

SERFF Tracking Number: UNLI-128285465 State: Arkansas
Filing Company: Unified Life Insurance Company State Tracking Number:
Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Filing at a Glance

Company: Unified Life Insurance Company

Product Name: Excess Stop-Loss 2012

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.004 Self-Funded Health Plan

Filing Type: Form

SERFF Tr Num: UNLI-128285465

SERFF Status: Closed-Approved

Co Tr Num: 1066

Authors: Cindy Dwigans, Celeste Williams

Date Submitted: 04/19/2012

State: Arkansas

State Tr Num:

State Status: Approved-Closed

Reviewer(s): Donna Lambert

Disposition Date: 06/12/2012

Disposition Status: Approved

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Excess Stop-Loss 2012

Project Number: 1066

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 06/12/2012

State Status Changed: 06/12/2012

Created By: Christina Handy

Corresponding Filing Tracking Number:

Filing Description:

The above referenced forms are being submitted for your review and approval. These forms are intended to be issued to employers to provide Excess Risk (Stop Loss) coverage for employee benefit plans. Coverage is issued to employer's with self-funded health plans subject to the Employee Retirement Income Security Act of 1974 (ERISA). Certificates are not issued to the employees. Attachment points will be greater than \$5,000 with the typical range of \$25,000 but may be as low as \$15,000. The threshold for aggregate stop loss shall be no less than 120% of expected claims. These forms are new and are not intended to replace any previously approved forms

State Narrative:

Company and Contact

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/04/2012

Domicile Status Comments:

Market Type: Group

Group Market Size: Large

Overall Rate Impact:

Deemer Date:

Submitted By: Christina Handy

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Filing Contact Information

Christina Handy, Sr. Compliance Analyst chandy@unifiedlife.com
 7201 W 129th St 913-871-7346 [Phone]
 Ste 300
 Overland Park, KS 66213

Filing Company Information

Unified Life Insurance Company	CoCode: 11121	State of Domicile: Texas
7201 W 129th	Group Code:	Company Type: Life and Health
Suite 300	Group Name:	State ID Number:
Overland Park, KS 66213	FEIN Number: 43-1917728	
(913) 871-7290 ext. [Phone]		

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: The retaliatory fee is \$50.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unified Life Insurance Company	\$50.00	04/19/2012	58167816
Unified Life Insurance Company	\$1,000.00	05/22/2012	59328688

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	06/12/2012	06/12/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	06/11/2012	06/11/2012	Cindy Dwigans	06/11/2012	06/11/2012
Pending Industry Response	Donna Lambert	06/04/2012	06/05/2012	Cindy Dwigans	06/05/2012	06/11/2012
Pending Industry Response	Donna Lambert	04/24/2012	04/24/2012	Cindy Dwigans	05/22/2012	05/22/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Response to 6/7/12 Note to Reviewer	Note To Filer	Donna Lambert	06/08/2012	06/08/2012
ACA 23-79-108(a)	Note To Reviewer	Cindy Dwigans	06/07/2012	06/07/2012
Fees are Okay	Note To Filer	Donna Lambert	05/23/2012	05/23/2012
Filing fees	Note To Reviewer	Cindy Dwigans	05/23/2012	05/23/2012

<i>SERFF Tracking Number:</i>	<i>UNLI-128285465</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unified Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>1066</i>		
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>
<i>Product Name:</i>	<i>Excess Stop-Loss 2012</i>		
<i>Project Name/Number:</i>	<i>Excess Stop-Loss 2012/1066</i>		

SERFF Tracking Number: UNLI-128285465 *State:* Arkansas
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TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
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Disposition

Disposition Date: 06/12/2012

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Application	Approved	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document (revised)	Flesch Certification	Approved	Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form (revised)	Stop Loss Policy	Approved	Yes
Form	Stop Loss Policy	Replaced	Yes
Form (revised)	Stop Loss Application/Schedule	Approved	Yes
Form	Stop Loss Application/Schedule	Replaced	Yes
Form	Acceptance of Plan Document Changes Rider	Approved	Yes
Form	Change to Policyholder Information	Approved	Yes
Form	Specific Terminal Liability Rider	Approved	Yes
Form	Aggregate Specific Attachment Point Rider	Approved	Yes
Form	Right to Medically Underwrite Rider	Approved	Yes
Form	Aggregate Terminal Liability Rider	Approved	Yes
Form	Aggregate Accommodation Option Rider	Approved	Yes
Form	Specific Advance Option Rider	Approved	Yes
Form	Policy Termination Rider	Approved	Yes
Form (revised)	Change in Premium Rider	Approved	Yes
Form	Change in Premium Rider	Replaced	Yes
Form (revised)	Change in Specific Stop Loss Coverage Rider	Approved	Yes
Form (revised)	Change in Basis of Coverage Rider	Replaced	Yes
Form	Change in Monthly Aggregate Factor Rider	Approved	Yes
Form	Change in Aggregate Stop Loss Coverage Rider	Approved	Yes
Form	Blank Rider	Approved	Yes
Form (revised)	Addition of Subsidiary or Other Affiliated Group Rider	Approved	Yes
Form	Qualified Clinical Trials Rider	Approved	Yes
Form	Exclusions/Limitations for Named Persons Rider	Approved	Yes

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Form	Domestic Claims Rider	Approved	Yes
Form	Prescription Drugs Covered Under Plan Rider	Approved	Yes
Form	Coverage of Disabled Persons Rider	Approved	Yes
Form	Stop Loss Policy	Replaced	Yes
Form	Stop Loss Application/Schedule	Replaced	Yes
Form	Change in Premium Rider	Replaced	Yes
Form	Change in Specific Stop Loss Coverage Rider	Replaced	Yes
Form	Change in Basis of Coverage Rider	Replaced	Yes
Form	Addition of Subsidiary or Other Affiliated Group Rider	Replaced	Yes

SERFF Tracking Number: UNLI-128285465 State: Arkansas
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TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/11/2012
Submitted Date	06/11/2012
Respond By Date	07/11/2012

Dear Christina Handy,

One final request: Please give us your assurance that your contract will be issued in compliance with ACA 23-62-111, effective 7-27-2011. Thank you.

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

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/11/2012
Submitted Date 06/11/2012

Dear Donna Lambert,

Comments:

Response 1

Comments: We have attached a statement of variability showing the range of variations which complies with ACA 23-62-111.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Statement of Variability

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Celeste Williams, Cindy Dwigans

SERFF Tracking Number: UNLI-128285465 State: Arkansas
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Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/05/2012
Submitted Date 06/05/2012
Respond By Date 07/05/2012

Dear Christina Handy,

Please provide your assurance that your contract will always comply with the guidelines of ACA 23-62-111 regarding Employee Benefit Stop-Loss Insurance.

Objection 1

- Stop Loss Policy, P100 (Form)

Comment: 1. Section 6 – Exclusions

Item 7. The Department will not approve exclusions for terrorism in life or accident and health contracts. The Department's position is that losses due to acts of terrorism are so inherent to the risk purported to be assumed in the general coverage of the contract, that any exclusion of such losses would be inconsistent with the general coverage of the contract. In that regard, please refer to A.C.A Sec. 23-79-111(a)(2). Please revise this item to exclude expenses resulting from or caused by war, whether declared or undeclared; riot or complications therefrom. Similar language can be substituted.

Objection 2

- Stop Loss Policy, P100 (Form)

Comment: 2. Section 10 – Claims Provisions

Payment of Claims Please remove the last sentence in this provision. It is not in compliance with ACA 23-79-203.

Objection 3

- Stop Loss Policy, P100 (Form)

Comment: 3. Section 11 – General Provisions

Entire Contract. Statements cannot be used to contest coverage unless contained in the application/written instrument with a copy provided to the insured. Please add the necessary language to bring the provision into compliance with ACA 23-86-108(1).

Objection 4

- Stop Loss Policy, P100 (Form)

Comment: 4. Please expand the last paragraph of the Entire Contract provision to comply with ACA 23-79-107(a), which states:

(a) All statements in any application for a life or accident and health insurance policy or annuity contract, or in

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Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:

- (1) Fraudulent;
- (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or
- (3) The insurer in good faith would not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the facts had been made known to the insurer as required by the application for the policy or contract or otherwise.

In addition, the time limit on certain defenses is 3 years 23-85-107, and should be included in this paragraph.

Objection 5

- Stop Loss Policy, P100 (Form)

Comment: 5. Disclaimer. The last sentence of the second paragraph is not in compliance with ACA 23-79-203. Please remove this statement.

Objection 6

- Stop Loss Policy, P100 (Form)

Comment: 6. Time Limit on Certain Defenses. The written application or other instrument should be provided to the insured whether or not you contest the policy. Please remove the next-to-the-last sentence and revise the last sentence to comply with ACA 23-79-107(a).

Objection 7

- Stop Loss Application/Schedule , A100 (Form)

Comment: 1. Please revise the fraud warning to more closely mirror 23-66-503, specifically, include the language ". . . is guilty of a crime and may be subject to fines and confinement in prison."

Objection 8

- Stop Loss Application/Schedule , A100 (Form)

Comment: 2. The notice required by Bulletin 6-2008 needs to be added to the application.

Objection 9

- Stop Loss Application/Schedule , A100 (Form)

Comment: 3. Section 6 - Notices and Signatures is not in compliance with ACA 23-79-108(a). By stating "It is agreed that the statements in this Application/Schedule or in any materials submitted with this Application/Schedule or attached to it are Your representations and shall be deemed material to acceptance of the risk by Us and that the Policy is issued by Us in reliance on the truth and accuracy of such representations." This indicates to me that any error on the application will be considered material and seems to circumvent the above stated statute. Please pay special attention to items (2) and (3) and revise this section of the application to comply.

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Filing Company: Unified Life Insurance Company *State Tracking Number:*
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TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Objection 10

- Change in Premium Rider, R109 (Form)

Comment: Change in Premium Riders

There are two forms attached to this Schedule Item which have the same form number, but they are two different forms. Please remove one form and attach it to its own Schedule Item, give it a new form number and submit an additional \$50 for review. Thank you.

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

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking Number: UNLI-128285465 State: Arkansas
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 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 06/05/2012
 Submitted Date 06/11/2012

Dear Donna Lambert,

Comments:

Response 1

Comments: We have removed the exclusion for expenses resulting from or caused by war, whether declared or undeclared; riot or complications therefrom, from the exclusions on page 8. The form number for the policy is now P100-AR. Attached is a revised Flesch cert.

Related Objection 1

Applies To:

- Stop Loss Policy, P100 (Form)

Comment:

1. Section 6 – Exclusions

Item 7. The Department will not approve exclusions for terrorism in life or accident and health contracts. The Department's position is that losses due to acts of terrorism are so inherent to the risk purported to be assumed in the general coverage of the contract, that any exclusion of such losses would be inconsistent with the general coverage of the contract. In that regard, please refer to A.C.A Sec. 23-79-111(a)(2). Please revise this item to exclude expenses resulting from or caused by war, whether declared or undeclared; riot or complications therefrom. Similar language can be substituted.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Flesch Certification

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Stop Loss Policy	P100		Policy/Contract/Fraternal	Initial		50.000	P100-AR

SERFF Tracking Number: UNLI-128285465 State: Arkansas
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 Company Tracking Number: 1066
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

Certificate

SL Policy
 2012
 060512.pdf

Previous Version

Stop Loss Policy	P100	Policy/Contract/Fraternal Initial Certificate	50.000	P100 - SL Policy 2012 05222012.pdf
Stop Loss Policy	P100	Policy/Contract/Fraternal Initial Certificate	50.000	P100 - SL Policy 2012.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: We have removed the last sentence.

Related Objection 1

Applies To:

- Stop Loss Policy, P100 (Form)

Comment:

2. Section 10 – Claims Provisions

Payment of Claims Please remove the last sentence in this provision. It is not in compliance with ACA 23-79-203.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

SERFF Tracking Number: UNLI-128285465 State: Arkansas
Filing Company: Unified Life Insurance Company State Tracking Number:
Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Comments: We have add the required language.

Related Objection 1

Applies To:

- Stop Loss Policy, P100 (Form)

Comment:

3. Section 11 – General Provisions

Entire Contract. Statements cannot be used to contest coverage unless contained in the application/written instrument with a copy provided to the insured. Please add the necessary language to bring the provision into compliance with ACA 23-86-108(1).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments: We have made the required changes.

Related Objection 1

Applies To:

- Stop Loss Policy, P100 (Form)

Comment:

4. Please expand the last paragraph of the Entire Contract provision to comply with ACA 23-79-107(a), which states:

(a) All statements in any application for a life or accident and health insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:

- (1) Fraudulent;
- (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or
- (3) The insurer in good faith would not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the facts had been made known to the insurer as required by the application for the policy or contract or otherwise.

SERFF Tracking Number: UNLI-128285465 State: Arkansas
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Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

In addition, the time limit on certain defenses is 3 years 23-85-107, and should be included in this paragraph.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments: We have removed the statement.

Related Objection 1

Applies To:

- Stop Loss Policy, P100 (Form)

Comment:

5. Disclaimer. The last sentence of the second paragraph is not in compliance with ACA 23-79-203. Please remove this statement.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments: A copy of the application is furnished when the policy is issued. We will furnish a second copy if we contest the policy. We added the language as required under objection 4.

Related Objection 1

Applies To:

- Stop Loss Policy, P100 (Form)

Comment:

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6. Time Limit on Certain Defenses. The written application or other instrument should be provided to the insured whether or not you contest the policy. Please remove the next-to-the-last sentence and revise the last sentence to comply with ACA 23-79-107(a).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 7

Comments: We have revised the application and included the fraud statement on the last page. The form number is now A100-AR.

Related Objection 1

Applies To:

- Stop Loss Application/Schedule , A100 (Form)

Comment:

1. Please revise the fraud warning to more closely mirror 23-66-503, specifically, include the language ". . . is guilty of a crime and may be subject to fines and confinement in prison."

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Application

Comment: See Form Schedule tab.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Stop Loss Application/Schedule	A100		Application/Enrollment Form	Initial		53.000	A100-AR - Application for Stop Loss

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061112.pdf

Previous Version

Stop Loss Application/Schedule	A100	Application/Enrollment Form	Initial	53.000	A100 - Application for Stop Loss 05012012.pdf
Stop Loss Application/Schedule	A100	Application/Enrollment Form	Initial	53.000	A100 - Application for Stop Loss 02222012.pdf

No Rate/Rule Schedule items changed.

Response 8

Comments: We have added the required notice to the application. The form number is now A100-AR.

Related Objection 1

Applies To:

- Stop Loss Application/Schedule , A100 (Form)

Comment:

2. The notice required by Bulletin 6-2008 needs to be added to the application.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 9

SERFF Tracking Number: UNLI-128285465 State: Arkansas
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TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Comments: We have revised item 1. under notices and signatures on page 4 of the application.

Related Objection 1

Applies To:

- Stop Loss Application/Schedule , A100 (Form)

Comment:

3. Section 6 - Notices and Signatures is not in compliance with ACA 23-79-108(a). By stating "It is agreed that the statements in this Application/Schedule or in any materials submitted with this Application/Schedule or attached to it are Your representations and shall be deemed material to acceptance of the risk by Us and that the Policy is issued by Us in reliance on the truth and accuracy of such representations." This indicates to me that any error on the application will be considered material and seems to circumvent the above stated statute. Please pay special attention to items (2) and (3) and revise this section of the application to comply.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 10

Comments: We have removed the extra form.

Related Objection 1

Applies To:

- Change in Premium Rider, R109 (Form)

Comment:

Change in Premium Riders

There are two forms attached to this Schedule Item which have the same form number, but they are two different forms. Please remove one form and attach it to its own Schedule Item, give it a new form number and submit an additional \$50 for review. Thank you.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

SERFF Tracking Number: UNLI-128285465 State: Arkansas
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Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Change in Premium Rider	R109		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		55.000	R109 - Chg in Premium Rdr 04302012.pdf
Previous Version Change in Premium Rider	R109		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		55.000	R109 - Chg in Premium Rdr.pdf R109 - Chg in Premium Rdr 04302012.pdf
Change in Premium Rider	R109		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		55.000	R109 - Chg in Premium Rdr.pdf

No Rate/Rule Schedule items changed.

We hope these changes will allow you to grant final approval to this filing.

Sincerely,
 Celeste Williams, Cindy Dwigans

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Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	04/24/2012
Submitted Date	04/24/2012
Respond By Date	05/24/2012

Dear Christina Handy,

The filing fee submitted is incorrect. We will accept the domicile state fees only if the domicile state fees are greater than the fees outlined for the State of Arkansas. The fee for this submission is \$50 per form for a total of \$1,150. Please submit an additional \$1,000.

We will begin our review of this submission upon receipt of the additional filing fee.

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

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

SERFF Tracking Number: UNLI-128285465 State: Arkansas
 Filing Company: Unified Life Insurance Company State Tracking Number:
 Company Tracking Number: 1066
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 05/22/2012
 Submitted Date 05/22/2012

Dear Donna Lambert,

Comments:

Response 1

Comments: We have submitted the requested additional filing fee of \$1000. We have also attached updated forms.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Application

Comment: See Form Schedule tab.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
<i>Stop Loss Policy</i>	<i>P100</i>		<i>Policy/Contract/Fraternal Certificate</i>	<i>Initial</i>		<i>50.000</i>	<i>P100 - SL Policy 2012 05222012.pdf</i>
Previous Version							
<i>Stop Loss Policy</i>	<i>P100</i>		<i>Policy/Contract/Fraternal Certificate</i>	<i>Initial</i>		<i>50.000</i>	<i>P100 - SL Policy 2012.pdf</i>
<i>Stop Loss Application/Schedule</i>	<i>A100</i>		<i>Application/Enrollment Form</i>	<i>Initial</i>		<i>53.000</i>	<i>A100 - Application for Stop Loss 05012012.</i>

SERFF Tracking Number: UNLI-128285465 State: Arkansas
 Filing Company: Unified Life Insurance Company State Tracking Number:
 Company Tracking Number: 1066
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

pdf

Previous Version

Stop Loss Application/Schedule	A100	Application/Enrollment Form	Initial	53.000	A100 - Application for Stop Loss 02222012.pdf
Change in Premium Rider	R109	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	55.000	R109 - Chg in Premium Rdr.pdf R109 - Chg in Premium Rdr 04302012.pdf

Previous Version

Change in Premium Rider	R109	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	55.000	R109 - Chg in Premium Rdr.pdf
Change in Specific Stop Loss Coverage Rider	R110	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	55.000	R110 - Change in Specific Stop Loss Rdr 05022012.pdf

Previous Version

Change in Specific Stop Loss Coverage Rider	R110	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	55.000	R110 - Change in Specific Stop Loss Rdr.pdf
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SERFF Tracking Number: UNLI-128285465 State: Arkansas
 Filing Company: Unified Life Insurance Company State Tracking Number:
 Company Tracking Number: 1066
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

Change in Basis of Coverage Rider	R111	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	64.000	R111 - Chg in Basis of Coverage Rdr 04302012.pdf
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Previous Version

Change in Basis of Coverage Rider	R111	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	64.000	R111 - Chg in Basis of Coverage Rdr.pdf
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Addition of Subsidiary or Other Affiliated Group Rider	R115	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	72.000	R115 - Addition of subsidiary or other Affiliated Group Rdr 05022012.pdf
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Previous Version

Addition of Subsidiary or Other Affiliated Group Rider	R115	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial	72.000	R115 - Addition of subsidiary or other Affiliated Group Rdr.pdf
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No Rate/Rule Schedule items changed.

Sincerely,
 Celeste Williams, Cindy Dwigans

SERFF Tracking Number: UNLI-128285465 State: Arkansas
Filing Company: Unified Life Insurance Company State Tracking Number:
Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Note To Filer

Created By:

Donna Lambert on 06/08/2012 03:09 PM

Last Edited By:

Donna Lambert

Submitted On:

06/12/2012 10:42 AM

Subject:

Response to 6/7/12 Note to Reviewer

Comments:

That was a typo on my part. It should have read 23-79-107. And in answer to your question, the statute was revised (in 2011), and there is no longer an item 3.

The part of the application that is not in compliance is the requirement that the applicant represent that all statements are material, when a misrepresentation is material only "if there is a causal relationship between the misrepresentation and the hazard resulting in a loss under the policy or contract." Please see 23-79-107.

SERFF Tracking Number: UNLI-128285465 *State:* Arkansas
Filing Company: Unified Life Insurance Company *State Tracking Number:*
Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Note To Reviewer

Created By:

Cindy Dwigans on 06/07/2012 04:15 PM

Last Edited By:

Donna Lambert

Submitted On:

06/12/2012 10:42 AM

Subject:

ACA 23-79-108(a)

Comments:

I am unable to locate this cite. Is this new or has it recently changed?

SERFF Tracking Number: UNLI-128285465 *State:* Arkansas
Filing Company: Unified Life Insurance Company *State Tracking Number:*
Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Note To Filer

Created By:

Donna Lambert on 05/23/2012 08:22 AM

Last Edited By:

Donna Lambert

Submitted On:

06/12/2012 10:42 AM

Subject:

Fees are Okay

Comments:

The fees you submitted are fine. I asked you to submit \$1,000, when It should have been \$1,100. My mistake. Thanks for asking.

SERFF Tracking Number: UNLI-128285465 *State:* Arkansas
Filing Company: Unified Life Insurance Company *State Tracking Number:*
Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Note To Reviewer

Created By:

Cindy Dwigans on 05/23/2012 08:03 AM

Last Edited By:

Donna Lambert

Submitted On:

06/12/2012 10:42 AM

Subject:

Filing fees

Comments:

We have submitted \$1050 in filing fees. Is more needed?

SERFF Tracking Number: UNLI-128285465 State: Arkansas
 Filing Company: Unified Life Insurance Company State Tracking Number:
 Company Tracking Number: 1066
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

Form Schedule

Lead Form Number: P100

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 06/12/2012	P100	Policy/Cont ract/Fratern al	Stop Loss Policy Certificate	Initial		50.000	P100-AR SL Policy 2012 060512.pdf
Approved 06/12/2012	A100	Application/ Enrollment	Stop Loss Application/Schedule Form	Initial		53.000	A100-AR - Application for Stop Loss 061112.pdf
Approved 06/12/2012	R100	Policy/Cont ract/Fratern al	Acceptance of Plan Document Changes Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		68.000	R100 - Acceptance of Plan Document Changes Rdr.pdf
Approved 06/12/2012	R101	Policy/Cont ract/Fratern al	Change to Policyholder Information Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		68.000	R101 - Chg to Policyholder Info Rdr.pdf
Approved 06/12/2012	R102	Policy/Cont ract/Fratern al	Specific Terminal Liability Rider Certificate: Amendmen	Initial		52.000	R102 - Specific Terminal Liability Rdr.pdf

SERFF Tracking Number: UNLI-128285465 State: Arkansas
 Filing Company: Unified Life Insurance Company State Tracking Number:
 Company Tracking Number: 1066
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

Approved 06/12/2012	R103	Policy/Cont Aggregate Specific ract/Fratern Attachment Point al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	52.000	R103 - Aggregate Specific Attachment Point Rider.pdf
Approved 06/12/2012	R104	Policy/Cont Right to Medically ract/Fratern Underwrite Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	51.000	R104 - Right to Medically Underwrite Rdr.pdf
Approved 06/12/2012	R105	Policy/Cont Aggregate Terminal ract/Fratern Liability Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	54.000	R105 - Aggregate Terminal Liability Rdr.pdf
Approved 06/12/2012	R106	Policy/Cont Aggregate ract/Fratern Accommodation al Option Rider Certificate: Amendmen t, Insert Page,	Initial	55.000	R106 - Aggregate Accommodati on Opition Rdr.pdf

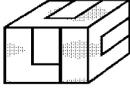
SERFF Tracking Number: UNLI-128285465 State: Arkansas
 Filing Company: Unified Life Insurance Company State Tracking Number:
 Company Tracking Number: 1066
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

Approved 06/12/2012	R107	Policy/Cont Specific Advance ract/Fratern Option Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	52.000	R107 - Specific Advance Option Rdr.pdf
Approved 06/12/2012	R108	Policy/Cont Policy Termination ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	69.000	R108 - Policy Termination Rdr.pdf
Approved 06/12/2012	R109	Policy/Cont Change in Premium ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	55.000	R109 - Chg in Premium Rdr 04302012.pdf
Approved 06/12/2012	R110	Policy/Cont Change in Specific ract/Fratern Stop Loss Coverage al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	55.000	R110 - Change in Specific Stop Loss Rdr 05022012.pdf

<i>SERFF Tracking Number:</i>	<i>UNLI-128285465</i>	<i>State:</i>	<i>Arkansas</i>	
<i>Filing Company:</i>	<i>Unified Life Insurance Company</i>	<i>State Tracking Number:</i>		
<i>Company Tracking Number:</i>	<i>1066</i>			
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>	
<i>Product Name:</i>	<i>Excess Stop-Loss 2012</i>			
<i>Project Name/Number:</i>	<i>Excess Stop-Loss 2012/1066</i>			
Replaced R111 06/12/2012	Policy/Cont Change in Basis of ract/Fratern Coverage Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	64.000	R111 - Chg in Basis of Coverage Rdr 04302012.pdf
Approved R112 06/12/2012	Policy/Cont Change in Monthly ract/Fratern Aggregate Factor al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	68.000	R112 - Chg in Monthly Aggregate Factor Rdr.pdf
Approved R113 06/12/2012	Policy/Cont Change in Aggregate ract/Fratern Stop Loss Coverage al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	70.000	R113 - Chg in Aggreate Stop Loss Coverage Rdr.pdf
Approved R114 06/12/2012	Policy/Cont Blank Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	59.000	R114 - Blank Rdr.pdf
Approved R115 06/12/2012	Policy/Cont Addition of ract/Fratern Subsidiary or Other	Initial	72.000	R115 - Addition of

<i>SERFF Tracking Number:</i>	<i>UNLI-128285465</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unified Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>1066</i>		
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>
<i>Product Name:</i>	<i>Excess Stop-Loss 2012</i>		
<i>Project Name/Number:</i>	<i>Excess Stop-Loss 2012/1066</i>		
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Approved R116	Policy/Cont Qualified Clinical	Initial	
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	Certificate:		Qualified
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Approved R117	Policy/Cont Exclusions/Limitation	Initial	
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	al Rider		R117 -
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	t, Insert		Named
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Approved R118	Policy/Cont Domestic Claims	Initial	
06/12/2012	ract/Fratern Rider		51.000
	al		R118 -
	Certificate:		Domestic
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Approved R119	Policy/Cont Prescription Drugs	Initial	
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			Covered

<i>SERFF Tracking Number:</i>	<i>UNLI-128285465</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unified Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>1066</i>		
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>
<i>Product Name:</i>	<i>Excess Stop-Loss 2012</i>		
<i>Project Name/Number:</i>	<i>Excess Stop-Loss 2012/1066</i>		
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Approved R120	Policy/Cont Coverage of	Initial	59.000
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			Disabled
			Persons
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UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213
XXX-XXX-XXXX]**

**STOP LOSS INSURANCE POLICY
Non-Participating**

Policyholder:	Effective Date:
Policyholder Address:	Expiration Date:
Policy Number:	
YOUR designated Third-Party Administrator:	

This Policy is issued in consideration of YOUR Application/Schedule and the payment of premiums. The attached Application/Schedule and a copy of YOUR ERISA Employee Welfare Benefit PLAN Document form a part of this Policy. All periods of coverage will begin and end at 12:01a.m. Standard Time at YOUR Principal Address.

This Policy is governed by the laws of the state of YOUR Principal Address.

This Policy is issued by US at OUR Underwriting Offices as of the Effective Date.

Notice: This is a reimbursement Policy. YOU or YOUR PLAN Administrator, are responsible for making benefit determinations under YOUR employee welfare benefit plan. WE have no duty or authority to administer, settle, adjust or provide advice regarding claims filed under YOUR employee benefit plan.

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

[

Chairman of the Board

Secretary

]

Table of Contents

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Section 1. Definitions

The following terms, wherever used in this Policy, or Application/Schedule, Rider, or disclosure statement attached hereto, shall have the meaning set forth in this section.

Aggregate Reimbursement Percentage means the percentage at which Eligible Expenses, in excess of YOUR Annual Aggregate Attachment Point, will be reimbursed by US.

Annual Aggregate Attachment Point means, for the Policy Period or any portion of the Policy Period, the PLAN benefits covered by this Policy and wholly retained by YOU. It is not considered for reimbursement under this Policy, and is the greater of:

1. the sum of Monthly Aggregate Factor amounts for each month of the Policy Period, determined by multiplying the total number of Covered Units by the Monthly Aggregate Factor amounts; or
2. the minimum annual Aggregate Attachment Point shown in the Application/Schedule.

The maximum per Covered Person that may be applied annually to the Annual Aggregate Attachment Point, (i.e. Individual Claim Limit) is shown in the Application/Schedule.

Application/Schedule means the Stop Loss insurance Application/Schedule signed by YOU and attached to this Policy. The Application/Schedule is subject to acceptance by US and if accepted, will become a part of this Policy.

Benefit Period means the period of time shown in the Application/Schedule during which Eligible Expenses Incurred by a Covered Person, which are paid by YOU during the Policy Period, are eligible for reimbursement under this Policy. This period does not alter the Policy Effective Date or Policy Period but does include any Run-In Period and/or Run-Out Period as shown on the Policy Application/Schedule. It does not waive this Policy's eligibility requirements.

COBRA Continuee means a Covered Unit that elects to extend its group health coverage under the PLAN as entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent regulations.

Company (WE, OUR, US) means Unified Life Insurance Company.

Covered Family means an employee and his or her dependents covered under the PLAN.

Covered Person means an individual covered under the PLAN.

Covered Unit means an employee with dependents, or such other defined unit as agreed upon between YOU and US, as shown in the Application/Schedule.

Disabled Persons are those persons who are or become unable to perform the same lifestyle functions as a person of similar age and sex who is in good health.

Disclosure Statement means the disclosure statement submitted by YOU to US in connection with the issuance of this Policy.

Eligible Expenses means the eligible charges payable under YOUR PLAN and for which the Covered Person is liable to pay. It does not include expenses specifically excluded or limited by this Policy, YOUR Application/Schedule of this Policy, or any Riders.

Experimental or Investigational means medical services, supplies or treatments, including drugs, devices and biological products, provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered Experimental/Investigational in any setting if the Covered Person is required to sign a consent form that indicates the proposed treatment, procedure, medical service, supply, drug, device or biological product is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment under the particular medical circumstances by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational. Off-label usage of any drug will be considered Experimental/Investigational. A drug, device or biological product is considered Experimental/Investigational if it does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption or is used off-label.

HIPAA refers to Public Law 104-191, otherwise known as the Health Insurance Portability and Accountability Act of 1996 and subsequent regulations.

Incurred means:

1. with respect to medical services or supplies, the date on which the services are rendered or supplies are received by the Covered Person; and
2. with respect to disability income benefits, the date each periodic benefit payment becomes payable to the Covered Person (not the date the disability commences), if this coverage was elected on the Application/Schedule; and
3. with respect to negotiated medical services or supplies, the date on which the service or supply was initially rendered or used.

Individual Claim Limit means the maximum amount of payments for Eligible Expenses that will be allowed for any one Covered Person under Aggregate Stop Loss coverage. The Individual Claim Limit is shown in the Application/Schedule. The maximum allowable amount of Eligible Expenses for a Covered Person who has been assigned a separate Specific Attachment Point will be the specified amount as shown under the Individual Claim Limit on the Application, regardless of that Covered Person's separate Individual Specific Attachment Point.

Large Claim (or LC) means paid, denied or pending claims reaching, or with the potential to reach, 50% of the Specific Attachment Point or a Potentially Catastrophic Loss (PCL).

Medically Necessary means a service or supply that is necessary to diagnose and treat a condition. Such service or supply must be commonly recognized by the medical profession as standard of care for the control or cure of the illness or injury being treated by physicians practicing in the same or related specialty field. This does not include any services or supplies that:

1. are provided only as a convenience to the Covered Person or provider; or
2. exceed in scope, duration, intensity, the level of care that is needed to provide safe, adequate, and appropriate diagnosis and treatment; or
3. are excluded under the PLAN Document, or Exclusions section of this Policy; or
4. are not listed as PLAN benefits under the PLAN Document.

Minimum Annual Aggregate Attachment Point means the lowest amount of total payments YOU must make under YOUR plan before YOU are eligible for reimbursement under Aggregate Stop Loss coverage. The Minimum Annual Aggregate Attachment Point is shown in the Application/Schedule.

Monthly Aggregate Factor means the factor(s) that is/are multiplied by the number of Covered Units for each Policy Month to determine the Annual Aggregate Attachment Point. The Monthly Aggregate Factor(s) is/are shown in the Application/Schedule.

Monthly Aggregate Deductible means the amount determined for each Policy Month by multiplying the number of Covered Units for that month by the applicable Monthly Aggregate Factor(s) shown on the Application.

Paid (or Payment) means that a claim has been adjudicated by the TPA and the funds are actually disbursed by the PLAN prior to the end of the Benefit Period. Payment of a claim is unconditional and direct payment of a claim to a Covered Person or their health care provider(s). Payment will be deemed made on the date that both:

1. the payer directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. the account upon which the payment is drawn contains, and continues to contain, sufficient funds of the Policyholder to permit the check or draft to be honored by the institution upon which it is drawn. If the account upon which the payment is drawn is funded by a separate account or line of credit or "sweep" account, then the funding account must contain sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

PLAN (or Employee Welfare Benefit PLAN) means the self-insured health care plan YOU have agreed to make available to YOUR employees and their eligible dependents and that is the subject of this Policy, whether or not it is subject to Employee Retirement Income Security Act of 1974, as is or as may be amended.

PLAN Benefits means the health benefits covered by the PLAN during the Policy Period that are:

1. Incurred on or after the Effective Date of this Policy; and
2. Incurred while this Policy is in force; and
3. Incurred and Paid during the Policy Period.

PLAN Benefits will also include those health benefits covered by the PLAN that are:

1. Incurred during the Policy Period and Paid during any Run-Out Period; and

2. Incurred during the Run-In Period and Paid during any Policy Period or Run-Out Period.

PLAN Benefits do not include:

1. deductibles of the PLAN; or
2. co-insurance or co-payment amounts of the PLAN; or
3. expenses that are not covered by the PLAN or this Policy; or
4. amounts recoverable from any other source; or
5. amounts Paid under a previous policy or arrangement of stop loss coverage, whether issued by US or another entity; or
6. Health Savings Accounts, Health Reimbursement Accounts, Flexible Spending Accounts or any similar plan enacted by legislation.

While the determination of benefits under the PLAN is the sole responsibility of the Policyholder, WE reserve the exclusive right to interpret the terms and conditions of the PLAN as it applies to this Policy. WE have the sole authority to approve or deny reimbursements under this Policy without deference to the benefit determination made by the PLAN.

PLAN Document means the written instrument that describes the PLAN and names the fiduciaries or trustees who jointly and separately have authority to control and manage the operations and administration of the PLAN. The PLAN Document must be in effect on the Effective Date of the Policy. Any changes to the PLAN Document must be accepted by US. (See the "Changes to YOUR PLAN" provision.)

Policy means this Stop Loss Policy issued by US to YOU.

Policy Month means, for the first Policy Month, the period beginning on the Effective Date of this Policy and ending on the corresponding date of the following month. Subsequent Policy Months begin on the corresponding date of each calendar month and continue until the corresponding date of the next month to the Policy expiration date.

Policy Period means the time period beginning on the Effective Date and ending on the Expiration Date.

Policyholder (PLAN Sponsor, YOU or YOUR) means the PLAN Sponsor, named on the face page, to whom this Policy is issued.

Potentially Catastrophic Loss (PCL) means a Paid, denied or pending claim that has the potential to be catastrophic. PCLs include, but are not limited to the conditions listed in Exhibit 1.

Premium Due Date is the first day of each calendar month. If the Effective Date of this Policy is other than the first day of a calendar month, the first month's premium will be pro-rated.

Proof of Loss means receipt of a complete claim form, satisfactory to the Company, and other supporting documentation required by the Company.

Rider means a written amendment or addendum that alters the terms of this Policy.

Run-In Limit means the maximum benefit amount paid by YOU under YOUR plan for Eligible Expenses Incurred by a Covered Person during the Run-In Period that will be applied toward payment under this Policy.

Run-In Period means the period of time shown in the Application/Schedule immediately prior to the first day of this Policy's Policy Period during which Eligible Expenses Incurred by a Covered Person, which are paid by YOU during the Policy Period, will be considered when determining benefit payments under this Policy.

Run-Out Period means the period of time shown in the Application/Schedule immediately following this Policy's Expiration Date during which Eligible Expenses Incurred by a Covered Person, which are paid by YOU during the Policy Period, will be considered when determining benefit payments under this Policy.

Specific Attachment Point means the amount that is retained and paid by YOU during the Policy Period. It is not considered for reimbursement under this Policy. The Specific Attachment Point applies separately to each Covered Person. The Specific Attachment Point is shown in the Application/Schedule.

Specific Policy Period Reimbursement Limit per Covered Person means that maximum amount WE will reimburse YOU per Policy Period with respect to any claims for a person covered under the PLAN that have been filed or submitted under this Policy issued by US. The Specific Policy Period Reimbursement Limit will not exceed the amount shown in the Application/Schedule.

Specific Lifetime Maximum Reimbursement means that maximum amount WE will reimburse YOU with respect to any claims for a person covered under the PLAN that have been filed or submitted under this and prior

or later Policies issued by US. The Lifetime Maximum excludes the Specific Attachment Point amount. The Lifetime Maximum will not exceed the lesser of:

1. the amount shown in the Application/Schedule; or
2. the lifetime amount set forth in the PLAN minus the sum of the Specific Attachment Point applicable to the claimant under each of the policies issued by US.

Specific Reimbursement Percentage means the percentage at which Eligible Expenses, in excess of YOUR Specific Attachment Point, will be reimbursed by US.

Third-Party Administrator (TPA) means a firm having a written agreement with YOU to process PLAN Benefits and provide administrative services.

The term Third-Party Administrator, as used in this Policy, does not refer to the PLAN Administrator used in the Employee Retirement Income Security Act (ERISA) of 1974, as amended, unless YOU have specifically appointed the Third-Party Administrator as such.

Usual and Customary Charges means the common charge for the same or comparable service or supply in the geographic area in which the service or supply is furnished. Usual and Customary Charges are determined based upon:

1. the amount of resources expended to deliver the treatment; and
2. the complexity of the treatment rendered; and
3. charging protocols and billing practices generally accepted by the medical community; and
4. the amount paid after discounts under governmental and private plans.

Section 2 – Specific Stop Loss Coverage

WE will reimburse YOU for PLAN Benefits paid in excess of the Specific Attachment Point, not to exceed the Specific Lifetime Maximum Reimbursement amount shown in the Application/Schedule.

WE will reimburse YOU after YOU have provided an acceptable Proof of Loss and satisfactory proof of Paid PLAN Benefits.

The Specific Stop Loss benefit applies to a Policy Period or fraction thereof (due to termination). As determined with regard to each Covered Person, it is the lesser of:

1. the Specific Lifetime Maximum Reimbursement; or
2. eligible PLAN Benefit Payments made with regard to a Covered Person, less the Specific Attachment Point, the result of which is then multiplied by the Specific Reimbursement Percentage.

If, for any reason, YOUR Specific Stop Loss coverage terminates before the end of the Policy Period:

1. all coverage under this Policy will end as of 12:01 a.m. on the date of YOUR termination;
2. the Run-Out Period, if any, will not apply; and
3. the Specific Attachment Point shown in the Application/Schedule will continue to apply and will not be reduced or prorated.

Section 3 – Aggregate Stop Loss Coverage

The Aggregate Stop Loss benefit for the Policy Period, or fraction thereof (due to termination), is the PLAN Benefit Payment made for Eligible Expenses during the Policy Period less:

1. the greater of the Minimum Annual Aggregate Attachment Point or the calculated Annual Aggregate Attachment Point; and less
2. the Specific Stop Loss benefits that have been or will be reimbursed by US under the Specific Stop Loss coverage; and less
3. any payments that exceed any limitations of coverage under this Policy or that are excluded under this Policy; multiplied by
4. the Aggregate Reimbursement Percentage.

In no event will the Aggregate Stop Loss benefit exceed the Maximum Aggregate Reimbursement specified under Aggregate Stop Loss Coverage in the Application/Schedule.

If, for any reason, YOUR Aggregate Stop Loss coverage terminates before the end of the Policy Period:

1. all coverage under this Policy will end as of 12:01 a.m. on the date of YOUR termination;
2. the Run-Out Period, if any, will not apply; and
3. the Minimum Annual Aggregate Attachment Point shown in the Application/Schedule will continue to apply and will not be reduced or prorated.

Section 4 – Reimbursement of Additional Coverages

PLAN Benefits that YOU have paid under YOUR Prescription Drug Card Plan will be considered for reimbursement under Specific Stop Loss Coverage only if shown as included on the Application/Schedule.

PLAN Benefits that YOU have paid under YOUR Prescription Drug Card Plan, Vision Plan, Dental Plan, and/or Weekly Income Plan will be considered for reimbursement under Aggregate Stop Loss Coverage only if shown as included on the Application/Schedule. The most WE will reimburse YOU for PLAN Benefits YOU pay under YOUR Weekly Income Plan, if included for reimbursement, is shown in the Application/Schedule.

Section 5 – Limitations

Our liability under this Policy will not be increased if the PLAN provides more liberal limitations provisions. In addition to the limitations provided under the PLAN, this Policy will not cover any of the following:

Non-Disclosed Losses

If YOU fail to disclose any required health information on:

1. a Covered Person when YOU make application for this Policy; or
2. on an employee, or a dependent of an employee, of a company YOU acquire or become affiliated with, when such subsidiary or affiliate will be included in YOUR PLAN,

then:

1. WE will not reimburse YOU for any PLAN Benefits paid for the illness or condition that was required to be disclosed;
2. such Paid PLAN Benefits may not be used towards satisfaction of the Specific Attachment Point for such Covered Person; and
3. such Paid PLAN Benefits may not be used towards satisfaction of YOUR Annual Aggregate Attachment Point.

Retired Employees

WE will reimburse Paid PLAN Benefits for Retired Employees and their dependents, who are eligible under the PLAN, only if such persons are indicated as included in the Application/Schedule.

COBRA Continuees

With respect to those persons qualifying as COBRA Continuees, and continuing coverage under YOUR PLAN as such, prior to, on or after the Effective Date of this Policy, WE will reimburse Paid PLAN Benefits for such individuals only if YOU made timely notification to such individuals of their rights to COBRA continuation coverage and if such individuals made a timely election of such coverage as required by applicable law and if all required COBRA premiums were paid timely.

Medicare Benefits

With respect to Covered Persons who are eligible and entitled to coverage under Medicare, any benefit reimbursable to YOU under this Policy shall be reduced by the amount of any similar Medicare benefit paid or reimbursable so that the total reimbursements hereunder with respect to a Covered Person or his or her dependents shall not exceed 100% of such person's actual expenses otherwise reimbursable under this Policy.

Medical Hardware, Devices, Implants

Reimbursements for medical hardware and devices and implants will be limited to an amount equal to 150% of the actual invoice cost of the medical hardware and device and implant paid by the hospital or other provider. No amount will be reimbursed under this Policy until a copy of the invoice is received by US.

Prescription Specialty Drugs and Drug Protocols

For Prescription Specialty Drugs and Drug Protocols delivered in an outpatient setting or in the physician's office, the maximum reimbursement will be 150% of the manufacturer's invoice price. No amount will be reimbursed under this Policy until:

1. a copy of the invoice is received by US; and
2. a copy of the physician's prescription instructions are received by US.

Liability For Reimbursement

WE shall not be liable under this Policy to directly reimburse any Covered Person or provider of professional or medical services for any benefits that YOU have agreed to provide under the terms of the PLAN. OUR sole liability is to YOU, in accordance with the terms of this Policy. YOU may not assign any Stop Loss benefits to Covered Persons or providers of services.

Section 6 – Exclusions

WE will not reimburse YOU for any loss or expense caused by or resulting from:

1. expenses Incurred while the PLAN is not in force with respect to the Covered Person, or for a person not covered under the PLAN;
2. expenses covered by PLAN changes made prior to OUR written approval of such changes;
3. expenses that result from any prescription card service, mail order prescription plan or any pre-paid prescription drug plan, dental, vision, or weekly income benefits, unless specifically included on the Application/Schedule and approved by US.
4. liability or obligations assumed by YOU under any contract or service agreement other than the PLAN;
5. expenses for services or supplies that are in violation of any law;
6. expenses for services or supplies billed above the Usual and Customary Charges for the area where provided, or that are greater than the PLAN Benefits;
7. expenses resulting from or caused by ~~war, whether declared or undeclared;~~ civil war; invasion; hostilities; ~~riot;~~ resistance to armed aggression; ~~or acts of terrorism, or complications therefrom;~~
8. expenses for benefits for accidental bodily injury or sickness arising out of or in the course of any occupation for wage or profit, or complications therefrom; or for which the Covered Person would be entitled to benefits under any Workers' Compensation, Longshoremen's and Harbor Workers' Compensation Act, or other occupational disease legislation or Policy, whether or not such Policy is actually in force;
9. cost of the administration of claims, including cost of investigation, payments, or other service(s) provided by YOUR TPA, consulting fees and/or expenses of any litigation;
10. expenses or complications resulting from an injury sustained while the Covered Person was committing a felony under the laws of the state in which such act occurred, whether or not such Covered Person was actually charged or convicted of any criminal conduct;
11. deductible, coinsurance, co-payment amounts, expenses that are not covered by the PLAN or this Policy, amounts recoverable from any other source, or amounts paid under a previous Policy or arrangement of Stop Loss coverage, whether issued by US or another entity, Health Savings Accounts, Health Reimbursement Accounts, or Flexible Spending Accounts or any similar plan enacted by legislation;
12. expenses or costs resulting from noncontractual damages, court costs and legal fees, including but not limited to compensatory, exemplary and punitive damages, fines or statutory penalties;
13. medical expenses or complications in connection with Experimental or Investigational services, supplies or treatments, including drugs, devices and biological products, as defined in this Policy;
14. payments recoverable through YOUR PLAN's Coordination of Benefits; Medicare, Medicaid, or TriCare where the other PLAN is primary;
15. expenses Incurred by an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application/Schedule, unless added by Rider;
16. legal expenses and fees including legal expenses and fees incurred on behalf of any Covered Person in obtaining medical treatment or expenses Incurred in connection with a judgment or settlement arising out of YOUR negligence in providing, arranging, or failing to provide or arrange a benefit to a Covered Person;
17. payments YOU make under YOUR PLAN for services and supplies that are not included in YOUR PLAN or that are outside the requirements of YOUR PLAN Document or this Policy even when the discretionary authority to make such payments is specifically granted in writing to the PLAN Sponsor and/or Third-Party Administrator by that same PLAN Document;
18. expenses Incurred after the Expiration Date; or
19. in the event this Policy is terminated before the Expiration Date, expenses Incurred after the date of such termination;
20. expenses Incurred by any COBRA Continuee whose COBRA continuation coverage was not offered in a timely manner or was not elected in a timely manner or for which premiums were not paid in a timely manner;

21. YOUR TPA's failure to provide timely payment to providers in their required time frame that results in non-receipt of any discounted fees for services or supplies. WE will reimburse only for the amount of the discounted amount had timely payment been made by YOUR TPA.

Section 7 – Premiums and Factors

Payment of Premiums

No coverage under this Policy will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent premium must be paid on or before the Premium Due Date. YOU are responsible for the payment of premiums. Payment of the premium to YOUR TPA does not constitute payment of the premium to US.

Premium is not considered paid until the premium check is received at OUR Underwriting Office and sufficient funds are transferred from YOUR account into OUR account.

Upon termination of this Policy, or coverage hereunder, if the earned premium exceeds the premium paid, YOU will pay the excess to US; if less, WE will return to YOU the unearned portion of premium paid, subject to the minimum premium, if any, shown in the Application/Schedule.

Grace Period

A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect, provided the premium is paid before the end of the Grace Period. If YOU do not pay the premium during the Grace Period, this Policy will terminate without further notice, retroactive to the date for which premiums were last paid.

Changes in Premium Rates or Factors

WE may change YOUR premium rates and/or Monthly Aggregate Stop Loss Factors on any of the following dates:

1. The date when the terms of this Policy are changed.
2. The date YOU add or delete subsidiary or affiliated companies or divisions with OUR approval.
3. The date YOU change YOUR PLAN with OUR written approval.

WE reserve the right to recalculate the premium rates and/or the Monthly Aggregate Stop Loss Factors retroactively for the Policy Period:

1. if there is more than 10% variance between:
 - a. the number of Covered Units on any Premium Due Date; and
 - b. the number of Covered Units on the Policy Effective Date;or
2. if there is more than 10% variance between:
 - a. the average monthly paid claims under the PLAN for the last two months of the 12-month period immediately prior to the Effective Date of this Policy; and
 - b. the average monthly paid claims under the PLAN for the first 10 months of the 12-month period immediately prior to the Effective Date of this Policy;or
3. with respect to a PLAN whose Stop Loss coverage arrangement for the period immediately prior to the Effective Date of this Policy contained a run-out period, if the claims paid during such run-out period of the prior stop loss coverage arrangement are more than 15% of the claims paid during the period of time beginning on the Effective Date of such prior Stop Loss coverage arrangement and the Effective Date of this Policy, whether the prior Stop Loss coverage arrangement was one of OUR policies or another carrier's.

Section 8 — Termination

This Policy and all coverage hereunder will end upon the earliest of the following:

1. At the end of any period for which the premium is paid, if the subsequent premium is not paid as provided in the Grace Period provision.
2. On the date YOU tell US YOU want to cancel this Policy, provided YOU have given US at least 31 days advance written notice. If YOU cancel within 30 days after the Effective Date, YOU may ask for a full refund of the premium less the amount of any reimbursements WE made to YOU before the time this

Policy was terminated. If YOU do so, this Policy will terminate on the Effective Date. If YOU cancel this Policy after more than 30 days, WE may keep the premium earned to the date of termination.

3. The Expiration Date of this Policy.
4. On the Effective Date if, within 90 days after the Effective Date:
 - a. YOU fail to provide US any information or materials requested by US; or
 - b. YOU fail to comply with any condition imposed by US when this Policy is issued.If so, WE will return the premium paid by YOU, less the amount of any reimbursements WE made to YOU before the time this Policy was terminated. If the amount reimbursed to YOU exceeds the premium paid to US, YOU will pay US the difference.
5. The date the PLAN terminates.
6. The date the administrative agreement between YOU and YOUR TPA terminates, unless WE consent in writing to YOUR naming of a new TPA.
7. The last day of the third consecutive month during which YOU fail to maintain the Minimum PLAN Enrollment as stated in the Application/Schedule, unless WE agree in writing to continue coverage;
8. The date YOU:
 - a. suspend active business operations; or
 - b. are placed in bankruptcy or receivership; or
 - c. dissolve.
9. Any date on which YOU do not pay claims or make funds available to pay claims as required by the PLAN.
10. At any time YOU intentionally and systematically withhold filing or paying claims so as to artificially control the timing of the payment of claims.
11. At date on which the PLAN is found to be in violation of Federal law.
12. YOU intentionally misstate or conceal any information that is required for processing of a claim.

Termination for reasons 6, 7 and 9 itemized above will not be effective until WE have given 10 days advance written notice to the Policyholder.

Concealment or Fraud

This entire Policy may be void:

1. if, before or after a claim or loss, YOU or YOUR TPA have concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim; (This includes failure to provide the required disclosure of health history of Disabled Persons, Large Claims or Potentially Catastrophic Losses.) or
2. in any case of fraud by YOU or YOUR TPA relating to this coverage.

Section 9 — Reinstatement

WE may, at OUR option, approve YOUR request to reinstate this Policy. YOU shall submit to US any forms and data WE may require, including YOUR representation as to losses Incurred or Paid as of the date of YOUR request for reinstatement. If this Policy is reinstated, YOU shall pay to US the premiums due from the date this Policy terminated.

Section 10 — Claim Provisions

Administration of Claims Under YOUR PLAN

WE have no duty to settle or adjust claims filed under YOUR PLAN. YOU must retain and pay a TPA at all times. No one, including YOU, may pay benefits for YOUR PLAN unless named as the TPA on YOUR Application/Schedule and approved by US. WE will not reimburse YOU for PLAN Benefits resulting from benefits paid by someone not authorized to do so.

YOU must make available sufficient funds to pay benefits when due.

The TPA shall:

1. supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims, in accordance with the PLAN;
2. maintain accurate records of all claim payments;
3. maintain separate records of expenses not covered; and
4. provide US, on or before the 15th day of each Policy Month, the following data for the preceding Policy Month:
 - a. number of Covered Persons and/or Covered Units; and

b. a total of claims paid.

Management of a Large Claim (LC) or a Potentially Catastrophic Loss (PCL)

Notice of LC - YOU or YOUR TPA must notify US of any LC (regardless of whether charges have been paid, denied or are pending payment) within 10 days of the date the claim exceeds or it appears that the claim will reach or exceed the defined limits for a LC.

Notice of PCL - YOU or YOUR TPA must notify US of any PCL within 10 days of receiving any information indicating that the claim (regardless of whether charges have been paid, denied or are pending payment) is Potentially Catastrophic. (See Exhibit 1 of this Policy.)

Failure to Notify - If for any reason a LC or PCL is not properly submitted to the TPA, YOU shall promptly notify the TPA of the claim. In the event YOU or YOUR TPA fails to follow the notification requirements set forth in this provision, YOUR losses related to such LC or PCL will not be considered for reimbursement under this Policy.

If YOU receive information that any claim may be or become a PCL, YOU will immediately notify YOUR TPA.

Notice of Claim

Specific Stop Loss - YOU must give written notice of claim to US within 30 days of the date YOU become aware of claims, with respect to a Covered Person, that have reached 50% of the Specific Attachment Point; however, LCs and PCLs should be reported within the time frame specified in the previous paragraph.

Aggregate Stop Loss - YOU must give written notice of claim to US within 30 days of the date YOU become aware of claims that have reached the Annual Aggregate Attachment Point.

YOUR failure to furnish written notice within 30 days will not invalidate or reduce any claim that was otherwise eligible for reimbursement if it was not reasonably possible to provide written notice within such time. However, written notice must be furnished as soon as possible, but in no event later than one year after the date written notice is first required. Claims under YOUR PLAN must be funded and paid within the Benefit Period in order to be eligible for reimbursement under this Policy.

YOU or YOUR TPA shall submit on a timely basis all proofs of claims, reports and supporting documents WE may request.

Proof of Loss

Written Proof of Loss must be submitted within 60 days after the date the Eligible Expenses under YOUR PLAN meet the Specific or Aggregate Attachment Point. Eligible Expenses under YOUR PLAN must be funded and paid within the Benefit Period shown on the Application/Schedule. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and within one year after the Benefit Period shown on the Application/Schedule. Claims not submitted within one year after the Benefit Period shown on the Application/Schedule will not be eligible for payment under this Policy.

Payment of Claims

Amounts payable under this Policy will be paid upon receipt and acceptance by US of all the required material. Required material shall include Proof of Loss and proof of payment for Eligible Expenses under the PLAN and any reasonably requested supporting documentation. ~~WE will have sole authority to reimburse or deny claims under this Policy.~~

Benefit Determination

Determination of benefits under YOUR PLAN is YOUR sole responsibility. WE have no duty to settle or adjust claims filed under YOUR PLAN with YOU or YOUR TPA. WE have the right to review each claim YOU submit to US for reimbursement to determine if YOU are entitled to reimbursement under OUR Policy. This review may include but is not limited to an on-site audit or requests for additional documentation. Only WE have the authority to reimburse losses covered by this Policy.

Subrogation

YOU may be entitled to recover from liable third parties for payments made due to covered injuries to, or on behalf of, Covered Persons under YOUR PLAN. If YOU recover from a liable third party, the recovered amount cannot be used to meet a Deductible amount or an Attachment Point.

WE will not reimburse YOU for the recovered amount. If WE have reimbursed YOU for all or part of a particular payment and that payment is later recovered from a liable third party, YOU must repay US to the extent that it was reimbursed to YOU, regardless of whether this Policy is still in force on the date of recovery. The repayment may be reduced by the reasonable and necessary expenses YOU paid in recovering from the liable third party.

WE may subrogate all YOUR rights if YOU fail to prosecute any valid claims for injury against liable third parties and WE, as a result, become liable to make payments under this Policy for such injury. The amount recovered will be used to pay the expenses of collection as well as payments made under this Policy. The remaining amount will be paid to YOU. However, no recovery will be made from a Covered Person unless that Covered Person has been made whole.

Notice of Appeal

Any objection, notice of legal action, or complaint received on a claim processed under YOUR PLAN on which it reasonably appears an Stop Loss benefit will be payable to YOU under this Policy shall be brought to the immediate attention of OUR Underwriting Office.

Section 11 — General Provisions

Taxes

If premium taxes should be assessed against YOU with respect to claims paid under YOUR PLAN, YOU shall hold US harmless from any tax liability.

Entire Contract

This entire contract consists of:

1. this Policy, including any Riders;
2. YOUR Application/Schedule and any attachments thereto, a copy of which is attached to this Policy;
3. YOUR Disclosure Statement and any attachments thereto; and
4. a copy of YOUR PLAN.

All statements made by YOU or any Covered Person are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to void the insurance or reduce benefits or contest coverage unless contained in the Application/Schedule, or any attachments to the Application/Schedule, a copy of which has been furnished to the policyholder.

All statements in any application, or in negotiations thereof, by or in behalf of the Insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the Policy unless either:
(1) fraudulent;
(2) material either to the acceptance of the risk or to the hazard assumed by US; or
(3) WE in good faith would not have issued the Policy or would not have issued a Policy in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the facts had been made known to US as required by the application for the Policy.

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In case of a conflict between the PLAN and this Policy, this Policy will prevail. WE have relied on the information YOU and YOUR TPA provided to issue this Policy. YOU represent such information is accurate. Should WE later learn such information was not correct, or in case of a substantial change in such information, WE may modify this Policy as of the Effective Date to reflect the correct information, or WE may terminate this Policy on written notice as of the next Premium Due Date.

Policy Nonparticipating

This Policy does not entitle YOU to share in OUR earnings.

Records and Review

YOU and/or YOUR TPA must:

1. keep appropriate records regarding administration of YOUR PLAN; and (YOUR records include records held by YOUR TPA.)
2. allow US to review and copy, during normal business hours, all records affecting OUR liability under this Policy; and
3. maintain records of all Covered Persons under the PLAN during the Policy Period and for a period of seven years after the termination of this Policy; and
4. maintain a separate record of any and all amounts YOU pay that exceed or are not covered by the benefits under YOUR PLAN.

As a result of any audit, WE may re-adjust premiums, attachment points or reimbursements to YOU as may be necessary to reflect YOUR and OUR original intent in issuing this Policy.

Clerical Error

If YOU or WE make a clerical error keeping records or calculating premiums or claims pertaining to this Policy, it will not invalidate this Policy. A clerical error will not expand OUR obligations under this Policy. A clerical error is a mistake in performing a clerical function, and does not include intentional acts or failure to comply with PLAN or Policy provisions. A clerical error is not:

1. the failure to disclose the required disclosure of health history of Disabled Persons, Large Claims, or Potentially Catastrophic Losses; or
2. the failure to process a claim within the Benefit Period of this Policy.

Changes To This Policy

Changes to this Policy may be made only by a Company officer or OUR Underwriting Office, with OUR approval. Any change must be by written Rider.

Changes To YOUR PLAN

WE must be notified of any change to YOUR PLAN. This notice must be in writing and provided to US at least 31 days prior to the Effective Date of the change. WE must accept the change in writing before coverage affected by this change will be provided by this Policy. WE reserve the right to amend the Application/Schedule to include any change to a statute that increases OUR liability under this Policy. If WE do not receive advance written notice of the change, or WE decline to accept the changes under this Policy, WE will be liable only for benefits provided by the PLAN prior to the change. YOU must provide US with a copy of YOUR written PLAN and all amendments prior to the time the change becomes effective.

Subsidiaries, Affiliated Companies Under YOUR PLAN

YOU must notify US in the event YOU acquire a subsidiary or affiliated company that will be included under YOUR PLAN. If YOU do acquire a subsidiary or affiliated company that will be included under YOUR PLAN, YOU must disclose certain required health history on persons whose coverage YOU will be assuming under YOUR PLAN. Failure to do so will subject benefits under this Policy to certain limitations, as described in "Non-Disclosed Losses," in Section 5.

Acquisition of a subsidiary or affiliated company that will be included under YOUR PLAN may affect YOUR premium rates and/or Monthly Aggregate Stop Loss Factors, as described in "Changes in Premium Rates or Factors," in Section 7.

YOU must notify US in the event YOU cede or dissolve a subsidiary or affiliated company that was included under YOUR PLAN. Failure to do so may subject this Policy to termination (if Minimum PLAN Enrollment is not maintained), or may affect YOUR premium rates and/or Monthly Aggregate Stop Loss Factors, as described in "Changes in Premium Rates or Factors," in Section 7.

Duties and Responsibilities of YOUR Designated Third-Party Administrator (TPA)

YOUR TPA must be approved by US.

WE agree to recognize YOUR TPA as YOUR agent for the administration of YOUR PLAN. YOU agree that YOUR TPA will:

1. audit, calculate and pay all claims eligible under the PLAN;
2. prepare reports required by US and keep and make available to US data WE may require; and
3. do what is necessary for YOU to comply with the terms of this Policy.

If YOU give YOUR TPA a Power of Attorney, or revoke a Power of Attorney, neither is binding on US until WE receive it.

YOU will pay YOUR TPA for all administrative functions performed in relation to this Policy.

YOUR TPA is YOUR agent and not OURS. YOU authorize YOUR TPA to:

1. submit Notice/Proof of Loss;
2. certify the payment of claims;
3. transmit reports and payment of premiums to US; and
4. receive payments from US.

Payments by US to YOUR TPA are payments to YOU.

Notice

For the purpose of any notice required from US under the terms of this Policy, notice to YOUR TPA is notice to YOU and notice to YOU is notice to YOUR TPA.

Disclaimer

WE act only as a provider of Stop Loss Insurance coverage to YOUR PLAN. WE are not a fiduciary. WE do not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974, as amended.

While the determination of benefits under the PLAN is the sole responsibility of the Policyholder, WE reserve the right to interpret the terms and conditions of the PLAN as it applies to this Policy.

~~WE have the sole authority to approve or deny reimbursement under this Policy.~~

WE have no right or obligation to pay any Covered Person or provider of professional or medical services. OUR sole liability is to YOU, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a Covered Person to have a direct right of action against US. WE will not be considered a party to YOUR PLAN or to any supplement or amendment to it.

Indemnification, Defense and Hold Harmless

YOU agree to indemnify, defend and hold US harmless from:

1. any liability resulting from or related to any negligence, error, omission or defalcation by YOUR TPA;
2. any liability related to:
 - a. any dispute involving a Covered Person unless it is a result of OUR sole negligence or intentional wrongful acts; and
 - b. any State premium taxes or assessments WE are assessed with respect to funds paid by or to YOU under YOUR PLAN. Taxes on amounts paid to US as premiums for this Policy are excluded.

WE will notify YOU if YOU have obligations. WE may participate in the defense at OUR expense. If YOU do not act promptly, WE may defend and compromise or settle the claim or other matter on YOUR behalf, for YOUR account, and at YOUR risk.

Offset

WE may offset payments due YOU under this Policy against claim overpayments and premiums due and unpaid.

Assignment

YOU may not assign any of YOUR rights under this Policy.

Severability

Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this Policy invalid.

Insolvency

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan or arrangement with creditors, or dissolution of YOU or YOUR TPA:

1. will not impose upon US any liability or additional duties other than those defined and provided for in this Policy; (For example, WE will have no responsibility to pay claims for YOUR PLAN to ensure reimbursement under this Policy.) and
2. will not make US liable to YOUR creditors, including Covered Persons.

Claims under YOUR PLAN must continue to be funded and paid within the Benefit Period in order to be eligible for reimbursement under this Policy.

Parties to This Policy

YOU and WE are the only parties to this Policy. OUR sole liability under this Policy is to YOU. This Policy does not create any right or legal relation between US and a Covered Person under YOUR PLAN. This Policy will not make US a party to any agreement between YOU and YOUR TPA.

Physical Examination and Medical Evidence

WE may require any medical evidence or other information, including a physical examination or health statement, regarding any Covered Person:

1. who submits an enrollment card for coverage under the PLAN more than 31 days after completing the waiting period specified in the PLAN. Such examination shall be provided without expense to US; or
2. for whom YOU have paid a claim under the PLAN and submitted such claim for reimbursement under this Policy. Such examination or evidence shall be provided as often as is reasonably necessary.

Legal Action

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written Proof of Loss is required to be furnished.

Time Limit on Certain Defenses

In the absence of fraud, all statements made by YOU or YOUR TPA shall be deemed representations and not warranties. If these statements appear as part of the written Application or other written instrument signed by YOU or YOUR TPA, WE may use them to contest this Policy. If WE do, WE will furnish YOU or YOUR TPA with a copy of the document in question. After ~~two~~three years, only fraudulent misstatements may be used to contest the coverage under this Policy.

Waiver

OUR failure to strictly enforce OUR rights under this Policy shall not waive any such right, regardless of the frequency or similarity of the circumstances.

Exhibit 1 — Potentially Catastrophic Losses (PCLs)

Some diagnoses that qualify as PCLs are listed below. This is not a comprehensive list. These are only examples of some types of conditions. WE reserve the right to change this list of PCLs at any time.

Infectious and Parasitic Diseases

- Septicemia
- AIDS/HIV
- Aids related illnesses
- Hepatitis

Cancer of any Type

Endocrine, Nutritional, Metabolic, Immune Disorders

- Diabetes
- Cystic fibrosis
- Obesity/Hyperalimentionation

Diseases of the Blood and Blood-Forming Organs

- Sickle cell anemia
- Aplastic anemia
- Coagulation defects and/or Hemophilia

Diseases of the Nervous System and Sense Organs

- Cerebral degenerations
- Quadriplegia and Quadripareisis
- Reye's Syndrome
- Paraplegia
- Encephalopathy
- Neuropathy/Myasthenia Gravis

Diseases of the Circulatory System

- Acute myocardial infarction
- Acute and Subacute Ischemic heart disease
- Coronary atherosclerosis
- Acute pulmonary heart disease
- Aneurysms
- Endocarditis
- Value disorders
- Cardiomyopathy
- Subarachnoid/Intracerebral hemorrhage
- Cardiac dysrhythmias
- Heart failure
- Conduction disorders
- Cerebral artery occlusion
- Acute cerebrovascular accident
- Atherosclerosis
- Myocarditis
- Cardiomyopathy

Diseases of the Respiratory System

- Chronic obstructive pulmonary disease (COPD)
- Pulmonary collapse and/or respiratory failure
- Pneumonia
- Postinflammatory Pulmonary Fibrosis

Diseases of the Digestive System

- Regional enteritis (Crohn's disease)
- Intestinal obstruction
- Diverticulitis of colon
- Peritonitis
- Liver disease and cirrhosis
- Pancreas diseases
- Gastrointestinal hemorrhage

Diseases of the Genitourinary System

- Acute renal failure
- Chronic renal failure
- Impaired renal function
- Calculus of kidney and/or ureter
- Dialysis treatment

Complications of Pregnancy and Childbirth

- Placenta previa
- Eclampsia, pre-eclampsia
- Premature labor
- Gestational diabetes
- Multiple gestation
- Cervical incompetence
- Supervision of high-risk pregnancy

Diseases of the Musculoskeletal System and Connective Tissue

- Osteoarthritis
- Spondylosis
- Intervertebral disc disorders
- Osteomyelitis and periostitis
- Kyphoscoliosis and scoliosis

Congenital Anomalies

- Aortic Atresia/Stenosis
- Other unspecified congenital anomalies
- Biliary atresia

Conditions Originating in the Perinatal Period

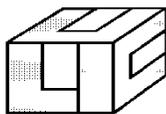
- Prematurity
- Respiratory distress syndrome
- Other respiratory conditions of a newborn
- Apnea
- Lack of expected normal physiological development
- Hyaline membrane disease
- Encephalocele
- Cephalohematoma
- Spina bifida

Injury and Poisoning

- Skull fracture
- Vertebral column fracture
- Spinal cord injury
- Multiple fractures
- Trauma to the elderly or chronically ill
- Internal injury
- Traumatic amputation
- Burns
- Intracranial injury

Other Serious Conditions

- Transplants of any kind
- Continuous hospitalization of 2 weeks or more
- Evaluation for transplants of any kind
- Mental disorders requiring hospital confinement
- Any serious condition that may require Large Case Management
- Sleep apnea
- Home health care greater than 20 days
- Coma
- Brain lesion or tumors
- Any illness or injury that requires intensive and prolonged treatment (such as nutritional support systems, intravenous therapies, and ventilators)



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

SECTION 1 – POLICYHOLDER INFORMATION

1. Full legal name of Policyholder (herein referred to as You/Your), as it will appear in Policy issued by US:
[Any Company]

2. Address of principal office (street, city, state, zip):
[### Street, City, State #####]

3. Contact Person:
Name: [Any Person] Telephone Number: [(###) ### - #####]
E-mail Address: [name@company.net] Fax Number: [(###) ### - #####]

4. Nature of Business:
[Any Company]

5. If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:
[Any Company]

6. Full name of Your Employee Welfare Benefit Plan:
[Any Company Health Plan]

NOTE: A copy of Your ERISA Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application/Schedule.

7. Your designated Third-Party Administrator (for the purposes of claims administration under Your Employee Welfare Benefit Plan):
Name: [Any Company] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

8. Your broker/agent of record:
Name: [Any Person] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

9. Our Underwriting Manager: [Any Company]

SECTION 2 – REQUESTED POLICY PERIOD

The Coverage shown as included in Section 3 and/or Section 4 is requested for, and applies only during the Policy Period from [Date] (the Effective Date) through [Date] (the Expiration Date) and is further subject to all of the provisions of the Policy.

SECTION 3 – SPECIFIC STOP LOSS COVERAGE

1. Coverage Election: YES – Specific coverage is included in this Policy.
 NO – Specific coverage is not included in this policy. **Do not complete this Section.**

2. Coverage to be included. Check one box below for each coverage listed:
Yes No
 Medical
 Prescription Drug Service:

NOTE: In no event will Dental, Vision, or Weekly Income be included under Specific Stop Loss Coverage.

3. Specific Attachment Point:
 Per Covered Person: \$[##,###.##]
 Per Covered Person: \$

4. Specific Reimbursement Percentage: 100%

5. Specific Policy Period Reimbursement Limit per Covered Person \$[#,##,###.##]

6. Specific Lifetime Maximum Reimbursement per Covered Person: \$[#,##,###.##]

7. Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Applicable only to [Any Company and all of its subsidiaries and affiliates]

Plan Benefits Incurred from [Date] through [Date]
and Paid from [Date] through [Date]

Applicable only to _____

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Applicable only to _____

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:
 \$[###,###.##] per Covered Person or
 \$ _____ for all Covered Persons combined

Related Rider(s): [Form Number Here]

8. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
<u>[Composite]</u>	: \$ <u>[##.##]</u>	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____

9. Minimum Annual Specific Premium: \$ [###,###.##]

SECTION 4 – AGGREGATE STOP LOSS COVERAGE

1. Coverage Election: YES – Aggregate coverage **is** included in this Policy.
 NO – Aggregate coverage **is not** included in this Policy. Do not complete this section.

2. Coverages to be included. Check one box below for each coverage listed:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Vision
<input type="checkbox"/>	<input type="checkbox"/>	Prescription Drug Service: _____
<input type="checkbox"/>	<input type="checkbox"/>	Weekly Income: Maximum _____, per covered employee per Policy Period.
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

3. Monthly Aggregate Factor:

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income	Totals
<u>[Composite]</u>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

4. Number of Covered Units: Quoted Actual

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income	Totals
[Employee]	[###]	_____	_____	_____	_____	_____
[Spouse]	[###]	_____	_____	_____	_____	_____
[Child]	[###]	_____	_____	_____	_____	_____
[Family]	[###]	_____	_____	_____	_____	_____

5. Minimum Annual Aggregate Attachment Point: \$ [###,###.##]
 (12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

6. Aggregate Reimbursement Percentage: _____

7. Individual Claim Limit: [###,###.##]

8. Maximum Aggregate Reimbursement (per Policy Period): \$ [#,###,###.##]

9. Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period):
 Applicable only to [Any Company and all of its subsidiaries and affiliates]
 Plan Benefits Incurred from [Date] through [Date]
 And paid from [Date] through [Date]

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 And paid from _____ through _____

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 And paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:
 \$ _____ Per Covered Person or
 \$ [#,###,###.##] For all Covered Persons combined
 Related Rider(s): [None]

10. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
[Composite]	:\$ [##.##]	_____	:\$ _____
_____	:\$ _____	_____	:\$ _____
_____	:\$ _____	_____	:\$ _____

11. Minimum Annual Aggregate Premium: \$ [###,###.##]

SECTION 5 – ELIGIBILITY, PREMIUM DEPOSIT, AND ENROLLMENT INFORMATION

1. Check one box for each of the following groups of persons to indicate if such groups are to be considered as Covered Persons under the Policy:

Yes*	No	
<input type="checkbox"/>	<input type="checkbox"/>	Retired Employees
<input type="checkbox"/>	<input type="checkbox"/>	COBRA Continues
<input type="checkbox"/>	<input type="checkbox"/>	Disabled Employees
<input type="checkbox"/>	<input type="checkbox"/>	Transplants

*All "Yes" answers must have disclosure information attached to this Application/Schedule.

2. Initial premium deposit accompanying this Application/Schedule: \$ [###,###.##]

3. Minimum Plan Enrollment: _____ Covered Units or
 _____ % of initial enrollment

SECTION 6 – NOTICES AND SIGNATURES

You have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by Us and as reflected in this Application/Schedule. You have formed Your Employee Welfare Benefit Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable provisions of the law or regulation. It is agreed that the statements in this Application/Schedule or in any materials submitted with this Application/Schedule or attached to it are Your representations and shall be deemed material to acceptance of the risk by Us only if there is a casual relationship between the misrepresentation and the hazard resulting in a loss under this Policy and that the Policy is issued by Us in reliance on ~~the truth and accuracy of~~ such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage hereunder, We will have the right to revise the premiums rates, factors, terms or conditions as of the Effective Date, by providing written notice to You. Any fraudulent statement will render the Policy null and void and all claims, if any, will be forfeited.

This Application does not bind coverage. Upon approval of the Application, the Policy evidencing that the coverage is in force will be issued by Us through Our Underwriting Manager. Coverage will commence on the Effective Date set forth in the Policy.

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

Accepted by the POLICYHOLDER:

Policyholder (full legal name): [Any Company]

Signed at (city, state): [City, State] Date: _____

Signed for the Policyholder by (officer's signature): _____

Printed Name: [Any Person] Title: _____

Accepted by the Company:

Signed at (city, state): [City, State] Date: _____

Signed for the Company by (officer's signature): _____

Printed Name: [Any Person] Title: _____

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

[Application FRAUD WARNING

ALL STATES EXCEPT AS INDICATED BELOW

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

ALASKA

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA

For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS

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.

CALIFORNIA

For your protection California Law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA

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

DELAWARE

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA

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

IDAHO

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS

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

KENTUCKY

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

LOUISIANA

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.

MAINE

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

MARYLAND

ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MINNESOTA

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

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 civil fines and criminal penalties.

NEW YORK

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

OHIO

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

OKLAHOMA

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

PENNSYLVANIA

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

RHODE ISLAND

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.

TENNESSEE

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

VIRGINIA

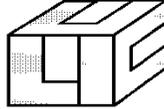
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VERMONT

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

WASHINGTON

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



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Acceptance of Plan Document Changes Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

As of the Effective Date of this Rider, WE consent to the following change(s) to YOUR Plan Document:

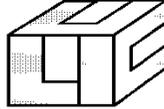
A copy of the Plan Document change(s) is attached to this Rider.

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

President

Secretary



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Change to Policyholder Information Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

- YOUR full legal name and/or address is changed as follows:

Name and address as of the Policy Effective Date:

Name: _____

Address of principal office:

Street: _____

City, State, Zip: _____

Telephone Number: () _____ Fax Number: () _____

Name and address as of the Effective Date of this Rider:

Name: _____

Address of principal office:

Street: _____

City, State, Zip: _____

Telephone Number: () _____ Fax Number: () _____

- YOUR designated Third-Party Administrator is changed to the following:

Name: _____

Address of principal office:

Street: _____

City, State, Zip: _____

Telephone Number: () _____ Fax Number: () _____

- YOUR broker/agent of record is changed to the following:

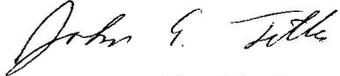
Name: _____ E-Mail Address _____

Address: _____

Telephone Number: () _____ Fax Number: () _____

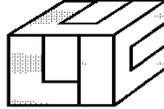
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Specific Terminal Liability Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

WE will extend the payment period for Specific Stop Loss coverage for three months beyond the Expiration Date if YOU:

1. terminate YOUR Plan on the Expiration Date of this Policy; and
2. furnish US acceptable proof that YOU have purchased conventional group insurance coverage that immediately replaces YOUR terminated Plan.

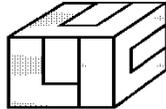
Only those Plan Benefits Incurred during the Policy Period and prior to the Expiration Date will be considered under YOUR Specific Stop Loss coverage.

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

President

Secretary



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Aggregate Specific Attachment Point Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

The Policy will include an Aggregate Specific Attachment Point, as follows: (Check only one box.)

- \$ _____
- The greater of:
\$ _____; or
\$ _____ per month per Single covered unit, plus \$ _____ per month per Family covered unit.
- The greater of:
\$ _____; or
\$ _____ per month per Composite covered unit.

No amounts will be payable to YOU under the Policy until the Aggregate Specific Attachment Point has been satisfied.

Aggregate Specific Attachment Point means an aggregate amount, in excess of and in addition to the Specific Attachment Point for each Covered Person, that YOU must also incur during the Policy Period before WE will reimburse YOU for Plan Benefits Paid.

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

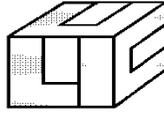
John E. Telle

President

Mary M. Bixey

Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Right to Medically Underwrite Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

- Medical underwriting will be performed on any person currently covered under the HMO plan who applies for coverage under the PPO plan.
- It is assumed that Medicare is primary payor for the following Covered Person(s), as of the effective date(s) shown below. If, for any reason, Medicare does not pay primary on such Covered Person(s) (thereby making the Plan Primary), WE have the right to:
 1. Set a Specific Attachment Point on such Covered Person(s) in the amount below; and/or
 2. Re-rate from the Covered Person's effective date of coverage; and/or
 3. Effect another underwriting correction retroactively.

Covered Person

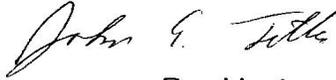
Effective Date

Attachment Point

- The Policy is issued on the basis that the Plan pays secondary on the Covered Person(s) listed below. YOU and WE agree that if, at some future date, the Plan becomes primary on such individual(s), WE reserve the right to medically underwrite to evaluate further coverage considerations on such individual(s):

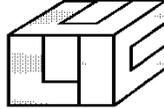
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Aggregate Terminal Liability Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

This Rider is applicable only if the following conditions exist:

1. The Policy to which this Rider is attached does not provide for payment of Aggregate Stop Loss coverage for claims Paid beyond the Expiration Date of the Policy.
2. In the event the Policy to which this Rider is attached is YOUR first policy, contract or agreement providing aggregate stop loss coverage:
 - a. this Rider must be attached and made effective the same date as the Policy Effective Date; and
 - b. the Policy does not provide for payment of claims incurred prior to the Effective Date of the Policy.
3. In the event the Policy to which this Rider is attached is subsequent to another Stop Loss policy, contract or agreement, issued by US or anyone else, all such previous Stop Loss Policies must have had this same or similar Rider attached thereto.

This Rider applies only to Aggregate Stop Loss Coverage and does not change or alter any coverage under the Specific Stop Loss Coverage provided by the Policy.

If, at the Expiration Date of the Policy, YOU terminate YOUR Plan and replace it with a fully-insured conventional group health benefit plan, WE will extend the Aggregate Stop Loss coverage provided by the Policy during the Terminal Extension Period, provided:

1. such fully-insured conventional group health benefit plan immediately replaces YOUR Plan, thereby eliminating any gap in coverage for YOUR Plan's beneficiaries;
2. such fully-insured conventional group health benefit plan provides benefits substantially similar to the benefits provided by YOUR Plan;
3. YOU provide proof acceptable to US of such replacement; and
4. YOUR Policy Period does not continue past the Expiration Date of the Policy.

If YOUR net Paid claims for the Policy Period plus the Terminal Extension Period exceed the Terminal Liability Extension Aggregate Reimbursement, WE will pay such excess amount to YOU. Net Paid claims are based on claims incurred prior to the Plan's termination date, less any claims reimbursed under the Specific Stop Loss coverage.

Any Aggregate Stop Loss benefit due under this Rider will be delayed until a final determination can be made following the Terminal Extension Period.

WE will reduce benefits payable under this Rider by the amount of benefits paid for the same losses by any other policy, contract or agreement.

YOU will pay a monthly service fee of \$ _____ per Covered Unit during the period this Rider is in effect. This fee is due and payable on or before the first day of each month.

Terminal Extension Period means the three consecutive calendar months immediately succeeding the Expiration Date of the Policy.

Terminal Liability Extension Aggregate Reimbursement is established by combining the Annual Aggregate Attachment Point for the Policy and the Terminal Extension Period, as follows:

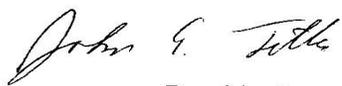
1. Multiply the Terminal Liability Extension Factors by the average of Covered Units for the three-month period immediately preceding the Expiration Date of the Policy and by three months.
2. Add the result of 1. above to the Annual Aggregate Attachment Point or Minimum Annual Aggregate Attachment Point, whichever is greater, that is determined for the Policy Period.

Terminal Liability Extension Factors are as follows:

Covered Unit Description: _____ : \$ _____
_____ : \$ _____
_____ : \$ _____
_____ : \$ _____

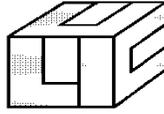
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Aggregate Accommodation Option Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

WE will provide YOU an Aggregate Accommodation if:

1. in any month, the total eligible claims paid by YOU to date exceed the sum of:
 - a. the greater of:
 - (1) the cumulative Annual Aggregate Attachment Point; or
 - (2) the cumulative pro rata share of the Minimum Annual Aggregate Attachment Point;
 - and
 - b. any previous advances of the Aggregate Excess Loss benefit; and
2. YOU properly pay claims, as described in the Policy; and
3. YOU meet the claims reporting requirements, as described in the Policy; and
4. YOUR premiums for coverage under the Policy are up-to-date; and
5. within 20 days following the end of the month for which the Aggregate Accommodation is requested, YOU submit to US:
 - a. Notice of Claim and Proof of Loss; and
 - b. evidence of Paid claims.

This Aggregate Accommodation Option is not available to YOU:

1. during the first ; or
2. during the last Policy Month of the Policy Period; or
3. during the last Policy Month the Policy is in effect, if the Policy is terminated before the end of the Policy Period.

Each Aggregate Accommodation will:

1. equal the sum of the drafts or checks prepared for payment; and
2. not exceed of the Minimum Annual Aggregate Attachment Point, when combined with any previous Aggregate Accommodations.

If an Aggregate Accommodation is determined to be payable at the end of the Policy Period, it will be reduced by the total of Aggregate Accommodations made, if any, according to the terms of this Rider.

Any Aggregate Accommodation made under the provisions of this Rider are for the sole purpose of claim payments under YOUR Plan. The claims cited as the basis for YOUR request for Aggregate Accommodation must be paid no later than five working days following YOUR receipt of the Aggregate Accommodation.

Repayment of Aggregate Accommodation

WHEN THERE ARE OUTSTANDING AGGREGATE ACCOMMODATIONS DURING THE POLICY PERIOD: If, during any month, the accumulated Annual Aggregate Attachment Point is greater than the accumulated claims plus outstanding Aggregate Accommodations, then YOU must repay US the amount by which the accumulated Annual Aggregate

Attachment Point exceeds the accumulated claims plus outstanding Aggregate Accommodations. Such repayment by YOU must be made within 30 days of YOUR reaching this repayment condition.

WHEN YOUR COVERAGE TERMINATES BEFORE THE END OF THE POLICY PERIOD: In the event YOU or WE terminate the Policy prior to the end of the Policy Period, YOU will pay any outstanding Aggregate Accommodations to US within 30 days of the date YOUR coverage terminates.

WHEN THERE ARE OUTSTANDING AGGREGATE ACCOMMODATIONS AT THE END OF THE POLICY PERIOD: If, at the end of the Policy Period, the Annual Aggregate Attachment Point is greater than the Paid Plan Benefits, reduced by the outstanding Aggregate Accommodations, then YOU will pay to US the lesser of:

1. the amount of the outstanding Aggregate Accommodations; or
2. the amount by which the Annual Aggregate Attachment Point exceeds the Paid Plan Benefits, reduced by the outstanding Aggregate Accommodations,

within 30 days of the end of the Policy Period. Any Aggregate Accommodations not repaid at the end of the Policy Period will be deducted from any Aggregate or Specific Excess Loss benefits payable under the terms of the Policy.

An Aggregate Accommodation provided under this Option is YOUR obligation to US. Such amount must be repaid in accordance with this Option.

An Aggregate Accommodation is not a loan or an advance on any payments to be made under the Policy. Any Aggregate Accommodation shall, at all times, be considered OUR funds, which are provided for YOUR use in accordance with this Option.

WE will have preference over all other claimants for the return of any Aggregate Accommodations made under the Policy. YOU will be liable for all costs and expenses (including reasonable attorney fees) incurred in the collection of any outstanding Aggregate Accommodations.

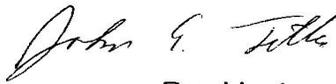
WE will not charge YOU interest on the amount of any Aggregate Accommodation; however, if YOU do not repay any outstanding Aggregate Accommodation within the time frames stated in this Rider, then WE:

1. will assess a late payment penalty equal to _____ of the outstanding Aggregate Accommodations; and
2. will deduct any outstanding Aggregate Accommodations from any reimbursements due YOU under the Specific or Aggregate Excess Loss benefits; and
3. shall have the right to terminate the benefits and services provided to YOU under this Option.

By YOUR authorized representative's signature below, YOU are verifying that YOU have read and understand the terms of this Rider, and YOUR obligations hereunder.

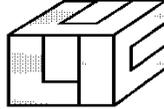
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Specific Advance Option Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

This provision is only applicable if indicated as included on the Application/Schedule.

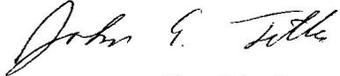
1. **AVAILABILITY OF SPECIFIC ADVANCE.** The Specific Advance is available when a Policyholder's Plan sustains losses that:
 - a. exceed the Specific Attachment Point, plus;
 - b. are determined in accord with the Policyholder's Plan Document; and
 - c. are processed for payment before the Policy Period ends.
2. **REQUEST FOR SPECIFIC ADVANCE.** To receive a Specific Advance, the Policyholder must send the Company a written request, along with proof that the Policyholder has paid up to the Specific Attachment Point plus and any other required documentation. The Company must receive this proof prior to the end of the Policy Period.
3. **USE OF REIMBURSEMENT.** Within five calendar days after receiving the Company's reimbursement, the Policyholder must:
 - a. pay the benefits described in 1.; and
 - b. deposits the Company's reimbursement draft.In no event may the Company's reimbursement draft be deposited before the benefits described in 1. have been paid. If the benefits are not paid within the five-day period, the reimbursement draft must be returned to the Company. The Policyholder must supply proof of such benefit payments, at the Company's request.
4. **REFUND OF ANY UNUSED AMOUNT.** If, for any reason, part of the reimbursement is not used to pay the eligible losses described in 1., then the Policyholder must refund the unused amount to the Company. This refund must be made within five business days after receiving the Company's reimbursement draft.

If the Policyholder fails to comply with the above conditions, the Policyholder's right to receive the Specific Advance shall be revoked. The Company does not waive any rights under this Stop Loss Insurance Policy by adding this provision.

By YOUR authorized representative's signature below, YOU are verifying that YOU have read and understand the terms of this Rider, and YOUR obligations hereunder.

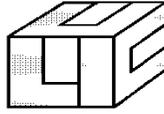
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Policy Termination Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

Your Policy is terminated effective _____ as a result of:

- YOUR request to terminate the Policy. (The stated termination date may or may not differ from the date you requested, based on the requirement that YOUR request must be a written notice, submitted at least 31 days in advance of the requested termination date.)
- YOUR failure to pay premium due. (Coverage ends on the last day for which premium has been paid.)

Due to termination of YOUR Policy prior to the Expiration Date, the Benefit Period for YOUR Policy has been changed as follows:

SPECIFIC STOP LOSS COVERAGE:

- Not included
- Included and changed to the following:
Plan Benefits Incurred from _____ through the date of termination
and from _____ through the date of termination.

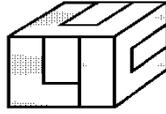
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

John E. Telle
President

Mary M. Rixey
Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Change in Premium Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following change to the Application/Schedule for the Stop Loss Policy to which this Rider applies:

- The monthly premium rates for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 8., are changed to the following:

8. Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$

- The Minimum Annual Specific Premium for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 9., is changed to \$.

- The monthly premium rates for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 10., are changed to the following:

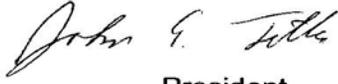
10. Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$

- The Minimum Annual Aggregate Premium for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 11., is changed to \$.

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

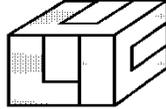


President



Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Change in Specific Stop Loss Coverage Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following changes to the Application/Schedule for the Stop Loss Policy to which this Rider applies:

- The Specific Attachment Point for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 3., is changed as follows:
 - Per Covered Person: \$ _____
 - Per Covered Family: \$ _____
- The Specific Policy Period Reimbursement Limit per Covered Person for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 5., is changed to \$ _____.
- The Specific Lifetime Maximum Reimbursement per Covered Person for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 6., is changed to \$ _____.

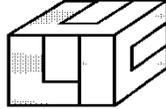
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

John E. Tittle
President

Mary M. Bixey
Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Change in Basis of Coverage Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following change to the Application/Schedule for the Stop Loss Policy to which this Rider applies:

- The basis for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 7., is changed to the following:

7. Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____.

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____.

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____.

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:

- \$ _____ per Covered Person *or*
- \$ _____ for all Covered Persons combined

- The basis for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 9., is changed to the following:

9. Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period):

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____.

Applicable only to _____
Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Applicable only to _____
Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:

- \$ _____ per Covered Person or
- \$ _____ for all Covered Persons combined

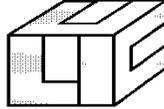
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Change in Monthly Aggregate Factor Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following change to the Application/Schedule for the Excess Loss Policy to which this Rider applies:

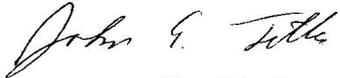
The Monthly Aggregate Factor for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 3., is changed to the following:

3. Monthly Aggregate Factor:

Covered Unit Description	Medical	Dental	Visions	Prescription Drug Service	Weekly Income	Totals
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

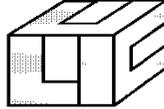
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Change in Aggregate Stop Loss Coverage Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following changes to the Application/Schedule for the Stop Loss Policy to which this Rider applies:

- The Minimum Annual Aggregate Attachment Point for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 5., is changed to \$ _____ (12 times Monthly Aggregate Factor[s], times total Number of Covered Units).
- The Individual Claim Limit for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 7., is changed to \$ _____.
- The Maximum Aggregate Reimbursement (per Policy Period) for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 8., is changed to \$ _____.

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

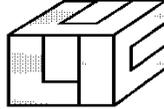
John E. Tuttle

President

Mary M. Rixey

Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

[Blank Rider]

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following changes to the Application/Schedule for the Stop Loss Policy to which this Endorsement applies:

[A change to Policy language that will either amend the terms of the Policy more favorably to the Policyholder, or amend the Policy to match the terms of the Plan Document.]

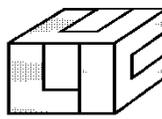
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

John E. Tittle
President

Mary M. Rixey
Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]

Addition of Subsidiary or Other Affiliated Group Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the addition of a subsidiary, or other affiliated group, to YOUR Policy, as follows:

Name of Subsidiary or Affiliated Group:

Effective Date: _____

SPECIFIC STOP LOSS INSURANCE

Specific Attachment Point: \$ _____ [] per Covered Person or [] per Covered Family

Specific Policy Period Reimbursement Limit per Covered Person \$ _____

Specific Lifetime Maximum Reimbursement per Covered Person: \$ _____

- Of this amount, reimbursement for treatment of drug or alcohol abuse will be limited to:
 - \$ _____ or
 - _____ days or
 - _____ days, up to \$ _____

or

- Treatment of drug or alcohol abuse considered as any other illness.

Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Plan Benefits Incurred prior to the Effective Date (Run-In Period) will be limited to:

- \$ _____ per Covered Person or
- \$ _____ for all Covered Persons combined

Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>	<i>Covered Unit Description</i>	<i>Amount</i>
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$

AGGREGATE STOP LOSS INSURANCE

Monthly Aggregate Factor:

<i>Covered Unit Description</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Prescription Drug Service</i>	<i>Weekly Income</i>	<i>Totals</i>
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Number of Covered Units:

- Quoted
- Actual

<i>Covered Unit Description</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Prescription Drug Service</i>	<i>Weekly Income</i>
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Minimum Annual Aggregate Attachment Point: \$ _____
 (12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

Maximum Aggregate Reimbursement (per Policy Period): \$ _____

Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____ .

Plan Benefits Incurred prior to the Effective Date (Run-In Period) will be limited to:

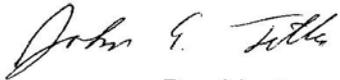
- \$ _____ per Covered Person
- \$ _____ for all Covered Persons combined

Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>	<i>Covered Unit Description</i>	<i>Amount</i>
_____:	\$	_____:	\$
_____:	\$	_____:	\$
_____:	\$	_____:	\$
_____:	\$	_____:	\$
_____:	\$	_____:	\$
_____:	\$	_____:	\$

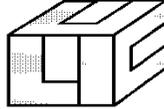
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Qualified Clinical Trials Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

WE will include Plan Benefits Paid for Patient Care Services furnished in connection with Covered Persons' participation in Qualified Clinical Trials when WE calculate reimbursements to YOU under the Policy. The Plan Benefits Paid for Patient Care Services furnished in connection with Covered Persons' participation in Qualified Clinical Trials, for which WE will consider in OUR reimbursement calculations, will be limited to [\$50,000 to \$250,000, in \$50,000 increments] per Covered Person's lifetime, under this and prior or later Policies issued by US. In no event does this consideration:

1. increase any reimbursement levels or limits stated in the Policy, or expand any other provision of the Policy; or
2. allow YOU to change the terms of YOUR Plan with respect to benefits YOU pay to Covered Persons incurring expense as the result of participation in a clinical trial.

This Rider shall apply only to Qualified Clinical Trial expenses for treatment incurred by a Covered Person after the Effective Date of this Rider. This Rider shall not apply to Qualified Clinical Trial expenses for treatment incurred by a Covered Person if the Covered Person:

1. is enrolled in; or
2. has been evaluated for participation in; or
3. has signed a consent form for; or
4. has been recommended to participate in, a Phase II or III or IV clinical trial prior to the effective date of this Rider.

All Policy provisions shall apply as if this Rider did not exist for Plan Benefits Paid and submitted for reimbursement under the Policy that are for expenses other than Qualified Clinical Trial Eligible Expenses.

Stop Loss Policy benefits paid under this Rider shall not create any legal presumption that either WE or OUR Underwriting Manager have recommended, directed, endorsed or required any Covered Person's Participation in the Qualified Clinical Trial.

The following changes are made to the Policy as a result of the above added provision:

(1) In Section 1, the definition of **Eligible Expenses** is changed to include the following:

Eligible Expenses will not include expenses of a Qualified Clinical Trial unless YOU provide US with:

1. a copy of the clinical trial treatment protocol from the facility that conducted the clinical trial; and

2. a copy of the Covered Person's signed consent and authorization to participate in the clinical trial; and
3. documentation that the clinical trial meets the definition and requirements to be a Qualified Clinical Trial.

(2) The following definitions are added to Section 1:

Patient Care Services means health care items or services that are furnished to a Covered Person while he or she is enrolled in a Qualified Clinical Trial that:

1. are consistent with the usual and customary standard of care for someone with the Covered Person's diagnosis; and
2. are consistent with the study protocol for the Qualified Clinical Trial; and
3. would be considered eligible charges payable under YOUR Plan, regardless if the Covered Person was participating in the Qualified Clinical Trial.

An FDA-approved drug, device, or biological product shall be a Patient Care Service only to the extent that the drug, device, or biological product is not paid for by the manufacturer, the distributor, or the provider of such drug, device, or biological product.

The term Patient Care Services does not include any of the following:

1. Non-health care services that a Covered Person may be required to receive as a result of being enrolled in the Qualified Clinical Trial.
2. Costs associated with managing the research associated with the Qualified Clinical Trial.
3. Costs that would not be covered for non-investigational treatments.
4. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial.
5. The costs of services that are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly intended guidelines.

Qualified Clinical Trial means a clinical trial that meets all the following conditions:

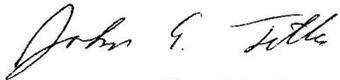
1. The clinical trial is intended to treat cancer in a patient who has been so diagnosed.
2. The clinical trial has been peer-reviewed and is approved by at least one of the following:
 - a. One of the United States National Institutes of Health.
 - b. A cooperative group or center of the National Institutes of Health.
 - c. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants.
 - d. The United States Food and Drug Administration, pursuant to an investigational new drug exemption.
 - e. The United States Department of Defense or Veterans Affairs.
 - f. With respect to Phase II, III, and IV clinical trials only, a qualified institutional review board.
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise.
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
7. The clinical trial does not unjustifiably duplicate existing studies.
8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

(3) In Section 6, the exclusion for "medical expenses or complications in connection with Experimental or Investigational surgery or treatment" is changed to "medical expenses or complications in connection with Experimental or Investigational services, supplies or treatments, including drugs, devices and biological products, except as provided in any Rider providing reimbursement of Plan Benefits Paid for Qualified Clinical Trials."

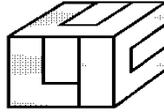
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


 President


 Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Exclusions/Limitations for Named Persons Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that if the individual(s) listed on the following page(s) is/are a Covered Person(s) under the Plan, then the claims on such Covered Person(s) will be excluded or limited, as described in this Rider.

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

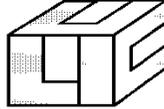
This Rider is subject to all of the provisions of the Policy as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy to which it is attached.


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:

Name of Covered Person	Treatment of Such Covered Person's Claims under Specific Stop Loss Coverage	Treatment of Such Covered Person's Claims under Aggregate Stop Loss Coverage
	<p><i>Check only one box:</i></p> <p><input type="checkbox"/> No Specific Stop Loss Coverage provided under Policy.</p> <p><input type="checkbox"/> Not covered.</p> <p><input type="checkbox"/> Different Specific Attachment Point: \$_____</p> <p><input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____</p>	<p><i>Check only one box:</i></p> <p><input type="checkbox"/> No Aggregate Stop Loss Coverage provided under Policy.</p> <p><input type="checkbox"/> Not covered.</p> <p><input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$_____</p> <p><input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____</p>
	<p><i>Check only one box:</i></p> <p><input type="checkbox"/> No Specific Stop Loss Coverage provided under Policy.</p> <p><input type="checkbox"/> Not covered.</p> <p><input type="checkbox"/> Different Specific Attachment Point: \$_____</p> <p><input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____</p>	<p><i>Check only one box:</i></p> <p><input type="checkbox"/> No Aggregate Stop Loss Coverage provided under Policy.</p> <p><input type="checkbox"/> Not covered.</p> <p><input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$_____</p> <p><input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____</p>
	<p><i>Check only one box:</i></p> <p><input type="checkbox"/> No Specific Stop Loss Coverage provided under Policy.</p> <p><input type="checkbox"/> Not covered.</p> <p><input type="checkbox"/> Different Specific Attachment Point: \$_____</p> <p><input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____</p>	<p><i>Check only one box:</i></p> <p><input type="checkbox"/> No Aggregate Stop Loss Coverage provided under Policy.</p> <p><input type="checkbox"/> Not covered.</p> <p><input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$_____</p> <p><input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____</p>
	<p><i>Check only one box:</i></p> <p><input type="checkbox"/> No Specific Stop Loss Coverage provided under Policy.</p> <p><input type="checkbox"/> Not covered.</p> <p><input type="checkbox"/> Different Specific Attachment Point: \$_____</p> <p><input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____</p>	<p><i>Check only one box:</i></p> <p><input type="checkbox"/> No Aggregate Stop Loss Coverage provided under Policy.</p> <p><input type="checkbox"/> Not covered.</p> <p><input type="checkbox"/> Maximum amount of Paid Plan Benefits counted towards satisfaction of Annual Aggregate Attachment Point: \$_____</p> <p><input type="checkbox"/> Different Benefit Period: Incurred from _____ to _____ and Paid from _____ to _____</p>



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Domestic Claims Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

- (1) To ensure that Domestic Claim charges are considered at the negotiated percentage of accumulation and reimbursement, WE require that documentation of YOUR hospitals, centers, and facilities that YOU own, operate, or with which YOU are otherwise affiliated, be provided to US. Disclosing all such hospitals, centers, and facilities will ensure proper application of the Policy provisions. Notification of the addition or deletion of any hospitals, or centers, or facilities that YOU own, operate, or with which YOU are otherwise affiliated, must be provided to US in writing within 30 days of such change.

Name and Addresses of Hospitals, Centers, and Facilities to be covered:

(Attach additional pages, if necessary.)

Name	Address (City, State, Zip)	Tax ID #

(2) Charges for Domestic Claims will be considered as follows: (Check only one box.)

- Charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility which YOU own, operate, or with which YOU are otherwise affiliated, will not be considered Eligible Expenses.
- Eligible Expenses relating to charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility that YOU own, operate, or with which YOU are otherwise affiliated, will be limited to _____ % of such hospital's or facility's actual charges.
- Eligible Expenses relating to charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility that YOU own, operate, or with which YOU are otherwise affiliated, will be limited to _____ % of such hospital's or facility's negotiated PPO charges.
- Eligible Expenses relating to charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility that YOU own, operate, or with which YOU

are otherwise affiliated, will be limited to _____ % of such hospital's or facility's Usual and Customary Charges.

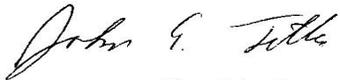
- Eligible Expenses relating to charges for treatments, services and/or supplies rendered to Covered Persons of YOUR Plan in a hospital, or center, or facility that YOU own, operate, or with which YOU are otherwise affiliated, will be limited to % of such hospital's or facility's Usual and Customary Charges, less any applicable PPO discounts.
- [Any other limitation of Domestic Charges that is agreed to by Unified Life Insurance Company, such limitation being prescribed by Unified Life Insurance Company.]

(3) The following definition is added to Section 1:

Domestic Claim means a claim for treatments, services and/or supplies that are provided to a Covered Person by one or more of YOUR hospitals, or centers, or facilities that YOU own, operate, or with which YOU are otherwise affiliated, that are licensed to provide such treatments, services and/or supplies.

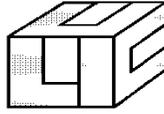
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Prescription Drugs Covered Under Plan Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

YOUR Plan covers prescription drugs under the Medical coverage instead of providing for a Prescription Drug Service. As such, Plan Benefits which YOU have paid for prescription drugs will be considered for reimbursement under Specific Stop Loss Coverage and, if applicable, under Aggregate Stop Loss Coverage, regardless if the Prescription Drug Service box(es) has/have been checked on the Application/Schedule.

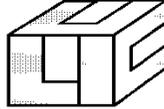
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

John E. Tille
President

May M. Rixey
Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Coverage of Disabled Persons Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree that the Policy is changed as follows:

Claims on Disabled Persons, for whom WE have received a Disclosure Statement, are covered under the Stop Loss Policy to which this Rider is attached. The response in the Application/Schedule for the Stop Loss Policy as to whether or not Disabled Employees are covered is hereby changed to 'Yes.'

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

John E. Tuttle
President

Mary M. Rixey
Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:

SERFF Tracking Number: UNLI-128285465
Filing Company: Unified Life Insurance Company
Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

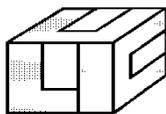
State: Arkansas
State Tracking Number:
Sub-TOI: H12.004 Self-Funded Health Plan

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Application Comments: See Form Schedule tab. Attachment: A100-AR - Application for Stop Loss 061112.pdf	Approved	06/12/2012

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR Readability Certification.pdf	Approved	06/12/2012

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: AR Statement of Variability P100_06112012.pdf	Approved	06/12/2012



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

SECTION 1 – POLICYHOLDER INFORMATION

1. Full legal name of Policyholder (herein referred to as You/Your), as it will appear in Policy issued by US:
[Any Company]

2. Address of principal office (street, city, state, zip):
[### Street, City, State #####]

3. Contact Person:
Name: [Any Person] Telephone Number: [(###) ### - #####]
E-mail Address: [name@company.net] Fax Number: [(###) ### - #####]

4. Nature of Business:
[Any Company]

5. If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:
[Any Company]

6. Full name of Your Employee Welfare Benefit Plan:
[Any Company Health Plan]

NOTE: A copy of Your ERISA Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application/Schedule.

7. Your designated Third-Party Administrator (for the purposes of claims administration under Your Employee Welfare Benefit Plan):
Name: [Any Company] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

8. Your broker/agent of record:
Name: [Any Person] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

9. Our Underwriting Manager: [Any Company]

SECTION 2 – REQUESTED POLICY PERIOD

The Coverage shown as included in Section 3 and/or Section 4 is requested for, and applies only during the Policy Period from [Date] (the Effective Date) through [Date] (the Expiration Date) and is further subject to all of the provisions of the Policy.

SECTION 3 – SPECIFIC STOP LOSS COVERAGE

1. Coverage Election: YES – Specific coverage is included in this Policy.
 NO – Specific coverage is not included in this policy. **Do not complete this Section.**

2. Coverage to be included. Check one box below for each coverage listed:
Yes No
 Medical
 Prescription Drug Service:

NOTE: In no event will Dental, Vision, or Weekly Income be included under Specific Stop Loss Coverage.

3. Specific Attachment Point:
 Per Covered Person: \$[##,###.##]
 Per Covered Person: \$

4. Specific Reimbursement Percentage: 100%

5. Specific Policy Period Reimbursement Limit per Covered Person \$[#,##,###.##]

6. Specific Lifetime Maximum Reimbursement per Covered Person: \$[#,##,###.##]

7. Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Applicable only to [Any Company and all of its subsidiaries and affiliates]

Plan Benefits Incurred from [Date] through [Date]
and Paid from [Date] through [Date]

Applicable only to _____

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Applicable only to _____

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:
 \$[###,###.##] per Covered Person or
 \$ _____ for all Covered Persons combined

Related Rider(s): [Form Number Here]

8. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
<u>[Composite]</u>	: \$ <u>[##.##]</u>	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____

9. Minimum Annual Specific Premium: \$ [###,###.##]

SECTION 4 – AGGREGATE STOP LOSS COVERAGE

1. Coverage Election: YES – Aggregate coverage **is** included in this Policy.
 NO – Aggregate coverage **is not** included in this Policy. Do not complete this section.

2. Coverages to be included. Check one box below for each coverage listed:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Vision
<input type="checkbox"/>	<input type="checkbox"/>	Prescription Drug Service: _____
<input type="checkbox"/>	<input type="checkbox"/>	Weekly Income: Maximum _____, per covered employee per Policy Period.
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

3. Monthly Aggregate Factor:

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income	Totals
<u>[Composite]</u>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

4. Number of Covered Units: Quoted Actual

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income	Totals
[Employee]	[###]	_____	_____	_____	_____	_____
[Spouse]	[###]	_____	_____	_____	_____	_____
[Child]	[###]	_____	_____	_____	_____	_____
[Family]	[###]	_____	_____	_____	_____	_____

5. Minimum Annual Aggregate Attachment Point: \$ [###,###.##]
 (12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

6. Aggregate Reimbursement Percentage: _____

7. Individual Claim Limit: [###,###.##]

8. Maximum Aggregate Reimbursement (per Policy Period): \$ [#,###,###.##]

9. Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period):
 Applicable only to [Any Company and all of its subsidiaries and affiliates]
 Plan Benefits Incurred from [Date] through [Date]
 And paid from [Date] through [Date]

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 And paid from _____ through _____

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 And paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:
 \$ _____ Per Covered Person or
 \$ [#,###,###.##] For all Covered Persons combined
 Related Rider(s): [None]

10. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
[Composite]	:\$ [##.##]	_____	:\$ _____
_____	:\$ _____	_____	:\$ _____
_____	:\$ _____	_____	:\$ _____

11. Minimum Annual Aggregate Premium: \$ [###,###.##]

SECTION 5 – ELIGIBILITY, PREMIUM DEPOSIT, AND ENROLLMENT INFORMATION

1. Check one box for each of the following groups of persons to indicate if such groups are to be considered as Covered Persons under the Policy:

Yes*	No	
<input type="checkbox"/>	<input type="checkbox"/>	Retired Employees
<input type="checkbox"/>	<input type="checkbox"/>	COBRA Continues
<input type="checkbox"/>	<input type="checkbox"/>	Disabled Employees
<input type="checkbox"/>	<input type="checkbox"/>	Transplants

*All "Yes" answers must have disclosure information attached to this Application/Schedule.

2. Initial premium deposit accompanying this Application/Schedule: \$ [###,###.##]

3. Minimum Plan Enrollment: _____ Covered Units or
 _____ % of initial enrollment

SECTION 6 – NOTICES AND SIGNATURES

You have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by Us and as reflected in this Application/Schedule. You have formed Your Employee Welfare Benefit Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable provisions of the law or regulation. It is agreed that the statements in this Application/Schedule or in any materials submitted with this Application/Schedule or attached to it are Your representations and shall be deemed material to acceptance of the risk by Us only if there is a casual relationship between the misrepresentation and the hazard resulting in a loss under this Policy and that the Policy is issued by Us in reliance on ~~the truth and accuracy of~~ such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage hereunder, We will have the right to revise the premiums rates, factors, terms or conditions as of the Effective Date, by providing written notice to You. Any fraudulent statement will render the Policy null and void and all claims, if any, will be forfeited.

This Application does not bind coverage. Upon approval of the Application, the Policy evidencing that the coverage is in force will be issued by Us through Our Underwriting Manager. Coverage will commence on the Effective Date set forth in the Policy.

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

Accepted by the POLICYHOLDER:

Policyholder (full legal name): [Any Company]

Signed at (city, state): [City, State] Date: _____

Signed for the Policyholder by (officer's signature): _____

Printed Name: [Any Person] Title: _____

Accepted by the Company:

Signed at (city, state): [City, State] Date: _____

Signed for the Company by (officer's signature): _____

Printed Name: [Any Person] Title: _____

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

[Application FRAUD WARNING

ALL STATES EXCEPT AS INDICATED BELOW

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

ALASKA

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA

For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS

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.

CALIFORNIA

For your protection California Law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA

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

DELAWARE

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA

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

IDAHO

Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS

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

KENTUCKY

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

LOUISIANA

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.

MAINE

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

MARYLAND

ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

MINNESOTA

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

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 civil fines and criminal penalties.

NEW YORK

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

OHIO

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

OKLAHOMA

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

PENNSYLVANIA

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

RHODE ISLAND

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.

TENNESSEE

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

VIRGINIA

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

VERMONT

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

WASHINGTON

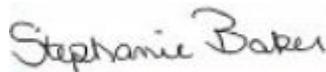
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

READABILITY CERTIFICATION

Company Name: Unified Life Insurance Company

I hereby certify, that the form listed below has the following readability score as calculated by the Flesch Reading Ease Test. Defined words have been excepted text.

Form Number	Score
P100-AR	50
A100-AR	53
R100	68
R101	68
R102	52
R103	52
R104	51
R105	54
R106	55
R107	52
R108	69
R109	55
R110	55
R111	64
R112	68
R113	70
R114	59
R115	72
R116	53
R117	52
R118	51
R119	50
R120	59



Stephanie Baker
Vice President – Risk Management

June 11, 2012

Date

STATEMENT OF VARIABILITY A100 and Riders

Arkansas

A100 Application/Schedule Page

Section	Item #	DESCRIPTION	VARIABLE
3	3	Specific Attachment Point	Varies from \$20,000 to \$1,000,000
3	4	Specific Reimbursement Percentage	Varies from 80% to 100% or 50% to a maximum of \$20,000 to \$1,000,000 and 100% of claims over \$20,000 to \$1,000,000
3	5	Specific Policy Period Reimbursement Limit per Covered Person	Varies from \$1,250,000 to unlimited
3	6	Specific Lifetime Maximum	Unlimited
3	7	Plan Benefits Incurred prior to the Effective Date will be limited to (per covered person)	Varies from \$15,000 to \$1,000,000 (1st ck box)
3	7	Plan Benefits Incurred prior to the Effective Date will be limited to (for all covered persons)	Varies from \$0 to \$1,000,000 (2nd ck box)
3	8	Premium Rates	Refer to rate filing
3	9	Minimum Annual Specific Premium	Refer to rate filing
4	2	Coverages to be included, Weekly Income	\$50 to \$10,000
4	3	Monthly Aggregate Factor	Refer to rate filing
4	5	Minimum Annual Aggregate Attachment Point	For groups under 51 lives - the greater of (a) \$4000 x number of covered members, (b) \$20,000 or (c) 120% of expected claims; For groups over 50 lives - 110% of expected claims.
4	6	Aggregate Reimbursement Percentage	Varies from 80% to 100% of expected claims. (90% to 100% of expected claims for groups over 50 lives)
4	7	Individual Claim Limit	Varies from \$20,000 to \$1,000,000
4	8	Maximum Aggregate Reimbursement (per policy period)	\$100,000 to unlimited
4	9	Plan Benefits Incurred prior to the Effective Date will be limited to (per covered person)	\$15,000 to \$1,000,000 (first ck box)
4	9	Plan Benefits Incurred prior to the Effective Date will be limited to (per covered person)	\$15,000 to \$1,000,000 x number of Covered units (2nd ck box)
4	10	Premium Rates	Refer to rate filing
4	11	Minimum Annual Aggregate Premium	amt in 10 above x number of covered units x 12 x 80% (90% for groups over 50 lives)
5	2	Initial Premium Deposit	\$0 to \$10,000 x number of covered units.
5	3	Minimum Plan enrollment	2 - 10,000 (1st ck box)
5	3	Minimum Plan enrollment	25% to 90% (2nd ck box)
5,6,7		Fraud statements	The fraud statements will be changed as required by each state.

Rider

R106

Page 1
Page 1

DESCRIPTION

Aggregate Accommodation Option

- during the first
- not exceed

VARIABLE

0-189 days of the Policy Period
0% - 200%

R107

Page 1
Page 1

Specific Advance Option Rider

- a. exceed the Specific Attachment Point, plus
- ...Specific Attachment Point plus

\$0 - \$10,000
\$0 - \$10,000

R110

Page 1
Page 1
Page 1
Page 1

Change in Specific Stop Loss Coverage Rider

Rider Number
Policy Number
Effective Date
Policyholder

Sequential Number assigned to rider
Sequential Number assigned to policy
Date rider is effective. Same as policy or subsequent to policy effective date
Company, policyholder, and/or insured specific information.

Page 1	Specific Attachment Point, per covered person	Varies from \$20,000 to \$1,000,000
Page 1	Specific Attachment Point, per covered family	Varies from \$20,000 to \$1,000,000
Page 1	Specific Policy Period Reimbursement Limit per Covered Person	Varies from \$1,250,000 to unlimited
Page 1	Specific Lifetime Maximum Reimbursement	Varies from \$1,250,000 to unlimited
R111	Change is Basis of Coverage Rider	
Page 1	Item 6. 1st variable under SPECIFIC STOP LOSS COVERAGE	Any company and all of its subsidiaries and affiliates
Page 1	Plan Benefits Incurred from	Date
Page 1	through	Date
Page 1	and Paid from	Date
Page 1	through	Date
Page 1	Plan Benefits Incurred prior to the Effective Date	\$15,000 to \$1,000,000 per Covered Person
Page 1		\$0 to \$1,000,000 for all Covered Persons combined
Page 1	Item 9. 1st variable under AGGREGATE STOP LOSS COVERAGE	Any company and all of its subsidiaries and affiliates
Page 1	Plan Benefits Incurred from	Date
Page 1	through	Date
Page 1	and Paid from	Date
Page 1	through	Date
Page 2	Plan Benefits Incurred prior to the Effective Date	\$15,000 to \$1,000,000 per Covered Person
Page 2		\$0 to \$1,000,000 for all Covered Persons combined
R115	Addition of Subsidiary or Other Affiliated Group Rider	
Page 1	Effective Date	Date
Page 1	Specific Attachment Point	\$20,000 to \$1,000,000
Page 1	Specific Policy Period Reimbursement Limit per Covered Person	Varies from \$1,250,000 to unlimited
Page 1	Specific Lifetime Maximum Reimbursement per Covered Person	unlimited
Page 1	<input type="checkbox"/> Of this amount, reimbursement for treatment of drug or alcohol abuse will be limited to:	(1st ck box) \$10,000 - \$1,000,000
Page 1		(2nd ck box) 10-365 days
Page 1		(3rd ck box) 10-365 days up to \$10,000 - \$1,000,000
Page 1	Plan Benefits Incurred prior to the Effective Date (Run-In Period) will be limited to:	
Page 1	per Covered Person	\$15,000 to \$1,000,000
Page 1	for all Covered Persons combined	\$15,000 to \$1,000,000 x number of Covered units
Page 2	Minimum Annual Aggregate Attachment Point	For groups under 51 lives - the greater of (a) \$4000 x number of covered members, (b) \$20,000 or (c) 120% of expected claims; For groups over 50 lives - 110% of expected claims.
Page 2	Maximum Aggregate Reimbursement (per Policy Period)	\$100,000 to unlimited
Page 2	Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period)	
Page 2	Plan Benefits Incurred prior to the Effective Date (Run-In Period) will be limited to	
Page 2	per Covered Person	\$15,000 to \$1,000,000 per Covered Person
Page 2	for all Covered Persons combined	\$15,000 to \$1,000,000 x number of Covered units
R118	Domestic Claims Rider	
Page 1	Each blank will be completed with a percentage from 0% to 100%	

SERFF Tracking Number: UNLI-128285465 State: Arkansas
 Filing Company: Unified Life Insurance Company State Tracking Number:
 Company Tracking Number: 1066
 TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan
 Product Name: Excess Stop-Loss 2012
 Project Name/Number: Excess Stop-Loss 2012/1066

Superseded Schedule Items

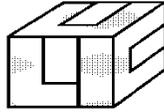
Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/22/2012	Form	Stop Loss Policy	06/11/2012	P100 - SL Policy 2012 05222012.pdf (Superseded)
05/22/2012	Form	Stop Loss Application/Schedule	06/11/2012	A100 - Application for Stop Loss 05012012.pdf (Superseded)
05/22/2012	Form	Change in Premium Rider	06/05/2012	R109 - Chg in Premium Rdr.pdf (Superseded) R109 - Chg in Premium Rdr 04302012.pdf
04/19/2012	Form	Stop Loss Policy	05/22/2012	P100 - SL Policy 2012.pdf (Superseded)
04/19/2012	Form	Stop Loss Application/Schedule	05/22/2012	A100 - Application for Stop Loss 02222012.pdf (Superseded)
04/19/2012	Form	Change in Premium Rider	05/22/2012	R109 - Chg in Premium Rdr.pdf
04/19/2012	Form	Change in Specific Stop Loss Coverage Rider	05/22/2012	R110 - Change in Specific Stop Loss Rdr.pdf (Superseded)
04/19/2012	Form	Change in Basis of Coverage Rider	05/22/2012	R111 - Chg in Basis of

SERFF Tracking Number: UNLI-128285465 *State:* Arkansas
Filing Company: Unified Life Insurance Company *State Tracking Number:*
Company Tracking Number: 1066
TOI: H12 Health - Excess/Stop Loss *Sub-TOI:* H12.004 Self-Funded Health Plan
Product Name: Excess Stop-Loss 2012
Project Name/Number: Excess Stop-Loss 2012/1066

Coverage Rdr.pdf
(Superceded)

04/19/2012	Form	Addition of Subsidiary or Other Affiliated Group Rider	05/22/2012	R115 - Addition of subsidiary or other Affiliated Group Rdr.pdf (Superceded)
05/22/2012	Supporting Document	Application	06/11/2012	A100 - Application for Stop Loss 05012012.pdf (Superceded)
04/19/2012	Supporting Document	Application	05/22/2012	
04/19/2012	Supporting Document	Flesch Certification	06/11/2012	SL Readability Certification 2012.pdf (Superceded)



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

**STOP LOSS INSURANCE POLICY
Non-Participating**

Policyholder:	Effective Date:
Policyholder Address:	Expiration Date:
Policy Number:	
YOUR designated Third-Party Administrator:	

This Policy is issued in consideration of YOUR Application/Schedule and the payment of premiums. The attached Application/Schedule and a copy of YOUR ERISA Employee Welfare Benefit PLAN Document form a part of this Policy. All periods of coverage will begin and end at 12:01a.m. Standard Time at YOUR Principal Address.

This Policy is governed by the laws of the state of YOUR Principal Address.

This Policy is issued by US at OUR Underwriting Offices as of the Effective Date.

Notice: This is a reimbursement Policy. YOU or YOUR PLAN Administrator, are responsible for making benefit determinations under YOUR employee welfare benefit plan. WE have no duty or authority to administer, settle, adjust or provide advice regarding claims filed under YOUR employee benefit plan.

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

John E. Tiller
President

May M. Bixey
Secretary

Table of Contents

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Section 1. Definitions

The following terms, wherever used in this Policy, or Application/Schedule, Rider, or disclosure statement attached hereto, shall have the meaning set forth in this section.

Aggregate Reimbursement Percentage means the percentage at which Eligible Expenses, in excess of YOUR Annual Aggregate Attachment Point, will be reimbursed by US.

Annual Aggregate Attachment Point means, for the Policy Period or any portion of the Policy Period, the PLAN benefits covered by this Policy and wholly retained by YOU. It is not considered for reimbursement under this Policy, and is the greater of:

1. the sum of Monthly Aggregate Factor amounts for each month of the Policy Period, determined by multiplying the total number of Covered Units by the Monthly Aggregate Factor amounts; or
2. the minimum annual Aggregate Attachment Point shown in the Application/Schedule.

The maximum per Covered Person that may be applied annually to the Annual Aggregate Attachment Point, (i.e. Individual Claim Limit) is shown in the Application/Schedule.

Application/Schedule means the Stop Loss insurance Application/Schedule signed by YOU and attached to this Policy. The Application/Schedule is subject to acceptance by US and if accepted, will become a part of this Policy.

Benefit Period means the period of time shown in the Application/Schedule during which Eligible Expenses Incurred by a Covered Person, which are paid by YOU during the Policy Period, are eligible for reimbursement under this Policy. This period does not alter the Policy Effective Date or Policy Period but does include any Run-In Period and/or Run-Out Period as shown on the Policy Application/Schedule. It does not waive this Policy's eligibility requirements.

COBRA Continuee means a Covered Unit that elects to extend its group health coverage under the PLAN as entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent regulations.

Company (WE, OUR, US) means Unified Life Insurance Company.

Covered Family means an employee and his or her dependents covered under the PLAN.

Covered Person means an individual covered under the PLAN.

Covered Unit means an employee with dependents, or such other defined unit as agreed upon between YOU and US, as shown in the Application/Schedule.

Disabled Persons are those persons who are or become unable to perform the same lifestyle functions as a person or similar age and sex who is in good health.

Disclosure Statement means the disclosure statement submitted by YOU to US in connection with the issuance of this Policy.

Eligible Expenses means the eligible charges payable under YOUR PLAN and for which the Covered Person is liable to pay. It does not include expenses specifically excluded or limited by this Policy, YOUR Application/Schedule of this Policy, or any Riders.

Experimental or Investigational means medical services, supplies or treatments, including drugs, devices and biological products, provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered Experimental/Investigational in any setting if the Covered Person is required to sign a consent form that indicates the proposed treatment, procedure, medical service, supply, drug, device or biological product is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment under the particular medical circumstances by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational. Off-label usage of any drug will be considered Experimental/Investigational. A drug, device or biological product is considered Experimental/Investigational if it does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption or is used off-label.

HIPAA refers to Public Law 104-191, otherwise known as the Health Insurance Portability and Accountability Act of 1996 and subsequent regulations.

Incurred means:

1. with respect to medical services or supplies, the date on which the services are rendered or supplies are received by the Covered Person; and
2. with respect to disability income benefits, the date each periodic benefit payment becomes payable to the Covered Person (not the date the disability commences), if this coverage was elected on the Application/Schedule; and
3. with respect to negotiated medical services or supplies, the date on which the service or supply was initially rendered or used.

Individual Claim Limit means the maximum amount of payments for Eligible Expenses that will be allowed for any one Covered Person under Aggregate Stop Loss coverage. The Individual Claim Limit is shown in the Application/Schedule. The maximum allowable amount of Eligible Expenses for a Covered Person who has been assigned a separate Specific Attachment Point will be the specified amount as shown under the Individual Claim Limit on the Application, regardless of that Covered Person's separate Individual Specific Attachment Point.

Large Claim (or LC) means paid, denied or pending claims reaching, or with the potential to reach, 50% of the Specific Attachment Point or a Potentially Catastrophic Loss (PCL).

Medically Necessary means a service or supply that is necessary to diagnose and treat a condition. Such service or supply must be commonly recognized by the medical profession as standard of care for the control or cure of the illness or injury being treated by physicians practicing in the same or related specialty field. This does not include any services or supplies that:

1. are provided only as a convenience to the Covered Person or provider; or
2. exceed in scope, duration, intensity, the level of care that is needed to provide safe, adequate, and appropriate diagnosis and treatment; or
3. are excluded under the PLAN Document, or Exclusions section of this Policy; or
4. are not listed as PLAN benefits under the PLAN Document.

Minimum Annual Aggregate Attachment Point means the lowest amount of total payments YOU must make under YOUR plan before YOU are eligible for reimbursement under Aggregate Stop Loss coverage. The Minimum Annual Aggregate Attachment Point is shown in the Application/Schedule.

Monthly Aggregate Factor means the factor(s) that is/are multiplied by the number of Covered Units for each Policy Month to determine the Annual Aggregate Attachment Point. The Monthly Aggregate Factor(s) is/are shown in the Application/Schedule.

Monthly Aggregate Deductible means the amount determined for each Policy Month by multiplying the number of Covered Units for that month by the applicable Monthly Aggregate Factor(s) shown on the Application.

Paid (or Payment) means that a claim has been adjudicated by the TPA and the funds are actually disbursed by the PLAN prior to the end of the Benefit Period. Payment of a claim is unconditional and direct payment of a claim to a Covered Person or their health care provider(s). Payment will be deemed made on the date that both:

1. the payer directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. the account upon which the payment is drawn contains, and continues to contain, sufficient funds of the Policyholder to permit the check or draft to be honored by the institution upon which it is drawn. If the account upon which the payment is drawn is funded by a separate account or line of credit or "sweep" account, then the funding account must contain sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

PLAN (or Employee Welfare Benefit PLAN) means the self-insured health care plan YOU have agreed to make available to YOUR employees and their eligible dependents and that is the subject of this Policy, whether or not it is subject to Employee Retirement Income Security Act of 1974, as is or as may be amended.

PLAN Benefits means the health benefits covered by the PLAN during the Policy Period that are:

1. Incurred on or after the Effective Date of this Policy; and
2. Incurred while this Policy is in force; and
3. Incurred and Paid during the Policy Period.

PLAN Benefits will also include those health benefits covered by the PLAN that are:

1. Incurred during the Policy Period and Paid during any Run-Out Period; and

2. Incurred during the Run-In Period and Paid during any Policy Period or Run-Out Period.

PLAN Benefits do not include:

1. deductibles of the PLAN; or
2. co-insurance or co-payment amounts of the PLAN; or
3. expenses that are not covered by the PLAN or this Policy; or
4. amounts recoverable from any other source; or
5. amounts Paid under a previous policy or arrangement of stop loss coverage, whether issued by US or another entity; or
6. Health Savings Accounts, Health Reimbursement Accounts, Flexible Spending Accounts or any similar plan enacted by legislation.

While the determination of benefits under the PLAN is the sole responsibility of the Policyholder, WE reserve the exclusive right to interpret the terms and conditions of the PLAN as it applies to this Policy. WE have the sole authority to approve or deny reimbursements under this Policy without deference to the benefit determination made by the PLAN.

PLAN Document means the written instrument that describes the PLAN and names the fiduciaries or trustees who jointly and separately have authority to control and manage the operations and administration of the PLAN. The PLAN Document must be in effect on the Effective Date of the Policy. Any changes to the PLAN Document must be accepted by US. (See the "Changes to YOUR PLAN" provision.)

Policy means this Stop Loss Policy issued by US to YOU.

Policy Month means, for the first Policy Month, the period beginning on the Effective Date of this Policy and ending on the corresponding date of the following month. Subsequent Policy Months begin on the corresponding date of each calendar month and continue until the corresponding date of the next month to the Policy expiration date.

Policy Period means the time period beginning on the Effective Date and ending on the Expiration Date.

Policyholder (PLAN Sponsor, YOU or YOUR) means the PLAN Sponsor, named on the face page, to whom this Policy is issued.

Potentially Catastrophic Loss (PCL) means a Paid, denied or pending claim that has the potential to be catastrophic. PCLs include, but are not limited to the conditions listed in Exhibit 1.

Premium Due Date is the first day of each calendar month. If the Effective Date of this Policy is other than the first day of a calendar month, the first month's premium will be pro-rated.

Proof of Loss means receipt of a complete claim form, satisfactory to the Company, and other supporting documentation required by the Company.

Rider means a written amendment or addendum that alters the terms of this Policy.

Run-In Limit means the maximum benefit amount paid by YOU under YOUR plan for Eligible Expenses Incurred by a Covered Person during the Run-In Period that will be applied toward payment under this Policy.

Run-In Period means the period of time shown in the Application/Schedule immediately prior to the first day of this Policy's Policy Period during which Eligible Expenses Incurred by a Covered Person, which are paid by YOU during the Policy Period, will be considered when determining benefit payments under this Policy.

Run-Out Period means the period of time shown in the Application/Schedule immediately following this Policy's Expiration Date during which Eligible Expenses Incurred by a Covered Person, which are paid by YOU during the Policy Period, will be considered when determining benefit payments under this Policy.

Specific Attachment Point means the amount that is retained and paid by YOU during the Policy Period. It is not considered for reimbursement under this Policy. The Specific Attachment Point applies separately to each Covered Person. The Specific Attachment Point is shown in the Application/Schedule.

Specific Policy Period Reimbursement Limit per Covered Person means that maximum amount WE will reimburse YOU per Policy Period with respect to any claims for a person covered under the PLAN that have been filed or submitted under this Policy issued by US. The Specific Policy Period Reimbursement Limit will not exceed the amount shown in the Application/Schedule.

Specific Lifetime Maximum Reimbursement means that maximum amount WE will reimburse YOU with respect to any claims for a person covered under the PLAN that have been filed or submitted under this and prior

or later Policies issued by US. The Lifetime Maximum excludes the Specific Attachment Point amount. The Lifetime Maximum will not exceed the lesser of:

1. the amount shown in the Application/Schedule; or
2. the lifetime amount set forth in the PLAN minus the sum of the Specific Attachment Point applicable to the claimant under each of the policies issued by US.

Specific Reimbursement Percentage means the percentage at which Eligible Expenses, in excess of YOUR Specific Attachment Point, will be reimbursed by US.

Third-Party Administrator (TPA) means a firm having a written agreement with YOU to process PLAN Benefits and provide administrative services.

The term Third-Party Administrator, as used in this Policy, does not refer to the PLAN Administrator used in the Employee Retirement Income Security Act (ERISA) of 1974, as amended, unless YOU have specifically appointed the Third-Party Administrator as such.

Usual and Customary Charges means the common charge for the same or comparable service or supply in the geographic area in which the service or supply is furnished. Usual and Customary Charges are determined based upon:

1. the amount of resources expended to deliver the treatment; and
2. the complexity of the treatment rendered; and
3. charging protocols and billing practices generally accepted by the medical community; and
4. the amount paid after discounts under governmental and private plans.

Section 2 – Specific Stop Loss Coverage

WE will reimburse YOU for PLAN Benefits paid in excess of the Specific Attachment Point, not to exceed the Specific Lifetime Maximum Reimbursement amount shown in the Application/Schedule.

WE will reimburse YOU after YOU have provided an acceptable Proof of Loss and satisfactory proof of Paid PLAN Benefits.

The Specific Stop Loss benefit applies to a Policy Period or fraction thereof (due to termination). As determined with regard to each Covered Person, it is the lesser of:

1. the Specific Lifetime Maximum Reimbursement; or
2. eligible PLAN Benefit Payments made with regard to a Covered Person, less the Specific Attachment Point, the result of which is then multiplied by the Specific Reimbursement Percentage.

If, for any reason, YOUR Specific Stop Loss coverage terminates before the end of the Policy Period:

1. all coverage under this Policy will end as of 12:01 a.m. on the date of YOUR termination;
2. the Run-Out Period, if any, will not apply; and
3. the Specific Attachment Point shown in the Application/Schedule will continue to apply and will not be reduced or prorated.

Section 3 – Aggregate Stop Loss Coverage

The Aggregate Stop Loss benefit for the Policy Period, or fraction thereof (due to termination), is the PLAN Benefit Payment made for Eligible Expenses during the Policy Period less:

1. the greater of the Minimum Annual Aggregate Attachment Point or the calculated Annual Aggregate Attachment Point; and less
2. the Specific Stop Loss benefits that have been or will be reimbursed by US under the Specific Stop Loss coverage; and less
3. any payments that exceed any limitations of coverage under this Policy or that are excluded under this Policy; multiplied by
4. the Aggregate Reimbursement Percentage.

In no event will the Aggregate Stop Loss benefit exceed the Maximum Aggregate Reimbursement specified under Aggregate Stop Loss Coverage in the Application/Schedule.

If, for any reason, YOUR Aggregate Stop Loss coverage terminates before the end of the Policy Period:

1. all coverage under this Policy will end as of 12:01 a.m. on the date of YOUR termination;
2. the Run-Out Period, if any, will not apply; and
3. the Minimum Annual Aggregate Attachment Point shown in the Application/Schedule will continue to apply and will not be reduced or prorated.

Section 4 – Reimbursement of Additional Coverages

PLAN Benefits that YOU have paid under YOUR Prescription Drug Card Plan will be considered for reimbursement under Specific Stop Loss Coverage only if shown as included on the Application/Schedule.

PLAN Benefits that YOU have paid under YOUR Prescription Drug Card Plan, Vision Plan, Dental Plan, and/or Weekly Income Plan will be considered for reimbursement under Aggregate Stop Loss Coverage only if shown as included on the Application/Schedule. The most WE will reimburse YOU for PLAN Benefits YOU pay under YOUR Weekly Income Plan, if included for reimbursement, is shown in the Application/Schedule.

Section 5 – Limitations

Our liability under this Policy will not be increased if the PLAN provides more liberal limitations provisions. In addition to the limitations provided under the PLAN, this Policy will not cover any of the following:

Non-Disclosed Losses

If YOU fail to disclose any required health information on:

1. a Covered Person when YOU make application for this Policy; or
2. on an employee, or a dependent of an employee, of a company YOU acquire or become affiliated with, when such subsidiary or affiliate will be included in YOUR PLAN,

then:

1. WE will not reimburse YOU for any PLAN Benefits paid for the illness or condition that was required to be disclosed;
2. such Paid PLAN Benefits may not be used towards satisfaction of the Specific Attachment Point for such Covered Person; and
3. such Paid PLAN Benefits may not be used towards satisfaction of YOUR Annual Aggregate Attachment Point.

Retired Employees

WE will reimburse Paid PLAN Benefits for Retired Employees and their dependents, who are eligible under the PLAN, only if such persons are indicated as included in the Application/Schedule.

COBRA Continuees

With respect to those persons qualifying as COBRA Continuees, and continuing coverage under YOUR PLAN as such, prior to, on or after the Effective Date of this Policy, WE will reimburse Paid PLAN Benefits for such individuals only if YOU made timely notification to such individuals of their rights to COBRA continuation coverage and if such individuals made a timely election of such coverage as required by applicable law and if all required COBRA premiums were paid timely.

Medicare Benefits

With respect to Covered Persons who are eligible and entitled to coverage under Medicare, any benefit reimbursable to YOU under this Policy shall be reduced by the amount of any similar Medicare benefit paid or reimbursable so that the total reimbursements hereunder with respect to a Covered Person or his or her dependents shall not exceed 100% of such person's actual expenses otherwise reimbursable under this Policy.

Medical Hardware, Devices, Implants

Reimbursements for medical hardware and devices and implants will be limited to an amount equal to 150% of the actual invoice cost of the medical hardware and device and implant paid by the hospital or other provider. No amount will be reimbursed under this Policy until a copy of the invoice is received by US.

Prescription Specialty Drugs and Drug Protocols

For Prescription Specialty Drugs and Drug Protocols delivered in an outpatient setting or in the physician's office, the maximum reimbursement will be 150% of the manufacturer's invoice price. No amount will be reimbursed under this Policy until:

1. a copy of the invoice is received by US; and
2. a copy of the physician's prescription instructions are received by US.

Liability For Reimbursement

WE shall not be liable under this Policy to directly reimburse any Covered Person or provider of professional or medical services for any benefits that YOU have agreed to provide under the terms of the PLAN. OUR sole liability is to YOU, in accordance with the terms of this Policy. YOU may not assign any Stop Loss benefits to Covered Persons or providers of services.

Section 6 – Exclusions

WE will not reimburse YOU for any loss or expense caused by or resulting from:

1. expenses Incurred while the PLAN is not in force with respect to the Covered Person, or for a person not covered under the PLAN;
2. expenses covered by PLAN changes made prior to OUR written approval of such changes;
3. expenses that result from any prescription card service, mail order prescription plan or any pre-paid prescription drug plan, dental, vision, or weekly income benefits, unless specifically included on the Application/Schedule and approved by US.
4. liability or obligations assumed by YOU under any contract or service agreement other than the PLAN;
5. expenses for services or supplies that are in violation of any law;
6. expenses for services or supplies billed above the Usual and Customary Charges for the area where provided, or that are greater than the PLAN Benefits;
7. expenses resulting from or caused by war, whether declared or undeclared; civil war; invasion; hostilities; riot; resistance to armed aggression; or acts of terrorism, or complications therefrom;
8. expenses for benefits for accidental bodily injury or sickness arising out of or in the course of any occupation for wage or profit, or complications therefrom; or for which the Covered Person would be entitled to benefits under any Workers' Compensation, Longshoremen's and Harbor Workers' Compensation Act, or other occupational disease legislation or Policy, whether or not such Policy is actually in force;
9. cost of the administration of claims, including cost of investigation, payments, or other service(s) provided by YOUR TPA, consulting fees and/or expenses of any litigation;
10. expenses or complications resulting from an injury sustained while the Covered Person was committing a felony under the laws of the state in which such act occurred, whether or not such Covered Person was actually charged or convicted of any criminal conduct;
11. deductible, coinsurance, co-payment amounts, expenses that are not covered by the PLAN or this Policy, amounts recoverable from any other source, or amounts paid under a previous Policy or arrangement of Stop Loss coverage, whether issued by US or another entity, Health Savings Accounts, Health Reimbursement Accounts, or Flexible Spending Accounts or any similar plan enacted by legislation;
12. expenses or costs resulting from noncontractual damages, court costs and legal fees, including but not limited to compensatory, exemplary and punitive damages, fines or statutory penalties;
13. medical expenses or complications in connection with Experimental or Investigational services, supplies or treatments, including drugs, devices and biological products, as defined in this Policy;
14. payments recoverable through YOUR PLAN's Coordination of Benefits; Medicare, Medicaid, or TriCare where the other PLAN is primary;
15. expenses Incurred by an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application/Schedule, unless added by Rider;
16. legal expenses and fees including legal expenses and fees incurred on behalf of any Covered Person in obtaining medical treatment or expenses Incurred in connection with a judgment or settlement arising out of YOUR negligence in providing, arranging, or failing to provide or arrange a benefit to a Covered Person;
17. payments YOU make under YOUR PLAN for services and supplies that are not included in YOUR PLAN or that are outside the requirements of YOUR PLAN Document or this Policy even when the discretionary authority to make such payments is specifically granted in writing to the PLAN Sponsor and/or Third-Party Administrator by that same PLAN Document;
18. expenses Incurred after the Expiration Date; or
19. in the event this Policy is terminated before the Expiration Date, expenses Incurred after the date of such termination;
20. expenses Incurred by any COBRA Continuee whose COBRA continuation coverage was not offered in a timely manner or was not elected in a timely manner or for which premiums were not paid in a timely manner;

21. YOUR TPA's failure to provide timely payment to providers in their required time frame that results in non-receipt of any discounted fees for services or supplies. WE will reimburse only for the amount of the discounted amount had timely payment been made by YOUR TPA.

Section 7 – Premiums and Factors

Payment of Premiums

No coverage under this Policy will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent premium must be paid on or before the Premium Due Date. YOU are responsible for the payment of premiums. Payment of the premium to YOUR TPA does not constitute payment of the premium to US.

Premium is not considered paid until the premium check is received at OUR Underwriting Office and sufficient funds are transferred from YOUR account into OUR account.

Upon termination of this Policy, or coverage hereunder, if the earned premium exceeds the premium paid, YOU will pay the excess to US; if less, WE will return to YOU the unearned portion of premium paid, subject to the minimum premium, if any, shown in the Application/Schedule.

Grace Period

A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect, provided the premium is paid before the end of the Grace Period. If YOU do not pay the premium during the Grace Period, this Policy will terminate without further notice, retroactive to the date for which premiums were last paid.

Changes in Premium Rates or Factors

WE may change YOUR premium rates and/or Monthly Aggregate Stop Loss Factors on any of the following dates:

1. The date when the terms of this Policy are changed.
2. The date YOU add or delete subsidiary or affiliated companies or divisions with OUR approval.
3. The date YOU change YOUR PLAN with OUR written approval.

WE reserve the right to recalculate the premium rates and/or the Monthly Aggregate Stop Loss Factors retroactively for the Policy Period:

1. if there is more than 10% variance between:
 - a. the number of Covered Units on any Premium Due Date; and
 - b. the number of Covered Units on the Policy Effective Date;or
2. if there is more than 10% variance between:
 - a. the average monthly paid claims under the PLAN for the last two months of the 12-month period immediately prior to the Effective Date of this Policy; and
 - b. the average monthly paid claims under the PLAN for the first 10 months of the 12-month period immediately prior to the Effective Date of this Policy;or
3. with respect to a PLAN whose Stop Loss coverage arrangement for the period immediately prior to the Effective Date of this Policy contained a run-out period, if the claims paid during such run-out period of the prior stop loss coverage arrangement are more than 15% of the claims paid during the period of time beginning on the Effective Date of such prior Stop Loss coverage arrangement and the Effective Date of this Policy, whether the prior Stop Loss coverage arrangement was one of OUR policies or another carrier's.

Section 8 — Termination

This Policy and all coverage hereunder will end upon the earliest of the following:

1. At the end of any period for which the premium is paid, if the subsequent premium is not paid as provided in the Grace Period provision.
2. On the date YOU tell US YOU want to cancel this Policy, provided YOU have given US at least 31 days advance written notice. If YOU cancel within 30 days after the Effective Date, YOU may ask for a full refund of the premium less the amount of any reimbursements WE made to YOU before the time this

Policy was terminated. If YOU do so, this Policy will terminate on the Effective Date. If YOU cancel this Policy after more than 30 days, WE may keep the premium earned to the date of termination.

3. The Expiration Date of this Policy.
4. On the Effective Date if, within 90 days after the Effective Date:
 - a. YOU fail to provide US any information or materials requested by US; or
 - b. YOU fail to comply with any condition imposed by US when this Policy is issued.If so, WE will return the premium paid by YOU, less the amount of any reimbursements WE made to YOU before the time this Policy was terminated. If the amount reimbursed to YOU exceeds the premium paid to US, YOU will pay US the difference.
5. The date the PLAN terminates.
6. The date the administrative agreement between YOU and YOUR TPA terminates, unless WE consent in writing to YOUR naming of a new TPA.
7. The last day of the third consecutive month during which YOU fail to maintain the Minimum PLAN Enrollment as stated in the Application/Schedule, unless WE agree in writing to continue coverage;
8. The date YOU:
 - a. suspend active business operations; or
 - b. are placed in bankruptcy or receivership; or
 - c. dissolve.
9. Any date on which YOU do not pay claims or make funds available to pay claims as required by the PLAN.
10. At any time YOU intentionally and systematically withhold filing or paying claims so as to artificially control the timing of the payment of claims.
11. At date on which the PLAN is found to be in violation of Federal law.
12. YOU intentionally misstate or conceal any information that is required for processing of a claim.

Termination for reasons 6, 7 and 9 itemized above will not be effective until WE have given 10 days advance written notice to the Policyholder.

Concealment or Fraud

This entire Policy may be void:

1. if, before or after a claim or loss, YOU or YOUR TPA have concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim; (This includes failure to provide the required disclosure of health history of Disabled Persons, Large Claims or Potentially Catastrophic Losses.) or
2. in any case of fraud by YOU or YOUR TPA relating to this coverage.

Section 9 — Reinstatement

WE may, at OUR option, approve YOUR request to reinstate this Policy. YOU shall submit to US any forms and data WE may require, including YOUR representation as to losses Incurred or Paid as of the date of YOUR request for reinstatement. If this Policy is reinstated, YOU shall pay to US the premiums due from the date this Policy terminated.

Section 10 — Claim Provisions

Administration of Claims Under YOUR PLAN

WE have no duty to settle or adjust claims filed under YOUR PLAN. YOU must retain and pay a TPA at all times. No one, including YOU, may pay benefits for YOUR PLAN unless named as the TPA on YOUR Application/Schedule and approved by US. WE will not reimburse YOU for PLAN Benefits resulting from benefits paid by someone not authorized to do so.

YOU must make available sufficient funds to pay benefits when due.

The TPA shall:

1. supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims, in accordance with the PLAN;
2. maintain accurate records of all claim payments;
3. maintain separate records of expenses not covered; and
4. provide US, on or before the 15th day of each Policy Month, the following data for the preceding Policy Month:
 - a. number of Covered Persons and/or Covered Units; and

- b. a total of claims paid.

Management of a Large Claim (LC) or a Potentially Catastrophic Loss (PCL)

Notice of LC - YOU or YOUR TPA must notify US of any LC (regardless of whether charges have been paid, denied or are pending payment) within 10 days of the date the claim exceeds or it appears that the claim will reach or exceed the defined limits for a LC.

Notice of PCL - YOU or YOUR TPA must notify US of any PCL within 10 days of receiving any information indicating that the claim (regardless of whether charges have been paid, denied or are pending payment) is Potentially Catastrophic. (See Exhibit 1 of this Policy.)

Failure to Notify - If for any reason a LC or PCL is not properly submitted to the TPA, YOU shall promptly notify the TPA of the claim. In the event YOU or YOUR TPA fails to follow the notification requirements set forth in this provision, YOUR losses related to such LC or PCL will not be considered for reimbursement under this Policy.

If YOU receive information that any claim may be or become a PCL, YOU will immediately notify YOUR TPA.

Notice of Claim

Specific Stop Loss - YOU must give written notice of claim to US within 30 days of the date YOU become aware of claims, with respect to a Covered Person, that have reached 50% of the Specific Attachment Point; however, LCs and PCLs should be reported within the time frame specified in the previous paragraph.

Aggregate Stop Loss - YOU must give written notice of claim to US within 30 days of the date YOU become aware of claims that have reached the Annual Aggregate Attachment Point.

YOUR failure to furnish written notice within 30 days will not invalidate or reduce any claim that was otherwise eligible for reimbursement if it was not reasonably possible to provide written notice within such time. However, written notice must be furnished as soon as possible, but in no event later than one year after the date written notice is first required. Claims under YOUR PLAN must be funded and paid within the Benefit Period in order to be eligible for reimbursement under this Policy.

YOU or YOUR TPA shall submit on a timely basis all proofs of claims, reports and supporting documents WE may request.

Proof of Loss

Written Proof of Loss must be submitted within 60 days after the date the Eligible Expenses under YOUR PLAN meet the Specific or Aggregate Attachment Point. Eligible Expenses under YOUR PLAN must be funded and paid within the Benefit Period shown on the Application/Schedule. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and within one year after the Benefit Period shown on the Application/Schedule. Claims not submitted within one year after the Benefit Period shown on the Application/Schedule will not be eligible for payment under this Policy.

Payment of Claims

Amounts payable under this Policy will be paid upon receipt and acceptance by US of all the required material. Required material shall include Proof of Loss and proof of payment for Eligible Expenses under the PLAN and any reasonably requested supporting documentation. WE will have sole authority to reimburse or deny claims under this Policy.

Benefit Determination

Determination of benefits under YOUR PLAN is YOUR sole responsibility. WE have no duty to settle or adjust claims filed under YOUR PLAN with YOU or YOUR TPA. WE have the right to review each claim YOU submit to US for reimbursement to determine if YOU are entitled to reimbursement under OUR Policy. This review may include but is not limited to an on-site audit or requests for additional documentation. Only WE have the authority to reimburse losses covered by this Policy.

Subrogation

YOU may be entitled to recover from liable third parties for payments made due to covered injuries to, or on behalf of, Covered Persons under YOUR PLAN. If YOU recover from a liable third party, the recovered amount cannot be used to meet a Deductible amount or an Attachment Point.

WE will not reimburse YOU for the recovered amount. If WE have reimbursed YOU for all or part of a particular payment and that payment is later recovered from a liable third party, YOU must repay US to the extent that it was reimbursed to YOU, regardless of whether this Policy is still in force on the date of recovery. The repayment may be reduced by the reasonable and necessary expenses YOU paid in recovering from the liable third party.

WE may subrogate all YOUR rights if YOU fail to prosecute any valid claims for injury against liable third parties and WE, as a result, become liable to make payments under this Policy for such injury. The amount recovered will be used to pay the expenses of collection as well as payments made under this Policy. The remaining amount will be paid to YOU. However, no recovery will be made from a Covered Person unless that Covered Person has been made whole.

Notice of Appeal

Any objection, notice of legal action, or complaint received on a claim processed under YOUR PLAN on which it reasonably appears an Stop Loss benefit will be payable to YOU under this Policy shall be brought to the immediate attention of OUR Underwriting Office.

Section 11 — General Provisions

Taxes

If premium taxes should be assessed against YOU with respect to claims paid under YOUR PLAN, YOU shall hold US harmless from any tax liability.

Entire Contract

This entire contract consists of:

1. this Policy, including any Riders;
2. YOUR Application/Schedule and any attachments thereto, a copy of which is attached to this Policy;
3. YOUR Disclosure Statement and any attachments thereto; and
4. a copy of YOUR PLAN.

All statements made by YOU or any Covered Person are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to contest coverage unless contained in the Application/Schedule, or any attachments to the Application/Schedule.

In case of a conflict between the PLAN and this Policy, this Policy will prevail. WE have relied on the information YOU and YOUR TPA provided to issue this Policy. YOU represent such information is accurate. Should WE later learn such information was not correct, or in case of a substantial change in such information, WE may modify this Policy as of the Effective Date to reflect the correct information, or WE may terminate this Policy on written notice as of the next Premium Due Date.

Policy Nonparticipating

This Policy does not entitle YOU to share in OUR earnings.

Records and Review

YOU and/or YOUR TPA must:

1. keep appropriate records regarding administration of YOUR PLAN; and (YOUR records include records held by YOUR TPA.)
2. allow US to review and copy, during normal business hours, all records affecting OUR liability under this Policy; and
3. maintain records of all Covered Persons under the PLAN during the Policy Period and for a period of seven years after the termination of this Policy; and
4. maintain a separate record of any and all amounts YOU pay that exceed or are not covered by the benefits under YOUR PLAN.

As a result of any audit, WE may re-adjust premiums, attachment points or reimbursements to YOU as may be necessary to reflect YOUR and OUR original intent in issuing this Policy.

Clerical Error

If YOU or WE make a clerical error keeping records or calculating premiums or claims pertaining to this Policy, it will not invalidate this Policy. A clerical error will not expand OUR obligations under this Policy. A clerical error is a mistake in performing a clerical function, and does not include intentional acts or failure to comply with PLAN or Policy provisions. A clerical error is not:

1. the failure to disclose the required disclosure of health history of Disabled Persons, Large Claims, or Potentially Catastrophic Losses; or
2. the failure to process a claim within the Benefit Period of this Policy.

Changes To This Policy

Changes to this Policy may be made only by a Company officer or OUR Underwriting Office, with OUR approval. Any change must be by written Rider.

Changes To YOUR PLAN

WE must be notified of any change to YOUR PLAN. This notice must be in writing and provided to US at least 31 days prior to the Effective Date of the change. WE must accept the change in writing before coverage affected by this change will be provided by this Policy. WE reserve the right to amend the Application/Schedule to include any change to a statute that increases OUR liability under this Policy. If WE do not receive advance written notice of the change, or WE decline to accept the changes under this Policy, WE will be liable only for benefits provided by the PLAN prior to the change. YOU must provide US with a copy of YOUR written PLAN and all amendments prior to the time the change becomes effective.

Subsidiaries, Affiliated Companies Under YOUR PLAN

YOU must notify US in the event YOU acquire a subsidiary or affiliated company that will be included under YOUR PLAN. If YOU do acquire a subsidiary or affiliated company that will be included under YOUR PLAN, YOU must disclose certain required health history on persons whose coverage YOU will be assuming under YOUR PLAN. Failure to do so will subject benefits under this Policy to certain limitations, as described in "Non-Disclosed Losses," in Section 5.

Acquisition of a subsidiary or affiliated company that will be included under YOUR PLAN may affect YOUR premium rates and/or Monthly Aggregate Stop Loss Factors, as described in "Changes in Premium Rates or Factors," in Section 7.

YOU must notify US in the event YOU cede or dissolve a subsidiary or affiliated company that was included under YOUR PLAN. Failure to do so may subject this Policy to termination (if Minimum PLAN Enrollment is not maintained), or may affect YOUR premium rates and/or Monthly Aggregate Stop Loss Factors, as described in "Changes in Premium Rates or Factors," in Section 7.

Duties and Responsibilities of YOUR Designated Third-Party Administrator (TPA)

YOUR TPA must be approved by US.

WE agree to recognize YOUR TPA as YOUR agent for the administration of YOUR PLAN. YOU agree that YOUR TPA will:

1. audit, calculate and pay all claims eligible under the PLAN;
2. prepare reports required by US and keep and make available to US data WE may require; and
3. do what is necessary for YOU to comply with the terms of this Policy.

If YOU give YOUR TPA a Power of Attorney, or revoke a Power of Attorney, neither is binding on US until WE receive it.

YOU will pay YOUR TPA for all administrative functions performed in relation to this Policy.

YOUR TPA is YOUR agent and not OURS. YOU authorize YOUR TPA to:

1. submit Notice/Proof of Loss;
2. certify the payment of claims;
3. transmit reports and payment of premiums to US; and
4. receive payments from US.

Payments by US to YOUR TPA are payments to YOU.

Notice

For the purpose of any notice required from US under the terms of this Policy, notice to YOUR TPA is notice to YOU and notice to YOU is notice to YOUR TPA.

Disclaimer

WE act only as a provider of Stop Loss Insurance coverage to YOUR PLAN. WE are not a fiduciary. WE do not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974, as amended.

While the determination of benefits under the PLAN is the sole responsibility of the Policyholder, WE reserve the right to interpret the terms and conditions of the PLAN as it applies to this Policy. WE have the sole authority to approve or deny reimbursement under this Policy.

WE have no right or obligation to pay any Covered Person or provider of professional or medical services. OUR sole liability is to YOU, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a Covered Person to have a direct right of action against US. WE will not be considered a party to YOUR PLAN or to any supplement or amendment to it.

Indemnification, Defense and Hold Harmless

YOU agree to indemnify, defend and hold US harmless from:

1. any liability resulting from or related to any negligence, error, omission or defalcation by YOUR TPA;
2. any liability related to:
 - a. any dispute involving a Covered Person unless it is a result of OUR sole negligence or intentional wrongful acts; and
 - b. any State premium taxes or assessments WE are assessed with respect to funds paid by or to YOU under YOUR PLAN. Taxes on amounts paid to US as premiums for this Policy are excluded.

WE will notify YOU if YOU have obligations. WE may participate in the defense at OUR expense. If YOU do not act promptly, WE may defend and compromise or settle the claim or other matter on YOUR behalf, for YOUR account, and at YOUR risk.

Offset

WE may offset payments due YOU under this Policy against claim overpayments and premiums due and unpaid.

Assignment

YOU may not assign any of YOUR rights under this Policy.

Severability

Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this Policy invalid.

Insolvency

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan or arrangement with creditors, or dissolution of YOU or YOUR TPA:

1. will not impose upon US any liability or additional duties other than those defined and provided for in this Policy; (For example, WE will have no responsibility to pay claims for YOUR PLAN to ensure reimbursement under this Policy.) and
2. will not make US liable to YOUR creditors, including Covered Persons.

Claims under YOUR PLAN must continue to be funded and paid within the Benefit Period in order to be eligible for reimbursement under this Policy.

Parties to This Policy

YOU and WE are the only parties to this Policy. OUR sole liability under this Policy is to YOU. This Policy does not create any right or legal relation between US and a Covered Person under YOUR PLAN. This Policy will not make US a party to any agreement between YOU and YOUR TPA.

Physical Examination and Medical Evidence

WE may require any medical evidence or other information, including a physical examination or health statement, regarding any Covered Person:

1. who submits an enrollment card for coverage under the PLAN more than 31 days after completing the waiting period specified in the PLAN. Such examination shall be provided without expense to US; or
2. for whom YOU have paid a claim under the PLAN and submitted such claim for reimbursement under this Policy. Such examination or evidence shall be provided as often as is reasonably necessary.

Legal Action

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written Proof of Loss is required to be furnished.

Time Limit on Certain Defenses

In the absence of fraud, all statements made by YOU or YOUR TPA shall be deemed representations and not warranties. If these statements appear as part of the written Application or other written instrument signed by YOU or YOUR TPA, WE may use them to contest this Policy. If WE do, WE will furnish YOU or YOUR TPA with a

copy of the document in question. After two years, only fraudulent misstatements may be used to contest the coverage under this Policy.

Waiver

OUR failure to strictly enforce OUR rights under this Policy shall not waive any such right, regardless of the frequency or similarity of the circumstances.

Exhibit 1 — Potentially Catastrophic Losses (PCLs)

Some diagnoses that qualify as PCLs are listed below. This is not a comprehensive list. These are only examples of some types of conditions. WE reserve the right to change this list of PCLs at any time.

Infectious and Parasitic Diseases

- Septicemia
- AIDS/HIV
- Aids related illnesses
- Hepatitis

Cancer of any Type

Endocrine, Nutritional, Metabolic, Immune Disorders

- Diabetes
- Cystic fibrosis
- Obesity/Hyperalimmentation

Diseases of the Blood and Blood-Forming Organs

- Sickle cell anemia
- Aplastic anemia
- Coagulation defects and/or Hemophilia

Diseases of the Nervous System and Sense Organs

- Cerebral degenerations
- Quadriplegia and Quadripareisis
- Reye's Syndrome
- Paraplegia
- Encephalopathy
- Neuropathy/Myasthenia Gravis

Diseases of the Circulatory System

- Acute myocardial infarction
- Acute and Subacute Ischemic heart disease
- Coronary atherosclerosis
- Acute pulmonary heart disease
- Aneurysms
- Endocarditis
- Value disorders
- Cardiomyopathy
- Subarachnoid/Intracerebral hemorrhage
- Cardiac dysrhythmias
- Heart failure
- Conduction disorders
- Cerebral artery occlusion
- Acute cerebrovascular accident
- Atherosclerosis
- Myocarditis
- Cardiomyopathy

Diseases of the Respiratory System

- Chronic obstructive pulmonary disease (COPD)
- Pulmonary collapse and/or respiratory failure
- Pneumonia
- Postinflammatory Pulmonary Fibrosis

Diseases of the Digestive System

- Regional enteritis (Crohn's disease)
- Intestinal obstruction
- Diverticulitis of colon
- Peritonitis
- Liver disease and cirrhosis
- Pancreas diseases
- Gastrointestinal hemorrhage

Diseases of the Genitourinary System

- Acute renal failure
- Chronic renal failure
- Impaired renal function
- Calculus of kidney and/or ureter
- Dialysis treatment

Complications of Pregnancy and Childbirth

- Placenta previa
- Eclampsia, pre-eclampsia
- Premature labor
- Gestational diabetes
- Multiple gestation
- Cervical incompetence
- Supervision of high-risk pregnancy

Diseases of the Musculoskeletal System and Connective Tissue

- Osteoarthritis
- Spondylosis
- Intervertebral disc disorders
- Osteomyelitis and periostitis
- Kyphoscoliosis and scoliosis

Congenital Anomalies

- Aortic Atresia/Stenosis
- Other unspecified congenital anomalies
- Biliary atresia

Conditions Originating in the Perinatal Period

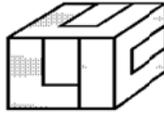
- Prematurity
- Respiratory distress syndrome
- Other respiratory conditions of a newborn
- Apnea
- Lack of expected normal physiological development
- Hyaline membrane disease
- Encephalocele
- Cephalohematoma
- Spina bifida

Injury and Poisoning

- Skull fracture
- Vertebral column fracture
- Spinal cord injury
- Multiple fractures
- Trauma to the elderly or chronically ill
- Internal injury
- Traumatic amputation
- Burns
- Intracranial injury

Other Serious Conditions

- Transplants of any kind
- Continuous hospitalization of 2 weeks or more
- Evaluation for transplants of any kind
- Mental disorders requiring hospital confinement
- Any serious condition that may require Large Case Management
- Sleep apnea
- Home health care greater than 20 days
- Coma
- Brain lesion or tumors
- Any illness or injury that requires intensive and prolonged treatment (such as nutritional support systems, intravenous therapies, and ventilators)



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

SECTION 1 – POLICYHOLDER INFORMATION

1. Full legal name of Policyholder (herein referred to as You/Your), as it will appear in Policy issued by US:
[Any Company]

2. Address of principal office (street, city, state, zip):
[### Street, City, State #####]

3. Contact Person:
Name: [Any Person] Telephone Number: [(###) ### - #####]
E-mail Address: [name@company.net] Fax Number: [(###) ### - #####]

4. Nature of Business:
[Any Company]

5. If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:
[Any Company]

6. Full name of Your Employee Welfare Benefit Plan:
[Any Company Health Plan]

NOTE: A copy of Your ERISA Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application/Schedule.

7. Your designated Third-Party Administrator (for the purposes of claims administration under Your Employee Welfare Benefit Plan):
Name: [Any Company] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

8. Your broker/agent of record:
Name: [Any Person] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

9. Our Underwriting Manager: [Any Company]

SECTION 2 – REQUESTED POLICY PERIOD

The Coverage shown as included in Section 3 and/or Section 4 is requested for, and applies only during the Policy Period from [Date] (the Effective Date) through [Date] (the Expiration Date) and is further subject to all of the provisions of the Policy.

SECTION 3 – SPECIFIC STOP LOSS COVERAGE

1. Coverage Election: YES – Specific coverage is included in this Policy.
 NO – Specific coverage is not included in this policy. **Do not complete this Section.**

2. Coverage to be included. Check one box below for each coverage listed:
Yes No
 Medical
 Prescription Drug Service:

NOTE: In no event will Dental, Vision, or Weekly Income be included under Specific Stop Loss Coverage.

3. Specific Attachment Point:
 Per Covered Person: \$[##,###.##]
 Per Covered Person: \$

4. Specific Reimbursement Percentage: 100%

5. Specific Policy Period Reimbursement Limit per Covered Person \$[#,##,###.##]

6. Specific Lifetime Maximum Reimbursement per Covered Person: \$[#,##,###.##]

7. Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Applicable only to [Any Company and all of its subsidiaries and affiliates]

Plan Benefits Incurred from [Date] through [Date]
and Paid from [Date] through [Date]

Applicable only to _____

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Applicable only to _____

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:
 \$[###,###.##] per Covered Person or
 \$ _____ for all Covered Persons combined

Related Rider(s): [Form Number Here]

8. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
<u>[Composite]</u>	: \$ <u>[##.##]</u>	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____

9. Minimum Annual Specific Premium: \$ [###,###.##]

SECTION 4 – AGGREGATE STOP LOSS COVERAGE

1. Coverage Election: YES – Aggregate coverage **is** included in this Policy.
 NO – Aggregate coverage **is not** included in this Policy. Do not complete this section.

2. Coverages to be included. Check one box below for each coverage listed:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Vision
<input type="checkbox"/>	<input type="checkbox"/>	Prescription Drug Service: _____
<input type="checkbox"/>	<input type="checkbox"/>	Weekly Income: Maximum _____, per covered employee per Policy Period.
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

3. Monthly Aggregate Factor:

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income	Totals
<u>[Composite]</u>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

SECTION 6 – NOTICES AND SIGNATURES

You have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by Us and as reflected in this Application/Schedule. You have formed Your Employee Welfare Benefit Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable provisions of the law or regulation. It is agreed that the statements in this Application/Schedule or in any materials submitted with this Application/Schedule or attached to it are Your representations and shall be deemed material to acceptance of the risk by Us and that the Policy is issued by Us in reliance on the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage hereunder, We will have the right to revise the premiums rates, factors, terms or conditions as of the Effective Date, by providing written notice to You. Any fraudulent statement will render the Policy null and void and all claims, if any, will be forfeited.

This Application does not bind coverage. Upon approval of the Application, the Policy evidencing that the coverage is in force will be issued by Us through Our Underwriting Manager. Coverage will commence on the Effective Date set forth in the Policy.

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

Accepted by the POLICYHOLDER:

Policyholder (full legal name): [Any Company]

Signed at (city, state): [City, State] Date:

Signed for the Policyholder by (officer's signature):

Printed Name: [Any Person] Title:

Accepted by the Company:

Signed at (city, state): [City, State] Date:

Signed for the Company by (officer's signature):

Printed Name: [Any Person] Title:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

SECTION 1 – POLICYHOLDER INFORMATION

1. Full legal name of Policyholder (herein referred to as You/Your), as it will appear in Policy issued by US:
[Any Company]

2. Address of principal office (street, city, state, zip):
[### Street, City, State #####]

3. Contact Person:
Name: [Any Person] Telephone Number: [(###) ### - #####]
E-mail Address: [name@company.net] Fax Number: [(###) ### - #####]

4. Nature of Business:
[Any Company]

5. If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:
[Any Company]

6. Full name of Your Employee Welfare Benefit Plan:
[Any Company Health Plan]

NOTE: A copy of Your ERISA Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application/Schedule.

7. Your designated Third-Party Administrator (for the purposes of claims administration under Your Employee Welfare Benefit Plan):
Name: [Any Company] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

8. Your broker/agent of record:
Name: [Any Person] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

9. Our Underwriting Manager: [Any Company]

SECTION 2 – REQUESTED POLICY PERIOD

The Coverage shown as included in Section 3 and/or Section 4 is requested for, and applies only during the Policy Period from [Date] (the Effective Date) through [Date] (the Expiration Date) and is further subject to all of the provisions of the Policy.

SECTION 3 – SPECIFIC STOP LOSS COVERAGE

1. Coverage Election: YES – Specific coverage is included in this Policy.
 NO – Specific coverage is not included in this policy. **Do not complete this Section.**

2. Coverage to be included. Check one box below for each coverage listed:
Yes No
 Medical
 Prescription Drug Service:

NOTE: In no event will Dental, Vision, or Weekly Income be included under Specific Stop Loss Coverage.

3. Specific Attachment Point:
 Per Covered Person: \$[##,###.##]
 Per Covered Person: \$

4. Specific Reimbursement Percentage: 100%

5. Specific Policy Period Reimbursement Limit per Covered Person \$[#,##,###.##]

6. Specific Lifetime Maximum Reimbursement per Covered Person: \$[#,##,###.##]

7. Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Applicable only to [Any Company and all of its subsidiaries and affiliates]
 Plan Benefits Incurred from [Date] through [Date]
 and Paid from [Date] through [Date]

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:
 \$[###,###.##] per Covered Person or
 \$ _____ for all Covered Persons combined
 Related Rider(s): [Form Number Here]

8. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
<u>[Composite]</u>	: \$ <u>[##.##]</u>	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____

9. Minimum Annual Specific Premium: \$ [###,###.##]

SECTION 4 – AGGREGATE STOP LOSS COVERAGE

1. Coverage Election: YES – Aggregate coverage **is** included in this Policy.
 NO – Aggregate coverage **is not** included in this Policy. Do not complete this section.

2. Coverages to be included. Check one box below for each coverage listed:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Vision
<input type="checkbox"/>	<input type="checkbox"/>	Prescription Drug Service: _____
<input type="checkbox"/>	<input type="checkbox"/>	Weekly Income: Maximum _____, per covered employee per Policy Period.
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

3. Monthly Aggregate Factor:

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income	Totals
<u>[Composite]</u>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

4. Number of Covered Units: Quoted Actual

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income	Totals
[Employee]	[###]	_____	_____	_____	_____	_____
[Spouse]	[###]	_____	_____	_____	_____	_____
[Child]	[###]	_____	_____	_____	_____	_____
[Family]	[###]	_____	_____	_____	_____	_____

5. Minimum Annual Aggregate Attachment Point: \$ [###,###.##]
 (12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

6. Aggregate Reimbursement Percentage: _____

7. Individual Claim Limit: [###,###.##]

8. Maximum Aggregate Reimbursement (per Policy Period): \$ [#,###,###.##]

9. Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period):
 Applicable only to [Any Company and all of its subsidiaries and affiliates]

Plan Benefits Incurred from [Date] through [Date]
 And paid from [Date] through [Date]

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 And paid from _____ through _____

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 And paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:
 \$ _____ Per Covered Person or
 \$ [#,###,###.##] For all Covered Persons combined
 Related Rider(s): [None]

10. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
[Composite]	:\$ [##.##]	_____	:\$ _____
_____	:\$ _____	_____	:\$ _____
_____	:\$ _____	_____	:\$ _____

11. Minimum Annual Aggregate Premium: \$ [###,###.##]

SECTION 5 – ELIGIBILITY, PREMIUM DEPOSIT, AND ENROLLMENT INFORMATION

1. Check one box for each of the following groups of persons to indicate if such groups are to be considered as Covered Persons under the Policy:

Yes*	No	
<input type="checkbox"/>	<input type="checkbox"/>	Retired Employees
<input type="checkbox"/>	<input type="checkbox"/>	COBRA Continues
<input type="checkbox"/>	<input type="checkbox"/>	Disabled Employees
<input type="checkbox"/>	<input type="checkbox"/>	Transplants

*All "Yes" answers must have disclosure information attached to this Application/Schedule.

2. Initial premium deposit accompanying this Application/Schedule: \$ [###,###.##]

3. Minimum Plan Enrollment: _____ Covered Units or
 _____ % of initial enrollment

SECTION 6 – NOTICES AND SIGNATURES

You have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by Us and as reflected in this Application/Schedule. You have formed Your Employee Welfare Benefit Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable provisions of the law or regulation. It is agreed that the statements in this Application/Schedule or in any materials submitted with this Application/Schedule or attached to it are Your representations and shall be deemed material to acceptance of the risk by Us and that the Policy is issued by Us in reliance on the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage hereunder, We will have the right to revise the premiums rates, factors, terms or conditions as of the Effective Date, by providing written notice to You. Any fraudulent statement will render the Policy null and void and all claims, if any, will be forfeited.

This Application does not bind coverage. Upon approval of the Application, the Policy evidencing that the coverage is in force will be issued by Us through Our Underwriting Manager. Coverage will commence on the Effective Date set forth in the Policy.

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

Accepted by the POLICYHOLDER:

Policyholder (full legal name): [Any Company]

Signed at (city, state): [City, State] Date:

Signed for the Policyholder by (officer's signature):

Printed Name: [Any Person] Title:

Accepted by the Company:

Signed at (city, state): [City, State] Date:

Signed for the Company by (officer's signature):

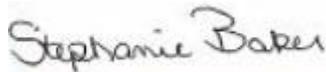
Printed Name: [Any Person] Title:

READABILITY CERTIFICATION

Company Name: Unified Life Insurance Company

I hereby certify, that the form listed below has the following readability score as calculated by the Flesch Reading Ease Test. Defined words have been excepted text.

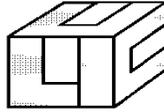
Form Number	Score
P100	50
A100	53
R100	68
R101	68
R102	52
R103	52
R104	51
R105	54
R106	55
R107	52
R108	69
R109	55
R110	55
R111	64
R112	68
R113	70
R114	59
R115	72
R116	53
R117	52
R118	51
R119	50
R120	59



Stephanie Baker
Vice President – Risk Management

April 3, 2012

Date



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

Change in Premium Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following change to the Application/Schedule for the Stop Loss Policy to which this Rider applies:

- The monthly premium rates for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 7., are changed to the following:

7. Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$

- The Minimum Annual Specific Premium for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 8., is changed to \$.

- The monthly premium rates for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 10., are changed to the following:

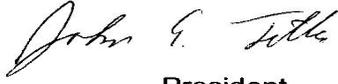
10. Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$
_____	: \$

- The Minimum Annual Aggregate Premium for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 11., is changed to \$.

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

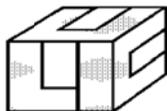


President



Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



UNIFIED LIFE INSURANCE COMPANY

**UNIFIED LIFE INSURANCE COMPANY
[7201 WEST 129th STREET, SUITE 300
OVERLAND PARK, KANSAS 66213]**

**STOP LOSS INSURANCE POLICY
Non-Participating**

Policyholder:	Effective Date:
Policyholder Address	Expiration Date:
Policy Number:	
YOUR designated Third-Party Administrator:	

This Policy is issued in consideration of YOUR Application/Schedule and the payment of premiums. The attached Application/Schedule and a copy of YOUR ERISA Employee Welfare Benefit Plan Document form a part of this Policy. All periods of coverage will begin and end at 12:01a.m. Standard Time at YOUR Principal Address.

This Policy is governed by the laws of the state of YOUR Principal Address.

This Policy is issued by US at OUR Underwriting Offices as of the Effective Date.

Notice: This is a reimbursement Policy YOU or YOUR Plan administrator, are responsible for making benefit determinations under YOUR employee welfare benefit plan. WE have no duty or authority to administer, settle, adjust or provide advice regarding claims filed YOUR employee benefit plan

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


President


Secretary

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Section 1. Definitions

The following terms, wherever used in this Policy, or Application/Schedule, Rider, or disclosure statement attached hereto, shall have the meaning set forth in this section.

Aggregate Reimbursement Percentage means the percentage at which Eligible Expenses, in excess of YOUR annual Aggregate Attachment Point, will be reimbursed by US.

Annual Aggregate Attachment Point means, for the Policy Period or any portion of the Policy Period, the PLAN benefits covered by this Policy and wholly retained by YOU. It is not considered for reimbursement under this Policy, and is the greater of:

1. the sum of monthly aggregate factor amounts for each month of the Policy Period, determined by multiplying the total number of Covered Units by the monthly aggregate factor amounts; or
2. the minimum annual Aggregate Attachment Point shown in the Application/Schedule.

The maximum per Covered Person that may be applied annually to the annual Aggregate Attachment Point, (i.e. Individual Claim Limit) is shown in the Application/Schedule.

Application/Schedule means the Stop Loss insurance Application/Schedule signed by YOU and attached to this Policy. The Application/Schedule is subject to acceptance by US and if accepted, will become a part of this Policy.

Benefit Period means the period of time shown in the Application/Schedule during which Eligible Expenses Incurred by a Covered Person, which are paid by YOU during the Policy Period, are eligible for reimbursement under this Policy. This period does not alter the Policy Effective Date or Policy Period but does include any Run-In Period and/or Run-Out Period as shown on the Policy Application/Schedule. It does not waive this Policy's eligibility requirements.

COBRA Continuee means a Covered Unit that elects to extend its group health coverage under the PLAN as entitled under the Consolidate Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent regulations.

Company (WE, OUR, US) means Unified Life Insurance Company.

Covered Family means an employee and his or her dependents covered under the PLAN.

Covered Person means an individual covered under the PLAN.

Covered Unit means an employee with dependents, or such other defined unit as agreed upon between YOU and US, as shown in the Application/Schedule.

Disabled Persons are those persons who are or become unable to perform the same lifestyle functions as a person of similar age and sex who is in good health.

Disclosure Statement means the disclosure statement submitted by YOU to US in connection with the issuance of this Policy.

Eligible Expenses means the eligible charges payable under YOUR Plan and for which the Covered Person is liable to pay. It does not include expenses specifically excluded or limited by this Policy, YOUR Application/Schedule of this Policy, or any Riders.

Experimental or Investigational means medical services, supplies or treatments, including drugs, devices and biological products, provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II or III). The covered service will also be considered experimental/investigational in any setting if the Covered Person is required to sign a consent form that indicates the proposed treatment, procedure, medical service, supply, drug, device or biological product is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment under the particular medical circumstances by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational. Off-label usage of any drug will be considered Experimental/Investigational. A drug, device or biological product is considered Experimental/Investigational if it does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigation device exemption or an investigational new drug exemption or is used off-label.

HIPAA refers to public law 104-191, otherwise known as the Health Insurance Portability and Accountability Act of 1996 and subsequent regulations.

Incurred means:

1. with respect to medical services or supplies, the date on which the services are rendered or supplies are received by the Covered Person; and
2. with respect to disability income benefits, the date each periodic benefit payment becomes payable to the Covered Person (not the date the disability commences), if this coverage was elected on the Application/Schedule; and
3. with respect to negotiated medical services or supplies, the date on which the service or supply was initially rendered or used.

Individual Claim Limit means the maximum amount of payments for Eligible Expenses that will be allowed for any one Covered Person under Aggregate Stop Loss coverage. The Individual Claim Limit is shown in the Application/Schedule. The maximum allowable amount of Eligible Expenses for a Covered Person who has been assigned a separate Specific Attachment Point will be the specified amount as shown under the Individual Claim Limit on the Application, regardless of that Covered Person's separate Individual Specific Attachment Point.

Large Claim (or LC) means paid, denied or pending claims reaching, or with the potential to reach, 50% of the Specific Attachment Point or a Potentially Catastrophic Loss (PCL).

Medically Necessary means a service or supply that is necessary to diagnose and treat a condition. Such service or supply must be commonly recognized by the medical profession as standard of care for the control or cure of the illness or injury being treated by physicians practicing in the same or related specialty field. This does not include any services or supplies that:

1. are provided only as a convenience to the Covered Person or provider; or
2. exceed in scope, duration, intensity, the level of care that is needed to provide safe, adequate, and appropriate diagnosis and treatment; or
3. are excluded under the PLAN Document, or exclusions section of this Policy; or
4. are not listed as PLAN benefits under the PLAN Document.

Minimum Annual Aggregate Attachment Point means the lowest amount of total payments YOU must make under YOUR plan before YOU are eligible for reimbursement under Aggregate Stop Loss coverage. The Minimum Annual Aggregate Attachment Point is shown in the Application/Schedule.

Monthly Aggregate Factor means the factor(s) that is/are multiplied by the number of Covered Units for each Policy Month to determine the Annual Aggregate Attachment Point. The Monthly Aggregate Factor(s) is/are shown in the Application/Schedule.

Monthly Aggregate Deductible means the amount determined for each Policy Month by multiplying the number of Covered Units for that month by the applicable Monthly Aggregate Factor(s) shown on the Application.

Paid (or Payment) means that a claim has been adjudicated by the TPA and the funds are actually disbursed by the PLAN prior to the end of the Benefit Period. Payment of a claim is unconditional and direct payment of a claim to a Covered Person or their health care provider(s). payment will be deemed made on the date that both:

1. the payer directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. the account upon which the payment is drawn contains, and continues to contain, sufficient funds of the Policyholder to permit the check or draft to be honored by the institution upon which it is draw. If the account upon which the payment is drawn is funded by a separate account or line of credit or "sweep" account, then the funding account must contain sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

Plan (or Employee Welfare Benefit Plan) means the self-insured health care plan YOU have agreed to make available to YOUR employees and their eligible dependents and that is the subject of this Policy, whether or not it is subject to Employee Retirement Income Security Act of 1974, as is or as may be amended.

Plan Benefits means the health benefits covered by the PLAN during the Policy Period that are:

1. Incurred on or after the Effective Date of this Policy; and
2. Incurred while this Policy is in force; and
3. Incurred and Paid during the Policy Period.

Plan benefits will also include those health benefits covered by the PLAN that are:

1. Incurred during the Policy Period and Paid during any Run-Out Period; and
2. Incurred during the Run-In Period and Paid during any Policy Period or Run-Out Period.

Plan benefits do not include:

1. deductibles of the PLAN; or
2. co-insurance or co-payment amounts of the Plan; or
3. expenses that are not covered by the PLAN or this Policy; or
4. amounts recoverable from any other source; or
5. amounts Paid under a previous policy or arrangement of stop loss coverage, whether issued by US or another entity; or
6. Health Savings Accounts, Health Reimbursement Accounts, Flexible Spending Accounts or any similar plan enacted by legislation.

While the determination of benefits under the PLAN is the sole responsibility of the Policyholder, WE reserve the exclusive right to interpret the terms and conditions of the PLAN as it applies to this Policy. WE have the sole authority to approve or deny reimbursements under this Policy without deference to the benefit determination made by the PLAN.

Plan Document means the written instrument that describes the PLAN and names the fiduciaries or trustees who jointly and separately have authority to control and manage the operations and administration of the PLAN. The PLAN Document must be in effect on the Effective Date of the Policy. Any changes to the PLAN Document must be accepted by US. (See the "Changes to YOUR plan" provision.)

Policy means this Stop Loss Policy issued by US to YOU.

Policy Month means, for the first Policy Month, the period beginning on the Effective Date of this Policy and ending on the corresponding date of the following month. Subsequent Policy Months begin on the corresponding date of each calendar month and continue until the corresponding date of the next month to the Policy expiration date.

Policy Period means the time period beginning on the Effective Date and ending on the Expiration Date.

Policyholder (Plan Sponsor, YOU or YOUR) means the Plan Sponsor, named on the face page, to whom this Policy is issued.

Potentially Catastrophic Loss (PCL) means a Paid, denied or pending claim that has the potential to be catastrophic. PCLs include, but are not limited to the conditions listed in Exhibit I.

Premium Due Date is the first day of each calendar month. If the Effective Date of this Policy is other than the first day of a calendar month, the first month's premium will be pro-rated.

Proof of Loss means receipt of a complete claim form, satisfactory to the Company, and other supporting documentation required by the Company.

Rider means a written amendment or addendum that alters the terms of this Policy.

Run-In Limit means the maximum benefit amount paid by YOU under YOUR plan for Eligible Expenses Incurred by a Covered Person during the Run-In Period that will be applied toward payment under this Policy.

Run-In Period means the period of time shown in the Application/Schedule immediately prior to the first day of this Policy's Policy Period during which Eligible Expenses incurred by a Covered Person, which are paid by YOU during the Policy Period, will be considered when determine benefit payments under this Policy.

Run-Out Period means the period of time shown in the Application/Schedule immediately following this Policy's Expiration Date during which Eligible Expenses Incurred by a Covered Person, which are paid by YOU during the Policy Period, will be considered when determining benefit payments under this Policy.

Specific Attachment Point means the amount that is retained and paid by YOU during the Policy Period. It is not considered for reimbursement under this Policy. The Specific Attachment Point applies separately to each Covered Person. The Specific Attachment Point is shown in the Application/Schedule.

Specific Lifetime Maximum Reimbursement means that maximum amount WE will reimburse YOU with respect to any claims for a person covered under the PLAN that have been filed or submitted under this and prior or later Policies issued by US. The Lifetime Maximum excludes the Specific Attachment Point amount. The lifetime maximum will not exceed the lesser of:

1. the amount shown in the Application/Schedule; or
2. the lifetime amount set forth in the PLAN minus the sum of the Specific Attachment Point applicable to the claimant under each of the policies issued by US.

Specific Reimbursement Percentage means the percentage at which Eligible Expenses, in excess of YOUR Specific Attachment Point, will be reimbursed by US.

Third-Party Administrator (TPA) means a firm having a written agreement with YOU to process Plan Benefits and provide administrative services.

The term Third-Party Administrator, as used in this Policy, does not refer to the Plan Administrator used in the Employee Retirement Income Security Act (ERISA) of 1974, as amended, unless YOU have specifically appointed the Third-Party Administrator as such.

Usual and Customary Charges means the common charge for the same or comparable service or supply in the geographic area in which the service or supply is furnished. Usual and Customary Charges are determined based upon:

1. the amount of resources expended to deliver the treatment; and
2. the complexity of the treatment rendered; and
3. charging protocols and billing practices generally accepted by the medical community; and
4. the amount paid after discounts under governmental and private plans.

Section 2 – Specific Stop Loss Coverage

WE will reimburse YOU for Plan Benefits paid in excess of the Specific Attachment Point, not to exceed the Specific Lifetime Maximum amount shown in the Application/Schedule.

WE will reimburse YOU after YOU have provided an acceptable proof of loss and satisfactory proof of Paid Plan Benefits.

The Specific Stop Loss benefit applies to a Policy Period or fraction thereof (due to termination). As determined with regard to each Covered Person, it is the lesser of:

1. the Specific Lifetime Maximum; or
2. eligible Plan Benefit Payments made with regard to a Covered Person, less the Specific Attachment Point, the result of which is then multiplied by the Specific Reimbursement Percentage.

If, for any reason, YOUR Specific Stop Loss coverage terminates before the end of the Policy Period:

1. all coverage under this Policy will end as of 12:01 a.m. on the date of YOUR termination;
2. the Run-Out Period, if any, will not apply; and
3. the Specific Attachment Point shown in the Application/Schedule will continue to apply and will not be reduced or prorated.

Section 3 – Aggregate Stop Loss Coverage

The Aggregate Stop Loss benefit for the Policy Period, or fraction thereof (due to termination), is the Plan Benefit Payment made for Eligible Expenses during the Policy Period less:

1. the greater of the Minimum Annual Aggregate Attachment Point or the calculated Annual Aggregate Attachment Point; and less
2. the Specific Stop Loss benefits that have been or will be reimbursed by US under the Specific Stop Loss coverage; and less
3. any payments that exceed any limitations of coverage under this Policy or that are excluded under this Policy; multiplied by
4. the Aggregate Reimbursement Percentage.

In no event will the Aggregate Stop Loss benefit exceed the Maximum Aggregate Reimbursement specified under Aggregate Stop Loss Coverage in the Application/Schedule.

If, for any reason, YOUR Aggregate Stop Loss coverage terminates before the end of the Policy Period:

1. all coverage under this Policy will end as of 12:01 a.m. on the date of YOUR termination;
2. the Run-Out Period, if any, will not apply; and
3. the Minimum Annual Aggregate Attachment Point shown in the Application/Schedule will continue to apply and will not be reduced or prorated.

Section 4 – Reimbursement of Additional Coverages

Plan Benefits that YOU have paid under YOUR Prescription Drug Card Plan will be considered for reimbursement under Specific Stop Loss Coverage only if shown as included on the Application/Schedule.

Plan Benefits that YOU have paid under YOUR Prescription Drug Card Plan, Vision Plan, Dental Plan, and/or Weekly Income Plan will be considered for reimbursement under Aggregate Stop Loss Coverage only if shown as included on the Application/Schedule. The most WE will reimburse YOU for Plan Benefits YOU Pay under YOUR Weekly Income Plan, if included for reimbursement, is shown in the Application/Schedule.

Section 5 – Limitations

Our liability under this Policy will not be increased if the Plan provides more liberal limitations provisions. In addition to the limitations provided under the Plan, this Policy will not cover any of the following:

Non-Disclosed Losses

If YOU fail to disclose any required health information on:

1. a Covered Person when YOU make application for this Policy; or
2. on an employee, or a dependent of an employee, of a company YOU acquire or become affiliated with, when such subsidiary or affiliate will be included in YOUR Plan,

then:

1. WE will not reimburse YOU for any Plan Benefits paid for the illness or condition that was required to be disclosed;
2. such Paid Plan Benefits may not be used towards satisfaction of the Specific Attachment Point for such Covered Person; and
3. such Paid Plan Benefits may not be used towards satisfaction of YOUR Annual Aggregate Attachment Point.

Retired Employees

WE will reimburse Paid Plan Benefits for Retired Employees and their dependents, who are eligible under the Plan, only if such persons are indicated as included in the Application/Schedule.

COBRA Continuees

With respect to those persons qualifying as COBRA Continuees, and continuing coverage under YOUR Plan as such, prior to, on or after the Effective Date of this Policy, WE will reimburse Paid Plan Benefits for such individuals only if YOU made timely notification to such individuals of their rights to COBRA continuation coverage and if such individuals made a timely election of such coverage as required by applicable law and if all required COBRA premiums were paid timely.

Medicare Benefits

With respect to Covered Persons who are eligible and entitled to coverage under Medicare, any benefit reimbursable to YOU under this Policy shall be reduced by the amount of any similar Medicare benefit paid or reimbursable so that the total reimbursements hereunder with respect to a Covered Person or his or her dependents shall not exceed 100% of such person's actual expenses otherwise reimbursable under this Policy.

Medical Hardware, Devices, Implants

Reimbursements for medical hardware and devices and implants will be limited to an amount equal to 150% of the actual invoice cost of the medical hardware and device and implant paid by the hospital or other provider. No amount will be reimbursed under this Policy until a copy of the invoice is received by US.

Prescription Specialty Drugs and Drug Protocols

For prescription specialty drugs and drug protocols delivered in an outpatient setting or in the physician's office, the maximum reimbursement will be 150% of the manufacturer's invoice price. No amount will be reimbursed under this Policy until:

1. a copy of the invoice is received by US; and
2. a copy of the physician's prescription instructions are received by US.

Liability For Reimbursement

WE shall not be liable under this Policy to directly reimburse any Covered Person or provider of professional or medical services for any benefits that YOU have agreed to provide under the terms of the Plan. OUR sole liability is to YOU, in accordance with the terms of this Policy. YOU may not assign any Stop Loss benefits to Covered Persons or providers of services.

Section 6 – Exclusions

WE will not reimburse YOU for any loss or expense caused by or resulting from:

1. expenses incurred while the Plan is not in force with respect to the Covered Person, or for a person not covered under the Plan;
2. expenses covered by Plan changes made prior to OUR written approval of such changes;
3. expenses that result from any prescription card service, mail order prescription plan or any pre-paid prescription drug plan, dental, vision, or weekly income benefits, unless specifically included on the Application/Schedule and approved by US.
4. liability or obligations assumed by YOU under any contract or service agreement other than the Plan;
5. expenses for services or supplies that are in violation of any law;
6. expenses for services or supplies billed above the Usual and Customary Charges for the area where provided, or that are greater than the Plan Benefits;
7. expenses resulting from or caused by war, whether declared or undeclared; civil war; invasion; hostilities; riot; resistance to armed aggression; or acts of terrorism, or complications therefrom;
8. expenses for benefits for accidental bodily injury or sickness arising out of or in the course of any occupation for wage or profit, or complications therefrom; or for which the Covered Person would be entitled to benefits under any Workers' Compensation, Longshoremen's and Harbor Workers' Compensation Act, or other occupational disease legislation or Policy, whether or not such Policy is actually in force;
9. cost of the administration of claims, including cost of investigation, payments, or other service(s) provided by YOUR TPA, consulting fees and/or expenses of any litigation;
10. expenses or complications resulting from an injury sustained while the Covered Person was committing a felony under the laws of the state in which such act occurred, whether or not such Covered Person was actually charged or convicted of any criminal conduct;
11. deductible, coinsurance, co-payment amounts, expenses that are not covered by the Plan or this Policy, amounts recoverable from any other source, or amounts paid under a previous Policy or arrangement of Stop Loss coverage, whether issued by US or another entity, Health Savings Accounts, Health Reimbursement Accounts, or Flexible Spending Accounts or any similar plan enacted by legislation;
12. expenses or costs resulting from noncontractual damages, court costs and legal fees, including but not limited to compensatory, exemplary and punitive damages, fines or statutory penalties;
13. medical expenses or complications in connection with Experimental or Investigational services, supplies or treatments, including drugs, devices and biological products, as defined in this Policy;
14. payments recoverable through YOUR Plan's Coordination of Benefits; Medicare, Medicaid, or TriCare where the other plan is primary;
15. expenses incurred by an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application/Schedule, unless added by Rider;
16. legal expenses and fees including legal expenses and fees incurred on behalf of any Covered Person in obtaining medical treatment or expenses incurred in connection with a judgment or settlement arising out of YOUR negligence in providing, arranging, or failing to provide or arrange a benefit to a Covered Person;
17. payments YOU make under YOUR Plan for services and supplies that are not included in YOUR Plan or that are outside the requirements of YOUR Plan Document or this Policy even when the discretionary authority to make such payments is specifically granted in writing to the Plan Sponsor and/or Third-Party Administrator by that same Plan Document;
18. expenses incurred after the Expiration Date; or

19. in the event this Policy is terminated before the Expiration Date, expenses incurred after the date of such termination;
20. expenses incurred by any COBRA Continuee whose COBRA continuation coverage was not offered in a timely manner or was not elected in a timely manner or for which premiums were not paid in a timely manner;
21. YOUR TPA's failure to provide timely payment to providers in their required time frame that results in non-receipt of any discounted fees for services or supplies. WE will reimburse only for the amount of the discounted amount had timely payment been made by YOUR TPA.

Section 7 – Premiums and Factors

Payment of Premiums

No coverage under this Policy will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent premium must be paid on or before the Premium Due Date. YOU are responsible for the payment of premiums. Payment of the premium to YOUR TPA does not constitute payment of the premium to US.

Premium is not considered paid until the premium check is received at OUR Underwriting Office and sufficient funds are transferred from YOUR account into OUR account.

Upon termination of this Policy, or coverage hereunder, if the earned premium exceeds the premium paid, YOU will pay the excess to US; if less, WE will return to YOU the unearned portion of premium paid, subject to the minimum premium, if any, shown in the Application/Schedule.

Grace Period

A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect, provided the premium is paid before the end of the Grace Period. If YOU do not pay the premium during the Grace Period, this Policy will terminate without further notice, retroactive to the date for which premiums were last paid.

Changes in Premium Rates or Factors

WE may change YOUR premium rates and/or Monthly Aggregate Stop Loss Factors on any of the following dates:

1. The date when the terms of this Policy are changed.
2. The date YOU add or delete subsidiary or affiliated companies or divisions with OUR approval.
3. The date YOU change YOUR Plan with OUR written approval.

WE reserve the right to recalculate the premium rates and/or the Monthly Aggregate Stop Loss Factors retroactively for the Policy Period:

1. if there is more than 10% variance between:
 - a. the number of Covered Units on any premium due date; and
 - b. the number of Covered Units on the Policy Effective Date;or
2. if there is more than 10% variance between:
 - a. the average monthly paid claims under the Plan for the last two months of the 12-month period immediately prior to the Effective Date of this Policy; and
 - b. the average monthly paid claims under the Plan for the first 10 months of the 12-month period immediately prior to the Effective Date of this Policy;or
3. with respect to a Plan whose Stop Loss coverage arrangement for the period immediately prior to the Effective Date of this Policy contained a run-out period, if the claims paid during such run-out period of the prior stop loss coverage arrangement are more than 15% of the claims paid during the period of time beginning on the effective date of such prior Stop Loss coverage arrangement and the Effective Date of this Policy, whether the prior Stop Loss coverage arrangement was one of OUR policies or another carrier's.

Section 8 — Termination

This Policy and all coverage hereunder will end upon the earliest of the following:

1. At the end of any period for which the premium is paid, if the subsequent premium is not paid as provided in the Grace Period provision.
2. On the date YOU tell US YOU want to cancel this Policy, provided YOU have given US at least 31 days advance written notice. If YOU cancel within 30 days after the Effective Date, YOU may ask for a full refund of the premium less the amount of any reimbursements WE made to YOU before the time this Policy was terminated. If YOU do so, this Policy will terminate on the Effective Date. If YOU cancel this Policy after more than 30 days, WE may keep the premium earned to the date of termination.
3. The Expiration Date of this Policy.
4. On the Effective Date if, within 90 days after the Effective Date:
 - a. YOU fail to provide US any information or materials requested by US; or
 - b. YOU fail to comply with any condition imposed by US when this Policy is issued.If so, WE will return the premium paid by YOU, less the amount of any reimbursements WE made to YOU before the time this Policy was terminated. If the amount reimbursed to YOU exceeds the premium paid to US, YOU will pay US the difference.
5. The date the Plan terminates.
6. The date the administrative agreement between YOU and YOUR TPA terminates, unless WE consent in writing to YOUR naming of a new TPA.
7. The last day of the third consecutive month during which YOU fail to maintain the Minimum Plan Enrollment as stated in the Application/Schedule, unless WE agree in writing to continue coverage;
8. The date YOU:
 - a. suspend active business operations; or
 - b. are placed in bankruptcy or receivership; or
 - c. dissolve.
9. Any date on which YOU do not pay claims or make funds available to pay claims as required by the Plan.
10. At any time YOU intentionally and systematically withhold filing or paying claims so as to artificially control the timing of the payment of claims.
11. At date on which the Plan is found to be in violation of Federal law.
12. YOU intentionally misstate or conceal any information that is required for processing of a claim.

Termination for reasons 6, 7 and 9 itemized above will not be effective until WE have given 10 days advance written notice to the Policyholder.

Concealment or Fraud

This entire Policy may be void:

1. if, before or after a claim or loss, YOU or YOUR TPA have concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim; (This includes failure to provide the required disclosure of health history of Disabled Persons, Large Claims or Potentially Catastrophic Losses.) or
2. in any case of fraud by YOU or YOUR TPA relating to this coverage.

Section 9 — Reinstatement

WE may, at OUR option, approve YOUR request to reinstate this Policy. YOU shall submit to US any forms and data WE may require, including YOUR representation as to losses Incurred or Paid as of the date of YOUR request for reinstatement. If this Policy is reinstated, YOU shall pay to US the premiums due from the date this Policy terminated.

Section 10 — Claim Provisions

Administration of Claims Under YOUR Plan

WE have no duty to settle or adjust claims filed under YOUR Plan. YOU must retain and pay a TPA at all times. No one, including YOU, may pay benefits for YOUR Plan unless named as the TPA on YOUR Application/Schedule and approved by US. WE will not reimburse YOU for Plan Benefits resulting from benefits paid by someone not authorized to do so.

YOU must make available sufficient funds to pay benefits when due.

The TPA shall:

1. supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims, in accordance with the Plan;
2. maintain accurate records of all claim payments;
3. maintain separate records of expenses not covered; and
4. provide US, on or before the 15th day of each Policy Month, the following data for the preceding Policy Month:
 - a. number of Covered Persons and/or Covered Units; and
 - b. a total of claims paid.

Management of a Large Claim (LC) or a Potentially Catastrophic Loss (PCL)

Notice of LC - YOU or YOUR TPA must notify US of any LC (regardless of whether charges have been paid, denied or are pending payment) within 10 days of the date the claim exceeds or it appears that the claim will reach or exceed the defined limits for a LC.

Notice of PCL - YOU or YOUR TPA must notify US of any PCL within 10 days of receiving any information indicating that the claim (regardless of whether charges have been paid, denied or are pending payment) is potentially catastrophic. (See Exhibit I of this Policy.)

Failure to Notify - If for any reason a LC or PCL is not properly submitted to the TPA, YOU shall promptly notify the TPA of the claim. In the event YOU or YOUR TPA fails to follow the notification requirements set forth in this provision, YOUR losses related to such LC or PCL will not be considered for reimbursement under this Policy.

If YOU receive information that any claim may be or become a PCL, YOU will immediately notify YOUR TPA.

Notice of Claim

Specific Stop Loss - YOU must give written notice of claim to US within 30 days of the date YOU become aware of claims, with respect to a Covered Person, that have reached 50% of the Specific Attachment Point; however, LCs and PCLs should be reported within the time frame specified in the previous paragraph.

Aggregate Stop Loss - YOU must give written notice of claim to US within 30 days of the date YOU become aware of claims that have reached the Annual Aggregate Attachment Point.

YOUR failure to furnish written notice within 30 days will not invalidate or reduce any claim that was otherwise eligible for reimbursement if it was not reasonably possible to provide written notice within such time. However, written notice must be furnished as soon as possible, but in no event later than one year after the date written notice is first required. Claims under YOUR Plan must be funded and paid within the Benefit Period in order to be eligible for reimbursement under this Policy.

YOU or YOUR TPA shall submit on a timely basis all proofs of claims, reports and supporting documents WE may request.

Proof of Loss

Written Proof of Loss must be submitted within 60 days after the date the Eligible Expenses under YOUR Plan meet the Specific or Aggregate Attachment Point. Eligible Expenses under YOUR Plan must be funded and paid within the Benefit Period shown on the Application/Schedule. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and within one year after the Benefit Period shown on the Application/Schedule. Claims not submitted within one year after the Benefit Period shown on the Application/Schedule will not be eligible for payment under this Policy.

Payment of Claims

Amounts payable under this Policy will be paid upon receipt and acceptance by US of all the required material. Required material shall include proof of loss and proof of payment for Eligible Expenses under the Plan and any reasonably requested supporting documentation. WE will have sole authority to reimburse or deny claims under this Policy.

Benefit Determination

Determination of benefits under YOUR Plan is YOUR sole responsibility. WE have no duty to settle or adjust claims filed under YOUR Plan with YOU or YOUR TPA. WE have the right to review each claim YOU submit to US for reimbursement to determine if YOU are entitled to reimbursement under OUR Policy. This review may include but is not limited to an on-site audit or requests for additional documentation. Only WE have the authority to reimburse losses covered by this Policy.

Subrogation

YOU may be entitled to recover from liable third parties for payments made due to covered injuries to, or on behalf of, Covered Persons under YOUR Plan. If YOU recover from a liable third party, the recovered amount cannot be used to meet a Deductible amount or an Attachment Point.

WE will not reimburse YOU for the recovered amount. If WE have reimbursed YOU for all or part of a particular payment and that payment is later recovered from a liable third party, YOU must repay US to the extent that it was reimbursed to YOU, regardless of whether this Policy is still in force on the date of recovery. The repayment may be reduced by the reasonable and necessary expenses YOU paid in recovering from the liable third party.

WE may subrogate all YOUR rights if YOU fail to prosecute any valid claims for injury against liable third parties and WE, as a result, become liable to make payments under this Policy for such injury. The amount recovered will be used to pay the expenses of collection as well as payments made under this Policy. The remaining amount will be paid to YOU. However, no recovery will be made from a Covered Person unless that Covered Person has been made whole.

Notice of Appeal

Any objection, notice of legal action, or complaint received on a claim processed under YOUR Plan on which it reasonably appears an Stop Loss benefit will be payable to YOU under this Policy shall be brought to the immediate attention of OUR Underwriting Office.

Section 11 — General Provisions

Taxes

If premium taxes should be assessed against YOU with respect to claims paid under YOUR Plan, YOU shall hold US harmless from any tax liability.

Entire Contract

This entire contract consists of:

1. this Policy, including any Riders;
2. YOUR Application/Schedule and any attachments thereto, a copy of which is attached to this Policy;
3. YOUR Disclosure Statement and any attachments thereto; and
4. a copy of YOUR Plan.

All statements made by YOU or any Covered Person are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to contest coverage unless contained in the Application/Schedule, or any attachments to the Application/Schedule.

In case of a conflict between the Plan and this Policy, this Policy will prevail. WE have relied on the information YOU and YOUR TPA provided to issue this Policy. YOU represent such information is accurate. Should WE later learn such information was not correct, or in case of a substantial change in such information, WE may modify this Policy as of the Effective Date to reflect the correct information, or WE may terminate this Policy on written notice as of the next Premium Due Date.

Policy Nonparticipating

This Policy does not entitle YOU to share in OUR earnings.

Records and Review

YOU and/or YOUR TPA must:

1. keep appropriate records regarding administration of YOUR Plan; and (YOUR records include records held by YOUR TPA.)
2. allow US to review and copy, during normal business hours, all records affecting OUR liability under this Policy; and
3. maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven years after the termination of this Policy; and
4. maintain a separate record of any and all amounts YOU pay that exceed or are not covered by the benefits under YOUR Plan.

As a result of any audit, WE may re-adjust premiums, attachment points or reimbursements to YOU as may be necessary to reflect YOUR and OUR original intent in issuing this Policy.

Clerical Error

If YOU or WE make a clerical error keeping records or calculating premiums or claims pertaining to this Policy, it will not invalidate this Policy. A clerical error will not expand OUR obligations under this Policy. A clerical error is a mistake in performing a clerical function, and does not include intentional acts or failure to comply with Plan or Policy provisions. A clerical error is not:

1. the failure to disclose the required disclosure of health history of Disabled Persons, Large Claims, or Potentially Catastrophic Losses; or
2. the failure to process a claim within the Benefit Period of this Policy.

Changes To This Policy

Changes to this Policy may be made only by a Company officer or OUR Underwriting Office, with OUR approval. Any change must be by written Rider.

Changes To YOUR Plan

WE must be notified of any change to YOUR Plan. This notice must be in writing and provided to US at least 31 days prior to the effective date of the change. WE must accept the change in writing before coverage affected by this change will be provided by this Policy. WE reserve the right to amend the Application/Schedule to include any change to a statute that increases OUR liability under this Policy. If WE do not receive advance written notice of the change, or WE decline to accept the changes under this Policy, WE will be liable only for benefits provided by the Plan prior to the change. YOU must provide US with a copy of YOUR written Plan and all amendments prior to the time the change becomes effective.

Subsidiaries, Affiliated Companies Under YOUR Plan

YOU must notify US in the event YOU acquire a subsidiary or affiliated company that will be included under YOUR Plan. If YOU do acquire a subsidiary or affiliated company that will be included under YOUR Plan, YOU must disclose certain required health history on persons whose coverage YOU will be assuming under YOUR Plan. Failure to do so will subject benefits under this Policy to certain limitations, as described in "Non-Disclosed Losses," in Section 5.

Acquisition of a subsidiary or affiliated company that will be included under YOUR Plan may affect YOUR premium rates and/or Monthly Aggregate Stop Loss Factors, as described in "Changes in Premium Rates or Factors," in Section 7.

YOU must notify US in the event YOU cede or dissolve a subsidiary or affiliated company that was included under YOUR Plan. Failure to do so may subject this Policy to termination (if Minimum Plan Enrollment is not maintained), or may affect YOUR premium rates and/or Monthly Aggregate Stop Loss Factors, as described in "Changes in Premium Rates or Factors," in Section 7.

Duties and Responsibilities of YOUR Designated Third-Party Administrator (TPA)

YOUR TPA must be approved by US.

WE agree to recognize YOUR TPA as YOUR agent for the administration of YOUR Plan. YOU agree that YOUR TPA will:

1. audit, calculate and pay all claims eligible under the Plan;
2. prepare reports required by US and keep and make available to US data WE may require; and
3. do what is necessary for YOU to comply with the terms of this Policy.

If YOU give YOUR TPA a Power of Attorney, or revoke a Power of Attorney, neither is binding on US until WE receive it.

YOU will pay YOUR TPA for all administrative functions performed in relation to this Policy.

YOUR TPA is YOUR agent and not OURS. YOU authorize YOUR TPA to:

1. submit Notice/proof of loss;
2. certify the payment of claims;
3. transmit reports and payment of premiums to US; and
4. receive payments from US.

Payments by US to YOUR TPA are payments to YOU.

Notice

For the purpose of any notice required from US under the terms of this Policy, notice to YOUR TPA is notice to YOU and notice to YOU is notice to YOUR TPA.

Disclaimer

WE act only as a provider of Stop Loss Insurance coverage to YOUR Plan. WE are not a fiduciary. WE do not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974, as amended.

While the determination of benefits under the Plan is the sole responsibility of the Policyholder, WE reserve the right to interpret the terms and conditions of the Plan as it applies to this Policy. WE have the sole authority to approve or deny reimbursement under this Policy.

WE have no right or obligation to pay any Covered Person or provider of professional or medical services. OUR sole liability is to YOU, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a Covered Person to have a direct right of action against US. WE will not be considered a party to YOUR Plan or to any supplement or amendment to it.

Indemnification, Defense and Hold Harmless

YOU agree to indemnify, defend and hold US harmless from:

1. any liability resulting from or related to any negligence, error, omission or defalcation by YOUR TPA;
2. any liability related to:
 - a. any dispute involving a Covered Person unless it is a result of OUR sole negligence or intentional wrongful acts; and
 - b. any State premium taxes or assessments WE are assessed with respect to funds paid by or to YOU under YOUR Plan. Taxes on amounts paid to US as premiums for this Policy are excluded.

WE will notify YOU if YOU have obligations. WE may participate in the defense at OUR expense. If YOU do not act promptly, WE may defend and compromise or settle the claim or other matter on YOUR behalf, for YOUR account, and at YOUR risk.

Offset

WE may offset payments due YOU under this Policy against claim overpayments and premiums due and unpaid.

Assignment

YOU may not assign any of YOUR rights under this Policy.

Severability

Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public Policy, will not render any of the remaining provisions of this Policy invalid.

Insolvency

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan or arrangement with creditors, or dissolution of YOU or YOUR TPA:

1. will not impose upon US any liability or additional duties other than those defined and provided for in this Policy; (For example, WE will have no responsibility to pay claims for YOUR Plan to ensure reimbursement under this Policy.) and
2. will not make US liable to YOUR creditors, including Covered Persons.

Claims under YOUR Plan must continue to be funded and paid within the Benefit Period in order to be eligible for reimbursement under this Policy.

Parties to This Policy

YOU and WE are the only parties to this Policy. OUR sole liability under this Policy is to YOU. This Policy does not create any right or legal relation between US and a Covered Person under YOUR Plan. This Policy will not make US a party to any agreement between YOU and YOUR TPA.

Physical Examination and Medical Evidence

WE may require any medical evidence or other information, including a physical examination or health statement, regarding any Covered Person:

1. who submits an enrollment card for coverage under the Plan more than 31 days after completing the waiting period specified in the Plan. Such examination shall be provided without expense to US; or
2. for whom YOU have paid a claim under the Plan and submitted such claim for reimbursement under this Policy. Such examination or evidence shall be provided as often as is reasonably necessary.

Legal Action

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Time Limit on Certain Defenses

In the absence of fraud, all statements made by YOU or YOUR TPA shall be deemed representations and not warranties. If these statements appear as part of the written Application or other written instrument signed by YOU or YOUR TPA, WE may use them to contest this Policy. If WE do, WE will furnish YOU or YOUR TPA with a copy of the document in question. After two years, only fraudulent misstatements may be used to contest the coverage under this Policy.

Waiver

OUR failure to strictly enforce OUR rights under this Policy shall not waive any such right, regardless of the frequency or similarity of the circumstances.

Exhibit 1 — Potentially Catastrophic Losses (PCLs)

Some diagnoses that qualify as PCLs are listed below. This is not a comprehensive list. These are only examples of some types of conditions. WE reserve the right to change this list of PCLs at any time.

Infectious and Parasitic Diseases

- Septicemia
- Aids/Hiv
- Aids related illnesses
- Hepatitis

Cancer of any Type

Endocrine, Nutritional, Metabolic, Immune Disorders

- Diabetes
- Cystic fibrosis
- Obesity/Hyperalimmentation

Diseases of the Blood and Blood-Forming Organs

- Sickle cell anemia
- Aplastic anemia
- Coagulation defects and/or Hemophilia

Diseases of the Nervous System and Sense Organs

- Cerebral degenerations
- Quadriplegia and Quadripareisis
- Reye's Syndrome
- Paraplegia
- Encephalopathy
- Neuropathy/Myasthenia Gravis

Diseases of the Circulatory System

- Acute myocardial infarction
- Acute and Subacute Ischemic heart disease
- Coronary atherosclerosis
- Acute pulmonary heart disease
- Aneurysms
- Endocarditis
- Value disorders
- Cardiomyopathy
- Subarachnoid/Intracerebral hemorrhage
- Cardiac dysrhythmias
- Heart failure
- Conduction disorders
- Cerebral artery occlusion
- Acute cerebrovascular accident
- Atherosclerosis
- Myocarditis
- Cardiomyopathy

Diseases of the Respiratory System

- Chronic obstructive pulmonary disease (COPD)
- Pulmonary collapse and/or respiratory failure
- Pneumonia
- Postinflammatory pulmonary fibrosis

Diseases of the Digestive System

- Regional enteritis (Crohn's disease)
- Intestinal obstruction
- Diverticulitis of colon
- Peritonitis
- Liver disease and cirrhosis
- Pancreas diseases
- Gastrointestinal hemorrhage

Diseases of the Genitourinary System

- Acute renal failure
- Chronic renal failure
- Impaired renal function
- Calculus of kidney and/or ureter
- Dialysis treatment

Complications of Pregnancy and Childbirth

- Placenta previa
- Eclampsia, pre-eclampsia
- Premature labor
- Gestational diabetes
- Multiple gestation
- Cervical incompetence
- Supervision of high-risk pregnancy

Diseases of the Musculoskeletal System and Connective Tissue

- Osteoarthritis
- Spondylosis
- Intervertebral disc disorders
- Osteomyelitis and periostitis
- Kyphoscoliosis and scoliosis

Congenital Anomalies

- Aortic atresia/stenosis
- Other unspecified congenital anomalies
- Biliary atresia

Conditions Originating in the Perinatal Period

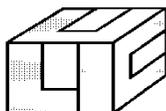
- Prematurity
- Respiratory distress syndrome
- Other respiratory conditions of a newborn
- Apnea
- Lack of expected normal physiological development
- Hyaline membrane disease
- Encephalocele
- Cephalohematoma
- Spina bifida

Injury and Poisoning

- Skull fracture
- Vertebral column fracture
- Spinal cord injury
- Multiple fractures
- Trauma to the elderly or chronically ill
- Internal injury
- Traumatic amputation
- Burns
- Intracranial injury

Other Serious Conditions

- Transplants of any kind
- Continuous hospitalization of 2 weeks or more
- Evaluation for transplants of any kind
- Mental disorders requiring hospital confinement
- Any serious condition that may require Large Case Management
- Sleep apnea
- Home health care greater than 20 days
- Coma
- Brain lesion or tumors
- Any illness or injury that requires intensive and prolonged treatment (such as nutritional support systems, intravenous therapies, and ventilators)



UNIFIED LIFE INSURANCE COMPANY

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SECTION 1 – POLICYHOLDER INFORMATION

1. Full legal name of Policyholder (herein referred to as You/Your), as it will appear in Policy issued by US:
[Any Company]

2. Address of principal office (street, city, state, zip):
[### Street, City, State #####]

3. Contact Person:
Name: [Any Person] Telephone Number: [(###) ### - #####]
E-mail Address: [name@company.net] Fax Number: [(###) ### - #####]

4. Nature of Business:
[Any Company]

5. If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:
[Any Company]

6. Full name of Your Employee Welfare Benefit Plan:
[Any Company Health Plan]

NOTE: A copy of Your ERISA Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application/Schedule.

7. Your designated Third-Party Administrator (for the purposes of claims administration under Your Employee Welfare Benefit Plan):
Name: [Any Company] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

8. Your broker/agent of record:
Name: [Any Person] E-mail Address: [name@company.net]
Address: [### Street, City, State #####]
Telephone Number: [(###) ### - #####] Fax Number: [(###) ### - #####]

9. Our Underwriting Manager: [Any Company]

SECTION 2 – REQUESTED POLICY PERIOD

The Coverage shown as included in Section 3 and/or Section 4 is requested for, and applies only during the Policy Period from [Date] (the Effective Date) through [Date] (the Expiration Date) and is further subject to all of the provisions of the Policy.

SECTION 3 – SPECIFIC STOP LOSS COVERAGE

1. Coverage Election: YES – Specific coverage is included in this Policy.
 NO – Specific coverage is not included in this policy. **Do not complete this Section.**

2. Coverage to be included. Check one box below for each coverage listed:
Yes No
 Medical
 Prescription Drug Service:

NOTE: In no event will Dental, Vision, or Weekly Income be included under Specific Stop Loss Coverage.

3. Specific Attachment Point:
 Per Covered Person: \$[##,###.##]
 Per Covered Person: \$

4. Specific Reimbursement Percentage: 100%

5. Specific Lifetime Maximum Reimbursement per Covered Person: \$[#,##,###.##]

6. Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Applicable only to [Any Company and all of its subsidiaries and affiliates]
 Plan Benefits Incurred from [Date] through [Date]
 and Paid from [Date] through [Date]

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____

Applicable only to _____
 Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:
 \$[###,###.##] per Covered Person or
 \$ _____ for all Covered Persons combined
 Related Rider(s): [Form Number Here]

7. Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
<u>[Composite]</u>	: \$ <u>[##.##]</u>	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____
_____	: \$ _____	_____	: \$ _____

8. Minimum Annual Specific Premium: \$ [###,###.##]

SECTION 4 – AGGREGATE STOP LOSS COVERAGE

1. Coverage Election: YES – Aggregate coverage **is** included in this Policy.
 NO – Aggregate coverage **is not** included in this Policy. Do not complete this section.

2. Coverages to be included. Check one box below for each coverage listed:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Medical
<input type="checkbox"/>	<input type="checkbox"/>	Dental
<input type="checkbox"/>	<input type="checkbox"/>	Vision
<input type="checkbox"/>	<input type="checkbox"/>	Prescription Drug Service: _____
<input type="checkbox"/>	<input type="checkbox"/>	Weekly Income: Maximum _____, per covered employee per Policy Period.
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

3. Monthly Aggregate Factor:

Covered Unit Description	Medical	Dental	Vision	Prescription Drug Service	Weekly Income	Totals
<u>[Composite]</u>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

SECTION 6 – NOTICES AND SIGNATURES

You have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by Us and as reflected in this Application/Schedule. You have formed Your Employee Welfare Benefit Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable provisions of the law or regulation. It is agreed that the statements in this Application/Schedule or in any materials submitted with this Application/Schedule or attached to it are Your representations and shall be deemed material to acceptance of the risk by Us and that the Policy is issued by Us in reliance on the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage hereunder, We will have the right to revise the premiums rates, factors, terms or conditions as of the Effective Date, by providing written notice to You. Any fraudulent statement will render the Policy null and void and all claims, if any, will be forfeited.

This Application does not bind coverage. Upon approval of the Application, the Policy evidencing that the coverage is in force will be issued by Us through Our Underwriting Manager. Coverage will commence on the Effective Date set forth in the Policy.

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

Accepted by the POLICYHOLDER:

Policyholder (full legal name): [Any Company]

Signed at (city, state): [City, State] Date:

Signed for the Policyholder by (officer's signature):

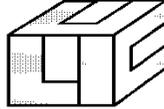
Printed Name: [Any Person] Title:

Accepted by the Company:

Signed at (city, state): [City, State] Date:

Signed for the Company by (officer's signature):

Printed Name: [Any Person] Title:



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Change in Specific Stop Loss Coverage Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following changes to the Application/Schedule for the Stop Loss Policy to which this Rider applies:

- The Specific Attachment Point for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 3., is changed as follows:
 - Per Covered Person: \$ _____
 - Per Covered Family: \$ _____
- The Specific Lifetime Maximum Reimbursement per Covered Person for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 5., is changed to \$ _____.

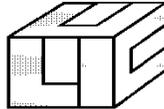
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

President

Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



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Change in Basis of Coverage Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the following change to the Application/Schedule for the Stop Loss Policy to which this Rider applies:

- The basis for SPECIFIC STOP LOSS COVERAGE, as specified in Section 3, item 6., is changed to the following:

6. Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Applicable only to _____
Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Applicable only to _____
Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Applicable only to _____
Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:

- \$ _____ per Covered Person *or*
- \$ _____ for all Covered Persons combined

- The basis for AGGREGATE STOP LOSS COVERAGE, as specified in Section 4, item 9., is changed to the following:

9. Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period):

Applicable only to _____
Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Applicable only to _____
Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

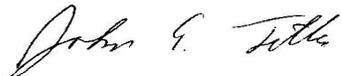
Applicable only to _____
Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Plan Benefits Incurred prior to the Effective Date (during the Run-In Period) will be limited to:

- \$ _____ per Covered Person or
- \$ _____ for all Covered Persons combined

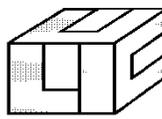
THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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


President


Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed:



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Addition of Subsidiary or Other Affiliated Group Rider

Rider Number:	Effective Date:
Policy Number:	Policyholder:

YOU and WE agree to the addition of a subsidiary, or other affiliated group, to YOUR Policy, as follows:

Name of Subsidiary or Affiliated Group:

Effective Date: _____

SPECIFIC STOP LOSS INSURANCE

Specific Attachment Point: \$ _____ [] per Covered Person or [] per Covered Family

Specific Lifetime Maximum Reimbursement per Covered Person: \$ _____

- Of this amount, reimbursement for treatment of drug or alcohol abuse will be limited to:
 - \$ _____ or
 - _____ days or
 - _____ days, up to \$ _____

or

- Treatment of drug or alcohol abuse considered as any other illness.

Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
and Paid from _____ through _____.

Plan Benefits Incurred prior to the Effective Date (Run-In Period) will be limited to:

- \$ _____ per Covered Person or
- \$ _____ for all Covered Persons combined

Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>	<i>Covered Unit Description</i>	<i>Amount</i>
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$
_____	: \$	_____	: \$

AGGREGATE STOP LOSS INSURANCE

Monthly Aggregate Factor:

<i>Covered Unit Description</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Prescription Drug Service</i>	<i>Weekly Income</i>	<i>Totals</i>
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Number of Covered Units:

- Quoted
- Actual

<i>Covered Unit Description</i>	<i>Medical</i>	<i>Dental</i>	<i>Vision</i>	<i>Prescription Drug Service</i>	<i>Weekly Income</i>
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Minimum Annual Aggregate Attachment Point: \$ _____
 (12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

Maximum Aggregate Reimbursement (per Policy Period): \$ _____

Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from _____ through _____
 and Paid from _____ through _____ .

Plan Benefits Incurred prior to the Effective Date (Run-In Period) will be limited to:

- \$ _____ per Covered Person
- \$ _____ for all Covered Persons combined

Premium Rates (per month):

<i>Covered Unit Description</i>	<i>Amount</i>	<i>Covered Unit Description</i>	<i>Amount</i>
_____:	\$	_____:	\$
_____:	\$	_____:	\$
_____:	\$	_____:	\$
_____:	\$	_____:	\$
_____:	\$	_____:	\$
_____:	\$	_____:	\$

THERE ARE NO POLICY CHANGES UNDER THIS RIDER OTHER THAN THOSE STATED ABOVE.

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

John E. Telle
 President

Mary M. Rixey
 Secretary

Signature of Policyholder's Representative	
Authorized Representative's Title	Date Signed: