium
App't # Mthly. Rt.		
1		
2		
3		
4		
Total		

Cancer Policy
 CFO-95-First Occurrence Cancer Benefit After 180 Days \$ _____
 CC-74 CC-91

App't #	Total Monthly Prem.
1	
2	
3	
4	
Total	

Cancer Policy ICD-2000
Daily Benefit: First 300 Days _____
Next 200 Days _____

App't #	Total Monthly Prem.
1	
2	
3	
4	
Total	

Critical Illness and Accidental Death Indemnity Policy CRI
Benefit for 1st Diagnosis Covered Critical Illness (after 180 days)/Accidental Death \$ _____

App't #	Total Monthly Prem.	PEB Table
1		
Total		

Note: One applicant per policy for CRI.

2. Residence of Proposed Insured _____
 Street No. / Rural Route and/or Box Number _____ City _____ State _____ Zip Code _____
- 2.(a) Mailing Address of Proposed Insured, if different from above _____
3. Residence Telephone No. area code (_____) No: _____ Business or alternate area code (_____) No: _____
- 3.(a) E-mail address _____ 3.(b) Name, Address and Telephone No. of payor, if different from above _____

- 3.(c) Each Applicant's State of Birth _____
- 4.(a) Proposed Insured's Occupation(s) (state duties) _____ (b) Spouse's Occupation(s) (state duties) _____
5. Full Name of Beneficiary(ies) and Relationship _____
 Without a Beneficiary Designation, benefits that are not assigned shall be paid to the Proposed Insured first named above if living, otherwise to the deceased's estate.
6. If submitted for purposes other than a new insurance application, please indicate: Policy Change Conversion Reinstatement:
 Policy(ies) Number(s) _____ What benefit(s) are being requested? _____

7. Does any applicant have any Medicare supplement, hospital, medical or surgical insurance in force at the time of this application?
 Yes No If yes, which applicant(s) and details? _____

8. Does any applicant intend the replacement or change of any of his/her existing insurance policy(ies) in connection with this application
 for insurance? Yes No If yes, which applicant(s), company and amount? _____
 _____ (Complete replacement of insurance form.)
9. Has any applicant used any form of tobacco within the past year? Yes No Within the past 3 years? Yes No
 If either are yes, which applicant(s)? _____
10. Does any applicant participate or contemplate participating in any type of aviation, other than as a passenger on a regularly
 scheduled airline? Yes No If yes, which applicant(s) and details? _____

11. In the last 5 years has any applicant participated in or does any applicant contemplate participating in any motorized vehicle racing,
 scuba or skin diving, sky diving, hang gliding, mountain climbing, rodeos, cliff diving, ballooning, parasailing and/or any professional or
 semi-professional athletics? Yes No Which applicant(s) and details? _____

12. Has any applicant been convicted of a felony or had his or her drivers license suspended or revoked? Yes No Which
 applicant(s) and details? _____

13. In the last 5 years, has any applicant had life, disability or health insurance declined, rated, modified, cancelled or not renewed?
 Yes No If yes, which applicant(s) and details? _____

14. Has any applicant ever requested or received a pension, benefits or payment because of an injury, sickness or disability?
 Yes No If yes, which applicant(s) and details? _____

15. Has any applicant applied for or is any applicant currently receiving Social Security disability benefits? Yes No If yes, which
 applicant(s) and details? _____

16. Does any applicant use a catheter, oxygen, respirator, dialysis machine, walker, wheelchair or similar medical equipment or ap-
 pliance? Yes No If yes, which applicant(s) and details? _____

17. Is any applicant using any medication or drugs? Yes No If yes, which applicant(s) and name of medication? _____

18. Does any applicant currently have a dental crown or bridge, or wear dentures? Yes No If yes, which applicant(s)

19. Has any applicant been advised to have any dental work which has not been completed? Yes No If yes, which applicant(s)
 and details? _____

20. Does any applicant currently wear eyeglasses or contact lenses? Yes No If yes, which applicant(s) and details _____

HAVE YOU, OR ANY APPLICANT, EVER HAD OR BEEN TOLD THAT YOU HAD, OR BEEN TREATED BY A PHYSICIAN OR OTHER PRACTITIONER FOR ANY OF THE FOLLOWING? (If "YES" circle the condition(s).)

- | | |
|---|--|
| <p>21. Disorder of eyes, ears, nose, throat or glands?.... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Dizzy or fainting spells, seizures or convulsions or recurrent headache? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Paralysis, transient ischemic attack, stroke, cerebrovascular disease or insufficiency or hemorrhage, or any residuals thereof?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Mental, nervous, psychiatric disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>25. Senility disorder, Alzheimer's disease, organic brain syndrome or disorder, cerebral palsy, muscular dystrophy, multiple sclerosis, Lou Gehrig's disease, neurologic or muscular wasting disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Persistent shortness of breath, cough, blood spitting, bronchitis, asthma, allergies, emphysema, tuberculosis, pneumonia or other</p> |
|---|--|

FOR HOME OFFICE USE

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National Insurance Company, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy related service organization, or other medical or medically related facility, insurance company or MIB, Inc. ("MIB"), that has any health or medical records or knowledge concerning me or any of the members of my family named in said application, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I understand that (a) an investigative consumer report may be obtained as to my insurability, including, if applicable, information as to character, general reputation, personal characteristics and

mode of living; (b) this information will be obtained through personal interviews with my friends, neighbors and associates; and (c) additional information as to the nature and scope of any investigation requested will be furnished to me upon my written request made within a reasonable time after this application is completed. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114.

I have paid to Reserve National Insurance Company the sum of \$ _____ which is a Monthly Quarterly Semi-Annual Annual premium, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

If accepted by the Company the applicant requests coverage to be effective: A. Date of application, applicable only on quarterly or longer modes. B. Date of issue C. Other _____

SEND POLICY TO APPLICANT OR AGENT TO DELIVER.

I acknowledge receipt of an outline of coverage for which this application is made..... Yes No

NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SPECIAL NOTICE: I UNDERSTAND THAT THE RESERVE NATIONAL INSURANCE COMPANY POLICY I HAVE APPLIED FOR IS NOT DESIGNED TO COVER ALL MEDICAL EXPENSES. IT CONTAINS LIMITS ON THE AMOUNT OF BENEFITS PAYABLE. IT IS NOT CONSIDERED MAJOR MEDICAL COVERAGE BECAUSE OF THESE LIMITS.

Town and State where signed _____ this _____ day of _____, _____.

Signature of Owner (if other than Proposed Insured)

Signature of Proposed Insured/Applicant

I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon. _____
Signature of Agent

UAP-1 AR (8/11)

Another easy way to pay your premium is with your VISA, Mastercard or DISCOVER card.

Please charge to my:



ACCOUNT# AS SHOWN ON CARD

____-____-____-____

EXPIRATION DATE _____

PLEASE SELECT

Please charge my credit card for the initial premium.

Please charge my credit card for all future renewal premiums. I understand this authorization will remain in effect until revoked by me or until my credit card expires: Monthly Payment Quarterly Payment

Amount authorized \$ _____

NAME OF CARDHOLDER _____
(PLEASE PRINT NAME AS SHOWN ON CARD)

AUTHORIZED SIGNATURE _____
(PLEASE SIGN HERE)

DATE AUTHORIZED _____



**THIS IS A SPECIFIED DISEASE POLICY.
IT PAYS BENEFITS FOR ONLY THE SPECIFIED DISEASES
SHOWN ON THE POLICY'S INSURED SCHEDULE. NO BENEFITS ARE
PAYABLE FOR ANY OTHER CONDITION, ACCIDENT OR SICKNESS.**

Outline of Coverage For Specified Disease Policy Form SD-1

Read Your Policy Carefully. This Outline of Coverage provides a very brief description of the important features of Specified Disease Policy Form SD-1. This is not the insurance contract and only the actual provisions in the Policy will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. **It is therefore important that you Read Your Policy Carefully!**

Specified Disease Policy Form SD-1 is designed to help cover hospital, medical and surgical expenses that you incur for **ONLY** (a) the Covered Specified Diseases shown on your Policy's Insured Schedule and (b) any condition directly caused or aggravated by one or more of the Covered Specified Diseases shown on the Policy's Insured Schedule. All benefits are subject to the Policy's limitations, deductible, benefit percentage, exclusions and other provisions. This coverage is renewable in accordance with the Policy's **Renewal Safeguard** provision. **THIS IS A LIMITED POLICY. THIS IS NOT MAJOR MEDICAL COVERAGE.**

I. LIMITATIONS

Benefits are provided for **ONLY** (a) the Covered Specified Diseases shown on your Policy's Insured Schedule and (b) any condition directly caused or aggravated by one or more of the Covered Specified Diseases shown on the Policy's Insured Schedule. No benefits are payable under the Policy for any other condition, accident or sickness.

"Covered Specified Disease" means only a primary or principal diagnosis of one or more of the following as shown on your Policy's Insured Schedule and as defined in the Policy: Cancer, Coronary Artery/Cardiovascular Disease, Diabetes, Stroke, Major Organ Transplant or End Stage Renal Failure. **SEE THE POLICY FOR DEFINITIONS.**

DEPENDING ON YOUR MEDICAL HISTORY, YOUR POLICY MAY NOT COVER ALL OF THESE CONDITIONS. SEE THE INSURED SCHEDULE OF YOUR POLICY FOR THE SPECIFIED DISEASES FOR WHICH BENEFITS ARE PAYABLE. NO BENEFITS ARE PAYABLE FOR ANY CONDITION, ACCIDENT OR SICKNESS NOT SHOWN ON YOUR POLICY'S INSURED SCHEDULE.

_____ (applicant's initials) to acknowledge limitations and select:

Deductible: \$ _____ (applies once in your lifetime to each Covered Specified Disease)

Maximum Miscellaneous Hospital Inpatient Benefit: \$ _____*

*See the benefit for Miscellaneous Hospital Expenses on page 2 of this Outline of Coverage.

II. BENEFITS

For covered treatment of each Covered Specified Disease: A Covered Person must first satisfy the Deductible *once in his/her lifetime for each Covered Specified Disease* while the Policy is in force before any benefits are payable for such condition. Then, benefits payable are 80% of the Expense Incurred, *but the amounts payable are limited to the maximum benefit amounts shown below.*

(A) Benefit for Daily Hospital Room and Board: For daily Hospital room and board, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$500 per day, limited to 365 days for an adult and 60 days for a child under age 18 for any one Covered Specified Disease.**

(B) Benefit for Miscellaneous Hospital Expenses: For miscellaneous hospital inpatient services and supplies billed by the Hospital, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed the Maximum Miscellaneous Hospital Inpatient Benefit shown on the first page of this Outline of Coverage for any one Covered Specified Disease. The Maximum Miscellaneous Hospital Inpatient Benefit payable for any one Covered Specified Disease is limited to the amount shown on the first page of this Outline of Coverage.**

***Outpatient Radiation/Chemotherapy Therapy:** Benefits relating to the Expense Incurred for outpatient radiation therapy or chemotherapy administered by or under the supervision of a Physician for the treatment of **Cancer** following a covered Hospital confinement or surgical procedure for which Miscellaneous Hospital Inpatient Benefits were payable for the treatment of such **Cancer**, will be payable as if incurred on an inpatient basis for such **Cancer**, **but not to exceed in the aggregate a maximum benefit of \$2,500 per day for such outpatient radiation therapy or chemotherapy.**

(C) Benefit for Inpatient Doctor Visits: For personal treatment by a Physician, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$75.00 for each treatment. This benefit is limited to one treatment per day, but not to exceed 24 treatments for any one Covered Specified Disease.**

(D) Benefit for Inpatient Diagnostic Radiology: For interpretation of X-rays, CT Scans or MRIs by a radiologist, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$2,500 for any one Covered Specified Disease.**

(E) Benefit for Inpatient Pathology: For services of a pathologist, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$2,500 for any one Covered Specified Disease.**

(F) Benefit for Surgeon: For surgery performed by a Physician, subject to the **Deductible**, we will pay **80%** of the Expense Incurred for the primary surgeon, **but not to exceed the applicable amount shown on the Schedule of Surgical Operations in the Policy** for the surgical operation that was performed. The maximum aggregate benefit for **all operations for any one Covered Specified Disease is limited to \$8,000.** This benefit is payable for surgery performed either on an **inpatient or outpatient** basis. This benefit is not payable for any Expense Incurred for a Physician who assists the primary surgeon with a surgical operation.

(G) Benefit for Anesthesiologist: For administration of anesthesia by a Physician for a surgical procedure covered by the Policy, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of 25% of the benefit payable for the primary surgeon for the surgical procedure.**

(H) Benefit for Prosthesis: For a prosthesis (a replacement part or device, whether organic or inorganic, implanted in the body to perform or augment a bodily function, such as a pacemaker, a defibrillator, artificial limbs, joints or eyes, casts, splints, trusses or braces), subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$15,000 for any one Covered Specified Disease.**

(I) Benefit for Daily Skilled Nursing Facility/Rehabilitation Facility Confinement: For confinement in a Skilled Nursing Facility or Rehabilitation Facility, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$300 for each full day of confinement. This benefit is limited in the aggregate to 30 days of such confinement for any one Covered Specified Disease.**

(J) Benefit for Physical Therapy: For physical therapy, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **limited to \$50 per day and not to exceed in the aggregate a maximum benefit of \$2,500 for any one Covered Specified Disease.**

III. Exclusions

The Policy does not cover any loss caused or contributed to by: (a) any condition, accident or sickness that is not a Covered Specified Disease specifically named on the Policy's Insured Schedule or that is not caused or aggravated by a Covered Specified Disease specifically named on the Policy's Insured Schedule; (b) alcoholism or drug addiction; (c) dental care or treatment; (d) cosmetic or elective surgery, except that excluded cosmetic surgery shall not include breast reconstruction in connection with mastectomy, including reconstructive surgery on a nondiseased breast to establish symmetry with a diseased breast on which reconstructive surgery has been performed (e) a Covered Specified Disease covered by any worker's compensation act or occupational diseases law; (f) rest cures, custodial care, and routine physical examinations; (g) expenses incurred to the extent benefits are actually paid by Medicare; (h) charges that a Covered Person is not legally required to pay or that would not have been made if no insurance coverage had existed; (i) treatment received in a U.S. Government or Veterans hospital for which a Covered Person is not required to pay; (j) eye glasses, hearing aids and examination for the prescription or fitting thereof; (k) any expense incurred for the acquisition, purchase, harvesting or transportation of human or animal organs used in transplant procedures; (l) a Covered Specified Disease sustained while serving in the armed forces of any country or international authority at war, whether war is declared or not (we will return the pro-rata premium for any period not covered by the Policy while you are in such service).

IV. Pre-Existing Conditions

Any Covered Specified Disease which is a Pre-Existing Condition, as defined herein, is not covered under your Policy until your Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is not shown on your Policy's Insured Schedule on the date of the loss. "Pre-Existing Condition" means a condition which has been diagnosed, or has manifested itself to the Covered Person within the five-year period immediately preceding the Effective Date of the Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the two-year period following the Effective Date of the Policy.

(1) A Covered Specified Disease which is a Pre-Existing Condition may be covered after 12 months for an additional premium payable during the life of your policy by attachment of the PEB-3 (7/89) Endorsement.

(2) _____ (applicant's initials to select) **Existing Condition Benefit Endorsement PEB-3 (7/89):** A Covered Specified Disease which is a Pre-Existing Condition disclosed on the application and listed on the Endorsement Form PEB-3 (7/89) will be covered after 12 months.

V. Termination

A Covered Person's coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the earlier of: (a) the end of the 31-day grace period following the due date of any premium for that Covered Person which is not paid; or (b) the date the Covered Person enrolls in and becomes eligible to receive benefits under Medicare, in which case any unearned premium under this Policy will be refunded to the Covered Person.

VI. Renewal Safeguard

The Policy is renewable as follows:

(a) Subject to the Termination provisions of the Policy, we may not decline to renew the Policy except for one or both of the following reasons:

(1) Renewal premiums are declined on all policies bearing the same form number as the Policy issued to persons in the state where you reside; or

(2) Failure to correctly report matters inquired of in the application for the Policy.

(b) While the Policy is in effect, we shall not have the right to add any restrictive amendment. There shall be no change in rate classification on account of any physical impairment or on account of any claims incurred.

VII. Premium Payments – Premiums Subject to Change

(a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium.

(b) Premiums are subject to change. Premiums are based on the attained age of each Covered Person, and each Covered Person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to sex, attained age, smoking status, the insured's state, county or ZIP code of residence. We will give you 31 days written notice before any such premium change.

THIS IS A LIMITED POLICY.

IT PROVIDES BENEFITS FOR ONLY COVERED SPECIFIED DISEASES AS DESCRIBED ABOVE.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

PLEASE READ BEFORE SIGNING

THE SOLICITING AGENT SIGNING BELOW DOES NOT HAVE THE AUTHORITY TO BIND THE COMPANY OR TO WAIVE, CHANGE OR AMEND ANY TERM OR CONDITION OF A POLICY WHICH MAY BE ISSUED BY THE COMPANY.

I understand and acknowledge that:

- **Form SD-1 provides limited benefits; it is not a major medical policy.**
- **I have received a copy of this outline of coverage, which I have reviewed.**
- **The Insured Schedule of my Policy, if issued, will show the Covered Specified Diseases for which benefits are payable. No benefits are payable or any condition, accident or sickness not shown on my Policy's Insured Schedule.**

Dated this _____ day of _____, 20_____.

Signed at _____, State of _____.

Applicant's Signature

Agent's Signature

Date

[This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed.]
"Specified Disease Policy" Form SD-1 is individually underwritten by Reserve National Insurance Company.

SERFF Tracking Number: RNIC-127212325 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number: 49078
 Company Tracking Number:
 TOI: H071 Individual Health - Specified Disease - Limited Benefit Sub-TOI: H071.002 Dread Disease
 Product Name: SD-1 Specified Disease Policy
 Project Name/Number: SD-1 Specified Disease Policy/

Rate Information

Rate data applies to filing.

Filing Method: Review & Approve
Rate Change Type: %
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

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

SERFF Tracking Number: RNIC-127212325 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number: 49078
 Company Tracking Number:
 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002 Dread Disease
 Limited Benefit
 Product Name: SD-1 Specified Disease Policy
 Project Name/Number: SD-1 Specified Disease Policy/

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 06/29/2011	Rate Sheets	SD-1	New		AR SD-1 rates.pdf

RESERVE NATIONAL INSURANCE COMPANY

Form SD-1

Arkansas Rates

Regular Monthly Rate

Rates for Policy Covering all Six Diseases (Non-Tobacco Rate)

Attained Age	100K Max.			250K Max.			500K Max.		
	5K Ded.	10K Ded.	20K Ded.	5K Ded.	10K Ded.	20K Ded.	5K Ded.	10K Ded.	20K Ded.
0-26	13.00	12.00	10.00	16.00	14.00	12.00	16.00	15.00	12.00
27-31	15.00	13.00	11.00	18.00	16.00	14.00	18.00	17.00	14.00
32-34	17.00	15.00	12.00	20.00	18.00	15.00	20.00	18.00	16.00
35-37	21.00	19.00	16.00	25.00	23.00	19.00	26.00	23.00	20.00
38-40	26.00	24.00	20.00	31.00	28.00	24.00	32.00	29.00	25.00
41-43	33.00	30.00	25.00	40.00	36.00	30.00	41.00	37.00	31.00
44-46	42.00	38.00	31.00	50.00	45.00	38.00	51.00	46.00	39.00
47-49	53.00	47.00	39.00	63.00	57.00	48.00	64.00	58.00	49.00
50-52	66.00	60.00	50.00	79.00	72.00	60.00	81.00	74.00	62.00
53-55	84.00	75.00	62.00	99.00	90.00	76.00	102.00	93.00	78.00
56-58	105.00	95.00	79.00	125.00	114.00	96.00	129.00	117.00	99.00
59-61	133.00	119.00	99.00	158.00	143.00	120.00	162.00	147.00	124.00
62-64	167.00	150.00	125.00	199.00	180.00	152.00	204.00	185.00	156.00
>64 *	195.00	175.00	146.00	232.00	210.00	177.00	238.00	216.00	183.00

Rates for Policy Excluding either Cancer or CAD/Cardiovascular but not Both (Non-Tobacco Rate)

Attained Age	100K Max.			250K Max.			500K Max.		
	5K Ded.	10K Ded.	20K Ded.	5K Ded.	10K Ded.	20K Ded.	5K Ded.	10K Ded.	20K Ded.
0-26	7.00	6.00	5.00	8.00	7.00	6.00	8.00	8.00	6.00
27-31	8.00	7.00	6.00	9.00	8.00	7.00	10.00	9.00	7.00
32-34	9.00	8.00	7.00	10.00	9.00	8.00	11.00	10.00	8.00
35-37	11.00	10.00	8.00	13.00	12.00	10.00	13.00	12.00	10.00
38-40	14.00	12.00	10.00	16.00	15.00	13.00	17.00	15.00	13.00
41-43	17.00	16.00	13.00	21.00	19.00	16.00	21.00	19.00	16.00
44-46	22.00	20.00	16.00	26.00	24.00	20.00	27.00	24.00	21.00
47-49	28.00	25.00	21.00	33.00	30.00	25.00	34.00	31.00	26.00
50-52	35.00	31.00	26.00	41.00	38.00	32.00	43.00	39.00	33.00
53-55	44.00	39.00	33.00	52.00	47.00	40.00	54.00	49.00	41.00
56-58	55.00	50.00	41.00	66.00	60.00	50.00	68.00	61.00	52.00
59-61	70.00	63.00	52.00	83.00	75.00	63.00	85.00	77.00	65.00
62-64	88.00	79.00	66.00	104.00	95.00	80.00	107.00	97.00	82.00
>64 *	102.00	92.00	76.00	122.00	110.00	93.00	125.00	113.00	96.00

Rates for Policy Covering all Six Diseases (Tobacco Rate)

Attained Age	100K Max.			250K Max.			500K Max.		
	5K Ded.	10K Ded.	20K Ded.	5K Ded.	10K Ded.	20K Ded.	5K Ded.	10K Ded.	20K Ded.
0-26	17.00	15.00	12.00	20.00	18.00	15.00	20.00	18.00	15.00
27-31	19.00	17.00	14.00	22.00	20.00	17.00	23.00	21.00	17.00
32-34	21.00	19.00	16.00	25.00	22.00	19.00	25.00	23.00	19.00
35-37	26.00	24.00	20.00	31.00	28.00	24.00	32.00	29.00	25.00
38-40	33.00	30.00	25.00	39.00	36.00	30.00	40.00	37.00	31.00
41-43	42.00	37.00	31.00	49.00	45.00	38.00	51.00	46.00	39.00
44-46	52.00	47.00	39.00	62.00	56.00	47.00	64.00	58.00	49.00
47-49	66.00	59.00	49.00	78.00	71.00	60.00	81.00	73.00	62.00
50-52	83.00	75.00	62.00	99.00	89.00	75.00	101.00	92.00	78.00
53-55	105.00	94.00	78.00	124.00	113.00	95.00	128.00	116.00	98.00
56-58	132.00	118.00	98.00	157.00	142.00	120.00	161.00	146.00	123.00
59-61	166.00	149.00	124.00	197.00	179.00	151.00	203.00	184.00	155.00
62-64	209.00	188.00	156.00	248.00	225.00	190.00	255.00	232.00	196.00
>64 *	244.00	219.00	182.00	290.00	263.00	221.00	298.00	270.00	228.00

Rates for Policy Excluding either Cancer or CAD/Cardiovascular but not Both (Tobacco Rate)

Attained Age	100K Max.			250K Max.			500K Max.		
	5K Ded.	10K Ded.	20K Ded.	5K Ded.	10K Ded.	20K Ded.	5K Ded.	10K Ded.	20K Ded.
0-26	9.00	8.00	7.00	10.00	9.00	8.00	11.00	10.00	8.00
27-31	10.00	9.00	7.00	12.00	11.00	9.00	12.00	11.00	9.00
32-34	11.00	10.00	8.00	13.00	12.00	10.00	13.00	12.00	10.00
35-37	14.00	12.00	10.00	16.00	15.00	13.00	17.00	15.00	13.00
38-40	17.00	16.00	13.00	21.00	19.00	16.00	21.00	19.00	16.00
41-43	22.00	20.00	16.00	26.00	24.00	20.00	27.00	24.00	20.00
44-46	27.00	25.00	21.00	33.00	30.00	25.00	34.00	30.00	26.00
47-49	35.00	31.00	26.00	41.00	37.00	31.00	42.00	38.00	32.00
50-52	44.00	39.00	33.00	52.00	47.00	40.00	53.00	48.00	41.00
53-55	55.00	49.00	41.00	65.00	59.00	50.00	67.00	61.00	51.00
56-58	69.00	62.00	52.00	82.00	75.00	63.00	85.00	77.00	65.00
59-61	87.00	78.00	65.00	104.00	94.00	79.00	106.00	97.00	82.00
62-64	110.00	99.00	82.00	130.00	118.00	100.00	134.00	122.00	103.00
>64 *	128.00	115.00	96.00	152.00	138.00	116.00	156.00	142.00	120.00

*Renewal Only

All Rates (including rates for different modes) are rounded to nearest dollar

Monthly Bank Draft = Monthly Rate X .92

Quarterly Rate = Monthly Rate X 2.94

Semi-Annual Rate = Monthly Rate X 5.82

Annual Rate = Monthly Rate X 11.04

SERFF Tracking Number: RNIC-127212325 State: Arkansas
 Filing Company: Reserve National Insurance Company State Tracking Number: 49078
 Company Tracking Number:
 TOI: H071 Individual Health - Specified Disease - Sub-TOI: H071.002 Dread Disease
 Limited Benefit
 Product Name: SD-1 Specified Disease Policy
 Project Name/Number: SD-1 Specified Disease Policy/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/29/2011
Comments:		
Attachment: SD-1 Policy Readability Certification.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	06/29/2011
Comments: This is also attached to the Form Schedule for your approval.		
Attachment: UAP-1 AR 8.11.pdf		

	Item Status:	Status Date:
Satisfied - Item: Health - Actuarial Justification	Approved-Closed	06/29/2011
Comments:		
Attachment: actu memo SD-1 AR.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	06/29/2011
Comments: This is also attached to the Form Schedule for your approval.		
Attachment: OC SD-1 .pdf		

	Item Status:	Status
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SERFF Tracking Number: RNIC-127212325 *State:* Arkansas
Filing Company: Reserve National Insurance Company *State Tracking Number:* 49078
Company Tracking Number:
TOI: H071 Individual Health - Specified Disease - Limited Benefit *Sub-TOI:* H071.002 Dread Disease
Product Name: SD-1 Specified Disease Policy
Project Name/Number: SD-1 Specified Disease Policy/

Satisfied - Item: Certification **Item Status:** Approved-Closed **Date:** 06/29/2011
Comments:
Attachment:
 AR - Certification.pdf

Satisfied - Item: Form RP-A&H **Item Status:** Approved-Closed **Status Date:** 06/29/2011
Comments:
 Form RP-A&H – Notice to Applicant Regarding Replacement of Health Insurance, which was previously approved by your office, will be used in replacement situations.
Attachment:
 Form RP-A&H.pdf

Satisfied - Item: AR-INP (11/09) **Item Status:** Approved-Closed **Status Date:** 06/29/2011
Comments:
 Form AR-INP (11/09) - Important Notice, which was previously approved by your office, will be issued with each SD-1 Policy.
Attachment:
 AR-INP 11-09.pdf



601 East Britton Road ▪ Oklahoma City, OK 73114
www.ReserveNational.com

READABILITY CERTIFICATION

FORM NUMBER: **Form SD-1 Specified Disease Policy**

The words, sentences, and syllables of Form SD-1 were counted to be used in the Flesch Readability Formula in order to determine the readability score of the form. Formal names, medical terms and words defined (implicitly or explicitly) in the policy/rider/endorsement were not counted.

WORDS: 3,241

SENTENCES: 174

Syllables: 3,970

This resulted in a Flesch Readability score of **84.295**.

Kyle D. Conrad

Digitally signed by Kyle D. Conrad
DN: CN = Kyle D. Conrad, C = US
Date: 2011.05.19 11:23:36 -05'00'

KYLE D. CONRAD
Senior Vice President
and Associate Corporate Counsel

AGENT CODE _____
MGR CODE _____

POLICY NUMBER(S): _____

EFFECTIVE DATE
Month _____ Day _____ Year _____

1. Full Name of Each Applicant			Social Security No.	Relation To Proposed Insured	BIRTH DATE			Age	Ht.	Wt.	Sex
First	Middle Initial	Last			Mo.	Day	Yr.				
1											
2											
3											
4											

Specified Disease Policy SD-1
 Scheduled Benefit Hospital, Medical, Surgical Expense Policy PS-1

Deductible \$	Daily Room Max. \$	Hospital Misc. Max. \$	Surgery Sch.*
Basic			
App't #	Mthly. Rt.	List Endorsements & Rates	PEB Table Total Monthly Premium
1			
2			
3			
4			
*See the Policy for details.			Total _____

Fixed Indemnity Policy ACS-1 Surgery Schedule* _____
Qualifying Period Before Daily Hospital Indemnity Payable: _____ Days
Daily Hospital Indemnity Amount First 5 Days _____

Scheduled Benefit Accident-Only Policy SA-1
Deductible \$ _____ Daily Room Max. \$ _____

Deductible \$	Daily Room Max. \$	Surgery Sch.*
Basic		
App't #	Mthly. Rt.	List Endorsements & Rates PEB Table Total Monthly Premium
1		
2		
3		
4		
*See the Policy for details.		Total _____

Accident Policy
 AP-79 AP-02-79
 AP-91 AP-91-70

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

Dental/Vision Expense Policy
Pol. Yr. Ded. \$ _____
Pol. Yr. Max. \$ _____

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

First Diagnosis Heart Attack / First Major Heart Surgery Indemnity Policy HRT-98
First Diagnosis Heart Attack Benefit (after 30 days) \$ _____
First Major Heart Surgery Benefit (after 30 days) \$ _____

App't #	Total Monthly Prem.	PEB Table
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
Total	_____	_____

Supplemental Outpatient Expense Policy
 OS-99 OP-2000 Deductible \$ _____

App't #	Mthly. Rt.	List Endorsements & Rates	PEB Table	Total Monthly Premium
1				
2				
3				
4				
Total				_____

Fixed Indemnity Policy SIP-1* Surgery Schedule** _____
 Hospital Indemnity Policy HDI **See the Policy for details.
Daily Indemnity Amount First 10 Days _____ Next 21 Days _____

App't #	Mthly. Rt.	List Endorsements & Rates	PEB Table	Total Monthly Premium
1				
2				
3				
4				
*Elimination Period Before Daily Indemnity is Payable: _____ Days				Total _____

Home Health Care Indemnity Policy HHC-95

App't #	Mthly. Rt.	List Endorsements & Rates	Total Monthly Premium
1			
2			
3			
4			
Total			_____

Cancer Policy
 CFO-95-First Occurrence Cancer Benefit After 180 Days \$ _____
 CC-74 CC-91

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

Cancer Policy ICD-2000
Daily Benefit: First 300 Days _____
Next 200 Days _____

App't #	Total Monthly Prem.
1	_____
2	_____
3	_____
4	_____
Total	_____

Critical Illness and Accidental Death Indemnity Policy CRI
Benefit for 1st Diagnosis Covered Critical Illness (after 180 days)/Accidental Death \$ _____

App't #	Total Monthly Prem.	PEB Table
1	_____	_____
Total		_____

Note: One applicant per policy for CRI.

2. Residence of Proposed Insured _____
 Street No. / Rural Route and/or Box Number _____ City _____ State _____ Zip Code _____
- 2.(a) Mailing Address of Proposed Insured, if different from above _____
3. Residence Telephone No. area code (_____) No: _____ Business or alternate area code (_____) No: _____
- 3.(a) E-mail address _____ 3.(b) Name, Address and Telephone No. of payor, if different from above _____

- 3.(c) Each Applicant's State of Birth _____
- 4.(a) Proposed Insured's Occupation(s) (state duties) _____ (b) Spouse's Occupation(s) (state duties) _____
5. Full Name of Beneficiary(ies) and Relationship _____
 Without a Beneficiary Designation, benefits that are not assigned shall be paid to the Proposed Insured first named above if living, otherwise to the deceased's estate.
6. If submitted for purposes other than a new insurance application, please indicate: Policy Change Conversion Reinstatement:
 Policy(ies) Number(s) _____ What benefit(s) are being requested? _____
7. Does any applicant have any Medicare supplement, hospital, medical or surgical insurance in force at the time of this application?
 Yes No If yes, which applicant(s) and details? _____
8. Does any applicant intend the replacement or change of any of his/her existing insurance policy(ies) in connection with this application
 for insurance? Yes No If yes, which applicant(s), company and amount? _____
 _____ (Complete replacement of insurance form.)
9. Has any applicant used any form of tobacco within the past year? Yes No Within the past 3 years? Yes No
 If either are yes, which applicant(s)? _____
10. Does any applicant participate or contemplate participating in any type of aviation, other than as a passenger on a regularly
 scheduled airline? Yes No If yes, which applicant(s) and details? _____
11. In the last 5 years has any applicant participated in or does any applicant contemplate participating in any motorized vehicle racing,
 scuba or skin diving, sky diving, hang gliding, mountain climbing, rodeos, cliff diving, ballooning, parasailing and/or any professional or
 semi-professional athletics? Yes No Which applicant(s) and details? _____
12. Has any applicant been convicted of a felony or had his or her drivers license suspended or revoked? Yes No Which
 applicant(s) and details? _____
13. In the last 5 years, has any applicant had life, disability or health insurance declined, rated, modified, cancelled or not renewed?
 Yes No If yes, which applicant(s) and details? _____
14. Has any applicant ever requested or received a pension, benefits or payment because of an injury, sickness or disability?
 Yes No If yes, which applicant(s) and details? _____
15. Has any applicant applied for or is any applicant currently receiving Social Security disability benefits? Yes No If yes, which
 applicant(s) and details? _____
16. Does any applicant use a catheter, oxygen, respirator, dialysis machine, walker, wheelchair or similar medical equipment or ap-
 pliance? Yes No If yes, which applicant(s) and details? _____
17. Is any applicant using any medication or drugs? Yes No If yes, which applicant(s) and name of medication? _____
18. Does any applicant currently have a dental crown or bridge, or wear dentures? Yes No If yes, which applicant(s)
19. Has any applicant been advised to have any dental work which has not been completed? Yes No If yes, which applicant(s)
 and details? _____
20. Does any applicant currently wear eyeglasses or contact lenses? Yes No If yes, which applicant(s) and details _____

**HAVE YOU, OR ANY APPLICANT, EVER HAD OR BEEN TOLD THAT YOU HAD, OR BEEN TREATED BY A PHYSICIAN OR
 OTHER PRACTITIONER FOR ANY OF THE FOLLOWING? (If "YES" circle the condition(s).)**

- | | |
|---|--|
| <p>21. Disorder of eyes, ears, nose, throat or glands?.... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Dizzy or fainting spells, seizures or convulsions or recurrent
 headache? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Paralysis, transient ischemic attack, stroke, cerebrovascular disease
 or insufficiency or hemorrhage, or any residuals thereof?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Mental, nervous, psychiatric disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>25. Senility disorder, Alzheimer's disease, organic brain syndrome
 or disorder, cerebral palsy, muscular dystrophy, multiple
 sclerosis, Lou Gehrig's disease, neurologic or muscular wasting
 disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Persistent shortness of breath, cough, blood spitting, bronchitis,
 asthma, allergies, emphysema, tuberculosis, pneumonia or other</p> |
|---|--|

FOR HOME OFFICE USE

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National Insurance Company, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy related service organization, or other medical or medically related facility, insurance company or MIB, Inc. ("MIB"), that has any health or medical records or knowledge concerning me or any of the members of my family named in said application, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I understand that (a) an investigative consumer report may be obtained as to my insurability, including, if applicable, information as to character, general reputation, personal characteristics and

mode of living; (b) this information will be obtained through personal interviews with my friends, neighbors and associates; and (c) additional information as to the nature and scope of any investigation requested will be furnished to me upon my written request made within a reasonable time after this application is completed. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114.

I have paid to Reserve National Insurance Company the sum of \$ _____ which is a Monthly Quarterly Semi-Annual Annual premium, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

If accepted by the Company the applicant requests coverage to be effective: A. Date of application, applicable only on quarterly or longer modes. B. Date of issue C. Other _____

SEND POLICY TO APPLICANT OR AGENT TO DELIVER.

I acknowledge receipt of an outline of coverage for which this application is made..... Yes No

NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SPECIAL NOTICE: I UNDERSTAND THAT THE RESERVE NATIONAL INSURANCE COMPANY POLICY I HAVE APPLIED FOR IS NOT DESIGNED TO COVER ALL MEDICAL EXPENSES. IT CONTAINS LIMITS ON THE AMOUNT OF BENEFITS PAYABLE. IT IS NOT CONSIDERED MAJOR MEDICAL COVERAGE BECAUSE OF THESE LIMITS.

Town and State where signed _____ this _____ day of _____, _____.

Signature of Owner (if other than Proposed Insured)

Signature of Proposed Insured/Applicant

I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon. _____
Signature of Agent

UAP-1 AR (8/11)

Another easy way to pay your premium is with your VISA, Mastercard or DISCOVER card.

Please charge to my:



ACCOUNT# AS SHOWN ON CARD

____-____-____-____

EXPIRATION DATE _____

PLEASE SELECT

Please charge my credit card for the initial premium.

Please charge my credit card for all future renewal premiums. I understand this authorization will remain in effect until revoked by me or until my credit card expires: Monthly Payment Quarterly Payment

Amount authorized \$ _____

NAME OF CARDHOLDER _____
(PLEASE PRINT NAME AS SHOWN ON CARD)

AUTHORIZED SIGNATURE _____
(PLEASE SIGN HERE)

DATE AUTHORIZED _____



**THIS IS A SPECIFIED DISEASE POLICY.
IT PAYS BENEFITS FOR ONLY THE SPECIFIED DISEASES
SHOWN ON THE POLICY'S INSURED SCHEDULE. NO BENEFITS ARE
PAYABLE FOR ANY OTHER CONDITION, ACCIDENT OR SICKNESS.**

Outline of Coverage For Specified Disease Policy Form SD-1

Read Your Policy Carefully. This Outline of Coverage provides a very brief description of the important features of Specified Disease Policy Form SD-1. This is not the insurance contract and only the actual provisions in the Policy will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. **It is therefore important that you Read Your Policy Carefully!**

Specified Disease Policy Form SD-1 is designed to help cover hospital, medical and surgical expenses that you incur for **ONLY** (a) the Covered Specified Diseases shown on your Policy's Insured Schedule and (b) any condition directly caused or aggravated by one or more of the Covered Specified Diseases shown on the Policy's Insured Schedule. All benefits are subject to the Policy's limitations, deductible, benefit percentage, exclusions and other provisions. This coverage is renewable in accordance with the Policy's **Renewal Safeguard** provision. **THIS IS A LIMITED POLICY. THIS IS NOT MAJOR MEDICAL COVERAGE.**

I. LIMITATIONS

Benefits are provided for **ONLY** (a) the Covered Specified Diseases shown on your Policy's Insured Schedule and (b) any condition directly caused or aggravated by one or more of the Covered Specified Diseases shown on the Policy's Insured Schedule. No benefits are payable under the Policy for any other condition, accident or sickness.

"Covered Specified Disease" means only a primary or principal diagnosis of one or more of the following as shown on your Policy's Insured Schedule and as defined in the Policy: Cancer, Coronary Artery/Cardiovascular Disease, Diabetes, Stroke, Major Organ Transplant or End Stage Renal Failure. **SEE THE POLICY FOR DEFINITIONS.**

DEPENDING ON YOUR MEDICAL HISTORY, YOUR POLICY MAY NOT COVER ALL OF THESE CONDITIONS. SEE THE INSURED SCHEDULE OF YOUR POLICY FOR THE SPECIFIED DISEASES FOR WHICH BENEFITS ARE PAYABLE. NO BENEFITS ARE PAYABLE FOR ANY CONDITION, ACCIDENT OR SICKNESS NOT SHOWN ON YOUR POLICY'S INSURED SCHEDULE.

_____ (applicant's initials) to acknowledge limitations and select:

Deductible: \$_____ (applies once in your lifetime to each Covered Specified Disease)

Maximum Miscellaneous Hospital Inpatient Benefit: \$_____*

*See the benefit for Miscellaneous Hospital Expenses on page 2 of this Outline of Coverage.

II. BENEFITS

For covered treatment of each Covered Specified Disease: A Covered Person must first satisfy the Deductible *once in his/her lifetime for each Covered Specified Disease* while the Policy is in force before any benefits are payable for such condition. Then, benefits payable are 80% of the Expense Incurred, *but the amounts payable are limited to the maximum benefit amounts shown below.*

(A) Benefit for Daily Hospital Room and Board: For daily Hospital room and board, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$500 per day, limited to 365 days for an adult and 60 days for a child under age 18 for any one Covered Specified Disease.**

(B) Benefit for Miscellaneous Hospital Expenses: For miscellaneous hospital inpatient services and supplies billed by the Hospital, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed the Maximum Miscellaneous Hospital Inpatient Benefit shown on the first page of this Outline of Coverage for any one Covered Specified Disease. The Maximum Miscellaneous Hospital Inpatient Benefit payable for any one Covered Specified Disease is limited to the amount shown on the first page of this Outline of Coverage.**

***Outpatient Radiation/Chemotherapy Therapy:** Benefits relating to the Expense Incurred for outpatient radiation therapy or chemotherapy administered by or under the supervision of a Physician for the treatment of **Cancer** following a covered Hospital confinement or surgical procedure for which Miscellaneous Hospital Inpatient Benefits were payable for the treatment of such **Cancer**, will be payable as if incurred on an inpatient basis for such **Cancer**, **but not to exceed in the aggregate a maximum benefit of \$2,500 per day for such outpatient radiation therapy or chemotherapy.**

(C) Benefit for Inpatient Doctor Visits: For personal treatment by a Physician, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$75.00 for each treatment. This benefit is limited to one treatment per day, but not to exceed 24 treatments for any one Covered Specified Disease.**

(D) Benefit for Inpatient Diagnostic Radiology: For interpretation of X-rays, CT Scans or MRIs by a radiologist, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$2,500 for any one Covered Specified Disease.**

(E) Benefit for Inpatient Pathology: For services of a pathologist, while you are confined in a Hospital as a resident inpatient, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$2,500 for any one Covered Specified Disease.**

(F) Benefit for Surgeon: For surgery performed by a Physician, subject to the **Deductible**, we will pay **80%** of the Expense Incurred for the primary surgeon, **but not to exceed the applicable amount shown on the Schedule of Surgical Operations in the Policy** for the surgical operation that was performed. The maximum aggregate benefit for **all operations for any one Covered Specified Disease is limited to \$8,000.** This benefit is payable for surgery performed either on an **inpatient or outpatient** basis. This benefit is not payable for any Expense Incurred for a Physician who assists the primary surgeon with a surgical operation.

(G) Benefit for Anesthesiologist: For administration of anesthesia by a Physician for a surgical procedure covered by the Policy, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of 25% of the benefit payable for the primary surgeon for the surgical procedure.**

(H) Benefit for Prosthesis: For a prosthesis (a replacement part or device, whether organic or inorganic, implanted in the body to perform or augment a bodily function, such as a pacemaker, a defibrillator, artificial limbs, joints or eyes, casts, splints, trusses or braces), subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$15,000 for any one Covered Specified Disease.**

(I) Benefit for Daily Skilled Nursing Facility/Rehabilitation Facility Confinement: For confinement in a Skilled Nursing Facility or Rehabilitation Facility, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **but not to exceed a maximum benefit of \$300 for each full day of confinement. This benefit is limited in the aggregate to 30 days of such confinement for any one Covered Specified Disease.**

(J) Benefit for Physical Therapy: For physical therapy, subject to the **Deductible**, we will pay **80%** of the Expense Incurred, **limited to \$50 per day and not to exceed in the aggregate a maximum benefit of \$2,500 for any one Covered Specified Disease.**

III. Exclusions

The Policy does not cover any loss caused or contributed to by: (a) any condition, accident or sickness that is not a Covered Specified Disease specifically named on the Policy's Insured Schedule or that is not caused or aggravated by a Covered Specified Disease specifically named on the Policy's Insured Schedule; (b) alcoholism or drug addiction; (c) dental care or treatment; (d) cosmetic or elective surgery, except that excluded cosmetic surgery shall not include breast reconstruction in connection with mastectomy, including reconstructive surgery on a nondiseased breast to establish symmetry with a diseased breast on which reconstructive surgery has been performed (e) a Covered Specified Disease covered by any worker's compensation act or occupational diseases law; (f) rest cures, custodial care, and routine physical examinations; (g) expenses incurred to the extent benefits are actually paid by Medicare; (h) charges that a Covered Person is not legally required to pay or that would not have been made if no insurance coverage had existed; (i) treatment received in a U.S. Government or Veterans hospital for which a Covered Person is not required to pay; (j) eye glasses, hearing aids and examination for the prescription or fitting thereof; (k) any expense incurred for the acquisition, purchase, harvesting or transportation of human or animal organs used in transplant procedures; (l) a Covered Specified Disease sustained while serving in the armed forces of any country or international authority at war, whether war is declared or not (we will return the pro-rata premium for any period not covered by the Policy while you are in such service).

IV. Pre-Existing Conditions

Any Covered Specified Disease which is a Pre-Existing Condition, as defined herein, is not covered under your Policy until your Policy has been in force for a period of two years; provided, however, that no benefits whatsoever will be payable for loss from any condition, either pre-existing or otherwise, which is not shown on your Policy's Insured Schedule on the date of the loss. "Pre-Existing Condition" means a condition which has been diagnosed, or has manifested itself to the Covered Person within the five-year period immediately preceding the Effective Date of the Policy by a symptom or symptoms, whether the specific condition has been medically diagnosed or not, and causes loss within the two-year period following the Effective Date of the Policy.

(1) A Covered Specified Disease which is a Pre-Existing Condition may be covered after 12 months for an additional premium payable during the life of your policy by attachment of the PEB-3 (7/89) Endorsement.

(2) _____ (applicant's initials to select) **Existing Condition Benefit Endorsement PEB-3 (7/89):** A Covered Specified Disease which is a Pre-Existing Condition disclosed on the application and listed on the Endorsement Form PEB-3 (7/89) will be covered after 12 months.

V. Termination

A Covered Person's coverage will immediately terminate at 12:01 A.M., Standard Time, at the place where the Insured resides, on the earlier of: (a) the end of the 31-day grace period following the due date of any premium for that Covered Person which is not paid; or (b) the date the Covered Person enrolls in and becomes eligible to receive benefits under Medicare, in which case any unearned premium under this Policy will be refunded to the Covered Person.

VI. Renewal Safeguard

The Policy is renewable as follows:

(a) Subject to the Termination provisions of the Policy, we may not decline to renew the Policy except for one or both of the following reasons:

(1) Renewal premiums are declined on all policies bearing the same form number as the Policy issued to persons in the state where you reside; or

(2) Failure to correctly report matters inquired of in the application for the Policy.

(b) While the Policy is in effect, we shall not have the right to add any restrictive amendment. There shall be no change in rate classification on account of any physical impairment or on account of any claims incurred.

VII. Premium Payments – Premiums Subject to Change

(a) You have a grace period of 31 days for the payment of each premium which becomes due after the first premium.

(b) Premiums are subject to change. Premiums are based on the attained age of each Covered Person, and each Covered Person's premium may increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. Classes may be determined according to sex, attained age, smoking status, the insured's state, county or ZIP code of residence. We will give you 31 days written notice before any such premium change.

THIS IS A LIMITED POLICY.

IT PROVIDES BENEFITS FOR ONLY COVERED SPECIFIED DISEASES AS DESCRIBED ABOVE.

READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

PLEASE READ BEFORE SIGNING

THE SOLICITING AGENT SIGNING BELOW DOES NOT HAVE THE AUTHORITY TO BIND THE COMPANY OR TO WAIVE, CHANGE OR AMEND ANY TERM OR CONDITION OF A POLICY WHICH MAY BE ISSUED BY THE COMPANY.

I understand and acknowledge that:

- **Form SD-1 provides limited benefits; it is not a major medical policy.**
- **I have received a copy of this outline of coverage, which I have reviewed.**
- **The Insured Schedule of my Policy, if issued, will show the Covered Specified Diseases for which benefits are payable. No benefits are payable or any condition, accident or sickness not shown on my Policy's Insured Schedule.**

Dated this _____ day of _____, 20_____.

Signed at _____, State of _____.

Applicant's Signature

Agent's Signature

Date

[This Outline of Coverage is to be delivered to the applicant at the time the application for insurance is completed.]
"Specified Disease Policy" Form SD-1 is individually underwritten by Reserve National Insurance Company.

State of Arkansas

Certification

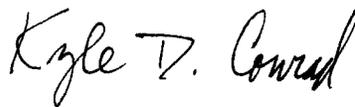
Carrier: Reserve National Insurance Company

Submission: Specified Disease Policy, General A&H Application and Outline of Coverage

Form Number(s): SD-1, UAP-1 AR (8/11), OC SD-1

The company has reviewed the above referenced form(s) and certifies that, to the best of its knowledge and belief, each form submitted is consistent and complies with the requirements of Arkansas Rule and Regulation 19, as well as all applicable requirements of the Arkansas Insurance Department.

6/17/11
Date



KYLE D. CONRAD
Senior Vice President and
Associate Corporate Counsel



5100 NORTHWEST GRAND BLVD. - OKLAHOMA CITY, OKLAHOMA 73118-1082

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or other information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Reserve National Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date

Applicant's Signature

IMPORTANT NOTICE

Customer Service Department of Reserve National Insurance Company:

601 East Britton Road

Oklahoma City, OK 73114-7710

Telephone # 1-800-654-9106.

If we at Reserve National Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department

Consumer Services Division

1200 West Third Street

Little Rock, Arkansas 72201-1904

Telephone (501) 371-2600