

**State:** Arkansas **Filing Company:** United National Life Insurance Company of America

**TOI/Sub-TOI:** H07I Individual Health - Specified Disease - Limited Benefit/H07I.002A Dread Disease - Cancer Only

**Product Name:** UNL Chemotherapy Benefits

**Project Name/Number:** UNL Chemotherapy Benefits/

### Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: UNL Chemotherapy Benefits

State: Arkansas

TOI: H07I Individual Health - Specified Disease - Limited Benefit

Sub-TOI: H07I.002A Dread Disease - Cancer Only

Filing Type: Form

Date Submitted: 05/16/2012

SERFF Tr Num: GRTT-128364455

SERFF Status: Closed-Approved-Closed

State Tr Num:

State Status: Approved-Closed

Co Tr Num: URA12-3

Implementation: On Approval

Date Requested:

Author(s): Mary Kole, Jeffrey Kollum

Reviewer(s): Rosalind Minor (primary)

Disposition Date: 07/27/2012

Disposition Status: Approved-Closed

Implementation Date: 07/27/2012

State Filing Description:

**State:** Arkansas **Filing Company:** United National Life Insurance Company of America  
**TOI/Sub-TOI:** H071 Individual Health - Specified Disease - Limited Benefit/H071.002A Dread Disease - Cancer Only  
**Product Name:** UNL Chemotherapy Benefits  
**Project Name/Number:** UNL Chemotherapy Benefits/

## General Information

Project Name: UNL Chemotherapy Benefits Status of Filing in Domicile: Pending  
Project Number: Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Individual Market Type:  
Overall Rate Impact: Filing Status Changed: 07/27/2012  
State Status Changed: 07/27/2012  
Deemer Date: Created By: Jeffrey Kollum  
Submitted By: Jeffrey Kollum Corresponding Filing Tracking Number:

Filing Description:  
May 15, 2012

State of Arkansas  
Department of Insurance  
1200 West Third Street  
Little Rock, AR 72201

RE: NAIC #903-92703  
FEIN #37-1095206  
Individual Health-Specified Disease  
Dread Disease – Cancer Only

Form URA12-3: Amendment Rider – Chemotherapy Benefits  
Form OCU0430-1-AR: Outline of Coverage  
Form U0430-AR Plan A (Rev. 4/12): Policy Schedule (Plan A)  
Form U0430-AR Plan B (Rev. 4/12): Policy Schedule (Plan B)  
Form U0430-AR Plan C (Rev. 4/12): Policy Schedule (Plan C)  
Form U0430-AR Plan D (Rev. 4/12): Policy Schedule (Plan D)  
Form UAPPH1-10A: Policy application

We are submitting the captioned forms for the Department's review and approval. These are new forms that are not intended to replace any forms the Department approved before. These new forms amend forms the Department approved on 12/16/2004 (Forms U0430-AR, et al).

Form URA12-3 is an Amendment Rider that amends the chemotherapy treatment benefits in the policy by differentiating the benefits for injected chemotherapy and oral chemotherapy, upon the first diagnosis of cancer -- on both an individual or family basis. Four benefit levels of coverage will be offered, and each form's use is as noted below.  
Form OCU0430-1-AR is the policy's outline of coverage.

Forms U0430-AR Plan A (Rev. 4/12) through U0430-AR Plan D (Rev. 4/12) are Policy Schedule pages for each of the offered plans.

Form UAPPHI-10A is the policy application

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There is neither an actuarial memorandum nor any rate sheet attached, because this submission has no pricing impact.

We use multiple computer systems to generate documents. Therefore, actual issued forms may have a different font style than these submitted forms. As a result, provisions may appear on different pages and lines may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate re-filing for a font style variation.

Your prompt review of this submission will be much appreciated. If I can provide additional information to assist you in your review, you may contact me collect at 1-847-904-5786, or by email at jkoll@gtlc.com.

Very truly yours,  
 Jeffrey M. Kollum, MBA, CLU, GBA, LTCP  
 Senior Compliance Analyst  
 Product Approval and Compliance  
 United National Life Insurance Company of America

## Company and Contact

### Filing Contact Information

Jeffrey Kollum, Senior Compliance Analyst jkoll@gtlc.com  
 1275 Milwaukee Avenue 847-904-5786 [Phone]  
 Glenview, IL 60025 847-699-0093 [FAX]

### Filing Company Information

United National Life Insurance Company of America	CoCode: 92703	State of Domicile: Illinois
1275 Milwaukee Ave.	Group Code: 687	Company Type:
Glenview, IL 60025	Group Name:	State ID Number:
(847) 803-5252 ext. [Phone]	FEIN Number: 37-1095206	

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$350.00  
 Retaliatory? Yes  
 Fee Explanation: Illinois charges a retaliatory fee of \$50 per form.

Therefore, this filing which consists of (1 rider, 1 outline, 1 app and 4 schedule plans) are 7 forms (no rates involved in this filing) x \$50 a form is \$350.00.

Per Company: No

Company	Amount	Date Processed	Transaction #
United National Life Insurance Company of America	\$350.00	05/16/2012	59198984

**SERFF Tracking #:**

GRTT-128364455

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

URA12-3

**State:**

Arkansas

**Filing Company:**

United National Life Insurance Company of America

**TOI/Sub-TOI:**

H071 Individual Health - Specified Disease - Limited Benefit/H071.002A Dread Disease - Cancer Only

**Product Name:**

UNL Chemotherapy Benefits

**Project Name/Number:**

UNL Chemotherapy Benefits/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/27/2012	07/27/2012
Approved-Closed	Rosalind Minor	05/17/2012	05/17/2012

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Outline of Coverage	Jeffrey Kollum	07/26/2012	07/26/2012

**State:** Arkansas **Filing Company:** United National Life Insurance Company of America  
**TOI/Sub-TOI:** H071 Individual Health - Specified Disease - Limited Benefit/H071.002A Dread Disease - Cancer Only  
**Product Name:** UNL Chemotherapy Benefits  
**Project Name/Number:** UNL Chemotherapy Benefits/

## Disposition

Disposition Date: 07/27/2012

Implementation Date: 07/27/2012

Status: Approved-Closed

Comment:

This submission was reopened at your request in order to replace Form OCU0430-1-AR, Outline of Coverage. We are withdrawing the previously approved form and are approving the new Outline of Coverage on this date.

The remainder of the forms will maintain the original approval date of 5/17/12.

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Amendment Rider - Chemotherapy Benefits	Approved-Closed	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Withdrawn	No
Form	Policy Schedule--Plan A	Approved-Closed	Yes
Form	Policy Schedule--Plan B	Approved-Closed	Yes
Form	Policy Schedule--Plan C	Approved-Closed	Yes
Form	Policy Schedule--Plan D	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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## Disposition

Disposition Date: 05/17/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Amendment Rider - Chemotherapy Benefits	Approved-Closed	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Withdrawn	No
Form	Policy Schedule--Plan A	Approved-Closed	Yes
Form	Policy Schedule--Plan B	Approved-Closed	Yes
Form	Policy Schedule--Plan C	Approved-Closed	Yes
Form	Policy Schedule--Plan D	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

**State:** Arkansas **Filing Company:** United National Life Insurance Company of America  
**TOI/Sub-TOI:** H071 Individual Health - Specified Disease - Limited Benefit/H071.002A Dread Disease - Cancer Only  
**Product Name:** UNL Chemotherapy Benefits  
**Project Name/Number:** UNL Chemotherapy Benefits/

## Amendment Letter

Submitted Date: 07/26/2012

Comments:

Ms. Minor:

Thank you for your kindness and consideration by re-opening this filing. This allows us to withdraw the form you approved recently, and substitute it with the correct, and most current, version of the document. We submit this new Outline of Coverage for Department approval.

Jeff Kollum

United National Life Insurance Company of America

Changed Items:

### Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
OCU0430-1-AR	Outline of Coverage	Outline of Coverage	Initial				51.370	UNL Outline of Coverage OCU0430-1-AR (Current 6-11-12).pdf

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## Form Schedule

### Lead Form Number: URA12-3

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1	Approved-Closed 05/17/2012	URA12-3	POLA	Amendment Rider - Chemotherapy Benefits	Initial:	55.940	URA12-3 Chemotherapy Benefits Amendment Rider.pdf
2	Approved-Closed 07/27/2012	OCU0430-1-AR	OUT	Outline of Coverage	Initial:	51.370	UNL Outline of Coverage OCU0430-1-AR (Current 6-11-12).pdf
3	Approved-Closed 05/17/2012	U0430-AR Plan A (Rev.4/12)	SCH	Policy Schedule--Plan A	Initial:		U0430-AR Schedule A (Rev. 4-12).pdf
4	Approved-Closed 05/17/2012	U0430-AR Plan B (Rev.4/12)	SCH	Policy Schedule--Plan B	Initial:		U0430-AR Schedule B (Rev. 4-12).pdf
5	Approved-Closed 05/17/2012	U0430-AR Plan C (Rev.4/12)	SCH	Policy Schedule--Plan C	Initial:		U0430-AR Schedule C (Rev. 4-12).pdf
6	Approved-Closed 05/17/2012	U0430-AR Plan D (Rev.4/12)	SCH	Policy Schedule--Plan D	Initial:		U0430-AR Schedule D (Rev. 4-12).pdf
7	Approved-Closed 05/17/2012	UAPPH1-10A	AEF	Application	Initial:	53.130	UNL Combo App UAPPH1-10A.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage

SERFF Tracking #:

GRTT-128364455

State Tracking #:

Company Tracking #:

URA12-3

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<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**

PO Box 1154 -- Glenview, Illinois 60025-1154

(800) 207-8050

**AMENDMENT RIDER  
TO THE  
FIRST DIAGNOSIS CANCER BENEFIT POLICY (FORM NUMBER: U0430-Series)**

**CHEMOTHERAPY BENEFITS**

This Amendment Rider is part of Your Specified Disease Policy (“The First Diagnosis Cancer Benefit Policy,” or simply, “the Policy and Your Policy”). You should attach this document to the Policy. This Amendment Rider, which begins on the Policy’s Effective Date, amends the Chemotherapy Benefits of the Policy. Wherever the Policy differs from the content of the sections below, refer to this Amendment Rider, and not to Your Policy, for the details of Your coverage for Chemotherapy Treatments.

**AMENDMENT RIDER DEFINITIONS**

The following definitions and those applicable definitions contained in the Policy will apply whenever the terms are used in the Amendment Rider.

**Chemotherapy Treatment:** Cytotoxic chemical substances and their administration.

**Injected Chemotherapy:** A Chemotherapy Treatment that is injected, involving the use of a short needle such as those used by diabetics for the injection of insulin.

**Oral Chemotherapy:** A Chemotherapy Treatment that can be swallowed orally. The oral forms of chemotherapy can be pills, tablets, capsules or liquid, all of which can be absorbed in the stomach or under the tongue.

**Topical Chemotherapy:** A Chemotherapy Treatment for which a cream is applied directly to the skin.

**AMENDMENT RIDER BENEFITS**

Subject to meeting the Eligibility for Benefits provision of the Policy to which this Amendment Rider is attached, a Covered Person shall be eligible for the following benefits.

**Chemotherapy Benefit**

We will pay for Chemotherapy Treatments prescribed by a Doctor for the treatment of Cancer as follows:

**Chemotherapy:**

- Injected: The Benefit Amount, as shown on the Policy Schedule, is paid for each day Injected Chemotherapy Treatment is administered. When chemotherapy is administered by a pump, benefits will be payable for the day the pump usage began and the day of each subsequent refill.
- Oral: The Benefit Amount, as shown on the Policy Schedule, is paid per month for Oral Chemotherapy Treatment medicines (and for covered Topical Chemotherapy Treatment). The Oral Chemotherapy benefit is payable for no more than thirty-six (36) months. The total Benefit Amount for Oral Chemotherapy shown in the Policy Schedule includes covered Topical Chemotherapy Treatment, as one combined, total Benefit Amount.

## **RIDER EXCLUSIONS**

This Amendment Rider does not pay benefits for experimental procedures or treatment methods not endorsed by the American Medical Association or any other appropriate Medical Society.

## **RENEWAL CONDITIONS AND PREMIUM**

This Amendment Rider is renewed when the Policy to which it is attached is renewed. This Amendment Rider does not require the payment of additional premium.

## **WHEN THIS AMENDMENT RIDER ENDS**

This Amendment Rider ends, and any benefits payable under it cease, on the date the Policy to which this Amendment Rider is attached ends.

## **CONDITIONS**

This Amendment Rider is subject to all terms, definitions, provisions, limitations and exclusions of the Policy to which it is attached, except where specifically changed by this Amendment Rider.

Signed at United National Life Insurance Company of America at its Home Office, by



Secretary



President

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
P.O. Box 1154, Glenview, Illinois 60025-1154 (847) 803-5252

**SPECIFIED DISEASE POLICY**

**OUTLINE OF COVERAGE**  
**FIRST DIAGNOSIS CANCER BENEFIT POLICY**

Policy Form U0430-AR  
With Optional Rider Forms RU04HAS, RU04LS and RU11ROP

**KEEP THIS OUTLINE FOR YOUR RECORDS**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY**

**THIS IS A LIMITED BENEFIT POLICY – READ YOUR POLICY CAREFULLY** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provision will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

**SPECIFIED DISEASE COVERAGE** – Policies of this category are designed to provide to persons insured restricted coverage paying benefits ONLY when certain losses occur as a result of specified disease. Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

**FIRST DIAGNOSIS CANCER BENEFITS** – We will pay expenses incurred for treatment of cancer following a first diagnosis of cancer, subject to the waiting period.

**CANCER IN SITU BENEFIT** – We will pay 50% of the benefit amounts for Cancer in situ. The Cancer in situ benefit does not apply to the optional Express Pay Rider, if such optional coverage is selected.

<b>Part One Benefits</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>
<b>Hospital Confinement</b> - For each day of hospital confinement, beginning with day 1 to day 90 .....	\$100	\$180	\$250	\$410
<b>Hospital Confinement Inflation Fighter</b> – Increases the hospital confinement benefit each year for the first five years the policy is in force by .....	N/A	\$10/day	\$15/day	\$20/day
<b>Extended Hospital Confinement</b> - Beginning with day 90 of consecutive hospital confinement, up to ..... During receipt of this benefit, no other benefits are payable under the policy except waiver of premium.	\$350/day	\$600/day	\$600/day	\$600/day
<b>Daily Room</b> - During the first 70 days of hospital confinement .. This benefit is paid in addition to the hospital confinement benefit.	\$100/day	\$150/day	\$200/day	\$300/day
<b>Inpatient Drugs and Diagnostic Testing</b> - For medications received or diagnostic testing, up to.....	\$10/day	\$25/day	\$40/day	\$50/day
<b>Attending Doctor</b> – For services while hospital confined, up to .....	\$10/day	\$30/day	\$35/day	\$40/day
<b>Nurse</b> – For full-time services of a nurse while hospital confined, other than those nursing services regularly furnished by a hospital, up to .....	\$50/day	\$125/day	\$125/day	\$125/day
<b>Ambulance</b> - For transportation to or from a hospital where you are confined as an inpatient, up to ..... Benefit is limited to 4 trips per calendar year.	\$75/trip	\$150/trip	\$225/trip	\$300/trip
<b>Surgical Procedure</b> - For surgery performed by a doctor due to cancer, according to the policy surgical schedule, up to .....	\$2,500	\$4,500	\$7,500	\$9,000
<b>Anesthesia</b> – For anesthesia during a surgery for which a surgical procedure benefit is payable, 25% of the surgical procedure benefit, up to .....	\$625	\$1,125	\$1,875	\$2,250
<b>Blood and Plasma</b> - For blood and plasma, other than your own blood, received during definitive treatment of cancer, up to .....	\$20/unit	\$40/unit	\$60/unit	\$80/unit

<b>Skilled Nursing Facility</b> - For confinement in a skilled nursing facility which begins within 14 days of discharge from a hospital, up to .....	\$50/day	\$100/day	\$125/day	\$150/day
<b>Home Care Recovery</b> - For home care and recovery, equal to the number of days paid for the hospital confinement benefit, up to..	N/A	\$15/day	\$15/day	\$25/day
<b>Family Member Transportation</b> - Coach class plane, train or bus expense on a regularly scheduled route for a family member when you are confined in a hospital located in the U.S. which is more than 100 miles one-way from a family member's home, up to..... For travel by automobile .....	\$500 \$.15/mile	\$1,000 \$.25/mile	\$1,500 \$.40/mile	\$2,500 \$.40/mile
<b>Non-Local Patient Transportation</b> - Coach class plane, train or bus expense on a regularly scheduled route within the U.S. to receive cancer treatment or consultation that is not available within 100 miles one-way from your home, up to .....	\$500 \$.15/mile	\$1,000 \$.25/mile	\$1,500 \$.40/mile	\$2,500 \$.40/mile
<b>Family Member Lodging</b> - For lodging expense incurred by a family member while you are confined as an inpatient for treatment of cancer in a hospital that is located in the U.S. and is more than 100 miles one-way from the family member's home, up to .....	\$20/day	\$40/day	\$50/day	\$60/day
<b>Second and Third Surgical Opinions</b> – A 2 <sup>nd</sup> surgical opinion if recommended due to the positive diagnosis of Cancer and a 3 <sup>rd</sup> opinion if the 2 <sup>nd</sup> fails to confirm the need for surgery, up to .....	N/A	\$150/ opinion	\$225/ opinion	\$225/ opinion
<b>Part Two Benefits</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>
<b>Hospice</b> - Hospice services when you are diagnosed as terminally ill, starting day 1 to day 60 .....	\$50/day	\$80/day	\$100/day	\$120/day
Starting with day 61 .....	\$25/day	\$40/day	\$50/day	\$60/day
<b>Radiation/Injected Chemotherapy Treatments</b> - For any combination of radiation and/or Injected Chemotherapy Treatments which are part of definitive treatment, the combined total, up to .	\$100/day	\$175/day	\$250/day	\$300/day
Plus, at the time of the 1 <sup>st</sup> radiation and/or Injected Chemotherapy Treatment, an additional amount of... ..	N/A	\$100	\$250	\$500
<b>Oral Chemotherapy Treatment</b> - For Oral Chemotherapy Treatments (benefits for Topical Chemotherapy Treatments are also included here in this section) which are part of definitive treatment, up to the monthly benefits shown here, but not more than a total of 36 months of benefits for the plan selected.....	\$100/month	\$200/month	\$300/month	\$400/month
<b>Breast Reconstruction</b> - For breast reconstruction as the direct result of surgery for which benefits are paid under the policy .....	Up to the surgical procedure benefit paid for the mastectomy			
<b>Comfort Benefit (Outpatient Drugs)</b> - For anti-nausea medication prescribed by a doctor charges, up to.....	N/A	N/A	\$200/yr	\$226/yr
<b>Prosthesis</b> - For prosthetic devices needed as the direct result of, and received within 3 years of, a cancer surgery for which benefits were paid under the policy, per prosthetic device, up to.....	\$250	\$1,000	\$2,000	\$2,500
<b>Bone Marrow Transplant</b> - For human bone marrow transplant for the definitive treatment of cancer, up to..... After coverage has been in force for one year, the initial bone marrow transplant benefit will increase by 5%. On each subsequent policy anniversary, the benefit will continue to increase by 5%. Such increases will continue to take place on each policy anniversary for a period not to exceed 10 years.	N/A	\$2,500	\$5,000	\$10,000

<b>Part Three Benefits</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>
<b>Waiver of Premium</b> - Premium payments will not be required if you are diagnosed as having cancer after the waiting period and while covered under the policy and are disabled due to cancer for more than 90 consecutive days. The disability must begin on or after the date of diagnosis.	Included	Included	Included	Included

**OPTIONAL HEART ATTACK OR STROKE BENEFIT RIDER** – We will pay Part One Benefits, as outlined above, for treatment of a heart attack or stroke, subject to the waiting period, if such optional coverage is selected at time of application. The benefit payable for a surgical procedure performed for heart attack or stroke is based on the heart attack or stroke rider surgical schedule. First Diagnosis Cancer Part Three Benefits, Waiver of Premium, will also include and apply to heart attack or stroke and is subject to the policy definition of disabled/disability.

**OPTIONAL EXPRESS PAY RIDER** – We will pay a lump sum benefit upon first diagnosis of cancer or when a heart attack or stroke is first diagnosed based on the amount selected at time of application if such optional coverage is selected, subject to the waiting period. The Cancer in situ benefit does not apply to any benefit payable under the optional Express Pay Rider.

**OPTIONAL RETURN OF PREMIUM BENEFIT RIDER** – If your coverage under the policy ends, due to cancellation or death, we will return the actual amount of premium paid equal to:

1. The sum of all premiums paid for the policy, including premiums paid for the rider and any other benefits riders attached to this rider;
2. Minus the sum of all benefit paid or then payable under the policy, including benefits paid or then payable under any attached benefit riders while the rider was in force.

To determine the return of premium percentage, we'll consider: (1) when your coverage under the policy (with this rider) ends; (2) your issue age at the beginning of the return of premium period and the number of years the policy and other benefit riders have been in force (with the rider); and (3) the return of premium percentage. The applicable issue age and number of years the policy (with the rider) has been in force and the return of premium percentages are as follows:

<u>Issue Age</u>	<u>Return of Premium Percentage</u>
18 through 60	100% after twenty (20) rider years and beyond.
61 through 79	100% after fifteen (15) rider years and beyond.

**EFFECT OF WAIVER OF PREMIUM ON RETURN OF PREMIUM**

Premiums waived under any Waiver of Premium Provision of the Policy will be treated both as premiums paid and claims incurred for purposes of calculating the Return of Premium benefit amount.

**WAITING PERIOD** – There is a 30 day waiting period before we will pay benefits for loss due to cancer or heart attack or stroke, if such optional coverage is purchased. If the first diagnosis of cancer is made during the waiting period, the insured has the option to cancel the policy and receive a refund of all premiums paid.

**EXCLUSIONS** – The policy does not pay benefits for:

1. Treatment, services or supplies which: are not medically necessary; are not prescribed by a doctor as necessary to treat cancer or attack or stroke; are received without charge or legal obligation to pay; would not routinely be paid in the absence of insurance; or are received from an immediate family member.
2. any loss due to injury, disease, sickness or incapacity, unless such definitive treatment is directly related to or attributable to Cancer as defined;
3. any loss due to injury, disease, sickness or incapacity, unless such treatment is directly related to or attributable to a heart attack or stroke as defined, if such optional coverage is selected.
4. care outside the United States;
5. experimental drugs or substances not approved by the Federal Food & Drug Administration for the treatment of Cancer; and
6. experimental procedures or treatment methods not endorsed by the American Medical Association or any other appropriate medical society.

**RENEWABILITY** – You may keep the policy and riders, if attached, in force during your entire lifetime by paying premiums when due or within the grace period. We can't cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

**PREMIUMS SUBJECT TO CHANGE** – We may change your premium rates by giving you at least 31 days prior written notice. We can change the premiums this way only if we change it on a class basis for all policies/riders of this class in your state.

**INITIAL PREMIUM**

<b>FIRST DIAGNOSIS CANCER BENEFIT PLAN</b> _____	\$ _____
<input type="checkbox"/> <b>HEART ATTACK OR STROKE BENEFIT RIDER</b>	\$ _____
<input type="checkbox"/> <b>EXPRESS PAY RIDER Benefit Amount \$</b> _____	\$ _____
<input type="checkbox"/> <b>RETURN OF PREMIUM RIDER</b>	\$ _____
<b>TOTAL PREMIUM</b>	\$ _____

Agent's Name: \_\_\_\_\_

Agent's Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

## **CANCER POLICY SCHEDULE – PLAN A**

**This is a summary of Benefits. Please read Your entire Policy for further explanations and limitations.**

Hospital Confinement, beginning with day 1 to day 90	\$100/day
Hospital Confinement Inflation Fighter	Not Applicable
Extended Hospital Confinement, beginning with day 90 of consecutive Hospital confinement, in lieu of all other benefits, except Waiver of Premium	up to \$350/day
Daily Room, First 70 days of Hospital confinement	\$100
Inpatient Drugs and Diagnostic Testing	up to \$10/day
Attending Doctor	up to \$10/day
Nurse	up to \$50/day
Ambulance, limited to 4 trips per Calendar Year	up to \$75/per trip
Surgical Procedure (see Policy Surgical Schedule)	\$2,500
Anesthesia	up to \$625
Blood and Plasma	\$20/unit
Skilled Nursing Facility	up to \$50/day
Home Care and Recovery	Not Applicable
Non-Local Patient Transportation – Air	up to \$500/trip one-way
Non-Local Patient Transportation – one way trip	\$.15/mile
Family Member Transportation – Air	up to \$500/trip one-way
Family Member Transportation – one way trip	\$.15/mile
Family Member Lodging	up to \$20/day
Second and Third Surgical Opinion	Not Applicable
Hospice	
Days 1-60	\$50/day
Days 61+	\$25/day
Radiation (combined benefit with Injected Chemotherapy Treatment):	up to a combined total of \$100/ <b><u>day</u></b>
Chemotherapy Treatment:	
Injected Chemotherapy Treatment (combined benefit with Radiation):	up to a combined total of \$100/ <b><u>day</u></b>
Oral Chemotherapy Treatment (combined benefit with Topical Chemotherapy Treatment):	up to \$100/ <b><u>month</u></b> ; but no more than 36 <b><u>months</u></b>
Breast Reconstruction	up to the mastectomy amount
Comfort (outpatient drugs)	Not Applicable
Prosthesis	up to \$250/device
Bone Marrow Transplant	Not Applicable
Waiver of Premium	Yes

**NOTE:** For Cancer in situ, we will pay 50% of the benefit amounts shown above.

## **CANCER POLICY SCHEDULE – PLAN B**

This is a summary of Benefits. Please read Your entire Policy for further explanations and limitations.

Hospital Confinement, beginning with day 1 to day 90	\$180/day
Hospital Confinement Inflation Fighter	\$10/day
Extended Hospital Confinement, beginning with day 90 of consecutive Hospital confinement, in lieu of all other benefits, except Waiver of Premium	up to \$600/day
Daily Room, First 70 days of Hospital confinement	\$150/day
Inpatient Drugs and Diagnostic Testing	up to \$25/day
Attending Doctor	up to \$30/day
Nurse	up to \$125/day
Ambulance, limited to 4 trips per Calendar Year	up to \$150/per trip
Surgical Procedure (see Policy Surgical Schedule)	\$4,500
Anesthesia	up to \$1,125
Blood and Plasma	\$40/unit
Skilled Nursing Facility	up to \$100/day
Home Care and Recovery	up to \$15/day
Non-Local Patient Transportation – Air	up to \$1,000/trip one-way
Non-Local Patient Transportation – one way trip	\$.25/mile
Family Member Transportation – Air	up to \$1,000/trip one-way
Family Member Transportation – one way trip	\$.25/mile
Family Member Lodging	up to \$40/day
Second and Third Surgical Opinion	up to \$150/opinion
Hospice	
Days 1-60	\$80/day
Days 61+	\$40/day
Radiation (combined benefit with Injected Chemotherapy Treatment):	up to a combined total of \$175/ <b><u>day</u></b>
Chemotherapy Treatment:	
Injected Chemotherapy Treatment (combined benefit with Radiation):	up to a combined total of \$175/ <b><u>day</u></b>
Plus, at the time of the 1 <sup>st</sup> radiation and/or Injected Chemotherapy Treatment, an additional amount of:	\$100
Oral Chemotherapy Treatment (combined benefit with Topical Chemotherapy Treatment):	up to \$200/ <b><u>month;</u></b> but no more than 36 <b><u>months</u></b>
Breast Reconstruction	up to the mastectomy amount
Comfort (outpatient drugs)	Not Applicable
Prosthesis	up to \$1,000/device
Bone Marrow Transplant	up to \$2,500
Waiver of Premium	Yes

**NOTE:** For Cancer in situ, we will pay 50% of the benefit amounts shown above.

## **Cancer Policy SCHEDULE – PLAN C**

**This is a summary of Benefits. Please read Your entire Policy for further explanations and limitations.**

Hospital Confinement, beginning with day 1 to day 90	\$250/day
Hospital Confinement Inflation Fighter	\$15/day
Extended Hospital Confinement, beginning with day 90 of consecutive Hospital confinement, in lieu of all other benefits, except Waiver of Premium	up to \$600/day
Daily Room, First 70 days of Hospital confinement	\$200
Inpatient Drugs and Diagnostic Testing	up to \$40/day
Attending Doctor	up to \$35/day
Nurse	up to \$125/day
Ambulance, limited to 4 trips per Calendar Year	up to \$225/per trip
Surgical Procedure (see Policy Surgical Schedule)	\$7,500
Anesthesia	up to \$1,875
Blood and Plasma	\$60/unit
Skilled Nursing Facility	up to \$125/day
Home Care and Recovery	up to \$15/day
Non-Local Patient Transportation – Air	up to \$1,500/trip one-way
Non-Local Patient Transportation – one way trip	\$.40/mile
Family Member Transportation – Air	up to \$1,500/trip one-way
Family Member Transportation – one way trip	\$.40/mile
Family Member Lodging	up to \$50/day
Second and Third Surgical Opinion	up to \$225/opinion
Hospice	
Days 1-60	\$100/day
Days 61+	\$50/day
Radiation (combined benefit with Injected Chemotherapy Treatment):	up to a combined total of \$250/ <b><u>day</u></b>
Chemotherapy Treatment:	
Injected Chemotherapy Treatment (combined benefit with Radiation):	up to a combined total of \$250/ <b><u>day</u></b>
Plus, at the time of the 1 <sup>st</sup> radiation and/or Injected Chemotherapy Treatment, an additional amount of:	\$250
Oral Chemotherapy Treatment (combined benefit with Topical Chemotherapy Treatment):	up to \$300/ <b><u>month</u></b> ; but no more than 36 <b><u>months</u></b>
Breast Reconstruction	up to the mastectomy amount
Comfort (outpatient drugs)	up to \$200/year
Prosthesis	up to \$2,000/device
Bone Marrow Transplant	up to \$5,000
Waiver of Premium	Yes

**NOTE:** For Cancer in situ, we will pay 50% of the benefit amounts shown above.

## **Cancer Policy SCHEDULE – PLAN D**

**This is a summary of Benefits. Please read Your entire Policy for further explanations and limitations.**

Hospital Confinement, beginning with day 1 to day 90	\$410/day
Hospital Confinement Inflation Fighter	\$20/day
Extended Hospital Confinement, beginning with day 90 of consecutive Hospital confinement, in lieu of all other benefits, except Waiver of Premium	up to \$600/day
Daily Room, First 70 days of Hospital confinement	\$300
Inpatient Drugs and Diagnostic Testing	up to \$50/day
Attending Doctor	up to \$40/day
Nurse	up to \$125/day
Ambulance, limited to 4 trips per Calendar Year	up to \$300/per trip
Surgical Procedure (see Policy Surgical Schedule)	\$9,000
Anesthesia	up to \$2,250
Blood and Plasma	\$80/unit
Skilled Nursing Facility	up to 150/day
Home Care and Recovery	up to \$25/day
Non-Local Patient Transportation – Air	up to \$2,500/trip one-way
Non-Local Patient Transportation – one way trip	\$.40/mile
Family Member Transportation – Air	up to \$2,500/trip one-way
Family Member Transportation – one way trip	\$.40/mile
Family Member Lodging	up to \$60/day
Second and Third Surgical Opinion	up to \$225/opinion
Hospice	
Days 1-60	\$120/day
Days 61+	\$60/day
Radiation (combined benefit with Injected Chemotherapy Treatment):	up to a combined total of \$300/ <b><u>day</u></b>
Chemotherapy Treatment:	
Injected Chemotherapy Treatment (combined benefit with Radiation):	up to a combined total of \$300/ <b><u>day</u></b>
Plus, at the time of the 1 <sup>st</sup> radiation and/or Injected Chemotherapy Treatment, an additional amount of:	\$500
Oral Chemotherapy Treatment (combined benefit with Topical Chemotherapy Treatment):	up to \$400/ <b><u>month</u></b> ; but no more than 36 <b><u>months</u></b>
Breast Reconstruction	up to the mastectomy amount
Comfort (outpatient drugs)	up to \$226/year
Prosthesis	up to \$2,500/device
Bone Marrow Transplant	up to \$10,000
Waiver of Premium	Yes

**NOTE:** For Cancer in situ, we will pay 50% of the benefit amounts shown above.

## Section A: Applicant Information

[  Applying For: (please check one)       New Coverage     Reinstatement     Increase in Benefits

**Primary Applicant**

1. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Age \_\_\_\_\_    Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Spouse**

2. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Age \_\_\_\_\_    Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Dependents**

3. Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

4. Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

5. Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

6. Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

(For additional dependents, please attach a separate piece of paper, signed by the applicant, including the above information for each dependent.)

7. Street Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_ Zip Code \_\_\_\_\_

8. Telephone (Day) \_\_\_\_\_ Applicant's E-mail Address \_\_\_\_\_

## Section B: Coverage Selection and Premiums

Hospital Confinement Indemnity (U9910)

Hospital Confinement & Home Care Indemnity (U0950)  
**Secure Advantage**

First Diagnosis Cancer (U0430)  
**Cancer Plus**

**Coverage: (check applicable)**

Primary Applicant

Spouse

Dependent Children

**Plan: (check one)**

Plan A \$37.50/Day

Plan B \$100/Day

Plan C \$150/Day

Plan D \$225/Day

Plan E \$300/day

Plan F \$400/Day

**Coverage: (check applicable)**

Primary Applicant

Spouse

**Plan: (check one)**

Plan A

Plan B

Plan C

Plan D

**Rider**

Dependent Children – Plan A Only

**Coverage: (check applicable)**

Primary Applicant

Family

**Scheduled Base Plan (check one)**

Plan A

Plan B

Plan C

Plan D

**Riders**

Heart Attack and Stroke

Return of Premium

Lump Sum

\$ \_\_\_\_\_  
\$1,000 - \$10,000

Modal Premium: \$ \_\_\_\_\_

+Policy Fee: \$ \_\_\_\_\_

= Premium Due: \$ \_\_\_\_\_

Modal Premium: \$ \_\_\_\_\_

+Policy Fee: \$ \_\_\_\_\_

= Premium Due: \$ \_\_\_\_\_

Modal Premium: \$ \_\_\_\_\_

+Policy Fee: \$ \_\_\_\_\_

= Premium Due: \$ \_\_\_\_\_

Premium Payment Modes:  Monthly Bank Draft (0.84)     Quarterly (.265)     Semi-Annual (.52)     Annual  
 (If applying for more than one product, only one Policy Fee is required)

**Total Premium Collected: \$ \_\_\_\_\_ ]**

## Section C: Medical/Underwriting Questions

### Replacement question must be answered for ALL plans.

- 1a. Will the coverage(s) being applied for replace any existing hospital, medical, major medical, or hospital confinement indemnity insurance in this or any other company? .....  Yes  No  
If yes, name of person this applies to \_\_\_\_\_ Company \_\_\_\_\_  
If yes, submit appropriate replacement form – (if needed in your state).

### Hospital Confinement Indemnity (U9910)

#### Answer the following question if applying for the Hospital Confinement Indemnity (U9910)

- 1b. Does any person to be insured have any inforce or applied for hospital confinement indemnity insurance in this or any other company? .....  Yes  No  
If yes, name of person this applies to \_\_\_\_\_ Amount of Coverage \_\_\_\_\_

### Secure Advantage - Hospital Confinement & Home Care Indemnity (U0950)

#### Answer the following questions if applying for the Secure Advantage Plan (U0950)

If the answer to any of the following questions is "Yes", that person does not qualify for this plan.

- 1c. Is any person to be insured currently in a hospital, nursing home or receiving home health care, or is disabled, receiving disability or is applying for disability benefits or will do so in the next 60 days? .....  Yes  No
- 2c. In the past 24 months, has any person to be insured been diagnosed by a member of the medical profession as having a heart attack or stroke or had heart surgery/ bypass or angioplasty? .....  Yes  No
- 3c. In the past 24 months has any person to be insured been diagnosed or received treatment by a member of the medical profession for chronic obstructive lung disease, insulin dependent diabetes, drug or alcohol use, cancer (not skin cancer), congestive heart failure or chronic liver or kidney disease? .....  Yes  No
- 4c. In the past 12 months, has any person to be insured been advised by a member of the medical profession to have surgery but has not yet done so? .....  Yes  No
- 5c. Has any person to be insured been treated or been diagnosed by a member of the medical profession for Acquired Immune Deficiency (AIDS), AIDS Related Complex (ARC), or HIV infection?.....  Yes  No

If yes, name of person this applies to \_\_\_\_\_

Primary Applicant's Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_

### Cancer Plus - First Diagnosis Cancer (U0430)

#### Answer the following questions if applying for the Cancer Plus (U0430):

- 1d. In the past 10 years, has any person to be insured had, ever diagnosed as having, received medication for, or been treated by a medical practitioner for:
- a. Internal cancer, Leukemia, Hodgkin's disease, malignant melanoma, or sarcoma? .....  Yes  No
- b. Heart attack, heart bypass, angioplasty or stent placement, angina, stroke or Transient Ischemic Attack (TIA)? .....  Yes  No
- 2d. In the past 10 years has any person applying for coverage been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency (AIDS), AIDs Related Complex (ARC) or HIV infection? .....  Yes  No
- 3d. In the past 24 months, has any person to be insured been advised to seek treatment or medical advice from a medical practitioner but has not done so or experienced any symptoms that would have caused a person to seek medical advice from a medical practitioner for any of the conditions listed in Questions 1d or 2d?.....  Yes  No

If yes, name of person this applies to \_\_\_\_\_

## Section D: Authorization / Agreement

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that insurance applied for will not become effective until: a) approved and issued by UNL; b) I (We) have been furnished written notice of the effective date; and c) I (We) have paid the premium in full. I (We) understand that any changes in my (our) health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of UNL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by UNL. If this application is completed electronically, I (We) understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

**AUTHORIZATION:** I (We) authorize United National Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company, or its reinsurers, may also obtain such information from MIB. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (We) or my (our) authorized representative may have a photocopy of it.

I (We) have received an Outline of Coverage. If this application is completed electronically, I (we) understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy.

I (We) understand that I (We) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as UNL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting Manager.

I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by UNL in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (We) choose not to sign this Authorization.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Signed at

\_\_\_\_\_

Date

\_\_\_\_\_

City and State

\_\_\_\_\_

Signature of Applicant

\_\_\_\_\_

Spouse/Domestic Partner Signature (if applicable)

## AGENT'S STATEMENT

I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until the applicant is notified in writing by United National Life Insurance Company of America. I certify that I asked all the questions and truthfully and accurately recorded the answers contained herein (except if application is completed electronically or over the phone). To the best of my knowledge and belief, the insurance applied for:  is or is likely or  is not or is not likely to replace or change any existing policy(ies) or contract(s).

\_\_\_\_\_  
Agent's Name (Printed)

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's E-mail Address

**Mail Policy to**     **Agent**     **Insured**

**State:** Arkansas **Filing Company:** United National Life Insurance Company of America  
**TOI/Sub-TOI:** H071 Individual Health - Specified Disease - Limited Benefit/H071.002A Dread Disease - Cancer Only  
**Product Name:** UNL Chemotherapy Benefits  
**Project Name/Number:** UNL Chemotherapy Benefits/

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/17/2012
Comments:			
Attachment(s):			
Readability Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	05/17/2012
Comments:	We also included this Application in the "Form Schedule" tab.		
Attachment(s):			
UNL Combo App UAPPH1-10A.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	05/17/2012
Bypass Reason:	There is no rate impact due to this filing..		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	05/17/2012
Comments:	We also included the Outline of Coverage in the "Form Schedule" tab.		
Attachment(s):			
UNL Outline of Coverage OCU0430-1-AR.pdf			

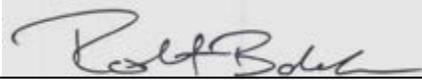
## CERTIFICATE OF READABILITY

Form Number(s): URA12-3, OCU0430-1-AR, and UAPPH1-10A

Flesch Test Score(s): 55.94; 51.37 and 53.13 respectively

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

UNITED NATIONAL LIFE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read "Robert B. Bole", is written over a light gray rectangular background. The signature is cursive and fluid.

General Counsel

Date: May 16, 2012

## Section A: Applicant Information

[  Applying For: *(please check one)*       New Coverage     Reinstatement     Increase in Benefits

**Primary Applicant**

1. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Age \_\_\_\_\_    Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Spouse**

2. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Age \_\_\_\_\_    Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Dependents**

3. Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

4. Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

5. Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

6. Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Sec # \_\_\_\_-\_\_\_\_-\_\_\_\_

*(For additional dependents, please attach a separate piece of paper, signed by the applicant, including the above information for each dependent.)*

7. Street Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_ Zip Code \_\_\_\_\_

8. Telephone (Day) \_\_\_\_\_ Applicant's E-mail Address \_\_\_\_\_

## Section B: Coverage Selection and Premiums

Hospital Confinement Indemnity (U9910)

Hospital Confinement & Home Care Indemnity (U0950)  
**Secure Advantage**

First Diagnosis Cancer (U0430)  
**Cancer Plus**

**Coverage: (check applicable)**

Primary Applicant

Spouse

Dependent Children

**Plan: (check one)**

Plan A \$37.50/Day

Plan B \$100/Day

Plan C \$150/Day

Plan D \$225/Day

Plan E \$300/day

Plan F \$400/Day

**Coverage: (check applicable)**

Primary Applicant

Spouse

**Plan: (check one)**

Plan A

Plan B

Plan C

Plan D

**Rider**

Dependent Children – Plan A Only

**Coverage: (check applicable)**

Primary Applicant

Family

**Scheduled Base Plan (check one)**

Plan A

Plan B

Plan C

Plan D

**Riders**

Heart Attack and Stroke

Return of Premium

Lump Sum

\$ \_\_\_\_\_  
\$1,000 - \$10,000

Modal Premium: \$ \_\_\_\_\_

+Policy Fee: \$ \_\_\_\_\_

= Premium Due: \$ \_\_\_\_\_

Modal Premium: \$ \_\_\_\_\_

+Policy Fee: \$ \_\_\_\_\_

= Premium Due: \$ \_\_\_\_\_

Modal Premium: \$ \_\_\_\_\_

+Policy Fee: \$ \_\_\_\_\_

= Premium Due: \$ \_\_\_\_\_

Premium Payment Modes:  Monthly Bank Draft (0.84)     Quarterly (.265)     Semi-Annual (.52)     Annual  
 (If applying for more than one product, only one Policy Fee is required)

**Total Premium Collected: \$ \_\_\_\_\_ ]**

## Section C: Medical/Underwriting Questions

### Replacement question must be answered for ALL plans.

- 1a. Will the coverage(s) being applied for replace any existing hospital, medical, major medical, or hospital confinement indemnity insurance in this or any other company? .....  Yes  No  
If yes, name of person this applies to \_\_\_\_\_ Company \_\_\_\_\_  
If yes, submit appropriate replacement form – (if needed in your state).

### Hospital Confinement Indemnity (U9910)

#### Answer the following question if applying for the Hospital Confinement Indemnity (U9910)

- 1b. Does any person to be insured have any inforce or applied for hospital confinement indemnity insurance in this or any other company? .....  Yes  No  
If yes, name of person this applies to \_\_\_\_\_ Amount of Coverage \_\_\_\_\_

### Secure Advantage - Hospital Confinement & Home Care Indemnity (U0950)

#### Answer the following questions if applying for the Secure Advantage Plan (U0950)

If the answer to any of the following questions is "Yes", that person does not qualify for this plan.

- 1c. Is any person to be insured currently in a hospital, nursing home or receiving home health care, or is disabled, receiving disability or is applying for disability benefits or will do so in the next 60 days? .....  Yes  No
- 2c. In the past 24 months, has any person to be insured been diagnosed by a member of the medical profession as having a heart attack or stroke or had heart surgery/ bypass or angioplasty? .....  Yes  No
- 3c. In the past 24 months has any person to be insured been diagnosed or received treatment by a member of the medical profession for chronic obstructive lung disease, insulin dependent diabetes, drug or alcohol use, cancer (not skin cancer), congestive heart failure or chronic liver or kidney disease? .....  Yes  No
- 4c. In the past 12 months, has any person to be insured been advised by a member of the medical profession to have surgery but has not yet done so? .....  Yes  No
- 5c. Has any person to be insured been treated or been diagnosed by a member of the medical profession for Acquired Immune Deficiency (AIDS), AIDS Related Complex (ARC), or HIV infection?.....  Yes  No

If yes, name of person this applies to \_\_\_\_\_

Primary Applicant's Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_

### Cancer Plus - First Diagnosis Cancer (U0430)

#### Answer the following questions if applying for the Cancer Plus (U0430):

- 1d. In the past 10 years, has any person to be insured had, ever diagnosed as having, received medication for, or been treated by a medical practitioner for:
- a. Internal cancer, Leukemia, Hodgkin's disease, malignant melanoma, or sarcoma? .....  Yes  No
  - b. Heart attack, heart bypass, angioplasty or stent placement, angina, stroke or Transient Ischemic Attack (TIA)? .....  Yes  No
- 2d. In the past 10 years has any person applying for coverage been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency (AIDS), AIDs Related Complex (ARC) or HIV infection? .....  Yes  No
- 3d. In the past 24 months, has any person to be insured been advised to seek treatment or medical advice from a medical practitioner but has not done so or experienced any symptoms that would have caused a person to seek medical advice from a medical practitioner for any of the conditions listed in Questions 1d or 2d?.....  Yes  No

If yes, name of person this applies to \_\_\_\_\_

## Section D: Authorization / Agreement

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that insurance applied for will not become effective until: a) approved and issued by UNL; b) I (We) have been furnished written notice of the effective date; and c) I (We) have paid the premium in full. I (We) understand that any changes in my (our) health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of UNL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by UNL. If this application is completed electronically, I (We) understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

**AUTHORIZATION:** I (We) authorize United National Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company, or its reinsurers, may also obtain such information from MIB. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (We) or my (our) authorized representative may have a photocopy of it.

I (We) have received an Outline of Coverage. If this application is completed electronically, I (we) understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy.

I (We) understand that I (We) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as UNL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting Manager.

I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by UNL in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (We) choose not to sign this Authorization.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Signed at

\_\_\_\_\_

Date

\_\_\_\_\_

City and State

\_\_\_\_\_

Signature of Applicant

\_\_\_\_\_

Spouse/Domestic Partner Signature (if applicable)

## AGENT'S STATEMENT

I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until the applicant is notified in writing by United National Life Insurance Company of America. I certify that I asked all the questions and truthfully and accurately recorded the answers contained herein (except if application is completed electronically or over the phone). To the best of my knowledge and belief, the insurance applied for:  is or is likely or  is not or is not likely to replace or change any existing policy(ies) or contract(s).

\_\_\_\_\_  
Agent's Name (Printed)

\_\_\_\_\_  
Agent Code

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's E-mail Address

**Mail Policy to**     **Agent**     **Insured**

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**  
P.O. Box 1154, Glenview, Illinois 60025-1154 (847) 803-5252

**SPECIFIED DISEASE POLICY**

**OUTLINE OF COVERAGE**  
**FIRST DIAGNOSIS CANCER BENEFIT POLICY**

Policy Form U0430-AR  
With Optional Rider Forms RU04HAS, RU04LS and RU04ROP

**KEEP THIS OUTLINE FOR YOUR RECORDS**

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY**

**THIS IS A LIMITED BENEFIT POLICY – READ YOUR POLICY CAREFULLY** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provision will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

**SPECIFIED DISEASE COVERAGE** – Policies of this category are designed to provide to persons insured restricted coverage paying benefits **ONLY** when certain losses occur as a result of specified disease. Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

**FIRST DIAGNOSIS CANCER BENEFITS** – We will pay expenses incurred for treatment of cancer following a first diagnosis of cancer, subject to the waiting period.

**CANCER IN SITU BENEFIT** – We will pay 50% of the benefit amounts for Cancer in situ. The Cancer in situ benefit does not apply to the optional Express Pay Rider, if such optional coverage is selected.

<b>Part One Benefits</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>
<b>Hospital Confinement</b> - For each day of hospital confinement, beginning with day 1 to day 90 .....	\$100	\$180	\$250	\$410
<b>Hospital Confinement Inflation Fighter</b> – Increases the hospital confinement benefit each year for the first five years the policy is in force by .....	N/A	\$10/day	\$15/day	\$20/day
<b>Extended Hospital Confinement</b> - Beginning with day 90 of consecutive hospital confinement, up to ..... During receipt of this benefit, no other benefits are payable under the policy except waiver of premium.	\$350/day	\$600/day	\$600/day	\$600/day
<b>Daily Room</b> - During the first 70 days of hospital confinement .. This benefit is paid in addition to the hospital confinement benefit.	\$100/day	\$150/day	\$200/day	\$300/day
<b>Inpatient Drugs and Diagnostic Testing</b> - For medications received or diagnostic testing, up to.....	\$10/day	\$25/day	\$40/day	\$50/day
<b>Attending Doctor</b> – For services while hospital confined, up to .....	\$10/day	\$30/day	\$35/day	\$40/day
<b>Nurse</b> – For full-time services of a nurse while hospital confined, other than those nursing services regularly furnished by a hospital, up to .....	\$50/day	\$125/day	\$125/day	\$125/day
<b>Ambulance</b> - For transportation to or from a hospital where you are confined as an inpatient, up to ..... Benefit is limited to 4 trips per calendar year.	\$75/trip	\$150/trip	\$225/trip	\$300/trip
<b>Surgical Procedure</b> - For surgery performed by a doctor due to cancer, according to the policy surgical schedule, up to .....	\$2,500	\$4,500	\$7,500	\$9,000
<b>Anesthesia</b> – For anesthesia during a surgery for which a surgical procedure benefit is payable, 25% of the surgical procedure benefit, up to .....	\$625	\$1,125	\$1,875	\$2,250
<b>Blood and Plasma</b> - For blood and plasma, other than your own blood, received during definitive treatment of cancer, up to .....	\$20/unit	\$40/unit	\$60/unit	\$80/unit

<b>Skilled Nursing Facility</b> - For confinement in a skilled nursing facility which begins within 14 days of discharge from a hospital, up to.....	\$50/day	\$100/day	\$125/day	\$150/day
<b>Home Care Recovery</b> - For home care and recovery, equal to the number of days paid for the hospital confinement benefit, up to..	N/A	\$15/day	\$15/day	\$25/day
<b>Family Member Transportation</b> - Coach class plane, train or bus expense on a regularly scheduled route for a family member when you are confined in a hospital located in the U.S. which is more than 100 miles one-way from a family member's home, up to..... For travel by automobile..... Benefit is limited to two one-way trips within the U.S. per period of confinement.	\$500 \$.15/mile	\$1,000 \$.25/mile	\$1,500 \$.40/mile	\$2,500 \$.40/mile
<b>Non-Local Patient Transportation</b> - Coach class plane, train or bus expense on a regularly scheduled route within the U.S. to receive cancer treatment or consultation that is not available within 100 miles one-way from your home, up to..... For travel by automobile.....	\$500 \$.15/mile	\$1,000 \$.25/mile	\$1,500 \$.40/mile	\$2,500 \$.40/mile
<b>Family Member Lodging</b> - For lodging expense incurred by a family member while you are confined as an inpatient for treatment of cancer in a hospital that is located in the U.S. and is more than 100 miles one-way from the family member's home, up to.....	\$20/day	\$40/day	\$50/day	\$60/day
<b>Second and Third Surgical Opinions</b> - A 2 <sup>nd</sup> surgical opinion if recommended due to the positive diagnosis of Cancer and a 3 <sup>rd</sup> opinion if the 2 <sup>nd</sup> fails to confirm the need for surgery, up to.....	N/A	\$150/ opinion	\$225/ opinion	\$225/ opinion
<b>Part Two Benefits</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>
<b>Hospice</b> - Hospice services when you are diagnosed as terminally ill, starting day 1 to day 60..... Starting with day 61.....	\$50/day \$25/day	\$80/day \$40/day	\$100/day \$50/day	\$120/day \$60/day
<b>Radiation/Injected Chemotherapy Treatments</b> - For any combination of radiation and/or Injected Chemotherapy Treatments which are part of definitive treatment, the combined total, up to .  Plus, at the time of the 1 <sup>st</sup> radiation and/or Injected Chemotherapy Treatment, an additional amount of... ..	\$100/day  N/A	\$175/day  \$100	\$250/day  \$250	\$300/day  \$500
<b>Oral Chemotherapy Treatment</b> - For Oral Chemotherapy Treatments (benefits for Topical Chemotherapy Treatments are also included here in this section) which are part of definitive treatment, up to the monthly benefits shown here, but not more than a total of 36 months of benefits for the plan selected.....	\$100/month	\$200/month	\$300/month	\$400/month
<b>Breast Reconstruction</b> - For breast reconstruction as the direct result of surgery for which benefits are paid under the policy.....	Up to the surgical procedure benefit paid for the mastectomy			
<b>Comfort Benefit (Outpatient Drugs)</b> - For anti-nausea medication prescribed by a doctor charges, up to.....	N/A	N/A	\$200/yr	\$226/yr
<b>Prosthesis</b> - For prosthetic devices needed as the direct result of, and received within 3 years of, a cancer surgery for which benefits were paid under the policy, per prosthetic device, up to.....	\$250	\$1,000	\$2,000	\$2,500
<b>Bone Marrow Transplant</b> - For human bone marrow transplant for the definitive treatment of cancer, up to..... After coverage has been in force for one year, the initial bone marrow transplant benefit will increase by 5%. On each subsequent policy anniversary, the benefit will continue to increase by 5%. Such increases will continue to take place on each policy anniversary for a period not to exceed 10 years.	N/A	\$2,500	\$5,000	\$10,000
<b>Part Three Benefits</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>	<b>Plan D</b>
<b>Waiver of Premium</b> - Premium payments will not be required if you				

are diagnosed as having cancer after the waiting period and while covered under the policy and are disabled due to cancer for more than 90 consecutive days. The disability must begin on or after the date of diagnosis.	Included	Included	Included	Included
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**OPTIONAL HEART ATTACK OR STROKE BENEFIT RIDER** – We will pay Part One Benefits, as outlined above, for treatment of a heart attack or stroke, subject to the waiting period, if such optional coverage is selected at time of application. The benefit payable for a surgical procedure performed for heart attack or stroke is based on the heart attack or stroke rider surgical schedule. First Diagnosis Cancer Part Three Benefits, Waiver of Premium, will also include and apply to heart attack or stroke and is subject to the policy definition of disabled/disability.

**OPTIONAL EXPRESS PAY RIDER** – We will pay a lump sum benefit upon first diagnosis of cancer or when a heart attack or stroke is first diagnosed based on the amount selected at time of application if such optional coverage is selected, subject to the waiting period.

**OPTIONAL RETURN OF PREMIUM BENEFIT RIDER** – If your coverage under the policy ends, due to cancellation or death, we will return the actual amount of premium paid equal to:

1. The sum of all premiums paid for the policy, including premiums paid for the rider and any other benefits riders attached to this rider;
2. Minus the sum of all benefit paid or then payable under the policy, including benefits paid or then payable under any attached benefit riders while the rider was in force.

To determine the return of premium percentage, we'll consider: (1) when your coverage under the policy (with this rider) ends; (2) your issue age at the beginning of the return of premium period and the number of years the policy and other benefit riders have been in force (with the rider); and (3) the return of premium percentage. The applicable issue age and number of years the policy (with the rider) has been in force and the return of premium percentages are as follows:

<u>Issue Age</u>	<u>Return of Premium Percentage</u>
18 through 64	100% after 20 rider years, or the attainment of age 75, whichever is earlier.
65 and over	100% after 10 rider years and beyond

**EFFECT OF WAIVER OF PREMIUM ON RETURN OF PREMIUM**

Premiums waived under any Waiver of Premium Provision of the Policy will be treated both as premiums paid and claims incurred for purposes of calculating the Return of Premium benefit amount.

**WAITING PERIOD** – There is a 30 day waiting period before we will pay benefits for loss due to cancer or heart attack or stroke, if such optional coverage is purchased. If the first diagnosis of cancer is made during the waiting period, the insured has the option to cancel the policy and receive a refund of all premiums paid.

**EXCLUSIONS** – The policy does not pay benefits for:

1. Treatment, services or supplies which: are not medically necessary; are not prescribed by a doctor as necessary to treat cancer or attack or stroke; are received without charge or legal obligation to pay; would not routinely be paid in the absence of insurance; or are received from an immediate family member.
2. any loss due to injury, disease, sickness or incapacity, unless such definitive treatment is directly related to or attributable to Cancer as defined;
3. any loss due to injury, disease, sickness or incapacity, unless such treatment is directly related to or attributable to a heart attack or stroke as defined, if such optional coverage is selected.
4. care outside the United States;
5. experimental drugs or substances not approved by the Federal Food & Drug Administration for the treatment of Cancer; and
6. experimental procedures or treatment methods not endorsed by the American Medical Association or any other appropriate medical society.

**RENEWABILITY** – You may keep the policy and riders, if attached, in force during your entire lifetime by paying premiums when due or within the grace period. We can't cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

**PREMIUMS SUBJECT TO CHANGE** – We may change your premium rates by giving you at least 31 days prior written notice. We can change the premiums this way only if we change it on a class basis for all policies/riders of this class in your state.

**INITIAL PREMIUM**

<b>FIRST DIAGNOSIS CANCER BENEFIT PLAN</b> _____	\$ _____
<input type="checkbox"/> <b>HEART ATTACK OR STROKE BENEFIT RIDER</b>	\$ _____
<input type="checkbox"/> <b>EXPRESS PAY RIDER Benefit Amount \$</b> _____	\$ _____
<input type="checkbox"/> <b>RETURN OF PREMIUM RIDER</b>	\$ _____
<b>TOTAL PREMIUM</b>	\$ _____

Agent's Name: \_\_\_\_\_

Agent's Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_