

SERFF Tracking Number: CAIC-128088719 State: Arkansas
 Filing Company: Continental American Insurance Company State Tracking Number:
 Company Tracking Number: 8459
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Critical Illness 20000
 Project Name/Number: Critical Illness 20000/8459

Filing at a Glance

Company: Continental American Insurance Company

Product Name: Critical Illness 20000 SERFF Tr Num: CAIC-128088719 State: Arkansas
 TOI: H07G Group Health - Specified Disease - SERFF Status: Closed-Approved- State Tr Num:
 Limited Benefit Closed
 Sub-TOI: H07G.001 Critical Illness Co Tr Num: 8459 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Author: Jennifer McLaughlin Disposition Date: 02/13/2012
 Date Submitted: 02/13/2012 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Critical Illness 20000
 Project Number: 8459
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Group Market Type: Employer, Association, Other

Status of Filing in Domicile: Pending
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Group Market Size: Small and Large
 Explanation for Other Group Market Type:
 Union
 Filing Status Changed: 02/13/2012
 State Status Changed: 02/13/2012
 Created By: Jennifer McLaughlin
 Corresponding Filing Tracking Number: 8459

Overall Rate Impact:

Deemer Date:

Submitted By: Jennifer McLaughlin

Filing Description:

Please see submission letter under the Supporting Documentation tab.

Company and Contact

Filing Contact Information

Jennifer McLaughlin,
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 803-461-4322 [Phone]

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Columbia, SC 29205

Filing Company Information

Continental American Insurance Company CoCode: 71730 State of Domicile: South Carolina
 2801 Devine Street Group Code: Company Type: LAH
 Columbia, SC 29205 Group Name: Continental Amer Ins State ID Number:
 Co
 (803) 256-6265 ext. [Phone] FEIN Number: 57-0514130

Filing Fees

Fee Required? Yes
 Fee Amount: \$400.00
 Retaliatory? No
 Fee Explanation: Filing or review of life and health policy/contracts, endorsements, certificate, riders, applications or annuity forms, per form...\$50.00.

One policy = \$50
 One certificate = \$50
 One application = \$50
 One enrollment form = \$50
 Four riders = \$200

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Continental American Insurance Company	\$400.00	02/13/2012	56295298

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/13/2012	02/13/2012

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Form Schedule

Lead Form Number: C20100AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/13/2012	C20100AR	Policy/Cont ract/Fratern al Certificate	Master Policy	Initial		43.400	C20100AR Policy.pdf
Approved-Closed 02/13/2012	C20101AR	Certificate	Certificate	Initial		44.800	C20101AR Certificate.pdf
Approved-Closed 02/13/2012	C20201AR	Application/ Enrollment Form	Master Application	Initial		0.000	C20201AR Master App.pdf
Approved-Closed 02/13/2012	C20202AR	Application/ Enrollment Form	Enrollment Application	Initial		0.000	C20202AR Enrollment Form.pdf
Approved-Closed 02/13/2012	C20301	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Dependent Child Benefit Rider	Initial		48.100	C20301 Dependent Child Benefit Rider.pdf
Approved-Closed 02/13/2012	C20302	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Automatic Increase Rider	Initial		47.800	C20302 Auto Increase Rider.pdf
Approved-Closed 02/13/2012	C20303	Certificate Amendmen t, Insert Page, Endorseme	Heart Event Rider	Initial		38.400	C20303 Heart Event Rider.pdf



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]

GROUP CRITICAL ILLNESS INSURANCE POLICY

This coverage is only for the Critical Illnesses listed in the Benefit Schedule of this Policy. It does not provide benefits for any other sickness or condition.

Any Certificates issued in the state of Arkansas are governed by the state of Arkansas.

[ABC COMPANY, INC.] (the "Policyholder") applied for coverage under this Group Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "we," "us," or "our"). Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as *he*, *him*, and *his*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

This is a limited Plan. Please read it carefully.

This Plan becomes effective on the Effective Date at 12:01 a.m., as determined by the Policyholder's address. Plan Termination is governed by Section I. The Plan continues to be effective while premiums are paid, as provided in Section II.

The Plan's first Anniversary Date appears below. Subsequent anniversaries will be the same date each following year.

The Policyholder may add new [Employees] or Dependents from time to time, according to the Plan's terms.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown below.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

[]

[Eugene C. Sorrel, President]

Group Policy Number [1234]

Effective Date [January 1, 2012]

Jurisdiction [State Name]

Anniversary Date [January 1, 2013]

Non-Participating

Notice of Non-Insured Benefits

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services
- Educational services
- Benefit statement services
- Payroll or plan administration services

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers (such as pharmacies, optometrists, dentists, and accountants) to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

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Section I – Eligibility, Effective Date, and Termination

Eligibility

A person is an eligible [Employee] under this Plan if he meets the following [four] requirements. He is:

1. [An Employee] of the Policyholder,
2. Engaged in [full; part]-time work, **and**
3. Included in the class of Employees eligible for coverage, as shown on the Application [. ; , **and**]
4. [Under age [70]].

If this coverage is offered only to [Employees], references in this Plan to “Dependent,” “Dependent Child,” “Dependent Children,” and “Spouse,” do not apply.

Dependents are eligible for coverage under this Plan. A *Dependent* is:

- The Spouse of [an Employee] **or**
- The Dependent Child of [an Employee]. *Dependent Children* are [an Employee’s] or [an Employee’s] Spouse’s natural children, stepchildren, legally adopted children, or Children Placed for Adoption who are younger than age 26 (details included in the **Definitions** section).

*Insureds** are those who might be eligible for coverage in the following classes under this Plan:

- **[Employee] Coverage** – We insure only the [Employee].
- **[Employee] and Spouse Coverage** – We insure the [Employee] and Spouse.
- **[Employee] and Child Coverage** – We insure the [Employee] and any Dependent Children.
- **Family Coverage** – We insure the [Employee], Spouse, and any Dependent Children.

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to Plan coverage are outlined in the following section (Effective Date**).*

Effective Date

The Plan’s Effective Date is shown on Page 1.

[An Employee’s] Effective Date is the date his insurance takes effect. That date is either the date:

- Shown on the Certificate Schedule if the [Employee] is Actively at Work on that date **or**
- The [Employee] returns to an Actively-at-Work status if he is not Actively at Work on the date shown on the Certificate Schedule.

The Effective Date for an existing Spouse or Dependent Child when the [Employee] originally applies for coverage is:

- The date on the Certificate Schedule **if** that Spouse or Dependent Child is not confined to a Hospital **and**:
 - Is eligible for coverage on that date,
 - Has been included on an Application for coverage, **and**
 - Has been included in the premium payment.

- The date the Spouse or Dependent Child is no longer confined to a Hospital (**if** that Spouse or Dependent Child was confined to a Hospital on the Certificate Schedule date) **and**:
 - Is eligible for coverage on that date,
 - Has been included on an Application for coverage, **and**
 - Has been included in the premium payment.

A day is measured from 12:01 a.m. standard time at the Spouse's or Dependent Child's place of residence.

A Spouse may be added to the Plan after the [Employee's] Effective Date. To be added, the [Employee] must complete an Application to add his Spouse to the Plan. The Company will assign the Effective Date for a Spouse's coverage after approving the application.

Newborn children will be covered from the moment of birth (if the [Employee] has chosen [Employee] and Child Coverage or Family Coverage).

If [Employee] or [Employee] and Spouse coverage is in force and the Employee desires uninterrupted coverage for a newborn, adopted child, or stepchild, the [Employee] must notify the Company in writing within 31 days of:

- The child's birth (for newborns),
- The date the petition is filed for adoption, **or**
- The date of the Employee's marriage (for stepchildren).

The Company will then convert the coverage to [Employee] and Child **or** Family and let the [Employee] know of any changes in premium.

Plan Termination

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number mutually agreed upon by the Company and the Policyholder in the signed master Application.

The Policyholder has the sole responsibility to notify [Employees] of the Plan's termination. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address. If the Plan terminates, we will provide coverage for claims arising from Critical Illnesses that were first Diagnosed while the Plan was in force.

Termination of [an Employee's] Insurance

[An Employee's] insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date he no longer meets the Plan's definition of [an Employee].
- The date he no longer belongs to an eligible class.

Insurance for a covered Spouse or Dependent Child will terminate on the earliest of any of the bullet points listed above, **or**:

- The premium due date following the date the covered Spouse or Dependent Child no longer qualifies as a Dependent.
- The premium due date following the date we receive the Employee's written request to terminate coverage for his Spouse or all Dependent Children.

If an Insured's coverage terminates, we will provide coverage for claims arising from Critical Illnesses that were first Diagnosed while his coverage was in force.

Portability Privilege

When [an Employee] [ends employment with the Employer] and his coverage would otherwise terminate, that [Employee] may elect to continue his coverage under this Plan. The [Employee] may continue the coverage that he had on the date his [employment] ended, including any in-force Spouse or Dependent Child coverage.

To keep his Certificate in force, the [Employee] must:

- Apply to the Company in writing within 31 days after the date his insurance would otherwise terminate, **and**
- Pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.

Coverage will end:

- 31 days after the date the [Employee] fails to pay any required premium **or**
- The date this Group Plan is terminated, whichever occurs first.

If [an Employee] qualifies for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.]

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount payable on any premium due date. [The rates shown in this Schedule can be changed annually.] The Company will give the Policyholder written notice 31 days before any change in rates becomes effective.

Premium Payments

The first premiums are due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

Grace Period

This Plan has a 31-day Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

Section III – Definitions

When the terms below are used in this Plan, the following definitions will apply:

Actively at Work refers to an Insured's ability to perform his regular employment duties for a full normal workday. The Insured may perform these activities either at his employer's regular place of business or at a location where the Insured may be required to travel to perform the regular duties of his employment.

[Cancer (internal or invasive) is defined as an Illness meeting **either** of the following definitions:

- A malignant tumor characterized by:
 - The uncontrolled growth and spread of malignant cells **and**
 - The invasion of distant tissue.
- A disease meeting the Diagnosis criteria of malignancy, as established by the American Board of Pathology. The Doctor must have studied the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Cancer includes leukemia and melanoma.

The following are **not** internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinoma in Situ
- Any skin cancers (except melanomas)
- Basal cell carcinoma and squamous cell carcinoma of the skin
- Melanoma that is Diagnosed as
 - Clark's Level I or II or
 - Breslow less than .77mm]

[Carcinoma in Situ is non-invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.]

[Cancer or Carcinoma in Situ must be Diagnosed in one of two ways:

1. **Pathological Diagnosis** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist whose malignancy Diagnosis conforms to the American Board of Pathology standards.
2. **Clinical Diagnosis** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis **only if**:
 - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
 - Medical evidence exists to support the Diagnosis, **and**
 - A Doctor is treating the Insured for Cancer or Carcinoma in Situ.]

[Coronary Artery Bypass means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.]

Critical Illness is a sickness or disease that first manifests while the Insured's coverage is in force [and after any applicable Waiting Period]. Any loss due to Critical Illness must begin while the Insured's coverage is in force. Critical Illness includes **only** the following:

- [Cancer]
- [Heart Attack] [due to coronary artery disease or acute coronary syndrome]
- [Stroke]
 - [Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain]
 - [Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation]
- [Sudden Cardiac Arrest][due to cardiac rhythm abnormalities or acute coronary syndrome]
- [Kidney Failure]
- [Major Organ Transplant]

Date of Diagnosis is defined for each Critical Illness as follows:

- [**Cancer and/or Carcinoma in Situ**: The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens). This includes the recurrence of a previously Diagnosed Cancer as long as the Insured:
 - Is free from any Signs or Symptoms for a consecutive 12-month period before the Date of Diagnosis (for the reoccurrence),
 - Is currently Treatment-Free from that Cancer, **and**
 - Has been Treatment-Free from that Cancer for [12] consecutive months.]
- [**Heart Attack**: The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack definition.]
- [**Ischemic or Hemorrhagic Stroke**: The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).]
- [**Sudden Cardiac Arrest**: The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).]
- [**Kidney Failure**: The date a Doctor recommends that an Insured begin renal dialysis.]
- [**Major Organ Transplant or Coronary Artery Bypass**: The date the surgery occurs.]

Dependent means the Spouse of [an Employee] **or** the Dependent Child of [an Employee]. **Dependent Children** are [an Employee's] or [an Employee's Spouse's] natural children, step-children, legally adopted children, or Children Placed for Adoption who are younger than age 26.

Children Placed for Adoption are Children for whom the [Employee] has entered a decree of adoption or for whom the [Employee] has instituted adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. The [Employee] must continue to have custody pursuant to the decree of the court.

There is an exception to the age-26 limit listed above. This limit will not apply to any Child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. [The Employee] or [the Employee's] Spouse must furnish proof of this incapacity and dependency to the Company.

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:

- Is made by a Doctor **and**
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness **must** meet the requirements outlined in this Plan for the particular Critical Illness being Diagnosed.

[Diagnosis must be made and treatment must be received in the United States.]

Doctor is defined as a person who is:

- Legally qualified to practice medicine,
- Licensed as a Doctor by the state where Treatment is received, **and**
- Licensed to treat the type of condition for which a claim is made.

A Doctor does **not** include the Insured or the Insured's Family Member.

[Employee] is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The [Employee] is the primary Insured under this Plan.

Family Member includes the [Employee]'s **Spouse** (who is defined as an Employee's legal wife or husband) as well as the following members of the Insured's immediate family:

- son
- daughter
- mother
- father
- sister
- brother

This includes Step-Family Members and Family-Members-in-law.

[Heart Attack (Myocardial Infarction)] is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries [due to coronary artery disease or acute coronary syndrome.]

Heart Attack does **not** include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Myocardial Infarction.

Diagnosis of a Heart Attack must include **all** of the following:

- New and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction;
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal (in the case of creatine phosphokinase {CPK}, a CPK-MB measurement must be used); **and**
- Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms.]

[Kidney Failure (Renal Failure)] refers to end-stage renal failure, which is the chronic, irreversible failure of both kidneys to function.

Kidney Failure is covered **only** if one of the following occurs:

- Regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) are necessary to treat the Kidney Failure; **or**
- The Kidney Failure results in kidney transplantation.

The Company will not cover Kidney Failure caused by a traumatic event, including surgical trauma.]

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into full remission because of primary treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat or suppress a Cancer that is still present.

[Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas.

Pathologist is a Doctor who is licensed:

- To practice medicine **and**
- By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology. Pathologist does **not** include the Insured or a Family Member.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of his license.

[Stroke means the death of a portion of the brain producing neurological sequelae, including infarction of brain tissue, hemorrhage, and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

[Stroke must be either:

- Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain, **or**
- Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation.]

Stroke does **not** include:

- Transient ischemic attacks (TIAs).
- Head injury.
- Chronic cerebrovascular insufficiency.
- Reversible ischemic neurological deficits.

Stroke will be covered **only** if the Insured submits evidence of the permanent neurological damage by providing:

- Computed Axial Tomography (CAT scan) images **or**
- Magnetic Resonance Imaging (MRI).]

[Successor Insured means that if an Employee dies while covered under a Certificate, then his surviving Spouse becomes the primary Insured if that Spouse is also insured under this Plan. If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date.]

[Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction[, due to cardiac rhythm abnormalities or acute coronary syndrome]. For the purposes of this Plan, a death is a Sudden Cardiac Arrest when the sole cause of death (as shown on the death certificate) is one of the following[, that is the result of cardiac rhythm abnormalities or acute coronary syndrome]:

- Cardiovascular collapse
- Sudden Cardiac Arrest
- Cardiac arrest
- Sudden cardiac death

Sudden Cardiac Arrest is **not** a Heart Attack.]

Total Disability or Totally Disabled means the Insured is:

- Unable to Work (defined later in this section),
- Not working at any job for pay or benefits, **and**
- Under the care of a Doctor for the treatment of a covered Critical Illness.

Treatment or Medical Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Carcinoma in Situ has returned.

Unable to Work means either:

- During the first 365 days of Total Disability, the Insured is unable to work at the occupation he was performing when his Total Disability began; **or**
- After the first 365 days of Total Disability, the Insured is unable to work at any gainful occupation for which he is suited by education, training, or experience.

[**Waiting Period** is the number of days after the Effective Date before we will pay benefits for a Critical Illness. We will not pay benefits for a Critical Illness whose Date of Diagnosis begins during the Waiting Period.]

Section IV – Benefit Provisions

The benefit amounts payable under this section are shown in the Benefit Schedule.

Critical Illness Benefit

We will pay this benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule. We will pay this benefit if:

- [The Date of Diagnosis is after the Waiting Period,]
- The Date of Diagnosis is while his coverage is in force, **and**
- The Certificate does not exclude the illness or condition by name or by specific description.

[If the date of a Critical Illness Diagnosis occurs during the Waiting Period, the Insured may return the Certificate for a full premium refund.]

[If the Schedule shows a Benefit Reduction Date, the Certificate's Benefit Amount will change to the Reduced Benefit Amount on that date.] Benefits will be based on the Benefit Amount in effect on the Critical Illness Date of Diagnosis.

The Company will pay benefits for a Critical Illness in the order the events occur. The Company will deduct any previously-paid partial benefits from the appropriate Critical Illness benefit.

[Separate Diagnosis Benefit

The Company will pay benefits for each **different** Critical Illness after the first when the following two conditions are met:

1. The Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least [6] months[, or if the Insured is Treatment-Free From Cancer for at least [6] months], **and**
2. The new Critical Illness is not caused or affected by a Critical Illness for which benefits have been paid.]

[Reoccurrence Benefit

Once benefits have been paid for a Critical Illness, the Company will pay additional benefits for that **same** Critical Illness when the Dates of Diagnosis are separated by at least [12] months [or the Insured has been Treatment-Free From Cancer for at least [12] months and is currently Treatment-Free].

Cancer that has metastasized (spread), even though there is a new tumor, is not considered an additional occurrence unless the Insured has been Treatment-Free for [12] months and is currently Treatment-Free].

[Health Screening Benefit (Calendar Year Limit)

We will pay the amount shown in the Benefit Schedule for Health Screening Tests performed [after the Waiting Period and] while an Insured’s coverage is in force. We will pay this benefit once per calendar year. Benefits are paid for Covered Dependent Children at 100% of the [Employee] benefit amount.

[This benefit is only payable for Health Screening Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.]

Health Screening Tests include, but are not limited to, the following:

- stress test on a bicycle or treadmill
- fasting blood glucose test
- blood test for triglycerides
- serum cholesterol test to determine level of HDL and LDL
- bone marrow testing
- breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- chest X-ray
- colonoscopy
- flexible sigmoidoscopy
- hemocult stool analysis
- mammography
- pap smear
- PSA (blood test for prostate cancer)
- serum protein electrophoresis (blood test for myeloma)
- thermography]

[Waiver of Premium Benefit

A Critical Illness may result in more than [90] days of Total Disability for an Insured. If a covered Critical Illness causes an Insured to be Totally Disabled for [90] days, the Company will waive the premium payments for this coverage for the first [90] days of Total Disability and for each following day until the earliest of the following:

- The Insured is no longer Totally Disabled,
- [The Company has waived premiums for a total of [24 months] of Total Disability,]
- [The Insured reaches age 65 or is 2 years from the date of Total Disability, whichever occurs last,] **or**
- Coverage ends according to the Termination of Coverage provision.

At the end of the waiver period, the Insured must resume paying premiums to keep this coverage in force. Premiums waived include those for the [Employee] and those for currently covered Dependents or Riders that are in force.

For premiums to be waived, the Insured must provide satisfactory proof of Total Disability at least once every 12 months.]

Section V – Exclusions

[This Plan contains a [30-day] Waiting Period. This means that we will not pay benefits to an Insured who has been Diagnosed [or had a Health Screening Test performed] before his coverage has been in force [30 days] from the Effective Date. If a Critical Illness is first Diagnosed during the Waiting Period, we will only pay benefits for loss beginning after coverage has been in force for [12 months]. Or, the Insured may elect to void the Certificate from the beginning and receive a full premium refund.]

[Pre-Existing Conditions Limitation*]

Pre-existing Condition is a sickness or physical condition that existed within the [3; 6; 12]-month period before the Insured's Effective Date. For this Pre-existing Condition, a medical professional must have advised, Diagnosed, or treated the Insured.

We will **not** pay benefits for any Critical Illness resulting from or affected by a Pre-existing Condition if the Critical Illness was Diagnosed within the [3; 6; 12]-month period **after** the Insured's Effective Date.

The Company will not reduce or deny a claim for benefits for any Critical Illness that was Diagnosed more than [3; 6; 12] months after the Insured's Effective Date.

**Benefits are payable for the reoccurrence of a previously Diagnosed Cancer and/or Carcinoma in Situ as long as the Insured:*

- *Has been free from Signs or Symptoms of that Cancer for a consecutive [12]-month period before the Date of Diagnosis (for the reoccurrence) **and***
- *Has been Treatment-Free from that Cancer for the [12] consecutive months before the Date of Diagnosis (for the reoccurrence).]*

Exclusions

We will not pay for loss due to **any** of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane [or insane]
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts
 - Insurrection or riot
 - Civil commotion or civil state of belligerence
- **Illegal substance abuse[, which includes the following:]**
 - Abuse of legally-obtained prescription medication
 - Illegal use of non-prescription drugs]

Section VI – Claim Provisions

Notice of Claim

The Insured must give written notice of claim:

- Within 60 days after a Diagnosis of Critical Illness **or**
- As soon as reasonably possible.

Notice must include the Insured's name and the Certificate number. Notice can be mailed to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202

Claim Forms

When the Company receives notice of a claim, we will send the Insured forms so that he can file Proof of Loss (details included in the **Proof of Loss** section below). If the Company does not provide the forms within 15 working days, the Insured can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. The Insured will also need to provide a statement by the treating Doctor. The Insured must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). The Insured must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202

The Insured must provide Proof of Loss documentation within 90 days after the date of Diagnosis of the Critical Illness. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for the Insured to provide this proof within the required time. The Insured must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after Diagnosis of the Critical Illness, except in the absence of the Insured's legal mental capacity.

Claims Payment Timeframe

Once we receive proper Proof of Loss, the Company will pay, deny, or settle all clean claims* within 30 calendar days after receiving the appropriate information.

**Clean claims contain all information/documentation needed for processing. These claims do not require further information from the provider, certificate holder, or employer/administrator.*

Payment of Claims

We will pay all benefits to the Insured unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

1. To any approved assignee,
2. To the Insured's beneficiary,
3. To the Insured's surviving Spouse,
4. To the Insured's estate.

Changing of Beneficiary

The Insured can ask us to change his beneficiary at any time. The request must be in writing, and the change must be approved by us. If approved, it will go into effect the day the Insured signs the request. The change will not have any bearing on payments made before we approved the request.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Physical Examination and Autopsy

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Legal Action

The Insured cannot take legal action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

Section VII – General Provisions

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- This Plan,
- The Application,
- Certificates,
- Endorsements,
- Benefit agreements, **and**
- Riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- The Policyholder, **or**
- The Insured, **or**
- The Insured's beneficiary.

This will ensure that Policyholders have an opportunity to review the information they have provided in their Applications. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Insured to be valid.

Misstatement of Age

If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Insured's Application. This does not apply to fraudulent misstatements.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will give the Policyholder a Certificate for each [Employee]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

Required Information

The Policyholder will furnish all information and proofs which the Company may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII – Benefit Schedule

Face Amount:	[See Certificates]
[Reduced Face Amount:	See Certificates]
[Reduced Face Amount Date:	First Renewal Date after age [70]]
[Waiting Period:	[30] days]]
Percentage for Partial Benefits:	25% of applicable Face Amount

Benefits*

The applicable benefit amount [(Face Amount or Reduced Face Amount)] is payable for the following Critical Illnesses:

- [Cancer (internal or invasive)]
- [Heart Attack] [due to coronary artery disease or acute coronary syndrome]
- [Kidney Failure]
- [Major Organ Transplant]
- [Stroke]
 - [Ischemic Stroke due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain]
 - [Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation]
- [Sudden Cardiac Arrest] [due to rhythm abnormalities or acute coronary syndrome]

**Benefits are paid for Covered Dependent Children at [25%] of the [Employee] benefit amount.*

Partial Benefits

[Carcinoma in Situ:

When this Partial Benefit is paid, it will reduce the Cancer Benefit by 25%.]

[Coronary Artery Bypass Surgery

When this Partial Benefit is paid, it will reduce the Heart Attack Benefit by 25%.]

[Additional Benefits]

[Health Screening Benefit Amount: [\$50] per Insured per calendar year.]

[Waiver of Premium]

Section IX – Classifications and Schedule of Premiums

[Section X – Incorporation of Rider Provisions

The attached listed Certificate Riders are made a part of this Plan.

Rider Name

[rider name

Form Number

form number]]



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]

CERTIFICATE OF INSURANCE FOR GROUP CRITICAL ILLNESS INSURANCE POLICY

**This coverage is only for the Critical Illnesses listed in the
Benefit Schedule of this Certificate.
It does not provide benefits for any other sickness or condition.**

**Any Certificates issued in the state of Arkansas are
governed by the state of Arkansas.**

[ABC COMPANY, INC.] (“the Policyholder”) applied for coverage under this Group Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “we,” “us,” or “our”). For the purpose of this Plan, “you” (including “your” and “yours”) may refer to the primary Insured or the primary Insured’s covered Dependents. Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. Your Application is maintained on file and made part of this Certificate. (Please note that male pronouns—such as *he*, *him*, and *his*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

Please read your Certificate carefully.

We certify that you are insured under the Group Critical Illness Policy (the “Plan”). The Plan was issued to your [Employer], the Policyholder. This coverage provides benefits for loss resulting from Critical Illness. The Certificate is subject to the definitions, exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

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Section VIII	-	Benefit Schedule
[Section IX	-	Incorporation of Rider Provisions]
Section X	-	Certificate Schedule

Section I – Eligibility, Effective Date, and Termination

Eligibility

You are an eligible [Employee] under this Plan if you meet the following [four] requirements. You are:

1. [An Employee] of the Policyholder,
2. Engaged in [full; part]-time work, **and**
3. Included in the class of Employees eligible for coverage, as shown on the Application [. ; , **and**]
4. [Under age [70]].

If this coverage is offered only to [Employees], references in this Plan to “Dependent,” “Dependent Child,” “Dependent Children,” and “Spouse,” do not apply.

Dependents are eligible for coverage under this Plan. A *Dependent* is:

- Your Spouse **or**
- The Dependent Child of you or your Spouse. *Dependent Children* are your or your Spouse’s natural children, stepchildren, legally adopted children, or Children Placed for Adoption who are younger than age 26 (details included in the **Definitions** section).

*Insureds** are those who might be eligible for coverage in the following classes under this Plan:

- **[Employee] Coverage** – We insure only the [Employee].
- **[Employee] and Spouse Coverage** – We insure the [Employee] and Spouse.
- **[Employee] and Child Coverage** – We insure the [Employee] and any Dependent Children.
- **Family Coverage** – We insure the [Employee], Spouse, and any Dependent Children.

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

**Details for adding Insureds to your coverage are outlined in the following section (Effective Date).*

Effective Date

Your Certificate Effective Date is the date your insurance takes effect. That date is either the date:

- Shown on the Certificate Schedule if you are Actively at Work on that date **or**
- You return to an Actively-at-Work status if you are not Actively at Work on the date shown on the Certificate Schedule.

The Effective Date for an existing Spouse or Dependent Child when you originally apply for coverage is:

- The date on the Certificate Schedule **if** that Spouse or Dependent Child is not confined to a Hospital **and**:
 - Is eligible for coverage on that date,
 - Has been included on an Application for coverage, **and**
 - Has been included in the premium payment.
- The date the Spouse or Dependent Child is no longer confined to a Hospital (**if** that Spouse or Dependent Child was confined to a Hospital on the Certificate Schedule date) **and**:
 - Is eligible for coverage on that date,
 - Has been included on an Application for coverage, **and**
 - Has been included in the premium payment.

A day is measured from 12:01 a.m. standard time at the Spouse’s or Dependent Child’s place of residence.

A Spouse may be added to the Plan after your Effective Date. To be added, you must complete an Application to add your Spouse to the Plan. The Company will assign the Effective Date for a Spouse's coverage after approving the application.

Newborn children will be covered from the moment of birth (if you have chosen [Employee] and Child Coverage or Family Coverage).

If [Employee] or [Employee] and Spouse coverage is in force and you desire uninterrupted coverage for a newborn, adopted child, or stepchild, you must notify the Company in writing within 31 days of:

- The child's birth (for newborns),
- The date the petition is filed for adoption, **or**
- The date of your marriage (for stepchildren).

The Company will then convert the coverage to [Employee] and Child **or** Family and let you know of any changes in premium.

Plan Termination

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number mutually agreed upon by the Company and the Policyholder in the signed master Application.

The Policyholder has the sole responsibility to notify you of the Plan's termination. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address. If the Plan terminates, we will provide coverage for claims arising from Critical Illnesses that were first Diagnosed while the Plan was in force.

Termination of [an Employee's] Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date you no longer meet the Plan's definition of [an Employee].
- The date you no longer belong to an eligible class.

Insurance for a covered Spouse or Dependent Child will terminate on the earliest of any of the bullet points listed above, **or**:

- The premium due date following the date the covered Spouse or Dependent Child no longer qualifies as a Dependent.
- The premium due date following the date we receive your written request to terminate coverage for your Spouse or all Dependent Children.

If your coverage terminates, we will provide coverage for claims arising from Critical Illnesses that were first Diagnosed while your coverage was in force.

Portability Privilege

When you [end employment with the Employer] and your coverage would otherwise terminate, you may elect to continue your coverage under this Plan. You may continue the coverage that you had on the date your [employment] ended, including any in-force Spouse or Dependent Child coverage.

To keep your Certificate in force, you must:

- Apply to the Company in writing within 31 days after the date your insurance would otherwise terminate, **and**
- Pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.

Coverage will end:

- 31 days after the date you fail to pay any required premium **or**
- The date this Group Plan is terminated, whichever occurs first.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in your previously issued Certificate.]

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount payable on any premium due date. [The rates shown in this Schedule can be changed annually.] The Company will give the Policyholder written notice 31 days before any change in rates becomes effective.

Premium Payments

The first premium is due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

Grace Period

This Plan has a 31-day Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

Section III – Definitions

When the terms below are used in this Plan, the following definitions will apply:

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

[Cancer (internal or invasive) is defined as an Illness meeting **either** of the following definitions:

- A malignant tumor characterized by:
 - The uncontrolled growth and spread of malignant cells **and**
 - The invasion of distant tissue.
- A disease meeting the Diagnosis criteria of malignancy, as established by the American Board of Pathology. The Doctor must have studied the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen.

Cancer includes leukemia and melanoma.

The following are **not** internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinoma in Situ
- Any skin cancers (except melanomas)
- Basal cell carcinoma and squamous cell carcinoma of the skin
- Melanoma that is Diagnosed as
 - Clark's Level I or II or
 - Breslow less than .77mm]

[Carcinoma in Situ is non-invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.]

[Cancer or Carcinoma in Situ must be Diagnosed in one of two ways:

1. **Pathological Diagnosis** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist whose malignancy Diagnosis conforms to the American Board of Pathology standards.
2. **Clinical Diagnosis** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis **only if**:
 - A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
 - Medical evidence exists to support the Diagnosis, **and**
 - A Doctor is treating you for Cancer or Carcinoma in Situ.]

[Coronary Artery Bypass means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.]

Critical Illness is a sickness or disease that first manifests while the Insured's coverage is in force [and after any applicable Waiting Period]. Any loss due to Critical Illness must begin while the Insured's coverage is in force. Critical Illness includes **only** the following:

- [Cancer]
- [Heart Attack] [due to coronary artery disease or acute coronary syndrome]
- [Stroke]
 - [Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain]
 - [Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation]
- [Sudden Cardiac Arrest][due to cardiac rhythm abnormalities or acute coronary syndrome]
- [Kidney Failure]
- [Major Organ Transplant]

Date of Diagnosis is defined for each Critical Illness as follows:

- [**Cancer and/or Carcinoma in Situ**: The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens). This includes the recurrence of a previously Diagnosed Cancer as long as you:
 - Are free from any Signs or Symptoms for a consecutive 12-month period before the Date of Diagnosis (for the reoccurrence),
 - Are currently Treatment-Free from that Cancer, **and**
 - Have been Treatment-Free from that Cancer for [12] consecutive months.]
- [**Heart Attack**: The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack definition.]
- [**Ischemic or Hemorrhagic Stroke**: The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).]
- [**Sudden Cardiac Arrest**: The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).]
- [**Kidney Failure**: The date a Doctor recommends that an Insured begin renal dialysis.]
- [**Major Organ Transplant or Coronary Artery Bypass**: The date the surgery occurs.]

Dependent means your Spouse or your Dependent Child. **Dependent Children** are your or your Spouse's natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

Children Placed for Adoption are Children for whom you have entered a decree of adoption or for whom you have instituted adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

There is an exception to the age-26 limit listed above. This limit will not apply to any Child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You or your Spouse must furnish proof of this incapacity and dependency to the Company.

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:

- Is made by a Doctor **and**
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness **must** meet the requirements outlined in this Certificate for the particular Critical Illness being Diagnosed.

[Diagnosis must be made and treatment must be received in the United States.]

Doctor is defined as a person who is:

- Legally qualified to practice medicine,
- Licensed as a Doctor by the state where Treatment is received, **and**
- Licensed to treat the type of condition for which a claim is made.

A Doctor does **not** include you or your Family Member.

[Employee] is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The [Employee] is the primary Insured under this Plan.

Family Member includes your **Spouse** (who is defined as your legal wife or husband) as well as the following members of your immediate family:

- son
- daughter
- mother
- father
- sister
- brother

This includes Step-Family Members and Family-Members-in-law.

[Heart Attack (Myocardial Infarction)] is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries [due to coronary artery disease or acute coronary syndrome.]

Heart Attack does **not** include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Myocardial Infarction.

Diagnosis of a Heart Attack must include **all** of the following:

- New and serial electrocardiographic (EKG) findings consistent with Myocardial Infarction;
- Elevation of cardiac enzymes above generally accepted laboratory levels of normal (in the case of creatine phosphokinase {CPK}, a CPK-MB measurement must be used); **and**
- Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms.]

[Kidney Failure (Renal Failure)] refers to end-stage renal failure, which is the chronic, irreversible failure of both kidneys to function.

Kidney Failure is covered **only** if one of the following occurs:

- Regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) are necessary to treat the Kidney Failure; **or**
- The Kidney Failure results in kidney transplantation.

The Company will not cover Kidney Failure caused by a traumatic event, including surgical trauma.]

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into full remission because of primary treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat or suppress a Cancer that is still present.

[Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas.

Pathologist is a Doctor who is licensed:

- To practice medicine **and**
- By the American Board of Pathology to practice pathologic anatomy.

A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology. Pathologist does **not** include you or a Family Member.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of his license.

[Stroke means the death of a portion of the brain producing neurological sequelae, including infarction of brain tissue, hemorrhage, and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

[Stroke must be either:

- Ischemic Stroke due to advanced arteriosclerosis of the arteries of the neck or brain
- Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation.]

Stroke does **not** include:

- Transient ischemic attacks (TIAs).
- Head injury.
- Chronic cerebrovascular insufficiency.
- Reversible ischemic neurological deficits.

Stroke will be covered **only** if you submit evidence of the permanent neurological damage by providing:

- Computed Axial Tomography (CAT scan) images **or**
- Magnetic Resonance Imaging (MRI).]

[Successor Insured means that if you die while covered under a Certificate, then your surviving Spouse becomes the primary Insured if that Spouse is also insured under this Plan. If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date.]

[Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction[, due to cardiac rhythm abnormalities or acute coronary syndrome]. For the purposes of this Plan, a death is a Sudden Cardiac Arrest when the sole cause of death (as shown on the death certificate) is one of the following[, that is the result of cardiac rhythm abnormalities or acute coronary syndrome]:

- Cardiovascular collapse
- Sudden Cardiac Arrest
- Cardiac arrest
- Sudden cardiac death

Sudden Cardiac Arrest is **not** a Heart Attack.]

Total Disability or **Totally Disabled** means you are:

- Unable to Work (defined later in this section),
- Not working at any job for pay or benefits, **and**
- Under the care of a Doctor for the treatment of a covered Critical Illness.

Treatment or **Medical Treatment** is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Carcinoma in Situ has returned.

Unable to Work means either:

- During the first 365 days of Total Disability, you are unable to work at the occupation you were performing when your Total Disability began; **or**
- After the first 365 days of Total Disability, you are unable to work at any gainful occupation for which you are suited by education, training, or experience.

[**Waiting Period** is the number of days after the Effective Date before we will pay benefits for a Critical Illness. We will not pay benefits for a Critical Illness whose Date of Diagnosis begins during the Waiting Period.]

Section IV – Benefit Provisions

The language in this provision matches that of the Plan. As this Certificate is issued to the primary Insured, we included the use of "you" and "yours."*

The benefit amounts payable under this section are shown in the Benefit Schedule.

**Remember, for the purpose of this Plan, “you” (including “your” and “yours”) may refer to the primary Insured or the primary Insured’s covered Dependents.*

Critical Illness Benefit

We will pay this benefit when you are Diagnosed with one of the Critical Illnesses shown in the Benefit Schedule. We will pay this benefit if:

- [The Date of Diagnosis is after the Waiting Period,]
- The Date of Diagnosis is while your coverage is in force, **and**
- The Certificate does not exclude the illness or condition by name or by specific description.

[If the date of a Critical Illness Diagnosis occurs during the Waiting Period, you may return the Certificate for a full premium refund.]

[If the Schedule shows a Benefit Reduction Date, the Certificate’s Benefit Amount will change to the Reduced Benefit Amount on that date.] Benefits will be based on the Benefit Amount in effect on the Critical Illness Date of Diagnosis.

The Company will pay benefits for a Critical Illness in the order the events occur. The Company will deduct any previously-paid partial benefits from the appropriate Critical Illness benefit.

[Separate Diagnosis Benefit

The Company will pay benefits for each **different** Critical Illness after the first when the following two conditions are met:

1. The Date of Diagnosis for the new Critical Illness is separated from the prior, different Critical Illness by at least [6] months[, or if you are Treatment-Free From Cancer for at least [6] months], **and**
2. The new Critical Illness is not caused or affected by a Critical Illness for which benefits have been paid.]

[Reoccurrence Benefit

Once benefits have been paid for a Critical Illness, the Company will pay additional benefits for that **same** Critical Illness when the Dates of Diagnosis are separated by at least [12] months [or you have been Treatment-Free From Cancer for at least [12] months and are currently Treatment-Free].

Cancer that has metastasized (spread), even though there is a new tumor, is not considered an additional occurrence unless you have been Treatment-Free for [12] months and are currently Treatment-Free].

[Health Screening Benefit (Calendar Year Limit)

We will pay the amount shown in the Benefit Schedule for Health Screening Tests performed [after the Waiting Period and] while your coverage is in force. We will pay this benefit once per calendar year. Benefits are paid for Covered Dependent Children at 100% of the [Employee] benefit amount.

[This benefit is only payable for Health Screening Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.]

Health Screening Tests include, but are not limited to, the following:

- stress test on a bicycle or treadmill
- CA 15-3 (blood test for breast cancer)
- hemocult stool analysis
- fasting blood glucose test
- CA 125 (blood test for ovarian cancer)
- mammography
- blood test for triglycerides
- CEA (blood test for colon cancer)
- pap smear
- serum cholesterol test to determine level of HDL and LDL
- chest X-ray
- PSA (blood test for prostate cancer)
- bone marrow testing
- colonoscopy
- serum protein electrophoresis (blood test for myeloma)
- breast ultrasound
- flexible sigmoidoscopy
- thermography]

[Waiver of Premium Benefit

A Critical Illness may result in more than [90] days of Total Disability for you. If a covered Critical Illness causes you to be Totally Disabled for [90] days, the Company will waive the premium payments for this coverage for the first [90] days of Total Disability and for each following day until the earliest of the following:

- You are no longer Totally Disabled,
- [The company has waived premiums for a total of [24 months] of Total Disability,]
- [You reach age 65 or are 2 years from the date of Total Disability, whichever occurs last,] **or**
- Coverage ends according to the Termination of Coverage provision.

At the end of the waiver period, you must resume paying premiums to keep this coverage in force. Premiums waived include those for the [Employee] and those for currently covered Dependents or Riders that are in force.

For premiums to be waived, you must provide satisfactory proof of Total Disability at least once every 12 months.]

Section V – Exclusions

[This Plan contains a [30-day] Waiting Period. This means that we will not pay benefits to you if you were Diagnosed [or had a Health Screening Test performed] before your coverage was in force [30 days] from the Effective Date. If a Critical Illness is first Diagnosed during the Waiting Period, we will only pay benefits for loss beginning after coverage has been in force for [12 months]. Or, you may elect to void the Certificate from the beginning and receive a full premium refund.]

Pre-Existing Conditions Limitation*

Pre-existing Condition is a sickness or physical condition that existed within the [3; 6; 12]-month period before your Effective Date. For this Pre-existing Condition, a medical professional must have advised, Diagnosed, or treated you.

We will **not** pay benefits for any Critical Illness resulting from or affected by a Pre-existing Condition if the Critical Illness was Diagnosed within the [3; 6; 12]-month period **after** your Effective Date.

The Company will not reduce or deny a claim for benefits for any Critical Illness that was Diagnosed more than [3; 6; 12] months after your Effective Date.

**Benefits are payable for the reoccurrence of a previously Diagnosed Cancer and/or Carcinoma in Situ as long as you:*

- *Have been free from Signs or Symptoms of that Cancer for a consecutive [12]-month period before the Date of Diagnosis (for the reoccurrence) **and***
- *Have been Treatment-Free from that Cancer for the [12] consecutive months before the Date of Diagnosis (for the reoccurrence).]*

Exclusions

We will not pay for loss due to **any** of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure yourself intentionally or taking action that causes you to become injured
- **Suicide** – committing or attempting to commit suicide, while sane [or insane]
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts
 - Insurrection or riot
 - Civil commotion or civil state of belligerence
- **Illegal substance abuse[, which includes:**
 - Abuse of legally-obtained prescription medication
 - Illegal use of non-prescription drugs]

Section VI – Claim Provisions

Notice of Claim

You must give written notice of claim:

- Within 60 days after Diagnosis of a Critical Illness **or**
- As soon as reasonably possible.

Notice must include your name and the Certificate number. Notice can be mailed to the Company at:
P.O. Box 427, Columbia, South Carolina, 29202

Claim Forms

When the Company receives notice of a claim, we will send you forms so that you can file Proof of Loss (details included in the **Proof of Loss** section below). If the Company does not provide the forms within 15 working days, you can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. You will also need to provide a statement by the treating Doctor. You must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). You must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202

You must provide Proof of Loss documentation within 90 days after the date of Diagnosis of a Critical Illness. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for you to provide this proof within the required time. You must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after Diagnosis of the Critical Illness, except in the absence of your legal mental capacity.

Claims Payment Timeframe

Once we receive proper Proof of Loss, the Company will pay, deny, or settle all clean claims* within 30 calendar days after receiving the appropriate information.

**Clean claims contain all information/documentation needed for processing. These claims do not require further information from the provider, certificate holder, or employer/administrator.*

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

1. To any approved assignee,
2. To your beneficiary,
3. To your surviving Spouse,
4. To your estate.

Changing Your Beneficiary

You can ask us to change your beneficiary at any time. The request must be in writing and the change must be approved by us. If approved, it will go into effect the day you sign the request. The change will not have any bearing on payments made before we approved the request.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Physical Examination and Autopsy

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Legal Action

You cannot take legal action against us for benefits under this Plan:

- Within 60 days after you have sent us written Proof of Loss **or**
- More than 3 years from the time written proof is required to be given.

Section VII – General Provisions

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- The Plan,
- The Application,
- Certificates,
- Endorsements,
- Benefit agreements, **and**
- Riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- The Policyholder, **or**
- The Insured, **or**
- The Insured's beneficiary.

This will ensure that Certificate holders have an opportunity to review the information they have provided in their Applications. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Insured to be valid.

Misstatement of Age

If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

Time Limit on Certain Defenses

After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Application. This does not apply to fraudulent misstatements.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will give the Policyholder a Certificate for each [Employee]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**

- The rights and privileges under the Plan.

Required Information

The Policyholder will furnish all information and proofs which the Company may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII – Benefit Schedule

Face Amount:	[\$xx.xx]
[Reduced Face Amount:	[\$xx.xx]]
[Reduced Face Amount Date:	First Renewal Date after age [70]]
[Waiting Period:	30 Days]
Percentage for Partial Benefits:	25% of applicable Face Amount

Benefits*

The applicable benefit amount [(Face Amount or Reduced Face Amount)] is payable for the following Critical Illnesses:

- [Cancer (internal or invasive)]
- [Heart Attack] [due to coronary artery disease or acute coronary syndrome]
- [Kidney Failure]
- [Major Organ Transplant]
- [Stroke]
 - [Ischemic Stroke due to advanced arteriosclerosis or arteriosclerosis of the arteries of the neck or brain]
 - [Hemorrhagic Stroke due to uncontrolled high blood pressure, malignant hypertension, brain aneurysm, or arteriovenous malformation]
- [Sudden Cardiac Arrest] [due to rhythm abnormalities or acute coronary syndrome]

**Benefits are paid for Covered Dependent Children at [25%] of the [Employee] benefit amount.*

Partial Benefits

[Carcinoma in Situ:

When this Partial Benefit is paid, it will reduce the Cancer Benefit by 25%.]

[Coronary Artery Bypass Surgery

When this Partial Benefit is paid, it will reduce the Heart Attack Benefit by 25%.]

[Additional Benefits]

[Health Screening Benefit Amount: [\$50] per Insured per calendar year.]

[Waiver of Premium]

[Section IX – Incorporation of Rider Provisions

The attached listed Certificate Riders are made a part of this Plan.

Rider Name

[rider name

Form Number

form number]]

Section X – Certificate Schedule

INSURED [John A. Doe]	GROUP POLICY NUMBER [1234]
EFFECTIVE DATE [January 1, 2012]	CERTIFICATE NUMBER [56789]
INITIAL PREMIUM* [\$109.75 Monthly]	FIRST RENEWAL DATE [January 1, 2013]

*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by your Certificate.

MASTER APPLICATION FOR GROUP CRITICAL ILLNESS INSURANCE

Application is hereby made to:



CONTINENTAL AMERICAN INSURANCE COMPANY

**[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]**

By _____
[Employer, Union] Name

Of _____
Home Office Location (City and State)

For a Plan of Group Critical Illness Insurance. Representations are made as follows:

1. Class of [Employees] Eligible for Coverage:

- Regular [full; part]-time [Employees] [under age [70]]
- Regular [full-part]-time [Employees] [under age [70]] except _____
- Other: _____

[Employee] Requirements

A [full; part]-time [Employee] is one who works ____ hours or more per week. An [Employee] must be Actively at Work on the date he applies for coverage and on the date his Group Critical Illness Insurance becomes effective. An [Employee] must complete _____ month[s] of continuous service to be eligible for coverage.

2. The minimum number of enrolled [Employees] necessary to keep the Group Policy in force: _____

3. The requested effective date for the Group Policy: _____

4. **Optional Features:** Automatic Increase Rider Dependent Child Benefit Rider
 Specified Critical Illness Rider

5. Will this Group Critical Illness Policy replace any existing Group Critical Illness Policy?
 Yes No

[If this coverage will replace any existing Aflac individual policy please be aware that it may be in your [Employees'] best interest to maintain their individual guaranteed-renewable policy with Aflac via direct bill. [Employees] may contact Aflac for an explanation of their options for both continuation or cancellation of any existing coverage.]

6. General Agreement:

[The policyholder agrees to transmit the total premiums under the Group Policy to Continental American Insurance Company at its Home Office when due.] No agent or other person except an officer can make or change any contract or agreement on behalf of Continental American Insurance Company.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

By (Signature)	Date
Title	



**CONTINENTAL AMERICAN
INSURANCE COMPANY**

ENROLLMENT FORM

Please Mail To: Post Office Box 427
Columbia, South Carolina 29202
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
<i>Critical Illness</i>		
Endorsement:		
EFFECTIVE DATE:		

[Employee] Name/Certificate Holder (First, MI, Last)		Social Security Number/ID Number	Gender	Date of Birth
Street Address		City	State	ZIP
[Employer]	Job Class	Location	Date of Hire	
Hours Worked	Daytime Phone Number ()	Beneficiary Name/Relationship (estate unless designated otherwise)		
Spouse's Name (if coverage is requested)		Gender	Spouse's Date of Birth	
		[Employee]	Spouse	
Are you actively at work?		<input type="checkbox"/> YES <input type="checkbox"/> NO		
Are you now hospitalized or unable to perform your normal duties and activities?				<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you used tobacco products in the last 12 months?		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

CRITICAL ILLNESS [Employee] [Employee] and Spouse] [Employee] and Child] Family] [Section 125: Yes No]

[Employee] Face Amount: \$_____ [Employee] Cost per pay period: \$_____

Automatic Increase Rider Specified Critical Illness Rider Dependent Child Benefit Rider

Spouse Face Amount: \$_____ Spouse Cost per pay period: \$_____

[NOTE: In addition to your total premium payment, you will be charged a [bi-weekly] administration fee of [\$x.xx].]

		[Employee]	Spouse
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever received any advice, treatment, or consultation for any disorder of the central nervous system, Parkinson's Disease, Alzheimer's Disease, dementia, senility, or organic brain syndrome?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	In the last 2 years, have you had a prolonged state of unconsciousness lasting more than 48 hours or that left you with a significant neurological disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

5	Have you ever been treated for or diagnosed with any of the following: a) Stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) Are you now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---	--	--

Does this coverage replace or change any existing insurance? YES NO
 If yes, provide carrier and policy number: _____

[If this coverage will replace any existing Aflac individual policy please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy with Aflac via direct bill. You may contact Aflac for an explanation of your options for both continuation or cancellation of your existing coverage.]

Coverage will not become effective unless you are actively at work on the enrollment date and the effective date.

CERTIFICATION: I have read the completed Application and I realize any false statement or misrepresentation in the Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Application is approved and the necessary premium is paid.

[I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.]

[I authorize my employer to deduct the appropriate dollar amount from my earnings to pay Continental American Insurance Company the required premium each pay period for my insurance.

Deduction start date _____]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ Agent No. _____ State of Enrollment _____



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]

DEPENDENT CHILD BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, **and**
- You paid the additional premium for this Rider.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Rider, “you” (including “your” and “yours”) may refer to the primary Insured or the primary Insured’s Spouse.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective on the Certificate Effective Date. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

Definitions

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Dependent Children are your natural children, step-children, legally adopted children, or children placed for adoption who are younger than age 26.

Children Placed for Adoption are Children for whom you have entered a decree of adoption or for whom you have instituted adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

Dependent Child coverage will terminate on that Child’s 26th birthday. If the Child is Diagnosed with a covered Critical Illness **before** his 26th birthday, we will pay this claim (whether the claim is filed before or after the Child’s 26th birthday).

There is an exception to the age-26 limit listed above. This limit will not apply to any Child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. The [Employee] or Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Child’s 26th birthday.

This Rider will cover Dependent Children from the moment of live birth in the following circumstances:

- Your natural Child is born after this Rider’s Effective Date. You do not have to provide notice or pay any additional premium.
- You enter a decree of adoption for a Child, **or** you and/or your Spouse have initiated adoption proceedings for a Child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You or your Spouse must continue to have custody pursuant to the decree of the court.

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:

- Is made by a Doctor **and**
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness **must** meet the requirements outlined in this Rider for the particular Specified Critical Illness being Diagnosed.

Specified Critical Illness is one of the following illnesses defined below and shown in the Rider Schedule:

Cystic Fibrosis is a hereditary chronic disease of the exocrine glands. This disease is characterized by the production of viscid mucus that obstructs the pancreatic ducts and bronchi, leading to infection and fibrosis.

Cerebral Palsy is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, involuntary and uncontrolled movements, or a disturbed sense.

- **Spastic Cerebral Palsy** is characterized by stiffness and movement difficulties.
- **Athetoid Cerebral Palsy** is characterized by involuntary and uncontrolled movements.
- **Ataxic Cerebral Palsy** is characterized by a disturbed sense of balance and depth perception.

Cleft Lip occurs when there is an opening (one or two vertical fissures) in the lip. A **Cleft Palate** occurs when the two sides of a palate do not join, resulting in an opening in the roof of the mouth or soft tissue in the back of the mouth. Sometimes, an opening in the bones of the upper jaw or upper gum accompanies a Cleft Palate.

A Cleft Lip or Palate can occur on one or both sides of the face. If a Child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

Down Syndrome is a chromosomal condition characterized by the presence of an extra copy of genetic material on the 21st chromosome, either in whole or part.

Spina Bifida refers to any birth defect involving incomplete closure of the spine. This includes:

- **Spina Bifida Cystica**, which is a condition where a cyst protrudes through the defect in the vertebral arch.
- **Spina Bifida Occulta**, which is a condition where the bones of the spine do not close, but the spinal cord and meninges remain in place. Skin usually covers the defect.
- **Meningocele**, which is a condition where the tissue covering the spinal cord sticks out of the spinal defect, but the spinal cord remains in place.
- **Myelomeningocele**, which is a condition where the unfused portion of the spinal column allows the spinal cord to protrude through an opening. The meningeal membranes that cover the spinal cord form a sac enclosing the spinal elements.

Benefit Provisions

While this Rider is in force, if a Dependent Child is Diagnosed with a covered Critical Illness or Specified Critical Illness [after any applicable Waiting Period], we will pay the benefit amounts shown in the Dependent Child Benefit Rider Schedule.

[Limitations and] Exclusions

[This Plan contains a [30-day] Waiting Period. This means that we will not pay benefits for a Dependent Child who has been Diagnosed before the Dependent Child's coverage has been in force [30 days] from the Effective Date. If a Critical Illness is first Diagnosed during the Waiting Period, we will only pay benefits for loss beginning after coverage has been in force for [12 months]. Or, the Insured may elect to void the Certificate from the beginning and receive a full premium refund.]

We will **not** pay benefits for any Critical Illness resulting from or affected by a Pre-existing Condition if the Critical Illness was Diagnosed within the [3; 6; 12]-month period **after** your Effective Date.

The Company will not reduce or deny a claim for benefits for any Critical Illness that was Diagnosed more than [3; 6; 12] months after the Effective Date of this Rider.

Exclusions

We will not pay for loss due to **any** of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure yourself intentionally or taking action that causes you to become injured
- **Suicide** – committing or attempting to commit suicide, while sane [or insane]
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts
 - Insurrection or riot
 - Civil commotion or civil state of belligerence
- **Illegal substance abuse[, which includes:]**
 - Abuse of legally-obtained prescription medication
 - Illegal use of non-prescription drugs

General Provisions

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Insured's Application. This does not apply to fraudulent misstatements.

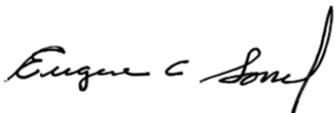
Contract

This Rider is part of the Critical Illness Certificate. It will terminate when:

- The Certificate terminates,
- Premiums are no longer paid for this Rider, or
- The covered Dependent Child reaches age 26 (details in the **Definitions** section under *Dependent Children*).

This Rider is subject to all of the terms of the Certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,



[Eugene C. Sorrel, President]

Sample Dependent Child Benefit Rider Schedule

Insured - John A. Doe
Effective Date - [December 1, 1999]
Initial Premium - [\$00.00 Monthly]

Group Policy Number - XXXX
Certificate Number - XXXX
First Renewal Date - [December 1, 2000]

BENEFITS

[Cystic Fibrosis]	[100]% of applicable Face Amount]
[Cerebral Palsy]	[100]% of applicable Face Amount]
[Cleft Lip or Cleft Palate]	[100]% of applicable Face Amount]
[Down Syndrome]	[100]% of applicable Face Amount]
[Spina Bifida]	[100]% of applicable Face Amount]



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]

AUTOMATIC INCREASE RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, **and**
- You paid the additional premium for this Rider.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Rider, “you” (including “your” and “yours”) may refer to the primary Insured or the primary Insured’s covered Dependents.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective on the Certificate Effective Date. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

Notification of Automatic Increase

Before each Certificate Effective Date, we will send you a new Certificate Schedule showing your new Face Amount. You may refuse an automatic increase by sending us written notice within 31 days after you receive your new Certificate Schedule. However, if you refuse an automatic increase:

- This Rider will automatically stop,
- You will not be eligible for any further automatic increases, **and**
- You cannot reinstate this Rider at a future date.

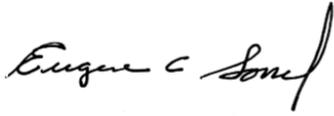
General Provisions

This Rider is part of the Critical Illness Certificate and will terminate when that Certificate terminates, or when premiums are no longer paid for this Rider.

The premium for this Rider is shown in the Rider Schedule. Premiums for this Rider are payable until the Rider terminates.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,



[Eugene C. Sorrel, President]

Rider Schedule

Insured - SAMPLE
Effective Date - SAMPLE

Group Policy Number - SAMPLE
Certificate Number - SAMPLE
First Renewal Date - SAMPLE

Aflac[®]

CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]

HEART EVENT RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, **and**
- You paid the additional premium for this Rider.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Rider, “you” (including “your” and “yours”) may refer to the primary Insured or the primary Insured’s covered Dependents.

The Benefits provided in this Rider amend any benefits shown in the base plan for the same conditions.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective on the Certificate Effective Date. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

Definitions

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Covered Heart Procedure is one of the Category I or Category II procedures defined below:

Category I – Specified Surgeries of the Heart

Specified Surgeries of the Heart (Open Heart Surgery) refers to open chest surgery, where the heart is exposed and/or manipulated for open cardiothoracic situations. We will pay benefits for the following Open Heart Surgery procedures **only**:

- **Coronary Artery Bypass Surgery** (also **Coronary Artery Bypass Graft Surgery** or **Bypass Surgery**) is a surgical procedure performed to relieve angina and reduce the risk of death from coronary artery disease.
 - **Off-Pump Coronary Artery Bypass (OPCAB)** is a form of bypass surgery that does not stop the heart or use the heart lung machine.
 - **Coronary Artery Bypass Grafting (CABG)** is used to treat a narrowing of the coronary arteries when the blockages are hard to reach or are too long or hard for angioplasty. A blood vessel, usually taken from the leg or chest, is grafted onto the blocked artery, creating a bypass around the blockage. **If more than one artery is blocked, a bypass can be done on each, but only one benefit is payable under this Rider.**
- **Mitral Valve Replacement** or **Repair** refers to a cardiac surgery procedure in which a patient’s mitral valve is repaired or replaced by a different valve.

- **Aortic Valve Replacement** or **Repair** is a cardiac surgery procedure in which a patient's aortic valve is repaired or replaced by a different valve.
- **Surgical Treatment of Abdominal Aortic Aneurysm** (to prevent aneurysm rupture) involves opening the abdomen, finding the aorta, and removing (excising) the aneurysm. Abdominal aortic aneurysm is a ballooning or widening of the main artery (the aorta) as it courses down through the abdomen. At the point of the aneurysm, the aneurysm generally measures at least 3 centimeters in diameter.

*Category I benefits exclude all procedures not specifically listed above. For example, procedures such as (but not limited to) the ones listed below are **not** covered:*

- *Angioplasty*
- *Laser relief*
- *Stents*

Category II – Invasive Procedures and Techniques of the Heart

We will pay Category II benefits for the following procedures **only**:

- **AngioJet Clot Busting** clears blood clots from coronary arteries before angioplasty and stenting. The device delivers a high-pressure saline solution through the artery to the clot, breaking it up and simultaneously drawing it out.
- **Balloon Angioplasty** (or **Balloon Valvuloplasty**) opens a clogged blood vessel. A thin tube is threaded through an artery to the narrowed heart vessel, where a small balloon at its tip is inflated. A balloon opens the narrowing by compressing atherosclerotic plaque against the vessel wall. The balloon is then deflated and removed.
- **Laser Angioplasty**, which is similar to balloon angioplasty, uses a laser tip to burn/break down plaque in the clogged blood vessel.
- **Atherectomy** opens blocked coronary arteries or clear bypass grafts by using a device on the end of a catheter to cut or shave away atherosclerotic plaque.
- **Stent Implantation** is the implantation of a stainless steel mesh coil in a narrowed part of an artery to keep it propped open.
- **Cardiac Catheterization** (also **Heart Catheterization**) is a diagnostic and occasionally therapeutic procedure that allows a comprehensive examination of the heart and surrounding blood vessels.
- **Automatic Implantable** (or **Internal**) **Cardioverter Defibrillator (AICD)** refers to the initial placement of the AICD. AICDs are used for treating irregular heartbeats. The defibrillator is surgically placed inside the patient's chest where it monitors the heart's rhythm. When it identifies a serious arrhythmia, it produces an electrical shock to disrupt the arrhythmia.
- **Pacemaker Placement** refers to the initial placement/implantation of a pacemaker, which sends electrical signals to make the heart beat when a person's natural pacemaker is not working properly. This electrical device is placed under the skin. A lead extends from the device to the right side of the heart. Most pacemakers are used to correct a slow heart rate.

Subject to the Reoccurrence Benefit in your Certificate, only one Category II benefit is payable. Benefits will not be paid for multiple procedures listed under the Category II benefit.

Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If a Category I and a Category II procedure are performed at the same time, benefits are eligible only at the [100%] (higher) event and will not exceed the initial face amount shown on the Rider Schedule. You are eligible to receive only one payment for each benefit category listed on the schedule page. The dates of loss for covered procedures must be separated by at least [12 months] for benefits to be payable for multiple covered procedures.

*Category II Benefits exclude **all** procedures that are not specifically listed above.*

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:

- Is made by a Doctor **and**
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness **must** meet the requirements outlined in this Rider for the particular condition being Diagnosed.

[Diagnosis must be made and treatment must be received in the United States.]

Treatment or Medical Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

[**Waiting Period** means the number of days after the Effective Date before we will pay benefits for loss due to a Covered Heart Procedure. We will not pay benefits for a Covered Heart Procedure that begins during the Waiting Period.]

Benefit Provisions

We will pay the applicable Category I or Category II benefit if you are treated with one of the procedures shown on the Rider Schedule as long as:

- [The Date of Treatment is after the Waiting Period,]
- Treatment is incurred while this Rider is in force,
- Treatment is recommended by a physician, **and**
- It is not excluded by name or specific description in this Rider.

This Rider pays the indicated percentages of the Face Amount shown in the Certificate Schedule that occurs while this Rider is in force. Benefits are not payable under this Rider for loss if these conditions result from another Specified Critical Illness other than Heart Attack. For Heart Attack, we will pay applicable benefits.

[Payment of initial, Reoccurrence, or Separate Diagnosis benefits are subject to the Benefit Provisions section of your Certificate.]

[Limitations and] Exclusions

[This Plan contains a [30-day] Waiting Period. This means that we will not pay benefits to an Insured who has been Diagnosed before his coverage has been in force [30 days] from the Effective Date. If a Covered Heart Procedure is first Diagnosed during the Waiting Period, we will only pay benefits for loss beginning after coverage has been in force for [12 months]. Or, the Insured may elect to void the Certificate from the beginning and receive a full premium refund.]

Pre-Existing Conditions Limitation

Pre-existing Condition is a sickness or physical condition that existed within the [3; 6; 12]-month period before the Insured's Effective Date. For this Pre-existing Condition, a medical professional must have advised, Diagnosed, or treated the Insured.

We will **not** pay benefits for any Covered Heart Procedure resulting from or affected by a Pre-existing Condition if the Covered Heart Procedure was Diagnosed within the [3; 6; 12]-month period **after** the Insured's Effective Date.

The Company will not reduce or deny a claim for benefits for any Covered Heart Procedure that was Diagnosed more than [3; 6; 12] months after the Effective Date of this Rider.]

Any benefits for Coronary Artery Bypass Surgery denied under this rider due to pre-existing conditions may be paid at the reduced benefit amount under the certificate, subject to the terms of the Certificate.

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts
 - Insurrection or riot
 - Civil commotion or civil state of belligerence
- **Illegal substance abuse**

No benefits will be paid for loss that occurred before the Effective Date of this Rider.

General Provisions

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Insured's Application. This does not apply to fraudulent misstatements.

Contract

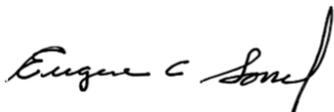
This Rider is part of the Critical Illness Certificate. It will terminate when:

- That Certificate terminates, **or**
- Premiums are no longer paid for this Rider.

The Rider Schedule shows the premium amount. Premiums for this Rider must be paid for the number of years shown in the Rider Schedule or until the Rider terminates.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,



[Eugene C. Sorrel, President]

RIDER SCHEDULE

Insured -	John A. Doe	Group Policy Number -	XXXX
Effective Date -	December 1, 2008	Certificate Number -	XXXX
Initial Premium -	\$00.00 Monthly	First Renewal Date -	January 1, 2009

BENEFITS

Face Amount: **[\$10,000]**
Benefits reduce by [50%] at age [70].

Category I
Specified Surgeries of the Heart: [100%*] of Face Amount

Category II
Invasive Procedures and Techniques of the Heart: [10%] of Face Amount

This [100%] represents the combination of total of applicable benefits available in this Rider **and benefits available in the Certificate (for the same conditions). When combined, benefits from the Rider and Certificate **will not exceed [100%]** of the maximum applicable benefit. Note that the 25% Coronary Artery Bypass Surgery (CABS) partial benefit in your base certificate is increased to [100%] with this Rider. The CABS benefit in this Rider, combined with the benefit in your base certificate, equal [100%] of the maximum benefit—**not [125%]**.*

Benefits for Category II will reduce the benefit amounts payable for Category I benefits. Benefits will be paid only at the highest benefit level. If a Category I and a Category II procedure are performed at the same time, benefits are eligible only at the [100%] (higher) event and will not exceed the initial face amount shown on the Rider Schedule. You are eligible to receive only one payment for each benefit category listed on the schedule page. The dates of loss for covered procedures must be separated by at least [12 months] for benefits to be payable for multiple covered procedures.



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]

SPECIFIED CRITICAL ILLNESS RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, **and**
- You paid the additional premium for this Rider.

Unless amended by this Rider, all Certificate definitions, exclusions, limitations, terms, and other provisions apply. For the purpose of this Rider, “you” (including “your” and “yours”) may refer to the primary Insured or the primary Insured’s covered Dependents.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective on the Certificate Effective Date. If issued after the Certificate, this Rider will have a later Effective Date, which is shown in the Rider Schedule following this Rider.

Definitions

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this policy, ADLs include the following:

- **Maintaining continence** – controlling urination and bowel movements, including the ability to use ostomy supplies or other devices (such as catheters).
- **Transferring** – moving between a bed and a chair or a bed and a wheelchair.
- **Dressing** – putting on and taking off all necessary items of clothing.
- **Toileting** – getting to and from a toilet, getting on and off a toilet, and performing associated personal hygiene.
- **Eating** – performing all major tasks of getting food into the body.
- **Bathing** – washing oneself by sponge bath or in either a tub or shower, including getting into or out of the tub or shower.

Covered Accident means an unforeseen and unexpected traumatic event resulting in bodily injury. An event meets the qualifications of Covered Accident if it:

- Occurs on or after the Plan’s Effective Date,
- Occurs while coverage is in force, **and**
- Is not specifically excluded.

A Covered Accident **must** occur while you are covered by this Rider.

Date of Diagnosis is defined for each Specified Critical Illness as follows:

- [**Advanced Alzheimer's Disease** – The date a Doctor Diagnoses you as incapacitated due to Alzheimer's disease.]
- [**Advanced Parkinson's Disease:** The date a Doctor Diagnoses you as incapacitated due to Parkinson's disease.]
- [**Benign Brain Tumor:** The date a Doctor determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.]
- [**Coma:** The first day of the period for which a Doctor confirms a Coma has lasted for 7 consecutive days.]
- [**Loss of Sight, Speech, or Hearing:** The date the loss is objectively determined by a Doctor to be total and irreversible.]
- [**Occupational HIV:** The date a Doctor determines you are HIV positive as supported by the ELISA test, Western Blot test, or another test approved by the FDA.]
- [**Paralysis:** The date a Doctor establishes the Diagnosis of Paralysis on clinical and/or laboratory findings as supported by medical records (based on the Paralysis definition).]
- [**Severe Burn:** The date the burn takes place.]

Diagnosis (also Diagnosed) refers to the definitive and certain identification of an illness that:

- Is made by a Doctor **and**
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness **must** meet the requirements outlined in this Rider for the particular Specified Critical Illness being Diagnosed.

[Diagnosis must be made and treatment must be received in the United States.]

HIV-Specific Covered Injury means an accidental:

- Cutaneous exposure through abraded skin,
- Percutaneous exposure, **or**
- Mucocutaneous exposure.

An HIV-Specific Covered Injury **must** occur while you are covered by this Rider.

Specified Critical Illness is one of the illnesses defined below and shown in the Rider Schedule:

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the Insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is Diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. To be incapacitated due to Alzheimer's Disease, the Insured must:

- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning, **and**
- Require substantial physical assistance from another adult to perform **at least three** ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the Insured to be incapacitated. Parkinson's Disease is a brain disorder that is Diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the Insured must:

- Exhibit **at least two** of the following clinical manifestations:
 - Muscle rigidity
 - Tremor
 - Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses), **and**
- Require substantial physical assistance from another adult to perform **at least three** ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer.

Coma means a state of unconsciousness for 7 consecutive days with:

- No reaction to external stimuli,
- No reaction to internal needs, **and**
- The use of life support systems.

HIV means Human Immunodeficiency Virus.

HIV Positive means the presence of HIV antibodies in the blood. This must be evidenced by:

- A positive screening test enzyme-linked immunosorbent assay (ELISA) **and**
- A positive supplement test, such as the Western Blot.

All such tests must be approved by the Food and Drug Administration (FDA), and the interpretation of positive results must be in keeping with the manufacturer's specifications.

Occupational HIV refers to your testing positive for HIV as a direct result of an HIV-Specific Covered Injury, subject to **all three** of the following provisions:

1. You must file an incident report (notice of exposure) with your Employer within 48 hours of the positive test result. This report must:
 - Be on a form acceptable to the Company,
 - Describe the nature of the exposure to HIV, **and**
 - Be sent to the Company as soon as reasonably possible after the Covered Injury.
2. You must not have previously tested positive for HIV. If you had previously tested positive for HIV, you must have subsequently tested negative for HIV before the date of the Covered Injury.
3. You must have a preliminary HIV screening test—such as an ELISA or other appropriate Food and Drug Administration (FDA) approved test (other than saliva or urine testing)— within 14 days of the Covered Injury at an authorized laboratory other than the laboratory of your employer. We must receive notification of the **negative** results as soon as reasonably possible.

Thereafter, you must test HIV positive within 26 weeks of the date of that Covered Injury.

Loss of Sight, Speech, or Hearing

- ***Loss of Sight*** means the total and irreversible loss of all sight in both eyes.
- ***Loss of Speech*** means the total and permanent loss of the ability to speak.
- ***Loss of Hearing*** means the total and irreversible loss of hearing in both ears. Loss of Hearing does not include hearing loss that can be corrected by the use of a hearing aid or device.

Paralysis or Paralyzed means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs as a result of a Covered Accident or disease. This must be supported by neurological evidence.

Severe Burn or Severely Burned means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must:

- Be a full-thickness or third-degree burn, as determined by a Doctor. A ***Full-Thickness Burn*** or ***Third-Degree Burn*** is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.

[***Waiting Period*** means the number of days after the Effective Date before we will pay benefits for loss due to a Specified Critical Illness. We will not pay benefits for a Specified Critical Illness that begins during the Waiting Period.]

Benefit Provisions

Occupational HIV Benefit

This benefit is payable for the initial Positive Diagnosis of Occupational HIV **if** the Diagnosis results from a Covered Injury. We will pay the indicated percentages of the applicable Face Amount.

Occupational HIV Injuries are payable only once. After the benefit is paid, coverage for that Insured will terminate.

Specified Critical Illness Benefit

We will pay the Specified Critical Illness Benefit if you are Diagnosed with one of the Specified Critical Illnesses shown in the Rider Schedule **if**:

- [The Date of Diagnosis is after the Waiting Period,]
- The Date of Diagnosis is while this Rider is in force, **and**
- The Specified Critical Illness is not excluded by name or by specific description in this Rider.

We will pay the indicated percentages of the applicable benefit amount shown in the Rider Schedule for loss occurring while this Rider is in force. We will not pay benefits under this Rider if these conditions result from another Specified Critical Illness. [For benefits to be payable on multiple Specified Critical Illnesses, the date of loss for each Illness must be separated by at least [12 months].]

[Limitations and] Exclusions

[This Plan contains a [30-day] Waiting Period. This means that we will not pay benefits to an Insured who has been Diagnosed before his coverage has been in force [30 days] from the Effective Date. If a Critical Illness is first Diagnosed during the Waiting Period, we will only pay benefits for loss beginning after coverage has been in force for [12 months]. Or, the Insured may elect to void the Certificate from the beginning and receive a full premium refund.]

Pre-Existing Conditions Limitation

Pre-existing Condition is a sickness or physical condition that existed within the [3; 6; 12]-month period before the Insured's Effective Date. For this Pre-existing Condition, a medical professional must have advised, Diagnosed, or treated the Insured.

We will **not** pay benefits for any Critical Illness resulting from or affected by a Pre-existing Condition if the Critical Illness was Diagnosed within the [3; 6; 12]-month period **after** the Insured's Effective Date.

The Company will not reduce or deny a claim for benefits for any Critical Illness that was Diagnosed more than [3; 6; 12] months after the Effective Date of this Rider.]

Exclusions

We will not pay for loss due to any of the following:

- **Occupational HIV** that occurred before this Rider's Effective Date and that resulted from:
 - A needle stick
 - A sharp injury
 - A mucous membrane exposure to blood
 - Bloodstained bodily fluid
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide** – committing or attempting to commit suicide, while sane or insane
- **Illegal Acts** – participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
 - War (declared or undeclared) or military conflicts
 - Insurrection or riot
 - Civil commotion or civil state of belligerence
- **Illegal substance abuse[, which includes:**
 - Abuse of legally-obtained prescription medication
 - Illegal use of non-prescription drugs]

No benefits will be paid for HIV contracted outside the United States.

General Provisions

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Insured's Application. This does not apply to fraudulent misstatements.

Contract

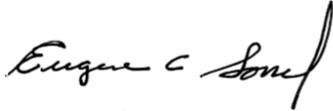
This Rider is part of the Critical Illness Certificate. It will terminate when:

- That Certificate terminates, **or**
- Premiums are no longer paid for this Rider.

The Rider Schedule shows the premium amount. Premiums for this Rider must be paid for the number of years shown in the Rider Schedule or until the Rider terminates.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,

A handwritten signature in cursive script that reads "Eugene C. Sorrel". The signature is written in black ink and is positioned below the text "Signed for the Company at its Home Office,".

[Eugene C. Sorrel, President]

Sample Specified Critical Illness Rider Schedule

Insured - John A. Doe
Effective Date - [December 1, 1999]
Initial Premium - [\$00.00 Monthly]

Group Policy Number - XXXX
Certificate Number - XXXX
First Renewal Date - [December 1, 2000]

BENEFITS

[Advanced Alzheimer's Disease]	[100]% of applicable Face Amount]
[Advanced Parkinson's Disease]	[100]% of applicable Face Amount]
[Benign Brain Tumor]	[100]% of applicable Face Amount]
[Coma]	[100]% of applicable Face Amount]
[Loss of Sight, Speech or Hearing]	
Loss of Sight	[100]% of applicable Face Amount]
Loss of Speech	[100]% of applicable Face Amount]
Loss of Hearing	[100]% of applicable Face Amount]
[Occupational HIV]	[100]% of applicable Face Amount]
[Paralysis]	[100]% of applicable Face Amount]
[Severe Burn]	[100]% of applicable Face Amount]

SERFF Tracking Number: CAIC-128088719 State: Arkansas
 Filing Company: Continental American Insurance Company State Tracking Number:
 Company Tracking Number: 8459
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Critical Illness 20000
 Project Name/Number: Critical Illness 20000/8459

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: CAIC Critical Illness Readability Certification.pdf	Approved-Closed	02/13/2012

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Included the application and enrollment forms under the Forms Schedule tab.	Approved-Closed	02/13/2012

	Item Status:	Status Date:
Satisfied - Item: Submission letter Comments: Attachment: Arkansas - CAIC Critical Illness Cover Letter.pdf	Approved-Closed	02/13/2012



CONTINENTAL AMERICAN INSURANCE COMPANY

READABILITY CERTIFICATION

CRITICAL ILLNESS PRODUCT FORMS

I, James J. Hennessy, hereby certify that the forms listed below have the corresponding readability scores as calculated by the Flesch Reading Ease Test:

Form Number	Form Name	Flesch Reading Ease
C20100AR	Master Policy	43.4
C20101AR	Certificate	44.8
C20201AR	Master Application	n/a
C20202AR	Enrollment Application	n/a
C20301	Dependent Child Benefit Rider	48.1
C20302	Automatic Increase Rider	47.8
C20303	Heart Event Rider	38.4
C20304	Specified Critical Illness Rider	42.4

 Digitally signed by James J. Hennessy
DN: cn=James J. Hennessy,
o=Continental American Insurance
Company, ou=Vice President,
Compliance,
email=jhennessy@aflac.com, c=US
Date: 2012.02.09 11:45:07 -05'00'

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance
Continental American Insurance Company

February 9, 2012

Date



February 9, 2012

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130
TOI: H07G Group Health - Specified Disease - Limited Benefit
Sub-TOI: H07G.001 Critical Illness
Proposed Effective Date: On Approval
Domicile State Approval: SC – Pending Approval

Forms:

C20100AR	Master Policy	C20301	Dependent Child Benefit Rider
C20101AR	Certificate	C20302	Automatic Increase Rider
C20201AR	Master Application	C20303	Heart Event Rider
C20202AR	Enrollment Application	C20304	Specified Critical Illness Rider

Dear Sir or Madam:

The forms noted above are submitted for your review and approval. This is a new filing and will not replace any other forms on file with your department.

We are filing our Group Critical Illness insurance forms and will market this product to employer groups and union groups in accordance with your state guidelines. This product will be marketed on a voluntary, payroll-deduction basis.

The coverage provides a benefit for the employee when diagnosed with a covered critical illness. We are also submitting specified critical illness, dependent child, heart event, and automatic increase riders. These riders will be chosen at the group level and will not be optional at the employee level.

Bracketed items in this filing indicate variable information and may be removed from some group plans. Any or all of the variables could be used in each plan, policy, or certificate, and the variable benefits will be selected according to the group's specifications. For groups that require HSA-compatible coverage, we will amend the plan to include **only** HSA-compatible provisions.

Thank you for your consideration. If you have any questions, please contact Jennifer McLaughlin at 1-888-730-2244, ext. 4322 or at CompanyCompliance@aflac.com.

Sincerely,


Digitally signed by James J. Hennessy
DN: cn=James J. Hennessy, o=Continental
American Insurance Company, ou=Vice
President, Compliance,
email=jhennessy@aflac.com, c=US
Date: 2012.02.09 11:55:35 -05'00'

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance

/jlm