

State: Arkansas **Filing Company:** American Fidelity Assurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: G925 Group Critical Illness Limited Benefit Policy
Project Name/Number: Group Critical Illness Limited Benefit Policy et al /G/CG925

Filing at a Glance

Company: American Fidelity Assurance Company
 Product Name: G925 Group Critical Illness Limited Benefit Policy
 State: Arkansas
 TOI: H07G Group Health - Specified Disease - Limited Benefit
 Sub-TOI: H07G.001 Critical Illness
 Filing Type: Form
 Date Submitted: 12/07/2012
 SERFF Tr Num: AFDL-128794171
 SERFF Status: Closed-Approved-Closed
 State Tr Num:
 State Status: Approved-Closed
 Co Tr Num: G925
 Implementation: On Approval
 Date Requested:
 Author(s): Linda Martin, Lisa Blauch, Raini Lewis, Joelle Harbour
 Reviewer(s): Rosalind Minor (primary)
 Disposition Date: 12/18/2012
 Disposition Status: Approved-Closed
 Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** American Fidelity Assurance Company
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General Information

Project Name: Group Critical Illness Limited Benefit Policy et al Status of Filing in Domicile: Pending

Project Number: G/CG925

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filing is pending review in Oklahoma.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Association, Trust

Overall Rate Impact:

Filing Status Changed: 12/18/2012

State Status Changed: 12/18/2012

Deemer Date:

Created By: Joelle Harbour

Submitted By: Joelle Harbour

Corresponding Filing Tracking Number: G925

Filing Description:

Submitted for review is form G925 Group Critical Illness Limited Benefit policy, and its corresponding certificate CG925. This form is new and does not replace any previously approved form.

The G925 provides an indemnity benefit for each of the critical illnesses defined in the policy. Critical Illness, as defined in this policy is: heart attack, permanent damage due to stroke, end stage renal failure, major organ failure, and permanent paralysis due to a covered accident.

The policy provides coverage for the insured employee and his or her dependent child/children. Coverage for dependent children will be provided without application for coverage or evidence of insurability and at no additional cost to the insured. Coverage for dependent children is automatically provided, so we will never require the insured to provide notification to us of any newly acquired dependent child/children. A newly acquired dependent child will include: a newborn child, a legally adopted child, the child of a legal spouse, and a child under the insured's permanent legal guardianship.

Please note that the bracketed information in this policy is variable or optional to allow for flexibility in designing plans, negotiating contracts with eligible groups, and for ease of automated policy and certificate generation. Although the policy includes variable and/or optional information, the actual text is not variable.

You will note in your examination that the certificate pages are written in first person language, while the policy is written in third person. Other than the face page, the language is virtually identical. We have completed the forms in a "John Doe" fashion to illustrate the manner in which the policy and certificate may be issued. Any combination of pages of the policy or certificate form will produce a minimum Flesch Score of 46, excluding defined terms.

Also submitted for review are riders AMD2116, AMD2117, and AMD2118. These forms are all new and do not replace any previously approved forms. Rider AMD2116 extends the policy to provide a cancer critical illness benefit for the insured and dependent children. The Flesch score is 46. Rider AMD2117 extends the policy to provide critical illness benefits for the insured's spouse. The Flesch score is 54. Rider AMD2118 provides a cancer critical illness benefit for the insured's spouse. Flesch score is 48.

Insured group application A1275 is also submitted for review. This application is new and does not replace any previously approved application. The Flesch score is 41. The A1275 will be used for all approved group products. The group policyholder application used will be AGM105, previously approved in Arkansas on February 12, 2009.

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I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of the state of Arkansas and such forms contain no provisions previously disapproved by the Department.

Thank you for your assistance in this matter. If you should have any questions or comments, or if you need any additional information, please feel free to contact me at 1-800-654-8489, extension 5997.

Company and Contact

Filing Contact Information

Joelle Southerland, Compliance Analyst I joelle.harbour@af-group.com
 2000 N Classen Blvd 405-523-5997 [Phone]
 Oklahoma City, OK 73106

Filing Company Information

American Fidelity Assurance Company	CoCode: 60410	State of Domicile: Oklahoma
2000 North Classen Blvd	Group Code: 330	Company Type: LAH
Oklahoma City, OK 73106	Group Name:	State ID Number:
(405) 523-2000 ext. [Phone]	FEIN Number: 73-0714500	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$300.00
Retaliatory?	No
Fee Explanation:	G925-\$50 CG925-\$50 AMD2116-\$50 AMD2117-\$50 AMD2118-\$50 A1275-\$50
Per Company:	No

Company	Amount	Date Processed	Transaction #
American Fidelity Assurance Company	\$300.00	12/07/2012	65530731

SERFF Tracking #:

AFDL-128794171

State Tracking #:**Company Tracking #:**

G925

State:

Arkansas

Filing Company:

American Fidelity Assurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

G925 Group Critical Illness Limited Benefit Policy

Project Name/Number:

Group Critical Illness Limited Benefit Policy et al /G/CG925

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/18/2012	12/18/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	12/10/2012	12/10/2012

Response Letters

Responded By	Created On	Date Submitted
Joelle Harbour	12/18/2012	12/18/2012

State: Arkansas **Filing Company:** American Fidelity Assurance Company
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Disposition

Disposition Date: 12/18/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form (revised)	Group Critical Illness Limited Benefit Policy	Approved-Closed	Yes
Form	Group Critical Illness Limited Benefit Policy	Replaced	Yes
Form (revised)	Group Critical Illness Limited Benefit Certificate	Approved-Closed	Yes
Form	Group Critical Illness Limited Benefit Certificate	Replaced	Yes
Form	Cancer Critical Illness Limited Benefit Rider	Approved-Closed	Yes
Form	Spousal Critical Illness Limited Benefit Rider	Approved-Closed	Yes
Form	Spousal Cancer Critical Illness Limited Benefit Rider	Approved-Closed	Yes
Form	Group Insured Application	Approved-Closed	Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/10/2012
Submitted Date	12/10/2012
Respond By Date	01/10/2013

Dear Joelle Southerland,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Critical Illness Limited Benefit Policy , G925 (Form)
- Group Critical Illness Limited Benefit Certificate , CG925 (Form)

Comments: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity, Refer to ACA 23-86-108 (4) and Bulletin 14-81.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking #:

AFDL-128794171

State Tracking #:

Company Tracking #:

G925

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Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/18/2012
Submitted Date	12/18/2012

Dear Rosalind Minor,

Introduction:

Thank you for your correspondence.

Response 1

Comments:

We have attached a revised policy and certificate with the change you requested for the definition of Dependent Child in Section 1.

Related Objection 1

Applies To:

- Group Critical Illness Limited Benefit Policy , G925 (Form)
- Group Critical Illness Limited Benefit Certificate , CG925 (Form)

Comments: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity, Refer to ACA 23-86-108 (4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

American Fidelity Assurance Company

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Form Schedule Item Changes:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Group Critical Illness Limited Benefit Policy	G925	POL	Initial		46.000	G925AR.pdf	Date Submitted: 12/18/2012 By: Joelle Harbour
<i>Previous Version</i>								
1	<i>Group Critical Illness Limited Benefit Policy</i>	<i>G925</i>	<i>POL</i>	<i>Initial</i>		<i>46.000</i>	<i>G925.pdf</i>	<i>Date Submitted: 12/07/2012 By: Joelle Harbour</i>
2	Group Critical Illness Limited Benefit Certificate	CG925	CER	Initial		46.000	CG925AR.pdf	Date Submitted: 12/18/2012 By: Joelle Harbour
<i>Previous Version</i>								
2	<i>Group Critical Illness Limited Benefit Certificate</i>	<i>CG925</i>	<i>CER</i>	<i>Initial</i>		<i>46.000</i>	<i>CG925.pdf</i>	<i>Date Submitted: 12/07/2012 By: Joelle Harbour</i>

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your assistance in this matter. If you should have any questions or comments, or if you need any additional information, please feel free to contact me at 1-800-654-8489, extension 5997, or at Joelle.Southerland@af-group.com.

Sincerely,

Joelle Harbour

State: Arkansas **Filing Company:** American Fidelity Assurance Company
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Form Schedule

Lead Form Number: G925								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 12/18/2012	Group Critical Illness Limited Benefit Policy	G925	POL	Initial		46.000	G925AR.pdf
2	Approved-Closed 12/18/2012	Group Critical Illness Limited Benefit Certificate	CG925	CER	Initial		46.000	CG925AR.pdf
3	Approved-Closed 12/18/2012	Cancer Critical Illness Limited Benefit Rider	AMD2116	CERA	Initial		46.000	AMD2116_InsCan.pdf
4	Approved-Closed 12/18/2012	Spousal Critical Illness Limited Benefit Rider	AMD2117	CERA	Initial		54.000	AMD2117_CI-Spouse.pdf
5	Approved-Closed 12/18/2012	Spousal Cancer Critical Illness Limited Benefit Rider	AMD2118	CERA	Initial		48.000	AMD2118_Can-Spouse.pdf
6	Approved-Closed 12/18/2012	Group Insured Application	A1275	AEF	Initial		41.000	A1275.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

SERFF Tracking #:

AFDL-128794171

State Tracking #:

Company Tracking #:

G925

State:

Arkansas

Filing Company:

American Fidelity Assurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

G925 Group Critical Illness Limited Benefit Policy

Project Name/Number:

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POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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Our Family, Dedicated To Yours.®

[2000 N. CLASSEN BOULEVARD, OKLAHOMA CITY, OKLAHOMA 73106]

POLICYHOLDER: [ABC Company]
ADDRESS: [123 Main Street, Oklahoma City, Oklahoma, 73106]
EFFECTIVE DATE: [January 1, 2013]
DATE OF ISSUE: [January 30, 2013]
POLICY NUMBER: [G925-2]
POLICY ANNIVERSARY DATE: [January 1]

In consideration of:

- (a) the application of the Policyholder, a copy of which is attached to and made a part of this Policy; and
- (b) the payment of the first premium,

the Company agrees to pay the benefits of this Policy subject to all of its terms.

This Policy is executed by American Fidelity Assurance Company as of its Date of Issue. This Policy will take effect on the Effective Date.


President


Secretary

GROUP CRITICAL ILLNESS LIMITED BENEFIT POLICY

**THIS POLICY OFFERS LIMITED BENEFITS.
PLEASE READ YOUR POLICY CAREFULLY.
ALL BENEFITS ARE PAID DIRECTLY TO THE INSURED.**

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

FP

TABLE OF CONTENTS

Schedule of Benefits

Section 1Definitions

Section 2Eligibility and Effective Date

Section 3 Benefits

Section 4Limitations and Exclusions

Section 5 Termination of Insurance

Section 6Premium Calculation and Payment

Section 7 Claims

Section 7General Provisions

[Application]

TC

SCHEDULE OF BENEFITS

PLAN: [1]

POLICYHOLDER: [ABC Employer]

POLICY NUMBER: [G-XXX-2T]

EFFECTIVE DATE: [January 1, 2013]

ELIGIBILITY: [All active permanent certified and administrative employees.] [As defined by the Policyholder]

CRITICAL ILLNESS BENEFIT

Insured	Dependent Child
[[<u>\$5,000 up to \$100,000</u>] per Critical Illness] OR [Please refer to the Insured's individual application or enrollment form]	[25% of the Insured's Critical Illness Benefit] OR [[<u>\$1250 up to \$25,000</u>] per Critical Illness]

CRITICAL ILLNESS: Maximum of one Critical Illness Benefit amount payable per Critical Illness per Covered Person.

Heart Attack [Coronary Artery Bypass Surgery] Partial payments for Coronary Artery Bypass Surgery reduces the Heart Attack benefit. At no time will combined payments for any heart related benefits exceed 100% of the Critical Illness Benefit Amount.]	[50%, 100%] 25%
Permanent Damage Due To Stroke	[50%, 100%]
End Stage Renal Failure	[50%, 100%]
Major Organ Failure	[50%, 100%]
Permanent Paralysis Due To A Covered Accident	[50%, 100%]

[RECURRENT BENEFIT: 50% of the Critical Illness Benefit
Maximum of one Recurrent Benefit payable per Recurrent Diagnosis, per Covered Person, for a recurrent diagnosis of Heart Attack, Major Organ Failure, or Permanent Damage Due to Stroke.]

[HEALTH SCREENING BENEFIT: **[\$50, \$75, \$100]** per Calendar Year]

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SECTION 1 DEFINITIONS

ACCIDENT means a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity.

ACTIVE EMPLOYMENT means that the Insured is:

- (a) doing in the usual manner all of the regular duties of the Insured's employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where the Insured normally does such duties or at some location to which his or her employment sends the Insured.

The Insured will be said to be on Active Employment on a day which is not a scheduled work day only if the Insured is not disabled and would be able to perform in the usual manner all of the regular duties of his or her employment if it were a scheduled work day.

CERTIFICATE means the individual Certificate issued to the Insured. It describes the coverage under the Policy.

[CORONARY ARTERY BYPASS SURGERY means open heart surgery performed by a Physician to correct Coronary Artery Disease with bypass grafts. Coronary Artery Bypass Surgery does not include balloon angioplasty, laser angioplasty, stenting, valve replacement surgery, or procedures other than Coronary Artery Bypass Surgery.]

CORONARY ARTERY DISEASE means a severe narrowing or blockage of one or more coronary arteries.

COVERED PERSON(S) means the Insured and the Insured's eligible Dependent Child whose coverage is in force. (See Section 2 – Eligibility and Effective Date.)

CRITICAL ILLNESS: End Stage Renal Failure, Heart Attack (including Coronary Artery Bypass Surgery), Major Organ Failure, Permanent Damage Due To A Stroke, or Permanent Paralysis Due To A Covered Accident, as defined in the Policy, for which a positive diagnosis is made by a Physician.

CRITICAL ILLNESS BENEFIT AMOUNT: The amount shown on the Schedule of Benefits for the Covered Person.

DEPENDENT CHILD means:

- (a) the Insured's child (natural, step, adopted, or a minor for whom guardianship is granted to the Insured by court or testamentary appointment, other than temporary guardianship of less than 12 months duration) who is less than **[26 to 31]** years of age; or
- (b) the Insured's child who becomes incapable of self-support because of mental or physical handicap while covered under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on the Insured for support and maintenance. The Company must receive proof of incapacity as soon as reasonably possible. Coverage will then continue as long as the Insured's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age **[26 to 31]**; or
- (c) any minor under the Insured's charge, care and control, who has been placed in the Insured's home for adoption and is less than **[26 to 31]** years of age.

The term Dependent Child does not include the Insured's grandchild (unless required by law).

EFFECTIVE DATE means the date described in the Policy. The date shown in the Insured's individual Certificate or Policy will be the Insured's Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

END STAGE RENAL FAILURE means renal disease resulting in irreversible failure of both kidneys to function and which requires regular dialysis or renal transplantation to sustain life.

HEART ATTACK means an acute Myocardial Infarction due to Coronary Artery Disease resulting in death of a portion of the heart muscle. Diagnosis must be supported by onset of new symptoms and any of the following: EKG changes, elevation of biochemical markers, or imaging studies, consistent with an acute myocardial infarction. In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack will be acceptable.

Heart attack does not include congestive heart failure, atherosclerotic heart disease, angina, cardiac arrest, or any other disease or injury involving the cardiovascular system.

INSURED (You or Your) means a person whose coverage has been applied for and is in force under the terms of the Policy.

MAJOR ORGAN FAILURE means the diagnosis by a Physician of failure of the heart, liver, lung, or entire pancreas due to end stage organ failure, which results in the Covered Person being placed on the United Network for Organ Sharing (UNOS) list for a transplant.

OCCURRENCE DATE must occur on or after the Covered Person's Effective Date and while coverage is in force. The Occurrence Date for each of the Critical Illnesses is as follows:

- Heart Attack - the date the death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack definition;
- Coronary Artery Bypass Surgery - the date the Covered Person undergoes Coronary Artery Bypass Surgery;
- Major Organ Failure - the date the Covered Person is placed on the UNOS list for transplantation;
- Permanent Damage Due To A Stroke - the date new neurological deficits from the Stroke [are diagnosed as permanent] [have persisted for a minimum of [7, 14, 30] consecutive days];
- End Stage Renal Failure - the date End Stage Renal Failure is diagnosed.
- Permanent Paralysis Due To A Covered Accident – the date paralysis is diagnosed as permanent.

PERMANENT DAMAGE DUE TO A STROKE means permanent neurological damage to the brain which results from an acute or sub-acute interruption of blood flow to brain tissue, including infarction of brain tissue due to embolism, thrombus or bleeding. Diagnosis should be made by a physician, demonstrated by imaging (CT or MRI), and must result in permanent neurological deficits. Permanent Damage Due to a Stroke does not include Transient Ischemic Attacks (TIA).

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT (or Paralysis) means injuries to the spinal cord due to a Covered Accident which result in the loss of use of two or more limbs. Paralysis must be diagnosed as permanent, total, and irreversible.

PHYSICIAN means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for the Insured's Sickness or Accident; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat the Insured's condition.

The term Physician does not include the Insured, anyone related to the Insured by blood or marriage, or anyone living in the Insured's household.

POLICY means the Policy issued to the Policyholder that covers the Insured.

POLICYHOLDER means the association, employer, labor union, or trustee who holds the Policy.

[RECURRENT DIAGNOSIS: A second Occurrence Date for a Heart Attack, Permanent Damage Due To A Stroke, or Major Organ Failure, for which a Critical Illness Benefit Amount was previously paid under the Policy.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while the Insured's coverage is in force; and
- (b) be separated by at least 180 days.]

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

SICKNESS: Any illness or disease which is the direct cause of the Critical Illness and begins while the Covered Person's coverage is in force.

TRANSIENT ISCHEMIC ATTACK (or TIA) means a neurological condition or event with the signs and symptoms of a Stroke, but which disappear within 24 hours with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies. TIA's are not covered by the Policy.

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**SECTION 2
ELIGIBILITY AND EFFECTIVE DATE**

[The Insured's Eligibility: If the Insured:

- (a) is on Active Employment as an employee of the employer, or member or employee of a member of the Policyholder;
- (b) qualifies as an eligible Insured, as defined in the Policyholder's application; and
- (c) meets the definition of Eligibility, as stated in the Schedule,

the Insured is eligible to be insured under the Policy. Evidence of insurability acceptable to the Company may be required.

The Insured's Effective Date: If the Insured is eligible, the Insured's coverage or changes in coverage including increases will begin on the later of the requested Effective Date or the date the Company approves the written application, if the Insured:

- (a) applies in writing on or before said Effective Date;
- (b) meets the Company's underwriting rules;
- (c) is on Active Employment, as defined in Section 1; and
- (d) has paid all applicable premiums due.

If the Insured is not on Active Employment due to an Accident or Sickness when his or her coverage would otherwise take effect, coverage will take effect on the first of the month following the date the Insured returns to Active Employment for at least 5 consecutive workdays.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.

The Insured's Dependent Child: Coverage for the Insured's Dependent Child will also become effective on the Insured's Effective Date or on the date he or she acquires a Dependent Child or Children, whichever is later, as long as the Insured's coverage is in force. Application for coverage, evidence of insurability, or additional premium is not required for the Insured's Dependent Child.

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[ELIGIBILITY

All persons who:

- (a) are on Active Employment as employees of the employer; or members or employees of a member of the Policyholder;
- (b) qualify as eligible Covered Persons as defined by the employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

will be enrolled automatically by the Employer.

EFFECTIVE DATE: WHEN COVERAGE BEGINS

Coverage for all Covered Persons will begin on the date the Insured becomes eligible if his or her employer has paid all applicable premiums.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

EFF-EMPPDJ

SECTION 3 BENEFITS

CRITICAL ILLNESS

A benefit is payable once per Covered Person for each Critical Illness shown on the Schedule of Benefits. After the Occurrence Date of the first Critical Illness payable under the Policy or any attached riders, a benefit for each subsequent Critical Illness will only be payable if the Occurrence Date:

- (a) is for a Critical Illness for which a Critical Illness Benefit Amount has not been previously paid;
- (b) is separated by more than 90 days following the last Critical Illness Occurrence Date; and
- (c) occurs while the Covered Person is insured under the Policy, Certificate or any attached riders.

Any critical illness not specifically listed in the Critical Illness definition is not payable under the Policy. If the Occurrence Date of two or more Critical Illnesses is separated by less than 90 days, the Company will pay only one Critical Illness Benefit Amount. The Company will pay for the Critical Illness that occurred first. Critical Illnesses with a Critical Illness Benefit Amount of less than 100% are not subject to this requirement.

HEART ATTACK: Following the Occurrence Date of a Covered Person's Heart Attack, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Heart Attack must occur after the Covered Person's Effective Date.

If a Covered Person receives a benefit for a Coronary Artery Bypass Surgery and is later diagnosed with a Heart Attack, the Company will pay the Heart Attack benefit less the amount received for such Coronary Artery Bypass Surgery. For all heart related benefits combined, the Company will not pay more than 100% of the Critical Illness Benefit Amount shown on the Schedule of Benefits for the Covered Person.

[Coronary Artery Bypass Surgery: Following the Occurrence Date of a Covered Person's Coronary Artery Bypass Surgery, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Coronary Artery Bypass Surgery must occur after the Covered Person's Effective Date. This benefit is payable only once per Covered Person per lifetime. If a Covered Person has previously received a benefit for Heart Attack, then 100% of the heart related benefits have been exhausted and this benefit is not payable. The Coronary Artery Bypass Surgery Occurrence Date is not subject to the 90-day separation period.]

PERMANENT DAMAGE DUE TO A STROKE: Following the Occurrence Date of a Covered Person's Permanent Damage Due To A Stroke, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The stroke and the Permanent Damage Due to a Stroke must occur after the Covered Person's Effective Date.

MAJOR ORGAN FAILURE: Following the Occurrence Date of a Covered Person's Major Organ Failure, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Major Organ Failure must occur after the Covered Person's Effective Date.

END STAGE RENAL FAILURE: Following the Occurrence Date of a Covered Person's End Stage Renal Failure, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The End Stage Renal Failure must occur after the Covered Person's Effective Date.

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT: Following the Occurrence Date of a Covered Person's Paralysis, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Accident and the Paralysis must occur after the Covered Person's Effective Date.

BEN

[RECURRENT BENEFIT: If a Covered Person receives a Recurrent Diagnosis, the Company will pay an additional benefit for such Critical Illness equal to 50% of the Critical Illness Benefit Amount.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while the policy is in force; and
- (b) be separated by at least 180 days.

This benefit is payable once per Covered Person for each Recurrent Diagnosis of a Critical Illness. Once a Recurrent Diagnosis Benefit has been paid for a Critical Illness, no further Occurrence Dates of that same Critical Illness will be payable. Any Critical Illness not specifically listed in the Recurrent Diagnosis definition is not payable under this benefit.

RB]

[HEALTH SCREENING BENEFIT

The Company will pay the Health Screening Benefit amount shown on the Schedule of Benefits for the Insured when he or she receives one of the Health Screening tests listed below:

- | | |
|------------------------------|--|
| Blood Test For Triglycerides | Exercise Or Pharmacologic Stress Test |
| Neuroimaging Studies | Fasting Blood Glucose Test |
| Doppler Ultrasound | Serum Cholesterol Test To Determine HDL And LDL Levels |
| Echocardiogram | Electrocardiogram (EKG) |

The Health Screening Benefit amount shown in the Schedule of Benefits will be payable for the Insured a total of once per Calendar Year as long as the Insured's coverage under this benefit is in force. Calendar Year means the period beginning on January 1 and ending on December 31 of the same year. Coverage for Health Screening Benefits is not provided for the Insured's Dependent Child.

HSB]

SECTION 4 LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITION LIMITATION

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Occurrence Date occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months.

PE

PRE-EXISTING CONDITION means a disease, Accident, Sickness, physical condition or mental illness for which a Covered Person has experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Covered Person's Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness, physical condition or mental illness.

PEDEF

EXCLUSIONS: The Company will not pay benefits for any Critical Illness resulting from or caused, whether directly or indirectly, by:

- (a) An intentionally self-inflicted Accident or Sickness.
- (b) Suicide or attempted suicide, while sane or insane.
- (c) Participating in a riot, insurrection, rebellion, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority.
- (d) Being intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions. Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the event that caused the Critical Illness occurred.
- (e) Committing, or attempting to commit a felony.
- (f) Being incarcerated in any type of penal institution.
- (g) Alcoholism or drug addiction.
- (h) A diagnosis received outside the United States, or its territories, that cannot be confirmed by a Physician licensed and practicing in the United States.

EXC

[CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

For all employees who were insured by their current Employer's prior group critical illness carrier on the day preceding the Employer's Effective Date of coverage under the Policy and who became insured with American Fidelity Assurance Company on the Employer's Effective Date of coverage under the Policy, coverage for Pre-Existing Conditions will be administered as follows:

If the Insured was not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group critical illness carrier, there would be no Pre-Existing Condition Limitation applied under the American Fidelity plan. If the Insured was not eligible for benefits under the prior group critical illness carrier's plan because of a Pre-Existing Condition Limitation, the Insured would not be eligible for benefits under the American Fidelity plan until such time as he or she had satisfied the Pre-Existing Condition Limitation described in the Policy. Credit will be given for any portion of time satisfied with the Insured's current Employer's prior group critical illness carrier provided he or she replaced that coverage with American Fidelity's insurance on the Effective Date. This provision applies only up to the amount of coverage the Insured held with the prior group critical illness carrier on the day preceding American Fidelity's Effective Date or [\$10,000, \$15,000, \$20,000], whichever is less. Proof of Continuity of Coverage must be supplied upon request.

For those employees who were not enrolled under the current employer's prior group critical illness carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

CCJ

**SECTION 5
TERMINATION OF INSURANCE**

The Insured's Coverage: The Insured's Insurance coverage will end on the earliest of these dates:

- (a) the date the Insured no longer qualifies as an Insured;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Policy is discontinued;
- (d) the date the Insured retires;
- (e) if the Insured works for an employer employing less than 20 employees on a typical work day in the preceding Calendar Year, the date the Insured attains age 75;
- (f) the date the Insured ceases to be on Active Employment, as defined in Section 1;
- (g) the date the Insured ceases employment with the employer through whom he or she originally became insured under the Policy;
- (h) the date of the Insured's death;
- (i) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for the Insured.

Coverage On The Insured's Dependent Child: The coverage on Dependent Child(ren) will end on the earliest of these dates:

- (a) the date the Insured's coverage terminates;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Covered Person no longer meets the definition of Dependent Child, as defined in Section 1;
- (d) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for each Dependent Child.

If termination of coverage occurs because of termination of the Insured's employment or contract with the Policyholder, such termination shall be without prejudice to any Occurrence Date which commenced while this Certificate was in force.

The Company may end the coverage of any Covered Person who submits a fraudulent claim.

The Company or the Policyholder, may end the Policy and/or optional benefit riders on any premium due date. Thirty-one days advance written notice of such termination must be given.

The Company may end the coverage of a subscribing Employer unit if fewer persons are insured than required by the Policyholder's application.

LEAVE OF ABSENCE: The Insured's coverage may be continued for up to [1 year, 2 years] during a Leave of Absence approved in writing by his or her Employer.

TOI

[PORTABILITY

If the Insured no longer meets the definition of Eligibility as described in the Schedule of Benefits he or she may continue the coverage provided in this Certificate, including any attached riders. The Insured is eligible to continue his or her coverage if:

- (a) the Insured has been continuously covered under the Policy for at least 12 consecutive months prior to the date his or her coverage under the Policy ends;
- (b) the Insured notifies the Company no later than 30 days after the Insured's Eligibility under the Policy ends and submits the appropriate premium;
- (c) the Insured's coverage under the Policy is in force on the day his or her Eligibility ends; and
- (d) the Policy is still in force on the date the Insured's coverage under this Provision becomes effective.

The Insured's coverage under this Provision will remain the same as it was on the day prior to the date the Insured's coverage under this Provision begins. All provisions of the Policy remain applicable. No application or evidence of insurability will be required.

Any plan or rate changes made to the Policy will also be applicable to the Insured's coverage under the Portability Provision. Thirty-one days advance written notice of any such change will be provided.

Coverage under the Portability Provision will end on the earliest of these dates:

- (a) the end of the month following the Insured's 75th birthday;
- (b) the last day of the month ending ten (10) years from the date the Insured's coverage became effective under this Provision;
- (c) the date the Policy is terminated; or
- (d) the date the Insured fails to pay the required premium.

The Insured may cancel his or her coverage under this Provision at anytime by providing written notice. The Company will refund any unearned premium to the Insured. Cancellation will not prejudice any claim that originated prior to the date cancellation took effect.

PORT]

SECTION 6
PREMIUM CALCULATION AND PAYMENT

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before the Insured's Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

- (a) the Company's Home Office; or
- (b) an authorized entity of the Company.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases the Company's liability, premium rates may be changed on the date the liability is increased.

PREM

SECTION 7 CLAIMS

NOTICE OF CLAIM: The Insured should notify the Company, in writing, within 30 days after a Covered Person incurs a loss covered by the Policy. If it is not reasonably possible to give notice within this time period, the Insured's claim will not be denied or reduced due to the delay. Send the Insured's written notice to the Company at the following address:

American Fidelity Assurance Company
P.O. Box [25160, 268898, 248850]
Oklahoma City, Oklahoma [73125, 73126, 73124-8850]

CLAIM FORMS: Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

PROOF OF LOSS: Proof of Loss must be given to the Company within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at the Insured's expense, includes, but is not limited to, the following documentation:

- (a) certification by a Physician of the Critical Illness, as supported by a completed Claim Form provided by the Company, or some other mutually agreed-upon means;
- (b) the Occurrence Date of the Covered Person's Critical Illness;
- (c) the cause of the Covered Person's Critical Illness;
- (d) the objective test results, or documentation satisfactory to the Company, confirming the Critical Illness as required in the definition of such Critical Illness; and
- (e) a copy of the death certificate, if the Critical Illness resulted in the Covered Person's death.

TIME OF PAYMENT OF CLAIMS: Benefits for a covered loss will be paid promptly upon receipt of written Proof of Loss.

PAYMENT OF BENEFITS: The Company will pay all benefits to the Insured. Any benefits that have not been paid at the time of the Insured's death will be paid to the Insured's designated beneficiary, if living, or to the contingent beneficiary. If no such designation is made, or in the event of the death of both the beneficiary and contingent beneficiary, benefits will be paid to the Insured's estate. If benefits are payable to the Insured's estate or to any person who is not competent to give us a valid release, the Company has the right to pay up to \$1,000 of those benefits to any person related to the Insured by blood or marriage who the Company believes is justly entitled to such payment. If the Company makes a payment under this provision in good faith, the Company will be released from liability to the extent of the payment.

PHYSICAL EXAMINATION: While a claim is pending, the Company has the right to have the Insured:

- (a) examined as often as is reasonably necessary. The Company will pay for such examination; and/or
- (b) interviewed by the Company's authorized representative to determine the extent of any Sickness or Accident for which the Insured has made a claim. This right may be used as often as reasonably required.

LEGAL ACTION: No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

CLAIM OVERPAYMENT: The Company has the right to recover from the Insured any amount that the Company determines to be an overpayment. The Insured has the obligation to refund to the Company any such amount.

If benefits are overpaid on any claim, the Insured must reimburse the Company within 30 days.

If reimbursement is not made in a timely manner, the Company has the right to:

- (a) recover such overpayments from:
 - (1) the Insured;
 - (2) any other person to or for whom payment was made;
 - (3) the Insured's estate;
 - (4) the Insured's beneficiary;
 - (5) any other organization; and
 - (6) any other insurance company;
- (b) reduce against any future benefits payable to the Insured, the Insured's estate, the Insured's survivors, or the Insured's beneficiary, until full reimbursement is made. Payments for future benefits will continue when the overpayment has been fully recovered;
- (c) refer the Insured's unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.

CLAIMS

SECTION 8 GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
- (c) the Insured's application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or the Insured are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to the Insured.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of the Company. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the Insured's Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Critical Illness (as defined in the Policy) that starts after such 2-year period.

GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to Us, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

CERTIFICATES: An Individual Certificate will be issued to the Insured. The Certificate will describe:

- (a) the benefits under the Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to the Insured, only the last one issued will be in effect.

MISSTATEMENT OF FACTS: If relevant facts regarding the Insured are not accurate:

- (a) a fair adjustment of premium will be made; and
- (b) the true facts will decide if and in what amount of insurance coverage is valid.

CONFORMITY WITH STATE LAWS: A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

CHANGE OF BENEFICIARY: The Insured may change the beneficiary at any time by giving the Company written notice. The effective date of the beneficiary change will be the date the Company records the change at our home office.

GENPROV



Our Family, Dedicated To Yours.®

[2000 N. CLASSEN BOULEVARD, OKLAHOMA CITY, OKLAHOMA 73106]

Go paperless! Access your plan certificate and other information at www.americanfidelity.com

CERTIFICATE OF INSURANCE

American Fidelity Assurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain eligible persons, as described in the Policy.

This Certificate describes the benefits and provisions of the group Policy and becomes Your Certificate of insurance only if:

- (1) You are eligible for the insurance (see Eligibility on Schedule of Benefits);
- (2) You are on Active Employment on the date it is to take effect; and
- (3) You become insured and remain insured in accordance with all of the provisions of the Policy.

Further, the insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date.)

No agent may change the Policy or waive any of its provisions.

This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF, We cause this Certificate to take effect on the Effective Date.


President


Secretary

GROUP CRITICAL ILLNESS LIMITED BENEFIT CERTIFICATE

**THIS CERTIFICATE OFFERS LIMITED BENEFITS.
PLEASE READ YOUR CERTIFICATE CAREFULLY.
ALL BENEFITS ARE PAID DIRECTLY TO YOU.**

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

FP

TABLE OF CONTENTS

Schedule of Benefits

Section 1Definitions

Section 2.....Eligibility and Effective Date

Section 3..... Benefits

Section 4.....Limitations and Exclusions

Section 5..... Termination of Insurance

Section 6.....Premium Calculation and Payment

Section 7..... Claims

Section 7.....General Provisions

[Application]

TC

SCHEDULE OF BENEFITS

PLAN: [1]

POLICYHOLDER: [ABC Employer]

POLICY NUMBER: [G-XXX-2T]

CERTIFICATE EFFECTIVE DATE: [January 30, 2013]

ELIGIBILITY: [All active permanent certified and administrative employees.] [As defined by the Policyholder]

CRITICAL ILLNESS BENEFIT

Insured
[[**\$5,000 up to \$100,000**] per Critical Illness] **OR**
[Please refer to Your individual application or enrollment form]

Dependent Child
[25% of the Insured's Critical Illness Benefit] **OR**
[[**\$1250 up to \$25,000**] per Critical Illness]

CRITICAL ILLNESS: Maximum of one Critical Illness Benefit amount payable per Critical Illness per Covered Person.

Heart Attack [Coronary Artery Bypass Surgery] Partial payments for Coronary Artery Bypass Surgery reduces the Heart Attack benefit. At no time will combined payments for any heart related benefits exceed 100% of the Critical Illness Benefit Amount.]	[50%, 100%] 25%
Permanent Damage Due To Stroke	[50%, 100%]
End Stage Renal Failure	[50%, 100%]
Major Organ Failure	[50%, 100%]
Permanent Paralysis Due To A Covered Accident	[50%, 100%]

[RECURRENT BENEFIT: 50% of the Critical Illness Benefit
Maximum of one Recurrent Benefit payable per Recurrent Diagnosis, per Covered Person, for a recurrent diagnosis of Heart Attack, Major Organ Failure, or Permanent Damage Due to Stroke.]

[HEALTH SCREENING BENEFIT: **[\$50, \$75, \$100]** per Calendar Year]

SB

SECTION 1 DEFINITIONS

ACCIDENT means a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity.

ACTIVE EMPLOYMENT means that You are:

- (a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Employment on a day which is not a scheduled work day only if You are not disabled and would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

CERTIFICATE means the individual Certificate issued to You. It describes the coverage under the Policy.

[CORONARY ARTERY BYPASS SURGERY means open heart surgery performed by a Physician to correct Coronary Artery Disease with bypass grafts. Coronary Artery Bypass Surgery does not include balloon angioplasty, laser angioplasty, stenting, valve replacement surgery, or procedures other than Coronary Artery Bypass Surgery.]

CORONARY ARTERY DISEASE means a severe narrowing or blockage of one or more coronary arteries.

COVERED PERSON(S) means You and Your eligible Dependent Child whose coverage is in force. (See Section 2 – Eligibility and Effective Date.)

CRITICAL ILLNESS: End Stage Renal Failure, Heart Attack (including Coronary Artery Bypass Surgery), Major Organ Failure, Permanent Damage Due To A Stroke, or Permanent Paralysis Due To A Covered Accident, as defined in the Policy, for which a positive diagnosis is made by a Physician.

CRITICAL ILLNESS BENEFIT AMOUNT: The amount shown on the Schedule of Benefits for the Covered Person.

DEPENDENT CHILD means:

- (a) Your child (natural, step, adopted, or a minor for whom guardianship is granted to You by court or testamentary appointment, other than temporary guardianship of less than 12 months duration) who is less than **[26 to 31]** years of age; or
- (b) Your child who becomes incapable of self-support because of mental or physical handicap while covered under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on You for support and maintenance. We must receive proof of incapacity as soon as reasonably possible. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age **[26 to 31]**; or
- (c) any minor under Your charge, care and control, who has been placed in Your home for adoption and is less than **[26 to 31]** years of age.

The term Dependent Child does not include Your grandchild (unless required by law).

EFFECTIVE DATE means the date described in the Policy. The date shown in Your individual Certificate or Policy will be Your Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

END STAGE RENAL FAILURE means renal disease resulting in irreversible failure of both kidneys to function and which requires regular dialysis or renal transplantation to sustain life.

HEART ATTACK means an acute Myocardial Infarction due to Coronary Artery Disease resulting in death of a portion of the heart muscle. Diagnosis must be supported by onset of new symptoms and any of the following: EKG changes, elevation of biochemical markers, or imaging studies, consistent with an acute myocardial infarction. In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack will be acceptable.

Heart attack does not include congestive heart failure, atherosclerotic heart disease, angina, cardiac arrest, or any other disease or injury involving the cardiovascular system.

INSURED (You or Your) means a person whose coverage has been applied for and is in force under the terms of the Policy.

MAJOR ORGAN FAILURE means the diagnosis by a Physician of failure of the heart, liver, lung, or entire pancreas due to end stage organ failure, which results in the Covered Person being placed on the United Network for Organ Sharing (UNOS) list for a transplant.

OCCURRENCE DATE must occur on or after the Covered Person's Effective Date and while coverage is in force. The Occurrence Date for each of the Critical Illnesses is as follows:

- Heart Attack - the date the death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack definition;
- Coronary Artery Bypass Surgery - the date the Covered Person undergoes Coronary Artery Bypass Surgery;
- Major Organ Failure - the date the Covered Person is placed on the UNOS list for transplantation;
- Permanent Damage Due To A Stroke - the date new neurological deficits from the Stroke [are diagnosed as permanent] [have persisted for a minimum of [7, 14, 30] consecutive days];
- End Stage Renal Failure - the date End Stage Renal Failure is diagnosed.
- Permanent Paralysis Due To A Covered Accident – the date paralysis is diagnosed as permanent.

PERMANENT DAMAGE DUE TO A STROKE means permanent neurological damage to the brain which results from an acute or sub-acute interruption of blood flow to brain tissue, including infarction of brain tissue due to embolism, thrombus or bleeding. Diagnosis should be made by a physician, demonstrated by imaging (CT or MRI), and must result in permanent neurological deficits. Permanent Damage Due to a Stroke does not include Transient Ischemic Attacks (TIA).

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT (or Paralysis) means injuries to the spinal cord due to a Covered Accident which result in the loss of use of two or more limbs. Paralysis must be diagnosed as permanent, total, and irreversible.

PHYSICIAN means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for Your Sickness or Accident; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat Your condition.

The term Physician does not include You, anyone related to You by blood or marriage, or anyone living in Your household.

POLICY means the Policy issued to the Policyholder that covers You.

POLICYHOLDER means the association, employer, labor union, or trustee who holds the Policy.

[RECURRENT DIAGNOSIS: A second Occurrence Date for a Heart Attack, Permanent Damage Due To A Stroke, or Major Organ Failure, for which a Critical Illness Benefit Amount was previously paid under the Policy.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while Your coverage is in force; and
- (b) be separated by at least 180 days.]

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

SICKNESS: Any illness or disease which is the direct cause of the Critical Illness and begins while the Covered Person's coverage is in force.

TRANSIENT ISCHEMIC ATTACK (or TIA) means a neurological condition or event with the signs and symptoms of a Stroke, but which disappear within 24 hours with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies. TIA's are not covered by the Policy.

DEF-AR

**SECTION 2
ELIGIBILITY AND EFFECTIVE DATE**

[Your Eligibility: If You:

- (a) are on Active Employment as an employee of the employer, or member or employee of a member of the Policyholder;
- (b) qualify as an eligible Insured, as defined in the Policyholder's application; and
- (c) meet the definition of Eligibility, as stated in the Schedule,

You are eligible to be insured under the Policy. Evidence of insurability acceptable to Us may be required.

Your Effective Date: If You are eligible, Your coverage or changes in coverage including increases will begin on the later of the requested Effective Date or the date We approve the written application, if You:

- (a) apply in writing on or before said Effective Date;
- (b) meet Our underwriting rules;
- (c) are on Active Employment, as defined in Section 1; and
- (d) have paid all applicable premiums due.

If You are not on Active Employment due to an Accident or Sickness when Your coverage would otherwise take effect, coverage will take effect on the first of the month following the date You return to Active Employment for at least 5 consecutive workdays.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.

Your Dependent Child: Coverage for Your Dependent Child will also become effective on Your Effective Date or on the date You acquire a Dependent Child or Children, whichever is later, as long as Your coverage is in force. Application for coverage, evidence of insurability, or additional premium is not required for Your Dependent Child.

EFF-VOLJ

[ELIGIBILITY

All persons who:

- (a) are on Active Employment as employees of the employer; or members or employees of a member of the Policyholder;
- (b) qualify as eligible Covered Persons as defined by the employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

will be enrolled automatically by the Employer.

EFFECTIVE DATE: WHEN COVERAGE BEGINS

Coverage for all Covered Persons will begin on the date You become eligible if Your employer has paid all applicable premiums.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

EFF-EMPPD]

SECTION 3 BENEFITS

CRITICAL ILLNESS

A benefit is payable once per Covered Person for each Critical Illness shown on the Schedule of Benefits. After the Occurrence Date of the first Critical Illness payable under the Policy or any attached riders, a benefit for each subsequent Critical Illness will only be payable if the Occurrence Date:

- (a) is for a Critical Illness for which a Critical Illness Benefit Amount has not been previously paid;
- (b) is separated by more than 90 days following the last Critical Illness Occurrence Date; and
- (c) occurs while the Covered Person is insured under the Policy, Certificate or any attached riders.

Any critical illness not specifically listed in the Critical Illness definition is not payable under the Policy. If the Occurrence Date of two or more Critical Illnesses is separated by less than 90 days, We will pay only one Critical Illness Benefit Amount. We will pay for the Critical Illness that occurred first. Critical Illnesses with a Critical Illness Benefit Amount of less than 100% are not subject to this requirement.

HEART ATTACK: Following the Occurrence Date of a Covered Person's Heart Attack, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Heart Attack must occur after the Covered Person's Effective Date.

If a Covered Person receives a benefit for a Coronary Artery Bypass Surgery and is later diagnosed with a Heart Attack, We will pay the Heart Attack benefit less the amount received for such Coronary Artery Bypass Surgery. For all heart related benefits combined, We will not pay more than 100% of the Critical Illness Benefit Amount shown on the Schedule of Benefits for the Covered Person.

[Coronary Artery Bypass Surgery: Following the Occurrence Date of a Covered Person's Coronary Artery Bypass Surgery, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Coronary Artery Bypass Surgery must occur after the Covered Person's Effective Date. This benefit is payable only once per Covered Person per lifetime. If a Covered Person has previously received a benefit for Heart Attack, then 100% of the heart related benefits have been exhausted and this benefit is not payable. The Coronary Artery Bypass Surgery Occurrence Date is not subject to the 90-day separation period.]

PERMANENT DAMAGE DUE TO A STROKE: Following the Occurrence Date of a Covered Person's Permanent Damage Due To A Stroke, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The stroke and the Permanent Damage Due to a Stroke must occur after the Covered Person's Effective Date.

MAJOR ORGAN FAILURE: Following the Occurrence Date of a Covered Person's Major Organ Failure, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Major Organ Failure must occur after the Covered Person's Effective Date.

END STAGE RENAL FAILURE: Following the Occurrence Date of a Covered Person's End Stage Renal Failure, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The End Stage Renal Failure must occur after the Covered Person's Effective Date.

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT: Following the Occurrence Date of a Covered Person's Paralysis, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Accident and the Paralysis must occur after the Covered Person's Effective Date.

BEN

[RECURRENT BENEFIT: If a Covered Person receives a Recurrent Diagnosis, We will pay an additional benefit for such Critical Illness equal to 50% of the Critical Illness Benefit Amount.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while the policy is in force; and
- (b) be separated by at least 180 days.

This benefit is payable once per Covered Person for each Recurrent Diagnosis of a Critical Illness. Once a Recurrent Diagnosis Benefit has been paid for a Critical Illness, no further Occurrence Dates of that same Critical Illness will be payable. Any Critical Illness not specifically listed in the Recurrent Diagnosis definition is not payable under this benefit.

RB]

[HEALTH SCREENING BENEFIT

We will pay the Health Screening Benefit amount shown on the Schedule of Benefits for You when You receive one of the Health Screening tests listed below:

- | | |
|------------------------------|--|
| Blood Test For Triglycerides | Exercise Or Pharmacologic Stress Test |
| Neuroimaging Studies | Fasting Blood Glucose Test |
| Doppler Ultrasound | Serum Cholesterol Test To Determine HDL And LDL Levels |
| Echocardiogram | Electrocardiogram (EKG) |

The Health Screening Benefit amount shown in the Schedule of Benefits will be payable for You a total of once per Calendar Year as long as Your coverage under this benefit is in force. Calendar Year means the period beginning on January 1 and ending on December 31 of the same year. Coverage for Health Screening Benefits is not provided for Your Dependent Child.

HSB]

SECTION 4 LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITION LIMITATION

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Occurrence Date occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months.

PE

PRE-EXISTING CONDITION means a disease, Accident, Sickness, physical condition or mental illness for which a Covered Person has experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Covered Person's Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness, physical condition or mental illness.

PEDEF

EXCLUSIONS: We will not pay benefits for any Critical Illness resulting from or caused, whether directly or indirectly, by:

- (a) An intentionally self-inflicted Accident or Sickness.
- (b) Suicide or attempted suicide, while sane or insane.
- (c) Participating in a riot, insurrection, rebellion, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority.
- (d) Being intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions. Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the event that caused the Critical Illness occurred.
- (e) Committing, or attempting to commit a felony.
- (f) Being incarcerated in any type of penal institution.
- (g) Alcoholism or drug addiction.
- (h) A diagnosis received outside the United States, or its territories, that cannot be confirmed by a Physician licensed and practicing in the United States.

EXC

[CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

For all employees who were insured by their current Employer's prior group critical illness carrier on the day preceding the Employer's Effective Date of coverage under the Policy and who became insured with American Fidelity Assurance Company on the Employer's Effective Date of coverage under the Policy, coverage for Pre-Existing Conditions will be administered as follows:

If You were not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group critical illness carrier, there would be no Pre-Existing Condition Limitation applied under the American Fidelity plan. If You were not eligible for benefits under the prior group critical illness carrier's plan because of a Pre-Existing Condition Limitation, You would not be eligible for benefits under the American Fidelity plan until such time as You had satisfied the Pre-Existing Condition Limitation described in the Policy. Credit will be given for any portion of time satisfied with Your current Employer's prior group critical illness carrier provided You replaced that coverage with American Fidelity's insurance on the Effective Date. This provision applies only up to the amount of coverage You held with the prior group critical illness carrier on the day preceding American Fidelity's Effective Date or [\$10,000, \$15,000, \$20,000], whichever is less. Proof of Continuity of Coverage must be supplied upon request.

For those employees who were not enrolled under the current employer's prior group critical illness carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

CCJ

**SECTION 5
TERMINATION OF INSURANCE**

Your Coverage: Your Insurance coverage will end on the earliest of these dates:

- (a) the date You no longer qualify as an Insured;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Policy is discontinued;
- (d) the date You retire;
- (e) if You work for an employer employing less than 20 employees on a typical work day in the preceding Calendar Year, the date You attain age 75;
- (f) the date You cease to be on Active Employment, as defined in Section 1;
- (g) the date You cease employment with the employer through whom You originally became insured under the Policy;
- (h) the date of Your death;
- (i) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for You.

Coverage On Your Dependent Child: The coverage on Dependent Child(ren) will end on the earliest of these dates:

- (a) the date Your coverage terminates;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Covered Person no longer meets the definition of Dependent Child, as defined in Section 1;
- (d) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for each Dependent Child.

If termination of coverage occurs because of termination of Your employment or contract with the Policyholder, such termination shall be without prejudice to any Occurrence Date which commenced while this Certificate was in force.

We may end the coverage of any Covered Person who submits a fraudulent claim.

We or the Policyholder, may end the Policy and/or optional benefit riders on any premium due date. Thirty-one days advance written notice of such termination must be given.

LEAVE OF ABSENCE: Your coverage may be continued for up to [1 year, 2 years] during a Leave of Absence approved in writing by Your Employer.

TOI

[PORTABILITY

If You no longer meet the definition of Eligibility as described in the Schedule of Benefits You may continue the coverage provided in this Certificate, including any attached riders. You are eligible to continue Your coverage if:

- (a) You have been continuously covered under the Policy for at least 12 consecutive months prior to the date Your coverage under the Policy ends;
- (b) You notify Us no later than 30 days after Your Eligibility under the Policy ends and submit the appropriate premium;
- (c) Your coverage under the Policy is in force on the day Your Eligibility ends; and
- (d) the Policy is still in force on the date Your coverage under this Provision becomes effective.

Your coverage under this Provision will remain the same as it was on the day prior to the date Your coverage under this Provision begins. All provisions of the Policy remain applicable. No application or evidence of insurability will be required.

Any plan or rate changes made to the Policy will also be applicable to Your coverage under the Portability Provision. Thirty-one days advance written notice of any such change will be provided.

Coverage under the Portability Provision will end on the earliest of these dates:

- (a) the end of the month following Your 75th birthday;
- (b) the last day of the month ending ten (10) years from the date Your coverage became effective under this Provision;
- (c) the date the Policy is terminated; or
- (d) the date You fail to pay the required premium.

You may cancel Your coverage under this Provision at anytime by providing written notice. We will refund any unearned premium to You. Cancellation will not prejudice any claim that originated prior to the date cancellation took effect.

PORT]

SECTION 6
PREMIUM CALCULATION AND PAYMENT

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before Your Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

- (a) Our Home Office; or
- (b) an authorized entity of Ours.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases Our liability, premium rates may be changed on the date the liability is increased.

PREM

SECTION 7 CLAIMS

NOTICE OF CLAIM: You should notify Us, in writing, within 30 days after a Covered Person incurs a loss covered by the Policy. If it is not reasonably possible to give notice within this time period, Your claim will not be denied or reduced due to the delay. Send Your written notice to Us at the following address:

American Fidelity Assurance Company
P.O. Box [25160, 268898, 248850]
Oklahoma City, Oklahoma [73125, 73126, 73124-8850]

CLAIM FORMS: Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

PROOF OF LOSS: Proof of Loss must be given to Us within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at Your expense, includes, but is not limited to, the following documentation:

- (a) certification by a Physician of the Critical Illness, as supported by a completed Claim Form provided by the Company, or some other mutually agreed-upon means;
- (b) the Occurrence Date of the Covered Person's Critical Illness;
- (c) the cause of the Covered Person's Critical Illness;
- (d) the objective test results, or documentation satisfactory to Us, confirming the Critical Illness as required in the definition of such Critical Illness; and
- (e) a copy of the death certificate, if the Critical Illness resulted in the Covered Person's death.

TIME OF PAYMENT OF CLAIMS: Benefits for a covered loss will be paid promptly upon receipt of written Proof of Loss.

PAYMENT OF BENEFITS: We will pay all benefits to You. Any benefits that have not been paid at the time of Your death will be paid to Your designated beneficiary, if living, or to the contingent beneficiary. If no such designation is made, or in the event of the death of both the beneficiary and contingent beneficiary, benefits will be paid to Your estate. If benefits are payable to Your estate or to any person who is not competent to give us a valid release, We have the right to pay up to \$1,000 of those benefits to any person related to You by blood or marriage who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

PHYSICAL EXAMINATION: While a claim is pending, We have the right to have You:

- (a) examined as often as is reasonably necessary. We will pay for such examination; and/or
- (b) interviewed by Our authorized representative to determine the extent of any Sickness or Accident for which You have made a claim. This right may be used as often as reasonably required.

LEGAL ACTION: No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

CLAIM OVERPAYMENT: We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

- (a) recover such overpayments from:
 - (1) You;
 - (2) any other person to or for whom payment was made;
 - (3) Your estate;
 - (4) Your beneficiary;
 - (5) any other organization; and
 - (6) any other insurance company;
- (b) reduce against any future benefits payable to You, Your estate, Your survivors, or Your beneficiary, until full reimbursement is made. Payments for future benefits will continue when the overpayment has been fully recovered;
- (c) refer Your unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.

CLAIMS

SECTION 8 GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
- (c) Your application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to You.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of Ours. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from Your Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Critical Illness (as defined in the Policy) that starts after such 2-year period.

GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to Us, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

CERTIFICATES: An Individual Certificate will be issued to You. The Certificate will describe:

- (a) the benefits under the Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to You, only the last one issued will be in effect.

MISSTATEMENT OF FACTS: If relevant facts regarding You are not accurate:

- (a) a fair adjustment of premium will be made; and
- (b) the true facts will decide if and in what amount of insurance coverage is valid.

CONFORMITY WITH STATE LAWS: A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

CHANGE OF BENEFICIARY: You may change the beneficiary at any time by giving Us written notice. The effective date of the beneficiary change will be the date We record the change at Our home office.

GENPROV



Our Family, Dedicated To Yours.®

[2000 N. Classen Boulevard

Oklahoma City, OK 73106]

Effective Date: _____
(If different from the Policy or Certificate)

CANCER CRITICAL ILLNESS LIMITED BENEFIT RIDER

The Policy or Certificate to which this Rider is attached is hereby amended as follows:

You or **Your** as used throughout shall mean the Insured or the Insured's. **We, Us, Our** shall mean the Company.

RIDER SCHEDULE

**[INSURED
CANCER CRITICAL ILLNESS BENEFIT]
[\$5,000 up to \$100,000] OR [Please refer to your
individual application or enrollment form]**

**[DEPENDENT CHILD
CANCER CRITICAL ILLNESS BENEFIT]
[25% of the Insured's Cancer Critical Illness Benefit]
OR [\$1250 up to \$25,000]**

INVASIVE CANCER:

[50%, 100%]

Carcinoma In Situ (or Early Stage Cancer):

25% of the Invasive Cancer Benefit

Partial payments for Carcinoma in Situ reduces the Invasive Cancer benefit. At no time will combined payments for any Cancer related benefits exceed 100% of the Cancer Critical Illness Benefit Amount.

RIDER DEFINITIONS

CARCINOMA IN SITU (or Early Stage Cancer) means a malignant tumor which has not yet become invasive but is confined to the layer of cells from which it arose.

Carcinoma In Situ includes an early stage of internal cancer in which the tumor, or tumor cells, are confined to the organ or tissue where it first developed. The disease has not invaded other parts of the organ, tissue, or spread to distant parts of the body. Examples of Early Stage Cancer include, but are not limited to:

- (a) for prostate cancer: a diagnosis of Stage A1 or A2, or a diagnosis of T1a or T1b or equivalent staging; or
- (b) for breast cancer: a diagnosis of Tis; or
- (c) for colon cancer: a diagnosis of Stage 0, or Tis, or equivalent staging; or
- (d) for melanoma: a diagnosis of Stage 0, or Tis, or equivalent staging; or
- (e) any other cancer which meets the definition of Early Stage Cancer.

Carcinoma in Situ does not include Skin Cancer as defined in this Rider. Skin Cancer is not covered in this Rider.

Carcinoma In Situ and Early Stage Cancer is not: Myelodysplastic and non-malignant myeloproliferative disorders, Atypia, Non-malignant monoclonal gamopathy, or pre-malignant lesions, benign tumors or polyps.

CRITICAL ILLNESS means, in addition to the Critical Illnesses listed in the Policy, Carcinoma in Situ and Invasive Cancer as defined in this Rider, for which a positive diagnosis is made by a Physician.

INVASIVE CANCER means a disease that is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. For all cancers, the staging, as supported by medical documents including pathology, surgical and clinical information, will be used to determine if the cancer in question meets the definition of Invasive Cancer.

Invasive Cancer does not include Carcinoma in Situ or Skin Cancer as defined in this Rider.

Invasive Cancer is not: Myelodysplastic and non-malignant myeloproliferative disorders, Atypia, Non-malignant monoclonal gamopathy, or pre-malignant lesions, benign tumors or polyps.

OCCURRENCE DATE must occur on or after the Covered Person's Effective Date and while coverage is in force. The Occurrence Date for the Cancer Critical Illness Benefit is the date the Covered Person is diagnosed by a Physician with Carcinoma in Situ or Invasive Cancer.

SKIN CANCER means a cancer or malignant neoplasm of the skin that does not invade bone or does not metastasize to internal/visceral organs. For the purpose of this definition, melanoma is not Skin Cancer. For all cancers, the staging, as supported by medical documents including pathology, surgical and clinical information, will be used to determine if the cancer in question meets the definition of Skin Cancer. Skin Cancer is not covered by this rider.

BENEFITS

INVASIVE CANCER: Following the Occurrence Date of a Covered Person's Invasive Cancer, We will pay the percentage of the Cancer Critical Illness Benefit Amount as shown on the Schedule. The Invasive Cancer must occur after the Covered Person's Effective Date.

If a Covered Person receives a benefit for Carcinoma In Situ, and is later diagnosed with Invasive Cancer, We will pay the Invasive Cancer benefit less the amount received for Carcinoma In Situ. For all cancer related benefits combined, We will not pay more than 100% of the Cancer Critical Illness Benefit Amount shown on the Schedule for the Covered Person.

Carcinoma in Situ (or Early Stage Cancer): Following the Occurrence Date of a Covered Person's Carcinoma in Situ, We will pay the percentage of the Cancer Critical Illness Benefit Amount as shown on the Rider Schedule. The Carcinoma in Situ must occur after the Covered Person's Effective Date. This benefit is payable only once per Covered Person's per lifetime.

[HEALTH SCREENING BENEFIT

The Health Screening Benefit in the Policy is extended to include a screening test that is generally medically recognized to detect internal Cancer including, but not limited to:

Biopsy for skin cancer	Magnetic Resonance Imaging (MRI)
Bone marrow testing	Flexible sigmoidoscopy
Breast thermography	Hemoccult stool analysis
Breast ultrasound	Serum protein electrophoresis (myeloma test)
CA 125 (ovarian cancer blood test)	Mammography (including breast ultrasound)
CA 15-3 (breast cancer blood test)	Pap Smear (including ThinPrep Pap Test)
CEA (colon cancer blood test)	Positron Emission Tomography (PET scan)
Chest X-Ray	PSA (prostate cancer blood test)
Colonoscopy	Thermography
Computerized Axial Tomography (CAT scan)	Virtual colonoscopy

The Health Screening Benefit amount shown in the Schedule of Benefits will be payable for You a total of once per Calendar Year as long as Your coverage under this benefit is in force. Calendar Year means the period beginning on January 1 and ending on December 31 of the same year. Coverage for Health Screening Benefits is not provided for Your Dependent Child.]

LIMITATIONS AND EXCLUSIONS

The Pre-Existing Limitations and Exclusions stated in the Group Critical Illness Policy to which this Rider is attached are also applicable to the provisions of this Rider.

TERMINATION OF RIDER

Your coverage under this Rider will end on the earliest of:

- (a) the date 100% of Your Cancer Critical Illness Benefit has been paid;
- (b) the date the Certificate to which this Rider is attached terminates;
- (c) the end of the last period for which premium payment has been made to Us;
- (d) the date You notify Us in writing to terminate coverage;
- (e) the date You no longer meet the Eligibility requirements as stated in the Policy;
- (f) the end of the month following Your 75th birthday;
- (g) the date You die;
- (h) the date this Rider is discontinued;
- (i) the date the Policy is discontinued.

This Rider is subject to all the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.



Secretary



Our Family, Dedicated To Yours.®

[2000 N. Classen Boulevard

Oklahoma City, OK 73106]

Effective Date: _____
(If different from the Policy or Certificate)

SPOUSAL CRITICAL ILLNESS LIMITED BENEFIT RIDER

The Policy or Certificate to which this Rider is attached is hereby amended by adding a Spousal Critical Illness Limited Benefit for Your Spouse. The Benefits of this Rider will be paid to You.

You or Your as used throughout shall mean the Insured or the Insured's. We, Us, Our shall mean the Company.

RIDER SCHEDULE

SPOUSAL CRITICAL ILLNESS BENEFIT: **[\$2,500 up to \$100,000]** per Critical Illness] **OR**
[Please refer to Your individual application or enrollment form]

Heart Attack **[50%, 100%]**
[Coronary Artery Bypass Surgery **25%**
Partial payments for Coronary Artery Bypass Surgery reduces the Heart Attack benefit. At no time will combined payments for any heart related benefits exceed 100% of the Critical Illness Benefit Amount.]

Permanent Damage Due To Stroke **[50%, 100%]**

End Stage Renal Failure **[50%, 100%]**

Major Organ Failure **[50%, 100%]**

Permanent Paralysis Due To A Covered Accident **[50%, 100%]**

RIDER DEFINITIONS

COVERED PERSON(S) as stated in the Certificate is extended to include Your Spouse who is eligible for coverage under this Rider and for whom coverage is in force.

SPOUSE means Your lawful spouse who lives with You.

ELIGIBILITY AND EFFECTIVE DATE

Spouse Eligibility: If spouse coverage is available under the Policy, You will be eligible for such coverage on:

- (a) the day You become eligible for coverage; or
- (b) the day You acquire a Spouse;

whichever is later.

Spouse coverage may be elected by:

- (a) completing and signing an application within 31 days of the date Your Spouse becomes eligible; and
- (b) by completing any required form of payroll deduction authorization.

Spouse Effective Date: The Effective Date of coverage for Your Spouse will be the first of the month following:

- (a) Our acceptance of the application; and
- (b) receipt of the first premium.

However, if on such date Your coverage has not yet taken effect, the Effective Date for Spouse coverage will be the same as Your Effective Date.

[BENEFITS

HEALTH SCREENING BENEFIT

The Health Screening Benefit in the Policy is extended to include a screening test for Your Spouse when Your Spouse receives one of the Health Screening tests listed below:

- | | |
|------------------------------|--|
| Blood Test For Triglycerides | Exercise Or Pharmacologic Stress Test |
| Neuroimaging Studies | Fasting Blood Glucose Test |
| Doppler Ultrasound | Serum Cholesterol Test To Determine HDL And LDL Levels |
| Echocardiogram | Electrocardiogram (EKG) |

The Health Screening Benefit amount shown in the Policy Schedule of Benefits will be payable for Your Spouse a total of once per Calendar Year as long as Your Spouse's coverage under this Rider is in force. Calendar Year means the period beginning on January 1 and ending on December 31 of the same year.]

PRE-EXISTING CONDITION LIMITATION

The Pre-Existing Condition Limitation stated in the Group Critical Illness Policy to which this Rider is attached is also applicable to Your covered Spouse.

TERMINATION OF INSURANCE

Coverage on Your Covered Spouse: Insurance for Your covered Spouse will cease on the earliest of these dates:

- (a) the date Your coverage terminates;
- (b) the end of the premium term in which a divorce, annulment, or legal separation is obtained;
- (c) the end of the Month in which we receive a written request from You to delete Your Spouse;
- (d) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for Your Spouse;
- (e) the date of Your 75th birthday;
- (f) the date of Your Spouse's death.

GENERAL PROVISIONS

OTHER INSURANCE WITH THIS INSURER: If You or Your Spouse have more than one Group Critical Illness Certificate in force with Us at any one time, only one certificate may be in force. We will return all premiums paid for all other such Group Critical Illness Certificates for any months when premiums were paid on more than one Certificate with Us.

TERMINATION OF RIDER

Your Spouse's coverage under this Rider will end on the earliest of:

- (a) the date the Certificate to which this Rider is attached terminates;
- (b) the end of the last period for which premium payment has been made to Us;
- (c) the date You notify Us in writing to terminate coverage;
- (d) the date Your Spouse no longer meets the Eligibility requirements as stated in the Policy;
- (e) the date 100% of the Spousal Critical Illness Benefit Amount has been paid to You;
- (f) the date which a divorce, annulment, or legal separation is obtained;
- (g) the end of the month following Your Spouse's 75th birthday;
- (h) the end of the month following Your 75th birthday;
- (i) the date Your Spouse dies;
- (j) the date this Rider is discontinued;
- (k) the date the Policy is discontinued.

This Rider is subject to all the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.



Secretary



Our Family, Dedicated To Yours.®

[2000 N. Classen Boulevard

Oklahoma City, OK 73106]

Effective Date: _____
(If different from the Policy or Certificate)

SPOUSAL CANCER CRITICAL ILLNESS LIMITED BENEFIT RIDER

The Policy or Certificate to which this Rider is attached is hereby amended by adding a Spousal Critical Illness Limited Benefit for Your Spouse. The Benefits of this Rider will be paid to You.

You or **Your** as used throughout shall mean the Insured or the Insured's. **We, Us, Our** shall mean the Company.

RIDER SCHEDULE

SPOUSAL CANCER CRITICAL ILLNESS BENEFIT: **[\$2,500 up to \$100,000] OR** [Please refer to your individual application or enrollment form]

INVASIVE CANCER: **[50%, 100%]**
Carcinoma In Situ or Early Stage Cancer: 25% of the Invasive Cancer Benefit
Partial payments for Carcinoma in Situ reduces the Invasive Cancer benefit. At no time will combined payments for any Cancer related benefits exceed 100% of the Cancer Critical Illness Benefit Amount.

RIDER DEFINITIONS

COVERED PERSON(S) as stated in the Certificate is extended to include Your Spouse who is eligible for coverage under this Rider and for whom coverage is in force.

SPOUSE means Your lawful spouse who lives with You.

ELIGIBILITY AND EFFECTIVE DATE

Spouse Eligibility: If spouse coverage is available under the Policy, You will be eligible for such coverage on:

- (a) the day You become eligible for coverage; or
- (b) the day You acquire a Spouse;

whichever is later.

Spouse coverage may be elected by:

- (a) completing and signing an application within 31 days of the date Your Spouse becomes eligible; and
- (b) by completing any required form of payroll deduction authorization.

Spouse Effective Date: The Effective Date of coverage for Your Spouse will be the first of the month following:

- (a) Our acceptance of the application; and
- (b) receipt of the first premium.

However, if on such date Your coverage has not yet taken effect, the Effective Date for Spouse coverage will be the same as Your Effective Date.

CARCINOMA IN SITU (or Early Stage Cancer) means a malignant tumor which has not yet become invasive but is confined to the layer of cells from which it arose.

Carcinoma In Situ includes an early stage of internal cancer in which the tumor, or tumor cells, are confined to the organ or tissue where it first developed. The disease has not invaded other parts of the organ, tissue, or spread to distant parts of the body. Examples of Early Stage Cancer include, but are not limited to:

- (a) for prostate cancer: a diagnosis of Stage A1 or A2, or a diagnosis of T1a or T1b or equivalent staging; or
- (b) for breast cancer: a diagnosis of Tis; or
- (c) for colon cancer: a diagnosis of Stage 0, or Tis, or equivalent staging; or
- (d) for melanoma: a diagnosis of Stage 0, or Tis, or equivalent staging; or
- (e) any other cancer which meets the definition of Early Stage Cancer.

Carcinoma in Situ does not include Skin Cancer as defined in this Rider. Skin Cancer is not covered in this Rider.

Carcinoma In Situ and Early Stage Cancer is not: Myelodysplastic and non-malignant myeloproliferative disorders, Atypia, Non-malignant monoclonal gamopathy, or pre-malignant lesions, benign tumors or polyps.

CRITICAL ILLNESS means, in addition to the Critical Illnesses listed in the Spousal Critical Illness Rider, Carcinoma in Situ and Invasive Cancer as defined in this Rider, for which a positive diagnosis is made by a Physician.

INVASIVE CANCER means a disease that is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. For all cancers, the staging, as supported by medical documents including pathology, surgical and clinical information, will be used to determine if the cancer in question meets the definition of Invasive Cancer.

Invasive Cancer does not include Carcinoma in Situ or Skin Cancer as defined in this Rider.

Invasive Cancer is not: Myelodysplastic and non-malignant myeloproliferative disorders, Atypia, Non-malignant monoclonal gamopathy, or pre-malignant lesions, benign tumors or polyps.

OCCURRENCE DATE must occur on or after Your Spouse's Effective Date and while coverage is in force. The Occurrence Date for the Cancer Critical Illness Benefit is the date Your Spouse is diagnosed by a Physician with Carcinoma in Situ/Early Stage Cancer, or Invasive Cancer.

SKIN CANCER means a cancer or malignant neoplasm of the skin that does not invade bone or does not metastasize to internal/visceral organs. For the purpose of this definition, melanoma is not Skin Cancer. For all cancers, the staging, as supported by medical documents including pathology, surgical and clinical information, will be used to determine if the cancer in question meets the definition of Skin Cancer. Skin Cancer is not covered by this rider.

BENEFITS

INVASIVE CANCER: Following the Occurrence Date of Your covered Spouse's Invasive Cancer, We will pay the percentage of the Cancer Critical Illness Benefit Amount as shown on the Schedule. The Invasive Cancer must occur after Your covered Spouse's Effective Date.

If Your covered Spouse receives a benefit for Carcinoma In Situ, and is later diagnosed with Invasive Cancer, We will pay the Invasive Cancer benefit less the amount received for Carcinoma In Situ. For all cancer related benefits combined, We will not pay more than 100% of the Cancer Critical Illness Benefit Amount shown on the Rider Schedule.

Carcinoma in Situ (or Early Stage Cancer): Following the Occurrence Date of Your covered Spouse's Carcinoma in Situ, We will pay the percentage of the Cancer Critical Illness Benefit Amount as shown on the Schedule. The Carcinoma in Situ must occur after Your Spouse's Effective Date. This benefit is payable only once in Your covered Spouse's lifetime.

[HEALTH SCREENING BENEFIT

The Health Screening Benefit amount shown in the Policy Schedule of Benefits will be paid when Your Spouse receives a screening test that is generally medically recognized to detect internal Cancer including, but not limited to:

Biopsy for skin cancer	Magnetic Resonance Imaging (MRI)
Bone marrow testing	Flexible sigmoidoscopy
Breast thermography	Hemoccult stool analysis
Breast ultrasound	Serum protein electrophoresis (myeloma test)
CA 125 (ovarian cancer blood test)	Mammography (including breast ultrasound)
CA 15-3 (breast cancer blood test)	Pap Smear (including ThinPrep Pap Test)
CEA (colon cancer blood test)	Positron Emission Tomography (PET scan)
Chest X-Ray	PSA (prostate cancer blood test)
Colonoscopy	Thermography
Computerized Axial Tomography (CAT scan)	Virtual colonoscopy

The Health Screening Benefit amount shown in the Schedule of Benefits will be payable for Your Spouse a total of once per Calendar Year as long as Your Spouse's coverage under this benefit is in force. Calendar Year means the period beginning on January 1 and ending on December 31 of the same year.]

PRE-EXISTING CONDITION LIMITATION

The Pre-Existing Condition Limitation stated in the Group Critical Illness Policy to which this Rider is attached is also applicable to Your covered Spouse.

GENERAL PROVISIONS

OTHER INSURANCE WITH THIS INSURER: If You or Your Spouse have more than one Group Critical Illness Certificate in force with Us at any one time, only one certificate may be in force. We will return all premiums paid for all other such Group Critical Illness Certificates for any months when premiums were paid on more than one Certificate with Us.

TERMINATION OF RIDER

Your Spouse's coverage under this Rider will end on the earliest of:

- (a) the date the Certificate to which this Rider is attached terminates; or
- (b) the end of the last period for which premium payment has been made to Us; or
- (c) the date You notify Us in writing to terminate coverage; or
- (d) the date Your Spouse no longer meets the Eligibility requirements as stated in this Rider; or
- (e) the date 100% of the Spousal Cancer Critical Illness Benefit Amount has been paid to You; or
- (f) the date which a divorce, annulment, or legal separation is obtained; or
- (g) the end of the month following Your Spouse's 75th birthday;
- (h) the end of the month following Your 75th birthday;
- (i) the date Your Spouse dies; or
- (j) the date this Rider is discontinued; or
- (k) the date the Policy is discontinued.

This Rider is subject to all the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy or Certificate to which it is attached.



Secretary

GROUP APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N. Classen Blvd Oklahoma City, Oklahoma 73106

--	--	--	--	--	--	--	--	--	--	--	--

1. PROPOSED INSURED INFORMATION:

Last Name _____ First Name _____ Full Middle Name _____ Suffix _____

Age _____ Date of Birth MM/DD/YYYY _____ Sex M F SSN _____ Requested Effective Date MM/DD/YYYY _____ Date of Employment MM/DD/YYYY _____

Residence Address: Number & Street (Not a P.O. Box) _____ Work Phone # () _____ Home Phone # () _____

City _____ State _____ Zip _____ Country of Citizenship _____

Mailing Address (if different than Residence) _____ City _____ State _____ Zip _____

Employer Name _____ Employer/MCP # _____ Salary: \$ _____ Occupation _____
 Annual Monthly

Are you currently able to perform the duties of your occupation? Yes No

Spouse Last Name _____ First Name _____ Middle Initial _____ SSN _____ Date of Birth _____ Country of Citizenship _____

Has any adult to be covered used any form of nicotine in the last 12 months? Applicant Yes No Spouse Yes No

Applicant's Email Address:

2. BENEFITS APPLIED FOR:

Product	New/Chg	Billing Distribution ID	MCH	Persons Covered ¹	Plan Code	Plan Amount	PREMIUM:			Total
							Employee	Employer	Mode	
[CI-Base]	<input type="checkbox"/>	<input type="checkbox"/>								
[CI-Cancer]	<input type="checkbox"/>	<input type="checkbox"/>								
[CI-Spouse]	<input type="checkbox"/>	<input type="checkbox"/>								
[CI-Sps-can]	<input type="checkbox"/>	<input type="checkbox"/>								
[DI]	<input type="checkbox"/>	<input type="checkbox"/>								
[DI Rider]	<input type="checkbox"/>	<input type="checkbox"/>								
[DI Rider]	<input type="checkbox"/>	<input type="checkbox"/>								
[DI Rider]	<input type="checkbox"/>	<input type="checkbox"/>								
[GAP Plan]	<input type="checkbox"/>	<input type="checkbox"/>								

¹z=Individual; y=Individual & Spouse; x=Individual, Spouse & Child(ren); v=Individual & Children; s=Spouse TOTAL

3. BENEFICIARY: Last Name _____ First Name _____ Middle Initial _____ Relationship _____ Country of Citizenship _____

4. ELECTION: I hereby enroll, add or change, as selected above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay.

5. ACKNOWLEDGMENT: I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
- If applying for disability income coverage, **OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.**
- "Pre-Existing Conditions" may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any. I further understand that any increase in coverage must be applied for and approved by the company, and as explained in my Certificate, a new Pre-Existing Condition period will apply with respect to the increase.

6. FRAUD NOTICE: Any person, who knowingly and with intent to injure or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information may be guilty of insurance fraud.

[BROCHURE(S) # _____ HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S).]

Applicant Signature or PIN _____ Date _____

Agent # _____ Agent Signature or PIN _____
 (where required by law)

PROPOSED INSURED'S NAME:

Grid of 12 empty boxes for name entry.

HEALTH HISTORY

Section 7: Health history questions for Applicant and Spouse regarding diagnosis and treatment within the past 5, 7, or 10 years.

Section 8: Health history questions for Applicant and Spouse regarding Group Disability Income coverage.

Section 9: Health history questions for Applicant and Spouse regarding Group Disability Income coverage, including pregnancy status.

Section 10: Health history questions for Applicant and Spouse regarding Group Critical Illness coverage.

Section 11: Health history questions for Applicant and Spouse regarding Group Cancer coverage.

I hereby certify that I have read the above statements and all of the medical conditions or they have been read to me. I also understand that additional investigation could occur at time of claim and any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.

Applicant Initials or PIN: _____

SERFF Tracking #:

AFDL-128794171

State Tracking #:**Company Tracking #:**

G925

State:

Arkansas

Filing Company:

American Fidelity Assurance Company

TOI/Sub-TOI:

H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness

Product Name:

G925 Group Critical Illness Limited Benefit Policy

Project Name/Number:

Group Critical Illness Limited Benefit Policy et al /G/CG925

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/18/2012
Comments:			
Attachment(s):			
AR_Compliance_Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	12/18/2012
Comments:	The A1275 group insured application is included under the Form Schedule tab. The group policyholder application that will be used, AGM105 was approved in Arkansas on February 12, 2009.		



2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125

COMPLIANCE CERTIFICATION

ARKANSAS

This is to certify that the attached forms comply with the requirements of:

Arkansas Rule & Regulation 19

Arkansas Rule & Regulation 49

ACA 23-80-206

ACA-23-79-138

Rhonda Morse

Signature

Rhonda Morse, Assistant Vice President

Name and Title

12/6/2012

Date

State: Arkansas **Filing Company:** American Fidelity Assurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: G925 Group Critical Illness Limited Benefit Policy
Project Name/Number: Group Critical Illness Limited Benefit Policy et al /G/CG925

Superseded Schedule Items

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

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/06/2012	Replaced 12/18/2012	Form	Group Critical Illness Limited Benefit Policy	12/18/2012	G925.pdf (Superseded)
12/06/2012	Replaced 12/18/2012	Form	Group Critical Illness Limited Benefit Certificate	12/18/2012	CG925.pdf (Superseded)



Our Family, Dedicated To Yours.®

[2000 N. CLASSEN BOULEVARD, OKLAHOMA CITY, OKLAHOMA 73106]

POLICYHOLDER: [ABC Company]
ADDRESS: [123 Main Street, Oklahoma City, Oklahoma, 73106]
EFFECTIVE DATE: [January 1, 2013]
DATE OF ISSUE: [January 30, 2013]
POLICY NUMBER: [G925-2]
POLICY ANNIVERSARY DATE: [January 1]

In consideration of:

- (a) the application of the Policyholder, a copy of which is attached to and made a part of this Policy; and
- (b) the payment of the first premium,

the Company agrees to pay the benefits of this Policy subject to all of its terms.

This Policy is executed by American Fidelity Assurance Company as of its Date of Issue. This Policy will take effect on the Effective Date.

Dale Cumb
President

Secretary

GROUP CRITICAL ILLNESS LIMITED BENEFIT POLICY

**THIS POLICY OFFERS LIMITED BENEFITS.
PLEASE READ YOUR POLICY CAREFULLY.
ALL BENEFITS ARE PAID DIRECTLY TO THE INSURED.**

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

FP

TABLE OF CONTENTS

Schedule of Benefits

Section 1Definitions

Section 2.....Eligibility and Effective Date

Section 3..... Benefits

Section 4.....Limitations and Exclusions

Section 5..... Termination of Insurance

Section 6.....Premium Calculation and Payment

Section 7 Claims

Section 7.....General Provisions

[Application]

TC

SCHEDULE OF BENEFITS

PLAN: [1]

POLICYHOLDER: [ABC Employer]

POLICY NUMBER: [G-XXX-2T]

EFFECTIVE DATE: [January 1, 2013]

ELIGIBILITY: [All active permanent certified and administrative employees.] [As defined by the Policyholder]

CRITICAL ILLNESS BENEFIT

Insured

[\$5,000 up to \$100,000] per Critical Illness] OR
[Please refer to the Insured's individual application or enrollment form]

Dependent Child

[25% of the Insured's Critical Illness Benefit] OR
[\$1250 up to \$25,000] per Critical Illness]

CRITICAL ILLNESS: Maximum of one Critical Illness Benefit amount payable per Critical Illness per Covered Person.

Heart Attack	[50%, 100%]
[Coronary Artery Bypass Surgery	25%
Partial payments for Coronary Artery Bypass Surgery reduces the Heart Attack benefit. At no time will combined payments for any heart related benefits exceed 100% of the Critical Illness Benefit Amount.]	
Permanent Damage Due To Stroke	[50%, 100%]
End Stage Renal Failure	[50%, 100%]
Major Organ Failure	[50%, 100%]
Permanent Paralysis Due To A Covered Accident	[50%, 100%]

[RECURRENT BENEFIT: 50% of the Critical Illness Benefit
Maximum of one Recurrent Benefit payable per Recurrent Diagnosis, per Covered Person, for a recurrent diagnosis of Heart Attack, Major Organ Failure, or Permanent Damage Due to Stroke.]

[HEALTH SCREENING BENEFIT: **[\$50, \$75, \$100] per Calendar Year]**

SB

SECTION 1 DEFINITIONS

ACCIDENT means a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity.

ACTIVE EMPLOYMENT means that the Insured are:

- (a) doing in the usual manner all of the regular duties of the Insured's employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where the Insured normally does such duties or at some location to which his or her employment sends the Insured.

The Insured will be said to be on Active Employment on a day which is not a scheduled work day only if the Insured is not disabled and would be able to perform in the usual manner all of the regular duties of his or her employment if it were a scheduled work day.

CERTIFICATE means the individual Certificate issued to the Insured. It describes the coverage under the Policy.

[CORONARY ARTERY BYPASS SURGERY means open heart surgery performed by a Physician to correct Coronary Artery Disease with bypass grafts. Coronary Artery Bypass Surgery does not include balloon angioplasty, laser angioplasty, stenting, valve replacement surgery, or procedures other than Coronary Artery Bypass Surgery.]

CORONARY ARTERY DISEASE means a severe narrowing or blockage of one or more coronary arteries.

COVERED PERSON(S) means the Insured and the Insured's eligible Dependent Child whose coverage is in force. (See Section 2 – Eligibility and Effective Date.)

CRITICAL ILLNESS: End Stage Renal Failure, Heart Attack (including Coronary Artery Bypass Surgery), Major Organ Failure, Permanent Damage Due To A Stroke, or Permanent Paralysis Due To A Covered Accident, as defined in the Policy, for which a positive diagnosis is made by a Physician.

CRITICAL ILLNESS BENEFIT AMOUNT: The amount shown on the Schedule of Benefits for the Covered Person.

DEPENDENT CHILD means:

- (a) the Insured's child (natural, step, adopted, or a minor for whom guardianship is granted to the Insured by court or testamentary appointment, other than temporary guardianship of less than 12 months duration) who is less than **[26 to 31]** years of age; or
- (b) the Insured's child who becomes incapable of self-support because of mental or physical handicap while covered under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on the Insured for support and maintenance. The Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Coverage will then continue as long as the Insured's insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age **[26 to 31]**; or
- (c) any minor under the Insured's charge, care and control, who has been placed in the Insured's home for adoption and is less than **[26 to 31]** years of age.

The term Dependent Child does not include the Insured's grandchild (unless required by law).

EFFECTIVE DATE means the date described in the Policy. The date shown in the Insured's individual Certificate or Policy will be the Insured's Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

END STAGE RENAL FAILURE means renal disease resulting in irreversible failure of both kidneys to function and which requires regular dialysis or renal transplantation to sustain life.

HEART ATTACK means an acute Myocardial Infarction due to Coronary Artery Disease resulting in death of a portion of the heart muscle. Diagnosis must be supported by onset of new symptoms and any of the following: EKG changes, elevation of biochemical markers, or imaging studies, consistent with an acute myocardial infarction. In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack will be acceptable.

Heart attack does not include congestive heart failure, atherosclerotic heart disease, angina, cardiac arrest, or any other disease or injury involving the cardiovascular system

INSURED (You or Your) means a person whose coverage has been applied for and is in force under the terms of the Policy.

MAJOR ORGAN FAILURE means the diagnosis by a Physician of failure of the heart, liver, lung, or entire pancreas due to end stage organ failure, which results in the Covered Person being placed on the United Network for Organ Sharing (UNOS) list for a transplant.

OCCURRENCE DATE must occur on or after the Covered Person's Effective Date and while coverage is in force. The Occurrence Date for each of the Critical Illnesses is as follows:

- Heart Attack - the date the death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack definition;
- Coronary Artery Bypass Surgery - the date the Covered Person undergoes Coronary Artery Bypass Surgery;
- Major Organ Failure - the date the Covered Person is placed on the UNOS list for transplantation;
- Permanent Damage Due To A Stroke - the date new neurological deficits from the Stroke [are diagnosed as permanent] [have persisted for a minimum of [7, 14, 30] consecutive days];
- End Stage Renal Failure - the date End Stage Renal Failure is diagnosed.
- Permanent Paralysis Due To A Covered Accident – the date paralysis is diagnosed as permanent.

PERMANENT DAMAGE DUE TO A STROKE means permanent neurological damage to the brain which results from an acute or sub-acute interruption of blood flow to brain tissue, including infarction of brain tissue due to embolism, thrombus or bleeding. Diagnosis should be made by a physician, demonstrated by imaging (CT or MRI), and must result in permanent neurological deficits. Permanent Damage Due to a Stroke does not include Transient Ischemic Attacks (TIA).

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT (or Paralysis) means injuries to the spinal cord due to a Covered Accident which result in the loss of use of two or more limbs. Paralysis must be diagnosed as permanent, total, and irreversible.

PHYSICIAN means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for the Insured's Sickness or Accident; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat the Insured's condition.

The term Physician does not include the Insured, anyone related to the Insured by blood or marriage, or anyone living in the Insured's household.

POLICY means the Policy issued to the Policyholder that covers the Insured.

POLICYHOLDER means the association, employer, labor union, or trustee who holds the Policy.

[RECURRENT DIAGNOSIS: A second Occurrence Date for a Heart Attack, Permanent Damage Due To A Stroke, or Major Organ Failure, for which a Critical Illness Benefit Amount was previously paid under the Policy.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while the Insured's coverage is in force; and
- (b) be separated by at least 180 days.]

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

SICKNESS: Any illness or disease which is the direct cause of the Critical Illness and begins while the Covered Person's coverage is in force.

TRANSIENT ISCHEMIC ATTACK (or TIA) means a neurological condition or event with the signs and symptoms of a Stroke, but which disappear within 24 hours with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies. TIA's are not covered by the Policy.

DEF

SECTION 2 ELIGIBILITY AND EFFECTIVE DATE

[The Insured's Eligibility: If the Insured:

- (a) is on Active Employment as employees of the employer, or members or employees of a member of the Policyholder;
- (b) qualify as an eligible Insured, as defined in the Policyholder's application; and
- (c) meet the definition of Eligibility, as stated in the Schedule,

the Insured is eligible to be insured under the Policy. Evidence of insurability acceptable to the Company may be required.

The Insured's Effective Date: If the Insured is eligible, the Insured's coverage or changes in coverage including increases will begin on the later of the requested Effective Date or the date the Company approves the written application, if the Insured:

- (a) applies in writing on or before said Effective Date;
- (b) meet the Company's underwriting rules;
- (c) are on Active Employment, as defined in Section 1; and
- (d) have paid all applicable premiums due.

If the Insured is not on Active Employment due to an Accident or Sickness when his or her coverage would otherwise take effect, coverage will take effect on the first of the month following the date the Insured return to Active Employment for at least 5 consecutive workdays.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.

The Insured's Dependent Child: Coverage for the Insured's Dependent Child will also become effective on the Insured's Effective Date or on the date he or she acquires a Dependent Child or Children, whichever is later, as long as the Insured's coverage is in force. Application for coverage, evidence of insurability, or additional premium is not required for the Insured's Dependent Child.

EFF-VOLJ

[ELIGIBILITY

All persons who:

- (a) are on Active Employment as employees of the employer; or members or employees of a member of the Policyholder;
- (b) qualify as eligible Covered Persons as defined by the employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

will be enrolled automatically by the Employer.

EFFECTIVE DATE: WHEN COVERAGE BEGINS

Coverage for all Covered Persons will begin on the date the Insured becomes eligible if his or her employer has paid all applicable premiums.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

EFF-EMPPD]

SECTION 3 BENEFITS

CRITICAL ILLNESS

A benefit is payable once per Covered Person for each Critical Illness shown on the Schedule of Benefits. After the Occurrence Date of the first Critical Illness payable under the Policy or any attached riders, a benefit for each subsequent Critical Illness will only be payable if the Occurrence Date:

- (a) is for a Critical Illness for which a Critical Illness Benefit Amount has not been previously paid;
- (b) is separated by more than 90 days following the last Critical Illness Occurrence Date; and
- (c) occurs while the Covered Person is insured under the Policy, Certificate or any attached riders.

Any critical illness not specifically listed in the Critical Illness definition is not payable under the Policy. If the Occurrence Date of two or more Critical Illnesses is separated by less than 90 days, the Company will pay only one Critical Illness Benefit Amount. The Company will pay for the Critical Illness that occurred first. Critical Illnesses with a Critical Illness Benefit Amount of less than 100% are not subject to this requirement.

HEART ATTACK: Following the Occurrence Date of a Covered Person's Heart Attack, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Heart Attack must occur after the Covered Person's Effective Date.

If a Covered Person receives a benefit for a Coronary Artery Bypass Surgery and is later diagnosed with a Heart Attack, the Company will pay the Heart Attack benefit less the amount received for such Coronary Artery Bypass Surgery. For all heart related benefits combined, the Company will not pay more than 100% of the Critical Illness Benefit Amount shown on the Schedule of Benefits for the Covered Person.

[Coronary Artery Bypass Surgery: Following the Occurrence Date of a Covered Person's Coronary Artery Bypass Surgery, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Coronary Artery Bypass Surgery must occur after the Covered Person's Effective Date. This benefit is payable only once per Covered Person per lifetime. If a Covered Person has previously received a benefit for Heart Attack, then 100% of the heart related benefits have been exhausted and this benefit is not payable. The Coronary Artery Bypass Surgery Occurrence Date is not subject to the 90-day separation period.]

PERMANENT DAMAGE DUE TO A STROKE: Following the Occurrence Date of a Covered Person's Permanent Damage Due To A Stroke, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The stroke and the Permanent Damage Due to a Stroke must occur after the Covered Person's Effective Date.

MAJOR ORGAN FAILURE: Following the Occurrence Date of a Covered Person's Major Organ Failure, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Major Organ Failure must occur after the Covered Person's Effective Date.

END STAGE RENAL FAILURE: Following the Occurrence Date of a Covered Person's End Stage Renal Failure, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The End Stage Renal Failure must occur after the Covered Person's Effective Date.

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT: Following the Occurrence Date of a Covered Person's Paralysis, the Company will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Accident and the Paralysis must occur after the Covered Person's Effective Date.

BEN

[RECURRENT BENEFIT: If a Covered Person receives a Recurrent Diagnosis, the Company will pay an additional benefit for such Critical Illness equal to 50% of the Critical Illness Benefit Amount.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while the policy is in force; and
- (b) be separated by at least 180 days.

This benefit is payable once per Covered Person for each Recurrent Diagnosis of a Critical Illness. Once a Recurrent Diagnosis Benefit has been paid for a Critical Illness, no further Occurrence Dates of that same Critical Illness will be payable. Any Critical Illness not specifically listed in the Recurrent Diagnosis definition is not payable under this benefit.

RB]

[HEALTH SCREENING BENEFIT

The Company will pay the Health Screening Benefit amount shown on the Schedule of Benefits for the Insured when he or she receives one of the Health Screening tests listed below:

- | | |
|------------------------------|--|
| Blood Test For Triglycerides | Exercise Or Pharmacologic Stress Test |
| Neuroimaging Studies | Fasting Blood Glucose Test |
| Doppler Ultrasound | Serum Cholesterol Test To Determine HDL And LDL Levels |
| Echocardiogram | Electrocardiogram (EKG) |

The Health Screening Benefit amount shown in the Schedule of Benefits will be payable for the Insured a total of once per Calendar Year as long as the Insured's coverage under this benefit is in force. Calendar Year means the period beginning on January 1 and ending on December 31 of the same year. Coverage for Health Screening Benefits is not provided for the Insured's Dependent Child.

HSB]

SECTION 4 LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITION LIMITATION

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Occurrence Date occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months.

PE

PRE-EXISTING CONDITION means a disease, Accident, Sickness, physical condition or mental illness for which a Covered Person has experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Covered Person's Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness, physical condition or mental illness.

PEDEF

EXCLUSIONS: The Company will not pay benefits for any Critical Illness resulting from or caused, whether directly or indirectly, by:

- (a) An intentionally self-inflicted Accident or Sickness.
- (b) Suicide or attempted suicide, while sane or insane.
- (c) Participating in a riot, insurrection, rebellion, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority.
- (d) Being intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions. Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the event that caused the Critical Illness occurred.
- (e) Committing, or attempting to commit a felony.
- (f) Being incarcerated in any type of penal institution.
- (g) Alcoholism or drug addiction.
- (h) A diagnosis received outside the United States, or its territories, that cannot be confirmed by a Physician licensed and practicing in the United States.

EXC

[CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

For all employees who were insured by their current Employer's prior group critical illness carrier on the day preceding the Employer's Effective Date of coverage under the Policy and who became insured with American Fidelity Assurance Company on the Employer's Effective Date of coverage under the Policy, coverage for Pre-Existing Conditions will be administered as follows:

If the Insured was not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group critical illness carrier, there would be no Pre-Existing Condition Limitation applied under the American Fidelity plan. If the Insured was not eligible for benefits under the prior group critical illness carrier's plan because of a Pre-Existing Condition Limitation, the Insured would not be eligible for benefits under the American Fidelity plan until such time as he or she had satisfied the Pre-Existing Condition Limitation described in the Policy. Credit will be given for any portion of time satisfied with the Insured's current Employer's prior group critical illness carrier provided he or she replaced that coverage with American Fidelity's insurance on the Effective Date. This provision applies only up to the amount of coverage the Insured held with the prior group critical illness carrier on the day preceding American Fidelity's Effective Date or [\$10,000, \$15,000, \$20,000], whichever is less. Proof of Continuity of Coverage must be supplied upon request.

For those employees who were not enrolled under the current employer's prior group critical illness carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

cc]

**SECTION 5
TERMINATION OF INSURANCE**

The Insured's Coverage: The Insured's Insurance coverage will end on the earliest of these dates:

- (a) the date the Insured no longer qualifies as an Insured;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Policy is discontinued;
- (d) the date the Insured retires;
- (e) if the Insured works for an employer employing less than 20 employees on a typical work day in the preceding Calendar Year, the date the Insured attains age 75;
- (f) the date the Insured ceases to be on Active Employment, as defined in Section 1;
- (g) the date the Insured ceases employment with the employer through whom he or she originally became insured under the Policy;
- (h) the date of the Insured's death;
- (i) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for the Insured.

Coverage On The Insured's Dependent Child: The coverage on Dependent Child(ren) will end on the earliest of these dates:

- (a) the date the Insured's coverage terminates;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Covered Person no longer meets the definition of Dependent Child, as defined in Section 1;
- (d) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for each Dependent Child.

If termination of coverage occurs because of termination of the Insured's employment or contract with the Policyholder, such termination shall be without prejudice to any Occurrence Date which commenced while this Certificate was in force.

The Company may end the coverage of any Covered Person who submits a fraudulent claim.

The Company or the Policyholder, may end the Policy and/or optional benefit riders on any premium due date. Thirty-one days advance written notice of such termination must be given.

The Company may end the coverage of a subscribing Employer unit if fewer persons are insured than required by the Policyholder's application.

LEAVE OF ABSENCE: The Insured's coverage may be continued for up to [1 year, 2 years] during a Leave of Absence approved in writing by his or her Employer.

TOI

[PORTABILITY

If the Insured no longer meets the definition of Eligibility as described in the Schedule of Benefits he or she may continue the coverage provided in this Certificate, including any attached riders. The Insured is eligible to continue his or her coverage if:

- (a) the Insured has been continuously covered under the Policy for at least 12 consecutive months prior to the date his or her coverage under the Policy ends;
- (b) the Insured notifies the Company no later than 30 days after the Insured's Eligibility under the Policy ends and submit the appropriate premium;
- (c) the Insured's coverage under the Policy is in force on the day his or her Eligibility ends; and
- (d) the Policy is still in force on the date the Insured's coverage under this Provision becomes effective.

The Insured's coverage under this Provision will remain the same as it was on the day prior to the date the Insured's coverage under this Provision begins. All provisions of the Policy remain applicable. No application or evidence of insurability will be required.

Any plan or rate changes made to the Policy will also be applicable to the Insured's coverage under the Portability Provision. Thirty-one days advance written notice of any such change will be provided.

Coverage under the Portability Provision will end on the earliest of these dates:

- (a) the end of the month following the Insured's 75th birthday;
- (b) the last day of the month ending ten (10) years from the date the Insured's coverage became effective under this Provision;
- (c) the date the Policy is terminated; or
- (d) the date the Insured fails to pay the required premium.

The Insured may cancel his or her coverage under this Provision at anytime by providing written notice. The Company will refund any unearned premium to the Insured. Cancellation will not prejudice any claim that originated prior to the date cancellation took effect.

PORT]

SECTION 6
PREMIUM CALCULATION AND PAYMENT

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before the Insured's Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

- (a) the Company's Home Office; or
- (b) an authorized entity of the Company.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases the Company's liability, premium rates may be changed on the date the liability is increased.

PREM

SECTION 7 CLAIMS

NOTICE OF CLAIM: The Insured should notify the Company, in writing, within 30 days after a Covered Person incurs a loss covered by the Policy. If it is not reasonably possible to give notice within this time period, the Insured's claim will not be denied or reduced due to the delay. Send the Insured's written notice to the Company at the following address:

American Fidelity Assurance Company
P.O. Box [25160, 268898, 248850]
Oklahoma City, Oklahoma [73125, 73126, 73124-8850]

CLAIM FORMS: Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

PROOF OF LOSS: Proof of Loss must be given to the Company within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at the Insured's expense, includes, but is not limited to, the following documentation:

- (a) certification by a Physician of the Critical Illness, as supported by a completed Claim Form provided by the Company, or some other mutually agreed-upon means;
- (b) the Occurrence Date of the Covered Person's Critical Illness;
- (c) the cause of the Covered Person's Critical Illness;
- (d) the objective test results, or documentation satisfactory to the Company, confirming the Critical Illness as required in the definition of such Critical Illness; and
- (e) a copy of the death certificate, if the Critical Illness resulted in the Covered Person's death.

TIME OF PAYMENT OF CLAIMS: Benefits for a covered loss will be paid promptly upon receipt of written Proof of Loss.

PAYMENT OF BENEFITS: The Company will pay all benefits to the Insured. Any benefits that have not been paid at the time of the Insured's death will be paid to the Insured's designated beneficiary, if living, or to the contingent beneficiary. If no such designation is made, or in the event of the death of both the beneficiary and contingent beneficiary, benefits will be paid to the Insured's estate. If benefits are payable to the Insured's estate or to any person who is not competent to give us a valid release, the Company have the right to pay up to \$1,000 of those benefits to any person related to the Insured by blood or marriage who the Company believes is justly entitled to such payment. If the Company makes a payment under this provision in good faith, the Company will be released from liability to the extent of the payment.

PHYSICAL EXAMINATION: While a claim is pending, the Company have the right to have the Insured:

- (a) examined as often as is reasonably necessary. The Company will pay for such examination; and/or
- (b) interviewed by the Company's authorized representative to determine the extent of any Sickness or Accident for which the Insured has made a claim. This right may be used as often as reasonably required.

LEGAL ACTION: No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

CLAIM OVERPAYMENT: The Company has the right to recover from the Insured any amount that the Company determines to be an overpayment. The Insured has the obligation to refund to the Company any such amount.

If benefits are overpaid on any claim, the Insured must reimburse the Company within 30 days.

If reimbursement is not made in a timely manner, the Company has the right to:

- (a) recover such overpayments from:
 - (1) the Insured;
 - (2) any other person to or for whom payment was made;
 - (3) the Insured's estate;
 - (4) the Insured's beneficiary;
 - (5) any other organization; and
 - (6) any other insurance company;
- (b) reduce against any future benefits payable to the Insured, the Insured's estate, the Insured's survivors, or the Insured's beneficiary, until full reimbursement is made. Payments for future benefits will continue when the overpayment has been fully recovered;
- (c) refer the Insured's unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.

CLAIMS

SECTION 8 GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
- (c) the Insured's application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or the Insured are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to the Insured.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of the Company. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the Insured's Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Critical Illness (as defined in the Policy) that starts after such 2-year period.

GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to Us, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

CERTIFICATES: An Individual Certificate will be issued to the Insured. The Certificate will describe:

- (a) the benefits under the Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to the Insured, only the last one issued will be in effect.

MISSTATEMENT OF FACTS: If relevant facts regarding the Insured are not accurate:

- (a) a fair adjustment of premium will be made; and
- (b) the true facts will decide if and in what amount of insurance coverage is valid.

CONFORMITY WITH STATE LAWS: A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

CHANGE OF BENEFICIARY: The Insured may change the beneficiary at any time by giving the Company written notice. The effective date of the beneficiary change will be the date the Company records the change at our home office.

GENPROV



Our Family, Dedicated To Yours.®

[2000 N. CLASSEN BOULEVARD, OKLAHOMA CITY, OKLAHOMA 73106]

Go paperless! Access your plan certificate and other information at www.americanfidelity.com

CERTIFICATE OF INSURANCE

American Fidelity Assurance Company (We, Us, Our) hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain eligible persons, as described in the Policy.

This Certificate describes the benefits and provisions of the group Policy and becomes Your Certificate of insurance only if:

- (1) You are eligible for the insurance (see Eligibility on Schedule of Benefits);
- (2) You are on Active Employment on the date it is to take effect; and
- (3) You become insured and remain insured in accordance with all of the provisions of the Policy.

Further, the insurance is to be effective only if the required premium payments are made by You or on Your behalf to Us. (See Section 2, Eligibility and Effective Date.)

No agent may change the Policy or waive any of its provisions.

This Certificate takes the place of any other Certificate previously issued to You under the group Policy. It should be kept in a safe place.

IN WITNESS WHEREOF, We cause this Certificate to take effect on the Effective Date.


President


Secretary

GROUP CRITICAL ILLNESS LIMITED BENEFIT CERTIFICATE

**THIS CERTIFICATE OFFERS LIMITED BENEFITS.
PLEASE READ YOUR CERTIFICATE CAREFULLY.
ALL BENEFITS ARE PAID DIRECTLY TO YOU.**

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

FP

TABLE OF CONTENTS

Schedule of Benefits

Section 1Definitions

Section 2.....Eligibility and Effective Date

Section 3..... Benefits

Section 4.....Limitations and Exclusions

Section 5..... Termination of Insurance

Section 6.....Premium Calculation and Payment

Section 7 Claims

Section 7.....General Provisions

[Application]

TC

SCHEDULE OF BENEFITS

PLAN: [1]

POLICYHOLDER: [ABC Employer]

POLICY NUMBER: [G-XXX-2T]

CERTIFICATE EFFECTIVE DATE: [January 30, 2013]

ELIGIBILITY: [All active permanent certified and administrative employees.] [As defined by the Policyholder]

CRITICAL ILLNESS BENEFIT

Insured
[[**\$5,000 up to \$100,000**] per Critical Illness] **OR**
[Please refer to Your individual application or
enrollment form]

Dependent Child
[25% of the Insured's Critical Illness Benefit] **OR**
[[**\$1250 up to \$25,000**] per Critical Illness]

CRITICAL ILLNESS: Maximum of one Critical Illness Benefit amount payable per Critical Illness per Covered Person.

Heart Attack	[50%, 100%]
[Coronary Artery Bypass Surgery	25%
Partial payments for Coronary Artery Bypass Surgery reduces the Heart Attack benefit. At no time will combined payments for any heart related benefits exceed 100% of the Critical Illness Benefit Amount.]	

Permanent Damage Due To Stroke	[50%, 100%]
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End Stage Renal Failure	[50%, 100%]
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Major Organ Failure	[50%, 100%]
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Permanent Paralysis Due To A Covered Accident	[50%, 100%]
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[RECURRENT BENEFIT: 50% of the Critical Illness Benefit

Maximum of one Recurrent Benefit payable per Recurrent Diagnosis, per Covered Person, for a recurrent diagnosis of Heart Attack, Major Organ Failure, or Permanent Damage Due to Stroke.]

[HEALTH SCREENING BENEFIT: **[\$50, \$75, \$100]** per Calendar Year]

SB

SECTION 1 DEFINITIONS

ACCIDENT means a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity.

ACTIVE EMPLOYMENT means that You are:

- (a) doing in the usual manner all of the regular duties of Your employment on a full-time basis on a scheduled work day; and
- (b) these duties are being done at one of the places of business where You normally do such duties or at some location to which Your employment sends You.

You will be said to be on Active Employment on a day which is not a scheduled work day only if You are not disabled and would be able to perform in the usual manner all of the regular duties of Your employment if it were a scheduled work day.

CERTIFICATE means the individual Certificate issued to You. It describes the coverage under the Policy.

[CORONARY ARTERY BYPASS SURGERY means open heart surgery performed by a Physician to correct Coronary Artery Disease with bypass grafts. Coronary Artery Bypass Surgery does not include balloon angioplasty, laser angioplasty, stenting, valve replacement surgery, or procedures other than Coronary Artery Bypass Surgery.]

CORONARY ARTERY DISEASE means a severe narrowing or blockage of one or more coronary arteries.

COVERED PERSON(S) means You and Your eligible Dependent Child whose coverage is in force. (See Section 2 – Eligibility and Effective Date.)

CRITICAL ILLNESS: End Stage Renal Failure, Heart Attack (including Coronary Artery Bypass Surgery), Major Organ Failure, Permanent Damage Due To A Stroke, or Permanent Paralysis Due To A Covered Accident, as defined in the Policy, for which a positive diagnosis is made by a Physician.

CRITICAL ILLNESS BENEFIT AMOUNT: The amount shown on the Schedule of Benefits for the Covered Person.

DEPENDENT CHILD means:

- (a) Your child (natural, step, adopted, or a minor for whom guardianship is granted to You by court or testamentary appointment, other than temporary guardianship of less than 12 months duration) who is less than **[26 to 31]** years of age; or
- (b) Your child who becomes incapable of self-support because of mental or physical handicap while covered under the Policy and prior to reaching the limiting age for dependent children. The child must be dependent on You for support and maintenance. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. Coverage will then continue as long as Your insurance stays in force and the child remains incapacitated. Additional proof may be required from time to time but not more often than once a year after the child attains age **[26 to 31]**; or
- (c) any minor under Your charge, care and control, who has been placed in Your home for adoption and is less than **[26 to 31]** years of age.

The term Dependent Child does not include Your grandchild (unless required by law).

EFFECTIVE DATE means the date described in the Policy. The date shown in Your individual Certificate or Policy will be Your Effective Date of coverage. The Effective Date will start at 12:01 a.m. at the main place of business of the Policyholder.

END STAGE RENAL FAILURE means renal disease resulting in irreversible failure of both kidneys to function and which requires regular dialysis or renal transplantation to sustain life.

HEART ATTACK means an acute Myocardial Infarction due to Coronary Artery Disease resulting in death of a portion of the heart muscle. Diagnosis must be supported by onset of new symptoms and any of the following: EKG changes, elevation of biochemical markers, or imaging studies, consistent with an acute myocardial infarction. In the event of death, an autopsy, medical examiner's confirmation or death certificate identifying Heart Attack will be acceptable.

Heart attack does not include congestive heart failure, atherosclerotic heart disease, angina, cardiac arrest, or any other disease or injury involving the cardiovascular system

INSURED (You or Your) means a person whose coverage has been applied for and is in force under the terms of the Policy.

MAJOR ORGAN FAILURE means the diagnosis by a Physician of failure of the heart, liver, lung, or entire pancreas due to end stage organ failure, which results in the Covered Person being placed on the United Network for Organ Sharing (UNOS) list for a transplant.

OCCURRENCE DATE must occur on or after the Covered Person's Effective Date and while coverage is in force. The Occurrence Date for each of the Critical Illnesses is as follows:

- Heart Attack - the date the death of a portion of the heart muscle occurred based on the applicable criteria listed under the Heart Attack definition;
- Coronary Artery Bypass Surgery - the date the Covered Person undergoes Coronary Artery Bypass Surgery;
- Major Organ Failure - the date the Covered Person is placed on the UNOS list for transplantation;
- Permanent Damage Due To A Stroke - the date new neurological deficits from the Stroke [are diagnosed as permanent] [have persisted for a minimum of [7, 14, 30] consecutive days];
- End Stage Renal Failure - the date End Stage Renal Failure is diagnosed.
- Permanent Paralysis Due To A Covered Accident – the date paralysis is diagnosed as permanent.

PERMANENT DAMAGE DUE TO A STROKE means permanent neurological damage to the brain which results from an acute or sub-acute interruption of blood flow to brain tissue, including infarction of brain tissue due to embolism, thrombus or bleeding. Diagnosis should be made by a physician, demonstrated by imaging (CT or MRI), and must result in permanent neurological deficits. Permanent Damage Due to a Stroke does not include Transient Ischemic Attacks (TIA).

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT (or Paralysis) means injuries to the spinal cord due to a Covered Accident which result in the loss of use of two or more limbs. Paralysis must be diagnosed as permanent, total, and irreversible.

PHYSICIAN means a medical practitioner of the healing art(s) which is recognized by applicable state law, who:

- (a) is practicing within the scope of his or her license;
- (b) is certified or credentialed by the appropriate medical or professional board that provides certification or credentials for practitioners who perform the type of treatment or service appropriate for Your Sickness or Accident; and
- (c) possesses the necessary training and qualifications according to generally accepted medical standards, to evaluate and treat Your condition.

The term Physician does not include You, anyone related to You by blood or marriage, or anyone living in Your household.

POLICY means the Policy issued to the Policyholder that covers You.

POLICYHOLDER means the association, employer, labor union, or trustee who holds the Policy.

[RECURRENT DIAGNOSIS: A second Occurrence Date for a Heart Attack, Permanent Damage Due To A Stroke, or Major Organ Failure, for which a Critical Illness Benefit Amount was previously paid under the Policy.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while Your coverage is in force; and
- (b) be separated by at least 180 days.]

SCHEDULE OF BENEFITS (or Schedule) means the benefit schedule set forth in the Policy or Certificate.

SICKNESS: Any illness or disease which is the direct cause of the Critical Illness and begins while the Covered Person's coverage is in force.

TRANSIENT ISCHEMIC ATTACK (or TIA) means a neurological condition or event with the signs and symptoms of a Stroke, but which disappear within 24 hours with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies. TIA's are not covered by the Policy.

DEF

**SECTION 2
ELIGIBILITY AND EFFECTIVE DATE**

[Your Eligibility: If You:

- (a) are on Active Employment as employees of the employer, or members or employees of a member of the Policyholder;
- (b) qualify as an eligible Insured, as defined in the Policyholder's application; and
- (c) meet the definition of Eligibility, as stated in the Schedule,

You are eligible to be insured under the Policy. Evidence of insurability acceptable to Us may be required.

Your Effective Date: If You are eligible, Your coverage or changes in coverage including increases will begin on the later of the requested Effective Date or the date We approve the written application, if You:

- (a) apply in writing on or before said Effective Date;
- (b) meet Our underwriting rules;
- (c) are on Active Employment, as defined in Section 1; and
- (d) have paid all applicable premiums due.

If You are not on Active Employment due to an Accident or Sickness when Your coverage would otherwise take effect, coverage will take effect on the first of the month following the date You return to Active Employment for at least 5 consecutive workdays.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

Increases or changes in coverage will be subject to an additional Pre-Existing Condition Limitation.

Your Dependent Child: Coverage for Your Dependent Child will also become effective on Your Effective Date or on the date You acquire a Dependent Child or Children, whichever is later, as long as Your coverage is in force. Application for coverage, evidence of insurability, or additional premium is not required for Your Dependent Child.

EFF-VOLJ

[ELIGIBILITY

All persons who:

- (a) are on Active Employment as employees of the employer; or members or employees of a member of the Policyholder;
- (b) qualify as eligible Covered Persons as defined by the employer or Policyholder; and
- (c) meet the definition of Eligibility as stated in the Schedule,

will be enrolled automatically by the Employer.

EFFECTIVE DATE: WHEN COVERAGE BEGINS

Coverage for all Covered Persons will begin on the date You become eligible if Your employer has paid all applicable premiums.

Any change in coverage will apply only to a Critical Illness that begins after the Effective Date of such change, subject to all the provisions of the Policy.

EFF-EMPPD]

SECTION 3 BENEFITS

CRITICAL ILLNESS

A benefit is payable once per Covered Person for each Critical Illness shown on the Schedule of Benefits. After the Occurrence Date of the first Critical Illness payable under the Policy or any attached riders, a benefit for each subsequent Critical Illness will only be payable if the Occurrence Date:

- (a) is for a Critical Illness for which a Critical Illness Benefit Amount has not been previously paid;
- (b) is separated by more than 90 days following the last Critical Illness Occurrence Date; and
- (c) occurs while the Covered Person is insured under the Policy, Certificate or any attached riders.

Any critical illness not specifically listed in the Critical Illness definition is not payable under the Policy. If the Occurrence Date of two or more Critical Illnesses is separated by less than 90 days, We will pay only one Critical Illness Benefit Amount. We will pay for the Critical Illness that occurred first. Critical Illnesses with a Critical Illness Benefit Amount of less than 100% are not subject to this requirement.

HEART ATTACK: Following the Occurrence Date of a Covered Person's Heart Attack, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Heart Attack must occur after the Covered Person's Effective Date.

If a Covered Person receives a benefit for a Coronary Artery Bypass Surgery and is later diagnosed with a Heart Attack, We will pay the Heart Attack benefit less the amount received for such Coronary Artery Bypass Surgery. For all heart related benefits combined, We will not pay more than 100% of the Critical Illness Benefit Amount shown on the Schedule of Benefits for the Covered Person.

[Coronary Artery Bypass Surgery: Following the Occurrence Date of a Covered Person's Coronary Artery Bypass Surgery, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Coronary Artery Bypass Surgery must occur after the Covered Person's Effective Date. This benefit is payable only once per Covered Person per lifetime. If a Covered Person has previously received a benefit for Heart Attack, then 100% of the heart related benefits have been exhausted and this benefit is not payable. The Coronary Artery Bypass Surgery Occurrence Date is not subject to the 90-day separation period.]

PERMANENT DAMAGE DUE TO A STROKE: Following the Occurrence Date of a Covered Person's Permanent Damage Due To A Stroke, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The stroke and the Permanent Damage Due to a Stroke must occur after the Covered Person's Effective Date.

MAJOR ORGAN FAILURE: Following the Occurrence Date of a Covered Person's Major Organ Failure, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Major Organ Failure must occur after the Covered Person's Effective Date.

END STAGE RENAL FAILURE: Following the Occurrence Date of a Covered Person's End Stage Renal Failure, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The End Stage Renal Failure must occur after the Covered Person's Effective Date.

PERMANENT PARALYSIS DUE TO A COVERED ACCIDENT: Following the Occurrence Date of a Covered Person's Paralysis, We will pay the percentage of the Critical Illness Benefit Amount as shown on the Schedule of Benefits. The Accident and the Paralysis must occur after the Covered Person's Effective Date.

BEN

[RECURRENT BENEFIT: If a Covered Person receives a Recurrent Diagnosis, We will pay an additional benefit for such Critical Illness equal to 50% of the Critical Illness Benefit Amount.

The first Occurrence Date and the Recurrent Diagnosis must:

- (a) occur while the policy is in force; and
- (b) be separated by at least 180 days.

This benefit is payable once per Covered Person for each Recurrent Diagnosis of a Critical Illness. Once a Recurrent Diagnosis Benefit has been paid for a Critical Illness, no further Occurrence Dates of that same Critical Illness will be payable. Any Critical Illness not specifically listed in the Recurrent Diagnosis definition is not payable under this benefit.

RB]

[HEALTH SCREENING BENEFIT

We will pay the Health Screening Benefit amount shown on the Schedule of Benefits for You when You receive one of the Health Screening tests listed below:

Blood Test For Triglycerides
Neuroimaging Studies
Doppler Ultrasound
Echocardiogram

Exercise Or Pharmacologic Stress Test
Fasting Blood Glucose Test
Serum Cholesterol Test To Determine HDL And LDL Levels
Electrocardiogram (EKG)

The Health Screening Benefit amount shown in the Schedule of Benefits will be payable for You a total of once per Calendar Year as long as Your coverage under this benefit is in force. Calendar Year means the period beginning on January 1 and ending on December 31 of the same year. Coverage for Health Screening Benefits is not provided for Your Dependent Child.

HSB]

SECTION 4 LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITION LIMITATION

No Critical Illness Benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Occurrence Date occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months.

PE

PRE-EXISTING CONDITION means a disease, Accident, Sickness, physical condition or mental illness for which a Covered Person has experienced any of the following:

- (a) treatment;
- (b) incurred expense;
- (c) took medication;
- (d) received care or services including diagnostic testing or related measures; or
- (e) received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Covered Person's Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness, physical condition or mental illness.

PEDEF

EXCLUSIONS: We will not pay benefits for any Critical Illness resulting from or caused, whether directly or indirectly, by:

- (a) An intentionally self-inflicted Accident or Sickness.
- (b) Suicide or attempted suicide, while sane or insane.
- (c) Participating in a riot, insurrection, rebellion, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority.
- (d) Being intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician's instructions. Intoxication means that which is determined and defined by the laws and jurisdiction of the geographical area in which the event that caused the Critical Illness occurred.
- (e) Committing, or attempting to commit a felony.
- (f) Being incarcerated in any type of penal institution.
- (g) Alcoholism or drug addiction.
- (h) A diagnosis received outside the United States, or its territories, that cannot be confirmed by a Physician licensed and practicing in the United States.

EXC

[CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

For all employees who were insured by their current Employer's prior group critical illness carrier on the day preceding the Employer's Effective Date of coverage under the Policy and who became insured with American Fidelity Assurance Company on the Employer's Effective Date of coverage under the Policy, coverage for Pre-Existing Conditions will be administered as follows:

If You were not subject to or had already satisfied the Pre-Existing Condition Limitation under the prior group critical illness carrier, there would be no Pre-Existing Condition Limitation applied under the American Fidelity plan. If You were not eligible for benefits under the prior group critical illness carrier's plan because of a Pre-Existing Condition Limitation, You would not be eligible for benefits under the American Fidelity plan until such time as You had satisfied the Pre-Existing Condition Limitation described in the Policy. Credit will be given for any portion of time satisfied with Your current Employer's prior group critical illness carrier provided You replaced that coverage with American Fidelity's insurance on the Effective Date. This provision applies only up to the amount of coverage You held with the prior group critical illness carrier on the day preceding American Fidelity's Effective Date or [\$10,000, \$15,000, \$20,000], whichever is less. Proof of Continuity of Coverage must be supplied upon request.

For those employees who were not enrolled under the current employer's prior group critical illness carrier's plan, benefit payments will be subject to the Pre-Existing Condition Limitation as outlined above.

CCJ

SECTION 5 TERMINATION OF INSURANCE

Your Coverage: Your Insurance coverage will end on the earliest of these dates:

- (a) the date You no longer qualify as an Insured;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Policy is discontinued;
- (d) the date You retire;
- (e) if You work for an employer employing less than 20 employees on a typical work day in the preceding Calendar Year, the date You attain age 75;
- (f) the date You cease to be on Active Employment, as defined in Section 1;
- (g) the date You cease employment with the employer through whom You originally became insured under the Policy;
- (h) the date of Your death;
- (i) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for You.

Coverage On Your Dependent Child: The coverage on Dependent Child(ren) will end on the earliest of these dates:

- (a) the date Your coverage terminates;
- (b) the end of the last period for which premium has been paid;
- (c) the date the Covered Person no longer meets the definition of Dependent Child, as defined in Section 1;
- (d) the date 100% of the Critical Illness Benefit Amount for all Critical Illnesses has been paid for each Dependent Child.

If termination of coverage occurs because of termination of Your employment or contract with the Policyholder, such termination shall be without prejudice to any Occurrence Date which commenced while this Certificate was in force.

We may end the coverage of any Covered Person who submits a fraudulent claim.

We or the Policyholder, may end the Policy and/or optional benefit riders on any premium due date. Thirty-one days advance written notice of such termination must be given.

LEAVE OF ABSENCE: Your coverage may be continued for up to [1 year, 2 years] during a Leave of Absence approved in writing by Your Employer.

TOI

[PORTABILITY

If You no longer meet the definition of Eligibility as described in the Schedule of Benefits You may continue the coverage provided in this Certificate, including any attached riders. You are eligible to continue Your coverage if:

- (a) You have been continuously covered under the Policy for at least 12 consecutive months prior to the date Your coverage under the Policy ends;
- (b) You notify Us no later than 30 days after Your Eligibility under the Policy ends and submit the appropriate premium;
- (c) Your coverage under the Policy is in force on the day Your Eligibility ends; and
- (d) the Policy is still in force on the date Your coverage under this Provision becomes effective.

Your coverage under this Provision will remain the same as it was on the day prior to the date Your coverage under this Provision begins. All provisions of the Policy remain applicable. No application or evidence of insurability will be required.

Any plan or rate changes made to the Policy will also be applicable to Your coverage under the Portability Provision. Thirty-one days advance written notice of any such change will be provided.

Coverage under the Portability Provision will end on the earliest of these dates:

- (a) the end of the month following Your 75th birthday;
- (b) the last day of the month ending ten (10) years from the date Your coverage became effective under this Provision;
- (c) the date the Policy is terminated; or
- (d) the date You fail to pay the required premium.

You may cancel Your coverage under this Provision at anytime by providing written notice. We will refund any unearned premium to You. Cancellation will not prejudice any claim that originated prior to the date cancellation took effect.

PORT]

SECTION 6
PREMIUM CALCULATION AND PAYMENT

Premiums will be figured on the basis stated in the Policyholder's application.

The first premium is due on or before Your Effective Date of coverage. Premiums after the first are due on or before the premium due date stated in the Policyholder's application. Premiums may be paid to:

- (a) Our Home Office; or
- (b) an authorized entity of Ours.

The premium may be changed based on experience at the first anniversary date of the Policy or any premium due date after that. No such increase in rate will be made unless 31 days prior notice is given to the Policyholder.

If a change in benefit increases Our liability, premium rates may be changed on the date the liability is increased.

PREM

SECTION 7 CLAIMS

NOTICE OF CLAIM: You should notify Us, in writing, within 30 days after a Covered Person incurs a loss covered by the Policy. If it is not reasonably possible to give notice within this time period, Your claim will not be denied or reduced due to the delay. Send Your written notice to Us at the following address:

American Fidelity Assurance Company
P.O. Box [25160, 268898, 248850]
Oklahoma City, Oklahoma [73125, 73126, 73124-8850]

CLAIM FORMS: Claim forms should be used for filing Proof of Loss. They will be sent to the claimant within 15 days of receipt of Notice of Claim. If Claim Forms are not supplied within 15 days, a claimant can give proof as follows:

- (a) in writing;
- (b) containing the required information as indicated in the Proof of Loss Provision; and
- (c) within the time stated in the Proof of Loss Provision.

PROOF OF LOSS: Proof of Loss must be given to Us within 90 days after the loss. Late proof may be accepted if:

- (a) it was not reasonably possible to give Proof in that time; and
- (b) the proof is given within one year from the date of loss. This 1-year limit will not apply in the absence of legal capacity.

Proof of Loss, provided at Your expense, includes, but is not limited to, the following documentation:

- (a) certification by a Physician of the Critical Illness, as supported by a completed Claim Form provided by the Company, or some other mutually agreed-upon means;
- (b) the Occurrence Date of the Covered Person's Critical Illness;
- (c) the cause of the Covered Person's Critical Illness;
- (d) the objective test results, or documentation satisfactory to Us, confirming the Critical Illness as required in the definition of such Critical Illness; and
- (e) a copy of the death certificate, if the Critical Illness resulted in the Covered Person's death.

TIME OF PAYMENT OF CLAIMS: Benefits for a covered loss will be paid promptly upon receipt of written Proof of Loss.

PAYMENT OF BENEFITS: We will pay all benefits to You. Any benefits that have not been paid at the time of Your death will be paid to Your designated beneficiary, if living, or to the contingent beneficiary. If no such designation is made, or in the event of the death of both the beneficiary and contingent beneficiary, benefits will be paid to Your estate. If benefits are payable to Your estate or to any person who is not competent to give us a valid release, We have the right to pay up to \$1,000 of those benefits to any person related to You by blood or marriage who We believe is justly entitled to such payment. If We make a payment under this provision in good faith, We will be released from liability to the extent of the payment.

PHYSICAL EXAMINATION: While a claim is pending, We have the right to have You:

- (a) examined as often as is reasonably necessary. We will pay for such examination; and/or
- (b) interviewed by Our authorized representative to determine the extent of any Sickness or Accident for which You have made a claim. This right may be used as often as reasonably required.

LEGAL ACTION: No legal action may be brought to recover under the Policy:

- (a) within 60 days after written Proof of Loss has been furnished as required; or
- (b) more than 3 years from the time written Proof of Loss is required to be furnished.

CLAIM OVERPAYMENT: We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

- (a) recover such overpayments from:
 - (1) You;
 - (2) any other person to or for whom payment was made;
 - (3) Your estate;
 - (4) Your beneficiary;
 - (5) any other organization; and
 - (6) any other insurance company;
- (b) reduce against any future benefits payable to You, Your estate, Your survivors, or Your beneficiary, until full reimbursement is made. Payments for future benefits will continue when the overpayment has been fully recovered;
- (c) refer Your unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.

CLAIMS

SECTION 8 GENERAL PROVISIONS

ENTIRE CONTRACT-CHANGES: The entire contract shall include:

- (a) the Policy;
- (b) the application of the Policyholder and each Employer Participation Agreement (if applicable);
- (c) Your application, if any, attached to the Certificate; and
- (d) all endorsements and amendments.

Statements made by the Policyholder or You are representations and not warranties, if fraud was not intended. No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

- (a) the statement is in writing; and
- (b) a copy of that statement is given to You.

The terms of the Policy can be changed only by endorsement or amendment signed by an executive officer of Ours. Any amendment that reduces or eliminates coverage must be requested in writing or signed by the Policyholder. No agent may change the Policy or waive its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from Your Effective Date of coverage, no statements in the application, except fraudulent misstatements, can be used to:

- (a) avoid the coverage; or
- (b) deny a claim for loss incurred or Critical Illness (as defined in the Policy) that starts after such 2-year period.

GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Policyholder or subscribing Employer unit must still pay all unpaid premium. This includes the premium due for the grace period.

The Policyholder or subscribing Employer unit may, by writing to Us, cancel the coverage under the Policy:

- (a) on any future premium due date; or
- (b) on any date during the grace period.

If coverage is canceled on a premium due date, the grace period will not apply. If cancellation is during the grace period, the Policyholder or subscribing Employer unit will be liable for any unpaid premium including the pro rata premium for that part of the grace period while coverage was in force.

CERTIFICATES: An Individual Certificate will be issued to You. The Certificate will describe:

- (a) the benefits under the Policy;
- (b) to whom benefits will be paid; and
- (c) the limitations and terms of the Policy.

If more than one Certificate is issued under the Policy to You, only the last one issued will be in effect.

MISSTATEMENT OF FACTS: If relevant facts regarding You are not accurate:

- (a) a fair adjustment of premium will be made; and
- (b) the true facts will decide if and in what amount of insurance coverage is valid.

CONFORMITY WITH STATE LAWS: A provision of the Policy that conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law.

CHANGE OF BENEFICIARY: You may change the beneficiary at any time by giving Us written notice. The effective date of the beneficiary change will be the date We record the change at Our home office.

GENPROV