

SERFF Tracking Number: ICCI-127795448 State: Arkansas
Filing Company: American Medical and Life Insurance Company State Tracking Number:
Company Tracking Number: AMLI GP CI 2011-POL AAA
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
Limited Benefit
Product Name: AMLI GP CI 2011-POL AAA
Project Name/Number: AMLI GP CI 2011-POL AAA/AMLI GP CI 2011-POL AAA

Filing at a Glance

Company: American Medical and Life Insurance Company

Product Name: AMLI GP CI 2011-POL AAA SERFF Tr Num: ICCI-127795448 State: Arkansas

TOI: H07G Group Health - Specified Disease - SERFF Status: Closed-Approved- State Tr Num:

Limited Benefit Closed

Sub-TOI: H07G.001 Critical Illness Co Tr Num: AMLI GP CI 2011-POL State Status: Approved-Closed
AAA

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Ann Collins, Brenda

Disposition Date: 01/05/2012

Dawson

Date Submitted: 01/03/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AMLI GP CI 2011-POL AAA

Status of Filing in Domicile:

Project Number: AMLI GP CI 2011-POL AAA

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Association

Overall Rate Impact:

Filing Status Changed: 01/05/2012

State Status Changed: 01/05/2012

Deemer Date:

Created By: Brenda Dawson

Submitted By: Brenda Dawson

Corresponding Filing Tracking Number:

Filing Description:

Insurance Compliance Consultants is pleased to submit the enclosed forms on behalf of American Medical and Life Insurance Company (AMLI). A letter of filing authorization is enclosed.

The purpose of this submission is to allow AMLI to provide group critical illness coverage to residents of your state who are members of a group located outside of your state. The Group Policy will be issued to the American Advantage Association (AAA) previously approved by your Department on August 8, 2011 under SERFF Tracking # ICCI-

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127126793, situated in Nebraska.

The policy provides coverage for critical illness such as but not limited to Heart Attack, Stroke, Cancer in Situ, and Invasive Cancer.

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

We have enclosed the certificate of coverage for your review and approval. Amendatory Endorsement GP CI 2011 AE AR will be attached to certificates issued in Arkansas.

The enclosed forms are new and do not replace any forms currently on file with your Department.

The forms are in final format. Initially, the forms will be issued in paper format. AMLI reserves the right to change the type style and paper size. We also request the right to make the forms available electronically.

Regardless of the enrollment process used, AMLI will adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via secured socket layer/secured line. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act.

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

Company and Contact

Filing Contact Information

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

Filing Company Information

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

American Medical and Life Insurance Company CoCode: 81418 State of Domicile: New York
8 West 38th Street Group Code: Company Type:
Suite 1002 Group Name: State ID Number:

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New York City, NY 10018 FEIN Number: 13-2562243
(646) 223-9300 ext. [Phone]

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Medical and Life Insurance Company	\$300.00	01/03/2012	54973524

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/05/2012	01/05/2012

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Disposition

Disposition Date: 01/05/2012

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):
American Medical and Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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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	Authorization Letter	Approved-Closed	Yes
Form	Group Critical Illness Policy	Approved-Closed	Yes
Form	Group Critical Illness Certificate	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes
Form	Group Application	Approved-Closed	Yes
Form	Enrollment form	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

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Form Schedule

Lead Form Number: AMLI GP CI 2011-POL NE

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/05/2012	AMLI GP CI 2011-POL NE	Policy/Cont ract/Fraternal Certificate	Group Critical Illness Policy	Initial		0.000	NE AMLI Critical Illness Master Policy 10-28-11 clean copy.pdf
Approved-Closed 01/05/2012	AMLI GP CI 2011-CERT NE	Certificate	Group Critical Illness Certificate	Initial		0.000	NE CI Certificate 11-18-11 clean copy.pdf
Approved-Closed 01/05/2012	AMLI GP CI 2011-SCHED	Schedule Pages	Schedule of Benefits	Initial		0.000	Critical Illness Schedule Draft with Op Re Changes 10 24 clean copy.pdf
Approved-Closed 01/05/2012	AMLI GP CI 2011-APP	Application/Enrollment Form	Group Application	Initial		0.000	AMLI GRP CI 2011 APP 10-27-11 clean copy.pdf
Approved-Closed 01/05/2012	AMLI GP CI 2011-ENRL	Application/Enrollment Form	Enrollment Form	Initial		0.000	AMLI GP CI 2011 ENRL 12-27-11 added brackets clean copy.pdf
Approved-Closed	GP CI 2011 AE AR	Certificate Amendmen	Amendatory Endorsement	Initial			AR GP CI 2011 AE

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01/05/2012

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American Medical and Life Insurance Company
New York, New York

GROUP CRITICAL ILLNESS INSURANCE

THIS POLICY PROVIDES BENEFITS DUE TO CRITICAL ILLNESS. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.

Policy Holder: [ABC Company/Association]
Policy Number: [xxxxx]
Policy Date: [XX/XX/XXXX]
Anniversary Date: [XX/XX of each year]

MASTER POLICY

This Policy is a legal contract between You and Us. To understand the coverage, You must read this Policy as a whole.

In this Policy, the words You and Your refer to the Holder shown above. The words Named Insured refer to those persons who are members of an eligible class as described in the Certificate Schedule who hold a Certificate of coverage. Benefit payment is governed by the terms of this Policy. The words Covered Person refer to any person covered under this Policy as described on the Certificate Schedule. The words We, Us, Our or Company refer to American Medical and Life Insurance Company. The male pronoun includes the female whenever used.

We agree to insure certain individuals and to pay the benefits provided by this Policy in accordance with its provisions.

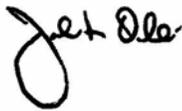
This Policy is issued in consideration of statements made in the application and the payment of premiums by the Holder. A copy of the signed application will be attached and made a part of this Policy.

This Policy is effective on the Policy Date. The Policy Date will be the date of issue. The first Policy Year will end on the anniversary date shown above. Each Policy Year after that will end on the same date of each year. All periods will begin and end at 12:01 A.M. Standard Time at the Holder's main address.

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

TO OBTAIN INFORMATION YOU MAY CALL OUR TOLL FREE NUMBER: [1-888-264-1512].

For American Medical and Life Insurance Company:



Chairman, President and CEO



Vice President and Chief Compliance Officer

Please read it carefully.
THE POLICY IS CANCELLABLE AT THE OPTION OF THE COMPANY.
PLEASE READ THE TERMINATION PROVISION.

This is Not Medicare Supplement Coverage

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TERMINATION OF INSURANCE [4]

PREMIUMS [4]

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INCORPORATION PROVISION

The provisions of the attached Certificate and all amendments to this Group Policy after its effective date are incorporated into and made part of this Group Policy.

Certificate

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

- benefits to which the Covered Person is entitled;
- to whom the benefits are payable; and
- limitations or requirements that may apply.

ELIGIBILITY AND EFFECTIVE DATE

Policy Effective Date

Coverage under this Policy begins at 12:01 a.m. Standard Time on the effective date shown in the Policy.

Delayed Effective Date of Coverage

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

TERMINATION OF THIS POLICY

Termination of This Policy

This Policy can be cancelled:

- by You; or
- by Us.

If the premium is not paid when it is due or during the grace period, this Policy will terminate at midnight on the last day of the grace period. You must pay all premium due for the full period each Certificate is in force.

If We cancel this Policy for reasons other than Your failure to remit premium, a written notice will be delivered to You at least 30 days prior to the cancellation date.

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

PREMIUMS

When and Where to Pay Premiums

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

The premium due dates are based on:

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

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

Grace Period (If Premiums Are Not Paid When Due)

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

Our Right to Change Premiums

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

A change in premium rate will not take effect before the end of the rate guarantee period shown on the Certificate Schedule. However, We may change premium rates at any time for reasons which affect the risk assumed, including the reasons shown below:

- a change occurs in the plan design;
- a division, subsidiary, or affiliated company is added or deleted;
- a substantial change occurs in the participation level of those eligible employees;
- the number of members changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this plan.

GENERAL PROVISIONS

Coverage Provided by This Policy

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

When making a benefit determination under this Policy, We have authority to determine the Covered Person's eligibility for the benefits and to interpret the terms and provisions of the Policy.

Entire Contract: Changes

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

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by Our executive officer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Furnishing Certificates

The Company will provide certificates [to the Holder for delivery] to each Named Insured. The Certificate will describe the insurance coverage and to whom payable. If the terms of a Certificate and this Policy differ, the Policy governs.

Benefit Amounts

Benefit amounts will be the amount of coverage selected at the time of application and reflected on the Named Insured's Certificate Schedule.

Conformity with State and Federal Law: Any provision of this Policy which, on its effective date, is in conflict with the law of the federal government or the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such law

[Information to Be Furnished By You

As the Holder, You must keep a record of the Named Insureds and the particulars of the insurance on each. You should provide Us at regular intervals, on forms acceptable to Us, information relative to persons:

- who are eligible to enroll;
- who are insured by the coverage; and/or
- whose coverage terminates pursuant to the "Termination of a Named Insured's Coverage" provision.

You should also provide Us with any other information about the coverage that may be reasonably required, such as Named Insureds on leave of absence, including Named Insureds who are on leave under the Family and Medical Leave Act.

We have the right to inspect Your records, which may have a bearing on the insurance provided by this Policy. We may inspect these at any time while this Policy is in force and within one year after the termination of this Policy.]

Incontestability

In the absence of fraud, all statements made in any application are considered representations and not warranties. After the Group Policy has been in force for two consecutive years, only fraudulent misstatements in the Policyholder Application may be used to void the Group Policy after the 2-year period. No representation of the Holder in applying for insurance under this Policy will make it void unless the representation is contained in the Policyholder Application.

American Medical and Life Insurance Company
8 West 38th Street Suite 1002
New York, New York 10018

GROUP CRITICAL ILLNESS INSURANCE

CERTIFICATE OF COVERAGE

Issued under the terms of

Group Insurance Policy Number: [12345]

Issued to: [XYZ Company]
(herein called the Policy Holder)

Certificate Effective Date: [September 1, 2011]

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

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

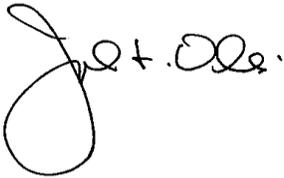
In this Certificate, the words "Named Insured" or "You" means a member of an eligible class as described on the Certificate Schedule, who is insured under the Policy and for whom premiums are remitted. The words "Covered Person" refer to any person covered under the Policy as described on the Certificate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

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

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

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

For American Medical and Life Insurance Company:



John Ollis
Chief Executive Officer



Kay Phillips
Vice President and Chief Compliance Officer

THE POLICY IS A CRITICAL ILLNESS POLICY. IT PROVIDES STATED BENEFITS FOR ONLY THOSE CRITICAL ILLNESSES SPECIFIED IN THIS CERTIFICATE AND SCHEDULE.

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CERTIFICATE SCHEDULE

The benefit specifications are shown on the following attachment(s) which are hereby made a part of this Certificate:

AML I GP CI 2011- SCHED

GENERAL DEFINITIONS

[Activities of Daily Living (ADLs)]

Basic, daily tasks necessary to maintain a person's health and safety. In the Policy, ADLs refer to the activities described below:

- **Transfer and Mobility** - The ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment.
- **Continence** - The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **Dressing** - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- **Toileting** - Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.
- **Eating** - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- **Bathing** - Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.]

Clinical Diagnosis

A Diagnosis of Invasive Cancer or Cancer In Situ based on the study of symptoms and diagnostic test results.

Covered Conditions or Procedures

A Covered Condition or Procedure:

- Occurs while this Certificate is in force;
- Is a Critical Illness as defined in this Certificate; and
- Is not excluded by name or specific description in the Certificate.

Covered Person(s)

You and Your Dependents who are insured under the Group Policy.

Critical Illness

The first-ever Diagnosis, while a Covered Person's coverage under the Policy is in force, of one of the following Covered Conditions, or the first time ever that a Covered Person has undergone one of the following Covered Procedures, as defined in this Certificate:

- Heart Attack
- Cancer In Situ
- Invasive Cancer
- Stroke
- End-Stage Renal Failure
- Major Organ Transplant
- [Heart Valve Replacement/Repair Surgery]
- [Coronary Bypass Surgery]
- [Coma]
- [Advanced Alzheimer's Disease]
- [Severe Burns]
- [Paralysis]
- [Motor Neuron Disease/ALS]

Diagnosis

The definitive establishment of a Covered Condition through the use of clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board-certified specialist, where required under the Policy.

First Ever Occurrence

The first time ever in his/her lifetime that a Covered Person has undergone the specific Covered Procedure, or has been diagnosed with the specific Covered Condition, included as a Critical Illness Covered Condition or Procedure.

Initial Benefit Amount

The Maximum Benefit Amount per Critical Illness, as defined in the Certificate Schedule.

Medically Necessary

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

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

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

Named Insured

A person who is a member of an eligible class and holds a Certificate of coverage.

Pathological Diagnosis

A Diagnosis of Invasive Cancer or Cancer in Situ based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board-certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

Physician

A person, other than the Named Insured, a member of the Named Insured's immediate family, or a business associate of the Named Insured, who is duly licensed, and who is legally qualified to diagnose and treat sickness and injuries. The physician must be providing services within the scope of his or her license, and must be a board-certified specialist where required under the Policy.

[Reduced Benefit Period – Association Members

The Reduced Benefit Period applies to any claim by an association member for Invasive Cancer or Cancer In Situ which occurs within the first [30][60][90] days after the Certificate Effective Date. Claims submitted during that period are subject to a reduced benefit payment equal to 10% of the Maximum Benefit Amount, and the cancer benefit is then terminated.]

[Reduced Benefit Period – Employer Group Members

The Reduced Benefit Period applies to any claim by an employer group member for Invasive Cancer or Cancer In Situ which occurs within the first 30 days after the Certificate Effective Date. Claims submitted during that period are subject to a reduced benefit payment equal to 10% of the Maximum Benefit Amount, and the cancer benefit is then terminated.]

[Substantial Assistance

- **Stand-By Assistance** means the presence of another person within the Covered Person's arm's reach, to prevent, by physical intervention, injury to the Covered Person while they perform an ADL (such as being ready to catch the Covered Person if they fall while getting into or out of the bathtub or shower as part of bathing, or being ready to remove food from the Covered Person's throat if they choke while eating).
- **Hands-On Assistance** means the physical assistance of another person without which the Covered Person would be unable to perform the ADL.]

ELIGIBILITY AND CERTIFICATE EFFECTIVE DATE

Certificate Effective Date of Coverage

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

Eligibility

To be eligible to enroll in the coverage, a Named Insured must:

- Be over 18 years of age; and
- Be a member of an eligible class as defined on the Certificate Schedule.

Enrollment

An individual who is a member of an eligible class may enroll for coverage during the open enrollment period, as shown on the Certificate Schedule that follows the latest of the following:

- Certificate Effective Date;
- [Policy Effective Date];
- Date the individual first becomes a member of an eligible class; or
- [Date the individual completes, signs and submits the medical history questionnaire].

[An individual who fails to enroll during the eligibility period may enroll only during the annual Open Enrollment Period shown on the Certificate Schedule.]

Delayed Certificate Effective Date of Coverage

The Certificate effective date of any Named Insured's coverage will be delayed for any Named Insured if he or she is not a member of an eligible class on the Certificate effective date shown on the Certificate Schedule. The coverage will be effective on the date that the Named Insured returns to status as a member of an eligible class. If this is Named Insured and Spouse [Domestic Partner] coverage or family coverage, coverage on the Spouse [Domestic Partner] and/or Dependent children will be effective on the date that the Named Insured returns to status as a member of an eligible class.

Who Is Covered By This Certificate

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

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

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

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

Domestic Partner means a person with whom You maintain a committed relationship and who has registered. Each partner must:

- Be at least 18 years old and competent to contract;
- Be the sole domestic partner of the other person; and
- Not be married.

Dependent children means:

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

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

Coverage for the Named Insured's Newborn Children:

A child born to You or Your insured Spouse [Domestic Partner] will automatically become insured as a Dependent. The child must be born to the Named Insured or Spouse [Domestic Partner] while Your coverage under the Policy is in force. We will cover each newborn child from the moment of live birth.

Coverage for the Named Insured's Adopted Child(ren):

We will cover the Named Insured's adopted child(ren) from the moment of birth if You take physical custody of the infant upon the infant's release from the hospital and file a petition for adoption, provided that consent to the adoption has not been revoked.

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

- the date of placement for the purpose of adoption; or

the entry of an order granting the adoptive parent custody of the child for purposes of adoption.

Coverage for adopted children will be to the same extent as is provided for other covered dependent children.

Coverage continues unless the placement is disrupted prior to legal adoption and the child is removed from placement.

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

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

If a newborn is not enrolled within 31 days of birth or adoption, coverage will be provided from the date that notice is given and You provide Us with evidence of insurability for the newborn. Any additional premium required must be made to the Policy Holder within 31 days of notification of birth or placement for the purposes of a step child and/ or adoption.

DESCRIPTION OF BENEFITS

For [each] [a] First-Ever Occurrence of a Critical Illness while insured under the Policy, [a Covered Person] [Named Insured and Spouse [Domestic Partner]] [Named Insured] is eligible for payment up to the Maximum Benefit Amount, based on the percentage specified in the Certificate Schedule for such Covered Condition or Procedure. In no event will benefits be payable for more than one occurrence of the same Critical Illness. The maximum benefit amount payable for any Covered Condition or Procedure will be reduced by 50% when the Covered Person reaches age 65.

COVERED CONDITIONS, PROCEDURES AND DIAGNOSTIC REQUIREMENTS

Category One:

Heart Attack. An acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The Diagnosis must be made by a Physician board-certified as a Cardiologist and based on both:

- New clinical presentation and electrocardiographic changes consistent with an evolving heart attack; and
- Serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

Established (old) Myocardial Infarction is excluded.

Major Organ Transplant (Heart and Heart/Lung). The clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the Insured to be replaced with an organ(s) or tissue from a suitable human donor (excluding the Covered Person) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to entire heart transplant or combination transplant that includes the heart and lung(s). In order for the Major Organ Transplant to be covered under the Policy, the Covered Person must be registered by the United Network of Organ Sharing (UNOS).

Stroke. Any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit, persisting for at least 96 hours and expected to be permanent. Transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded. The Diagnosis must be made by a Physician who is board-certified as a Neurologist.

[Coronary Bypass Surgery. The actual undergoing of coronary artery bypass surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed Medically Necessary to correct a narrowing or blockage of one or more coronary arteries. The Covered Procedure must be performed by a Physician board-certified as a Cardiologist. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.]

[Heart Valve Replacement/Repair Surgery. The actual undergoing of open-heart surgery to replace or repair one or more valves. The surgery must be deemed Medically Necessary and performed by a Physician board-certified as a Cardiologist or Cardiovascular Surgeon.]

Category Two:

Cancer In Situ. A Diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer In Situ includes:

- Early prostate cancer diagnosed as T1N0M0 or equivalent staging; and
- Melanoma not invading the dermis.

Cancer In Situ does **not** include:

- Other skin malignancies;
- Pre-malignant lesions (such as intraepithelial neoplasia); or
- Benign tumors or polyps.

Cancer In Situ must be diagnosed pursuant to a Pathological or Clinical Diagnosis as explained in the Definitions section of this Certificate. We will accept a Clinical Diagnosis of Cancer In Situ only if the following conditions are met:

- A Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
- There is medical evidence to support the Diagnosis; and
- A Physician is treating the Insured for Cancer In Situ.

If Diagnosis occurs within [30][60][90] days of the effective date of this Certificate, 10% of the maximum benefit listed on the Certificate Schedule will be paid, and cancer benefits will be terminated.

Invasive Cancer. A malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically excluded in this Certificate. Leukemias and lymphomas are included.

The following are **not** considered Invasive Cancer:

- Pre-malignant lesions (such as intraepithelial neoplasia);
- Benign tumors or polyps;
- Early prostate cancer diagnosed as T1N0M0 or equivalent staging;
- Cancer In Situ; or
- Any skin cancer (other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become metastatic).

Invasive Cancer must be diagnosed pursuant to a Pathological or Clinical Diagnosis as explained in the General Definitions section of this Certificate. We will accept a Clinical Diagnosis of Invasive Cancer only if the following conditions are met:

- A Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
- There is medical evidence to support the Diagnosis; and
- A Physician is treating the Insured for Invasive Cancer.

If Diagnosis occurs within [30][60][90] days of the effective date of this Certificate, 10% of the maximum benefit listed on the Certificate Schedule will be paid, and cancer benefits will be terminated.

Category Three:

End-Stage Renal Failure. The chronic and irreversible failure of both of a Covered Person's kidneys, which requires the Covered Person to undergo periodic and ongoing dialysis. The Diagnosis must be made by a Physician board-certified as a Nephrologist.

Major Organ Transplant (Liver, Kidney, Small Intestine, Pancreas, Pancreas/Kidney and Bone Marrow). The clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the Insured to be replaced with an organ(s) or tissue from a suitable human donor (excluding the Insured) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, kidney, lung, small intestine, pancreas, pancreas-kidney or bone marrow. Conditions covered under Major Organ Transplant, Category One (heart or heart and lung) are excluded. In order for the Major Organ Transplant to be covered under the Policy, the Covered Person must be registered by the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP).

[Advanced Alzheimer's Disease. The Diagnosis, by a Physician board-certified as a Neurologist, of Advanced Alzheimer's Disease. The Covered Person must exhibit loss of intellectual capacity involving impairment of memory and judgment as measured by clinical evidence and standardized testing. The disease must result in significant reduction in mental and social functioning such that the Covered Person requires Substantial Assistance, as defined in this Certificate, in performing at least three of the six Activities of Daily Living, as defined in this Certificate. No other dementing organic brain disorders or psychiatric illnesses shall meet the definition of Alzheimer's Disease, nor will they be considered a Critical Illness Covered Condition.]

[Coma. The diagnosis, by a Physician board-certified as a Neurologist that a Covered Person is in a state of unconsciousness from which the Covered Person cannot be aroused, in which external stimulation will produce no more than primitive avoidance reflexes, and that this state has persisted continuously for at least 96 hours.]

[Motor Neuron Disease/ALS. The unequivocal diagnosis, by a Physician board-certified as a Neurologist, of one of the following motor neuron diseases: amyotrophic lateral sclerosis (A.L.S. or Lou Gehrig's Disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy. Coverage is limited to these conditions, and all other variations of motor neuron disease are excluded.]

[Paralysis. The complete and permanent loss of use of two or more limbs through neurological injury for a continuous period of at least 180 days, confirmed by a Physician board-certified as a Neurologist.]

[Severe Burns. The Diagnosis, by a Physician board-certified as a Plastic Surgeon, that a Covered Person has sustained third-degree burns covering at least 20% of the surface area of his or her body. We will not pay the Severe Burns benefit for Dependent Children under the age of 18 years.]

[MULTIPLE PAYMENT BENEFIT

Benefits

The Multiple Payment Benefit is a feature of the Policy, which allows for multiple payments from the three categories of Covered Conditions or Procedures shown in the Certificate Schedule. The maximum Benefit Payment available in each Category is 100% of the Initial Benefit Amount. The maximum total Benefit Payment can be up to three times the Initial Benefit Amount stated in the Certificate Schedule. After your initial Benefit Payment under the Policy, You can choose to continue paying Premiums and be eligible to receive any available additional Benefit Payments.

There shall be only one Benefit Payment for each Covered Condition or Procedure.

There shall be only one Benefit Payment per 180-day period from all three categories combined. However, the 180-day limitation does not apply to Benefit Payments within the same category.

If a First-Ever Occurrence of a second event in a different Category occurs within the 180-day period after a Benefit Payment, hence not an eligible claim, a subsequent occurrence and diagnosis of that Covered Condition will be considered a First-Ever Occurrence under the Policy.

If more than one Covered Condition is diagnosed at the same time, the Benefit Payment shall be based on the larger Benefit Amount of those Covered Conditions diagnosed. If the Benefit Amounts are the same, there shall be only one Benefit Payment per 180-day period.

How This Benefit Is Calculated

Before Age 65:

- The Benefit Payment for a Covered Condition or Procedure equals the appropriate percentage of the Initial Benefit Amount for that Covered Condition or Procedure, but no greater than the benefit remaining for that category.
- The benefit available in a category equals the Initial Benefit Amount less the sum of any payments made to date for Covered Conditions or Procedures in that category.

On or After Age 65:

- The current benefit amount for a category equals 50% of the benefit remaining in that category on the day prior to the Policy anniversary.
- The Benefit Payment for a Covered Condition or Procedures equals the appropriate percentage of the current benefit amount for that Covered Condition or Procedure, but no greater than the benefit remaining for that category.
- The benefit available in a category equals the current benefit amount less the sum of any payments made since the Age 65 reduction for Covered Conditions or Procedures in that category.

Category 1:

- Heart Attack
- Stroke
- Major Organ Transplant (heart or combination transplant including heart)
- [Coronary Bypass Surgery]
- [Heart Valve Replacement or Repair Surgery]

Category 2:

- Invasive Cancer
- Cancer In Situ

Category 3:

- Major Organ Transplant (not including those conditions covered in Category 1)
- End-Stage Renal Failure
- [Coma]
- [Advanced Alzheimer's Disease]
- [Severe Burns]
- [Paralysis]
- [Motor Neuron Disease/ALS]

TERMINATION OF INSURANCE

Termination of a Named Insured's Coverage

The coverage on a Named Insured will terminate on the earliest of the following dates:

- The date the Policy terminates;
- Midnight on the last day of the grace period if premium is not paid by end of the grace period;
- 90 days after the date written notice was provided that the Named Insured is no longer in an eligible class;
- The date the Named Insured's class is no longer included for insurance;
- The date the Named Insured asks Us to end his or her coverage, provided We have received 30 days' written notification of such request;
- The date the Named Insured reaches age 70;
- The date the Maximum Benefit as listed on the Certificate Schedule has been paid; or
- The date the Named Insured dies.

When Coverage Ends on the Named Insured's Spouse[Domestic Partner] and/or Dependent Children

If this is Named Insured and Spouse [Domestic Partner] coverage, coverage on the Named Insured's Spouse [Domestic Partner] will end:

- When the Policy terminates;
- When the Named Insured's coverage terminates;
- If the premiums are not paid for the Named Insured's Spouse [Domestic Partner] when they are due;
- On the date the Named Insured asks Us to end his or her Spouse's [Domestic Partner's] coverage;
- On the date the Named Insured dies;
- On the date the next premium payment is due after the Named Insured becomes divorced from his or her Spouse;
- The date the Maximum Benefit as listed on the Certificate Schedule has been paid for the Named Insured's covered Spouse [Domestic Partner]; or
- On the date the Insured Spouse [Domestic Partner] reaches age 70.

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

- When the Policy terminates;
- When the Named Insured's coverage terminates;
- If the premium is not paid for the Named Insured's Dependent Children when it is due;
- On the date the Named Insured asks Us to end his or her Dependent coverage;
- The date the Maximum Benefit as listed on the Certificate Schedule has been paid for the Named Insured's covered Dependent Children; or
- On the date the Named Insured dies.

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

PREMIUMS

The premiums for the coverage must be paid when they are due and the Covered Person must remain a member of an eligible class with the Policy Holder.

Our Right to Change Premiums

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

Grace Period

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

EXCLUSIONS AND LIMITATIONS

We will not pay the Benefit Amount for a Covered Condition or Procedure if such Covered Condition or Procedure is caused by, occurs during or results from:

- [Intentional and self-inflicted injuries]
- Suicide or any attempt at suicide, while sane or insane;
- attempted commission of a felony;
- Participation in a riot or insurrection;
- Alcoholism or drug addiction; or
- Being intoxicated or under the influence of illegal drugs, a controlled substance or any narcotic) unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss or loss has occurred.

We will not pay the Benefit Amount for a Covered Condition or Procedure if:

- Such Covered Condition or Procedure is not covered under the Policy;
- Such Covered Condition or Procedure first occurred while the Policy was not in force;
- Such Covered Condition was diagnosed by a person who is not a Physician;
- Such Covered Condition was diagnosed outside the United States, unless the Diagnosis is confirmed in the United States;
- [Such Covered Procedure was performed outside the United States, unless on a United States military base or facility, or within another U.S. military or government building or facility]; or
- The Covered Person's date of birth, age or sex was misstated on the Application and at the correct date of birth, age or sex, the Certificate or coverage under the Policy would not have become effective or would have terminated.

GENERAL PROVISIONS

Entire Contract; Changes

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

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

- Policy;
- Certificate including the Certificate Schedule;
- Application(s), if any;
- Enrollment Form; and
- Attached riders or endorsements.

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

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

Incontestability

After the Policy has been in force for a period of two years during the lifetime of the Named Insured, excluding any period during which the Named Insured is disabled, it shall become incontestable as to the statements contained in the application. No claim for loss incurred or disability, commencing after two years from the date of issue of the Policy shall be reduced or denied on the ground that disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of the Policy.

Coverage Provided by the Policy

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

When making a benefit determination under the Policy, We have authority to determine the Covered Person's eligibility for the benefits and interpret the terms and provisions of the Policy.

Conformity with State and Federal Law

Any provision of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such law.

HOW TO FILE A CLAIM/CLAIM PROVISIONS

How to File a Claim

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

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

Proof of Loss

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

Payment of Claim

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

- Spouse;
- [Domestic Partner]
- Mother;
- Father
- Child or children; and
- Brothers or sisters.

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

Time of Payment of Claim

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

Questions Concerning the Named Insured's Claim

If the Named Insured has questions concerning a claim, he or she can call Us at Our home office.

Physical Examinations

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

Legal Action

We cannot be sued for benefits under the Policy until 60 days after written proof of loss has been given as required by the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

American Medical and Life Insurance Company
8 West 38th Street, Suite 1002
New York, New York 10018

GROUP CRITICAL ILLNESS CERTIFICATE SCHEDULE

[Named Insured: [John Employee]]

Certificate Schedule Number: [123]

Group Policy Number: [12345]

Policy Holder: [XYZ Company]

Certificate Effective Date: [September 1, 2011]

Certificate Anniversary Date: [September 1, of each year]

[Open Enrollment Period: [September 1] through [August 31] during each Policy Year]

1. Description of Eligible Classes

[[I. - All employees of [XYZ Company] who are working [actively employed] a minimum of [15 – 30] hours per week.]

[Actively Employed means the named insured is working at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. Normal vacation is considered active employment. The worksite must be:

- . • At the usual place of business;
- . • An alternative worksite; or
- . • A location to which the named insured's job requires him to travel.]

[I. - All active members of [ABC Association] in the member class [] as determined by bylaws or charter of the Association]

[II. Dependents of Named Insured as defined in the Policy.]

2. Eligibility Period: [31 days]

3. Plan Type: [Employer/Association-Paid – Employer/Association Contributions 1 – 100 %] [Voluntary]

4. Coverage: [Named Insured] [Named Insured and Spouse] [Family]

[5. Rate Guarantee Period: A change in premium rate will not take effect before [12] months after the Group Policy effective date.]

6. Benefits:

CERTIFICATE SCHEDULE

Maximum Benefit Amount Per Critical Illness for Named Insured: [\$2,500 - \$50,000]

[Maximum Benefit Percentage Per Critical Illness for Named Insured's Spouse [Domestic Partner]: [50-100%]]

[Maximum Benefit Percentage Per Critical Illness for Named Insured's Dependent Children: [0%-25%]]

Covered Conditions or Procedures	Benefit Percentage
Category One:	
Heart Attack	[50%-100%]
Stroke	[50%-100%]
Major Organ Transplant (heart or combination transplant including heart)	[50%-100%]
[Coronary Bypass Surgery]	[20%-50%]
[Heart Valve Replacement or Repair Surgery]	[20%-50%]

Maximum Benefit Payable, Category One:

100% of the Benefit Amount. Only one First-Ever Occurrence per Covered Condition or Procedure is eligible for the benefit.

The Maximum Benefit Amount reduces by 50% at age 65 and coverage terminates at age 70.

Category Two:	
Cancer In Situ – diagnosis more than [30][60][90] days after Effective Date	[20%-50%]
Cancer In Situ – diagnosis within first [30][60][90] days of Effective Date	[2.0%-5.0]
Invasive Cancer - diagnosis more than [30][60][90] days after Effective Date	[50%-100%]
Invasive Cancer - diagnosis within first [30][60][90] days of Effective Date	[5%-30%]

Maximum Benefit Payable, Category Two:

100% of the Benefit Amount. Only one First-Ever Occurrence per Covered Condition or Procedure is eligible for the benefit.

The Maximum Benefit Amount reduces by 50% at age 65 and coverage terminates at age 70.

Category Three:	
End-Stage Renal Failure	[50%-100%]
Major Organ Transplant (excluding conditions covered in Category One)	[50%-100%]
[Advanced Alzheimer's Disease]	[50%-100%]
[Coma]	[50%-100%]
[Motor Neuron Disease/ALS]	[50%-100%]
[Paralysis]	[50%-100%]
[Severe Burns (excluded for dependent children under 18 years of age)]	[50%-100%]

Maximum Benefit Payable, Category Three:

100% of the Benefit Amount. Only one First-Ever Occurrence per Covered Condition or Procedure is eligible for the benefit. The Maximum Benefit Amount reduces by 50% at age 65 and coverage terminates at age 70.

**American Medical and Life Insurance Company
New York, New York**

**POLICYHOLDER APPLICATION
FOR GROUP CRITICAL ILLNESS INSURANCE**

1. Name of [Employer][Association] _____ Group #: _____

2. Address (Street) _____

City: _____ State: _____ Zip Code: _____

3. Phone Number: _____

4. Plan Administrator: _____

5. Nature of [Business][Association]: _____

6. Effective Date of Coverage: _____

7. Initial Enrollment: Start Date _____

Stop Date: _____

[8. Subsequent Annual Enrollment Period,

Start Date _____

Stop Date: _____]

9. Eligibility Period: _____

10. Eligible Class

[Association Group

All active members of [ASSOCIATION NAME] as determined by bylaws or charter of the Association.

Number of eligible members: _____

Is there any association contribution?

Yes No If yes, what percentage? _____ %

Named Insured Only:

100% 75% 50% _____ (other)

Named Insured and Spouse [Domestic Partner]:

100% 75% 50% _____ (other)

Family:

100% 75% 50% _____ (other)

Plan Applied For:

Member Class: _____]

[Employer Group

All employees of [XYZ Company] who are working [actively employed] a minimum of [15-30] hours per week.

[Actively employed means the named insured is working at the worksite for earnings that are paid regularly and is performing the material and substantial duties of his regular occupation. Normal vacation is considered active employment. The worksite must be:

- At the usual place of business;
- An alternative worksite; or
- A location to which the named insured's job requires him or her to travel.

Number of eligible members: _____

Is there any employer contribution?

Yes No If yes, what percentage? _____ %

Named Insured Only:

100% 75% 50% _____ (other)

Named Insured and Spouse [Domestic Partner]:

100% 75% 50% _____ (other)

Family:

100% 75% 50% _____ (other)

Plan Applied For:

Member Class: _____]

11. Policy Benefits Selected:[Plan 1 Plan 2 Plan 3 Plan 4]

12. Is this a replacement of similar coverage? Yes No

13. Previous Company: _____

Termination Date of Prior Plan: _____

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

I understand that Covered Persons under this Critical Illness Plan are covered by group insurance benefits. The group insurance benefits vary depending on the plan design selected. These benefits are provided under a group insurance policy underwritten by American Medical and Life Insurance Company and are subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a critical illness plan that provides for limitations to the coverage for each Covered Condition or Procedure.

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

[Texas Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement in prison.]

My answers are true, complete and correct: I have personally reviewed all of my answers to the questions on this Policyholder Application and certify that all of the information I have provided is true, complete and correct. [I agree that any fraud, material misstatements or material failure to report information may be used as the basis of rescission or reformation of the Group Policy.] I understand that under no circumstances is any agent allowed to: (a) waive, alter or modify any questions or (b) permit me to inaccurately answer any question. I understand that no agent is authorized or has the authority to alter the terms of the Group Policy.

Dated at: _____
(City, State)

By: _____
(Authorized Signature/Title)

On: _____
Date (mm/dd/yyyy)

[By: _____
(Printed Agent/Broker Name)

(Signature of Agent/Broker)

To be Completed by Home Office

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

American Medical and Life Insurance Company
New York, New York

GROUP CRITICAL ILLNESS INSURANCE
[APPLICATION][ENROLLMENT] FORM

GENERAL INFORMATION

Applicant's Name: _____ Gender: _____ Date of Birth: _____ SSN: _____
 Home Address: _____ Phone: _____
 Height: _____ Weight: _____
 [Occupation/Job Title: _____ Employee Class: _____ Hire Date: _____ Hrs/Wk: _____
 Annual Salary: \$ _____ Employee ID: _____ Business Phone: _____
 [Employer Name: _____
 Employer Address: _____ Section/Dept. #: _____]
 [Member Class: _____ Join Date: _____
 Member ID: _____ Section/Dept. #: _____]]
 [Association Name: _____
 Association Address: _____]
 [Member Class: _____ Join Date: _____
 Member ID: _____ Section/Dept. #: _____]

[SPOUSE [DOMESTIC PARTNER] AND DEPENDENT INFORMATION

Name	Relationship to Applicant	Date of Birth	SSN	Height	Weight
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BENEFICIARY INFORMATION

Beneficiary Name	Relationship to Applicant	Age	SSN	Benefit %	Primary	Contingent
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

[HEALTH QUESTIONS:

For [employees] [members] up to a [\$10,000] maximum benefit per critical illness:

- Have you used tobacco in the last 12 months? If yes, please specify quantity? Yes No
- Have 2 or more family members (natural parents, brothers or sisters) been diagnosed with or died from the same condition: both before age 60 of cancer, heart disease, diabetes, stroke or kidney disease; or both before age 75 of colorectal cancer, Alzheimer's or Senile Dementia? Yes No]
- Has the proposed insured ever been diagnosed or treated for any of the following: Heart Attack, Angioplasty, Coronary Artery Bypass, Heart Valve Repair or Replacement, Stroke, Transient Ischemic Attack, Cancer (excluding non-invasive, non-melanoma Skin Cancer), End-Stage Renal Disease, Liver Cirrhosis, Hepatitis B or C (including carrier), Diabetes (other than during pregnancy), Organ or Bone Marrow Transplant, Alzheimer's or Senile Dementia, HIV, AIDS, or AIDS-Related Complex (ARC)? Yes No

For all spouses and for [employees] [members] above a \$10,000 maximum benefit per critical illness, also answer the following:

4. In the last 5 (FIVE) years, has the proposed insured been diagnosed with or treated for any of the following:
- Any Heart Disease (Including Angina) except mitral valve prolapse that does not require medication or treatment and innocent heart murmurs. Yes No
- Any Lung Disease except asthma that has never required hospitalization and non-chronic bronchitis. Yes No
- Any Disease of the Nervous System except non-chronic shingles. Yes No
- Any Liver Disease, Colitis, or Crohn's Disease except irritable bowel disease. Yes No
- Any Kidney Disease except non-chronic kidney stones or infections. Yes No
- Any diagnosis or treatment for: precancerous lesions/tumors, polyps, abnormal moles or lesions, dysplastic nevi, skin cancer, leukemia, lymphoma, abnormal Pap smear, abnormal PSA test, abnormal mammogram, fibrocystic breast disease, recurrent tumors, or unexplained tumors or growth? Yes No
- Any Eye or Ear Disorder. Yes No
- High Blood Pressure, High Cholesterol, or Hyperlipidemia except if all of the conditions present have been controlled for at least 1 year by using only one medication. Yes No
- Any Systemic Diseases, including but not limited to Multiple Sclerosis, Parkinson's Disease, sarcoidosis, paralysis, rheumatoid arthritis, autoimmune or connective tissue disease or disorder? Yes No
- Any Mental Illness including depression, bipolar disorder requiring inpatient treatment or hospitalization, or history of suicide attempt? Yes No
- Any treatment for alcohol and/or drug abuse or have used illegal drugs? Yes No
- Any Sexually Transmitted Disease or Recurrent Human Papillomavirus (HPV). Yes No
- Inability to perform any of the following activities independently: 1) dressing, 2) bathing, 3) feeding, 4) toileting or continence, 5) transferring in or out of a chair or bed? Yes No
5. In the past 2 (TWO) years, has the proposed insured been informed by a member of the medical profession of any abnormal test results or been advised to have any diagnostic/screening tests or procedures which have not yet been completed? Yes No]

I understand that Critical Illness Plan Covered Persons are covered by group insurance benefits. The group insurance benefits vary depending on plan design selected. These benefits are provided under a group insurance policy underwritten by American Medical and Life Insurance Company and subject to the exclusions, limitations, terms and conditions of coverage as set forth in the insurance certificate [which includes, but is not limited to, limitations for pre-existing conditions]. This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a critical illness plan that includes limitations to the coverage. The limitations are disclosed in the certificate which is issued to the Named Insured.

[I understand that MIB inquiries will be conducted on all applications for Critical Illness benefits with a face amount of \$30,000 or more.]

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

[Arkansas Residents - 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 is guilty of a crime and may be subject to fines and confinement in prison.]

[Kansas and Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of fraud as determined by a court of law.]

[Kentucky Residents - WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[Louisiana Residents - 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.]

[New Jersey Residents: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[New Mexico Residents - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present false information in an application of r insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[Ohio Residents - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.]

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

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

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

[Texas Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application/enrollment form containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement in prison.]

My answers are true, complete and correct: I have personally reviewed all of my answers to the questions on this [application][enrollment form] and any attachments to it and certify that all of the information I have provided is true, complete and correct, I agree that it is my responsibility to provide truthful, complete and correct information. I understand the questions asked. [I agree that any fraud, material misstatements or material failure to report information may be used as the basis of rescission or reformation of coverage for me or my dependents, if any.] I agree that under no circumstances is any agent allowed to: (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any question; or (c) instruct me not to disclose any particular medical condition on the application. I agree that no agent is authorized or has the authority to alter the terms of the Group Policy. **Attachments:** I understand that any attachments to this application become a part of this application.

Signed at: City _____ State _____

_____ Date _____ Signature of Applicant _____

Authorization for Release of Health-Related Information.

I authorize the disclosure of health information regarding, or related to the following individuals for whom an [application] [enrollment] for insurance has been submitted:

Print Name(s): (Last) (First) (MI) **Date of Birth** (Month/Day/Year)

1.				/	/
2.				/	/
3.				/	/
4.				/	/
5.				/	/
6.				/	/

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize American Medical and Life Insurance Company ("AMLIC"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit AMLIC, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, [including whether the individual is subject to a pre-existing condition exclusion].

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for coverage under the group policy is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment under the policy, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to American Medical and Life Insurance Company, 8 West 38th St., Suite 1002, New York, New York 10018, Attention Privacy Officer.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative:	Date:
X _____	_____
X _____	_____
X _____	_____

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual:

Name: _____ Authority: _____

**American Medical and Life Insurance Company
New York, New York**

ARKANSAS AMENDATORY ENDORSEMENT

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

A. Under **ELIGIBILITY AND CERTIFICATE EFFECTIVE DATE, Who is Covered By This Certificate**, the following changes are hereby made:

1. Coverage for the Named Insured's Newborn and Coverage for the Named Insured's Adopted Children, are deleted and replaced with the following:

Coverage for the Named Insured's Newborn and Adopted Children:

A child born to a Named Insured or a Named Insured's Spouse will automatically become insured as a Dependent. The child must be born to the Named Insured or to his or her Spouse while the Policy is in force. We will cover each newborn child from the moment of live birth, for up to 90 days. Such coverage includes:

- the necessary care and treatment of medically diagnosed congenital defects;
- birth abnormalities;
- prematurity'

For each newborn child, the Named Insured must:

- notify Us within 90 days of birth or when the Named Insured is named a party in a suit in which he or she is adopting the child; and
- pay the required premium for the newborn child, if any.

For each step child and/or adopted child, the Named Insured must:

- notify Us within 60 days of birth or when the Named Insured is named a party in a suit in which he or she is adopting the child; and
- pay the required premium for the child, if any.

If a newborn is not enrolled within 90 days of birth, coverage will be provided from the date that notice is given. Any additional premium required must be made to Us within 31 days of notification of birth or placement for the purposes of a step child and/ or adoption.

If a step child or adopted child is not enrolled within 60 days of birth, coverage will be provided from the date that notice is given. Any additional premium required must be made to Us within 31 days of notification of birth or placement for the purposes of a step child and/ or adoption.

Coverage Continuation for Handicapped Children

A child's attainment of age 25 does not terminate coverage while the child is:

- (1) incapable of self-sustaining employment because of mental retardation or physical disability; and
- (2) chiefly dependent on the Named Insured for support and maintenance.

To continue coverage for a handicapped child the Named Insured must provide proof of the child's incapacity and dependency:

- (1) after the date the child attains the limiting age; and
- (2) no more frequently than annually after the second anniversary of the date the child reaching age 25.

B. [Under **HOW TO FILE A CLAIM/CLAIM PROVISIONS, Time of Payment of Claim** is deleted and replaced with the following:

Time of Payment of Claim

We will pay, deny or settle all benefits due for clean claims within 30 calendar days after receipt of proof of loss submitted electronically or within 45 days by any other method.

If the resolution of a claim requires additional information, We will, within 30 calendar days after receipt of the claim, give You a full explanation of what additional information is needed. If You and the Provider have provided all such

additional information necessary to resolve the claim, the claim shall be paid, denied, or settled within 30 calendar days after receipt.

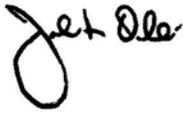
If We fail to pay, settle or deny a clean claim or take other required actions within 30 or 45 calendar days (excluding the time waiting for additional information), We will pay interest at the rate of 12% annually on the amount ultimately allowed on the claim, accruing from the date payment was due.

For the purpose of this provision, the following definition has been added:

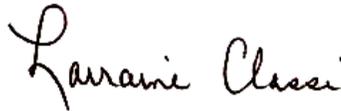
"Clean Claim" means a claim that is submitted on a HCFA 1500 or on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on the Plan's standard claim form with all required fields completed in accordance with the Plan's published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent, or (2) for which the Plan needs additional information in order to resolve one or more outstanding issues.

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

In Witness Whereof, We have caused this Endorsement to be signed by



Chairman, President and CEO



Executive Vice President & Chief Compliance Officer

SERFF Tracking Number: ICCL-127795448 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number:
 Company Tracking Number: AMLI GP CI 2011-POL AAA
 TOI: H07G Group Health - Specified Disease - Limited Benefit Sub-TOI: H07G.001 Critical Illness
 Product Name: AMLI GP CI 2011-POL AAA
 Project Name/Number: AMLI GP CI 2011-POL AAA/AMLI GP CI 2011-POL AAA

Rate Information

Rate data applies to filing.

Filing Method:

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):
American Medical and Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: ICCL-127795448 State: Arkansas
 Filing Company: American Medical and Life Insurance Company State Tracking Number:
 Company Tracking Number: AMLI GP CI 2011-POL AAA
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: AMLI GP CI 2011-POL AAA
 Project Name/Number: AMLI GP CI 2011-POL AAA/AMLI GP CI 2011-POL AAA

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	01/05/2012
Comments:		
Attachment: Cert of Comp. with Rule 19 AMLI NE CI.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	01/05/2012
Comments: See Form schedule tab		

	Item Status:	Status Date:
Satisfied - Item: Authorization Letter	Approved-Closed	01/05/2012
Comments:		
Attachment: auth letter (2012).pdf		

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

Insurer: American Medical and Life Insurance Company

Form Number(s):

Group Critical Illness Policy – AMLI GP CI 2011 POL NE

Certificate of Insurance – AMLI GP CI 2011-CERT NE

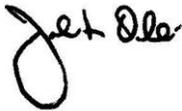
Schedule – AMLI GP CI 2011-SCHED

Group Application – AMLI GP CI 2011 APP

Enrollment form – AMLI GP CI 2011-ENRL

Amendatory Endorsement – GP CI 2011 AE AR

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



Signature of Company Officer

John Ollis
Name

CEO and President
Title

January 3, 2012
Date



8 WEST 38TH STREET – SUITE 1002
NEW YORK, NY 10018

MICHAEL F. MURPHY

EXECUTIVE VICE PRESIDENT & CHIEF MARKETING OFFICER

301.299.7802

CELL 301.943.2222

FAX 301.299.3410

mmurphy@usamli.com

www.usamli.com

January 1, 2012

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
3925 East State Street, Suite 200
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc., has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of American Medical and Life Insurance Company regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. American Medical may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants.

Sincerely,

A handwritten signature in blue ink, appearing to read "Michael F. Murphy", with a long horizontal flourish extending to the right.