

State: Arkansas **Filing Company:** Philadelphia American Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: H-0186
Project Name/Number: H-0186/H-0186

Filing at a Glance

Company: Philadelphia American Life Insurance Company
Product Name: H-0186
State: Arkansas
TOI: H071 Individual Health - Specified Disease - Limited Benefit
Sub-TOI: H071.001 Critical Illness
Filing Type: Form/Rate
Date Submitted: 08/27/2012
SERFF Tr Num: NELI-128652362
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: H-0186

Implementation: On Approval
Date Requested:
Author(s): John Mays
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 09/14/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: H-0186
Filing Company: Philadelphia American Life Insurance Company
Project Name/Number: H-0186/H-0186

General Information

Project Name: H-0186
 Project Number: H-0186
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Deemer Date:
 Submitted By: John Mays

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Individual Market Type:
 Filing Status Changed: 09/14/2012
 State Status Changed: 09/14/2012
 Created By: John Mays
 Corresponding Filing Tracking Number:

Filing Description:

NEW FORMS FILING – INDIVIDUAL CRITICAL ILLNESS POLICY
 PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY
 NAIC # 67784 / FEIN # 74-1952955

Form Number / Description

H-0186.AR / Critical Illness Policy
 H-0186.OC / Outline of Coverage
 H-0186.AP / Application
 H-0186.CB.AP / Combination Application

We are submitting the captioned forms for approval. These forms are new and not intended to replace any previously filed forms. They will be marketed by independent agents. We would like to use application form H-0186.CB.AP for marketing our Accident coverage as well, form H-0089 filed on 8/3/09 SERFF tracking number NELI-126253324.

Company and Contact

Filing Contact Information

John Mays, jmays@neweralife.com
 11720 Katy Fwy., Ste. 1700
 Houston, TX 77079
 281-368-7178 [Phone]

Filing Company Information

Philadelphia American Life Insurance Company
 200 Westlake Park #1200
 Houston, TX 77079
 (281) 368-7200 ext. [Phone]

CoCode: 67784
 Group Code: 520
 Group Name:
 FEIN Number: 74-1952955

State of Domicile: Texas
 Company Type:
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? Yes
 Fee Explanation:

State: Arkansas **Filing Company:** Philadelphia American Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: H-0186
Project Name/Number: H-0186/H-0186

Per Company: No

Company	Amount	Date Processed	Transaction #
Philadelphia American Life Insurance Company	\$250.00	08/27/2012	62050329

SERFF Tracking #:

NELI-128652362

State Tracking #:

Company Tracking #:

H-0186

State: Arkansas

Filing Company:

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: H-0186

Project Name/Number: H-0186/H-0186

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/14/2012	09/14/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/10/2012	09/10/2012

Response Letters

Responded By	Created On	Date Submitted
John Mays	09/14/2012	09/14/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application	John Mays	09/14/2012	09/14/2012
Form	Combination Application	John Mays	09/14/2012	09/14/2012
Form	Application	John Mays	09/14/2012	09/14/2012

SERFF Tracking #:

NELI-128652362

State Tracking #:

Company Tracking #:

H-0186

State: Arkansas

Filing Company:

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: H-0186

Project Name/Number: H-0186/H-0186

Disposition

Disposition Date: 09/14/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Philadelphia American Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

NELI-128652362

State Tracking #:

Company Tracking #:

H-0186

State: Arkansas **Filing Company:** Philadelphia American Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form (revised)	Policy	Approved-Closed	Yes
Form	Policy	Approved-Closed	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes
Form	Application	Replaced	Yes
Form (revised)	Combination Application	Approved-Closed	Yes
Form	Combination Application	Replaced	Yes
Form (revised)	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes
Rate	Rates	Approved-Closed	Yes

State: Arkansas **Filing Company:** Philadelphia American Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
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Project Name/Number: H-0186/H-0186

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/10/2012
Submitted Date 09/10/2012
Respond By Date

Dear John Mays,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Policy, H-0186.AR (Form)
- Outline of Coverage, H-0186.OC (Form)

Comments: The policy contains reduced benefits for the first 90 days. The 90 days is not in compliance with Rule and Regulation 18, APPENDIX 1.A.(5) which states that...."No policy issued pursuant to this Section shall contain a waiting or probationary period greater than thirty (30) days....".

Objection 2

- Policy, H-0186.AR (Form)

Comments:

With respect to your definition of CANCER (Internal Cancer) and Non-Invasive Carcinoma In-Situ, please review Rule and Regulation 18, APPENDIX 1.A.(2) which states that...."No policy issued pursuant to this Section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.

Conclusion:

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

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State: Arkansas **Filing Company:** Philadelphia American Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: H-0186
Project Name/Number: H-0186/H-0186

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/14/2012
Submitted Date	09/14/2012

Dear Rosalind Minor,

Introduction:

Thank you for the review of our filing.

Response 1

Comments:

Both the Outline of Coeverage and Policy have met this objection.

Related Objection 1

Applies To:

- Policy, H-0186.AR (Form)
- Outline of Coverage, H-0186.OC (Form)

Comments: The policy contains reduced benefits for the first 90 days. The 90 days is not in compliance with Rule and Regulation 18, APPENDIX 1.A.(5) which states that...."No policy issued pursuant to this Section shall contain a waiting or probationary period greater than thirty (30) days....".

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: H-0186

Project Name/Number: H-0186/H-0186

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments	Submitted
1	H-0186.AR	POL	Policy	Initial	41.300	H-0186.AR.pdf	Date Submitted: 09/14/2012 By: John Mays
<i>Previous Version</i>							
1	H-0186.AR	POL	Policy	Initial	41.300	H-0186.AR.pdf	Date Submitted: 09/14/2012 By: John Mays
2	H-0186.OC	OUT	Outline of Coverage	Initial	40.800	H-0186.OC.AR.pdf	Date Submitted: 09/14/2012 By: John Mays
<i>Previous Version</i>							
2	H-0186.OC	OUT	Outline of Coverage	Initial	40.800	H-0186.OC.pdf	Date Submitted: 09/14/2012 By: John Mays

No Rate/Rule Schedule items changed.

Response 2**Comments:**

Both the Outline of Coeverage and Policy have met this objection.

Related Objection 2

Applies To:

- Policy, H-0186.AR (Form)

State: Arkansas **Filing Company:** Philadelphia American Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: H-0186
Project Name/Number: H-0186/H-0186

Comments:

With respect to your definition of CANCER (Internal Cancer) and Non-Invasive Carcinoma In-Situ, please review Rule and Regulation 18, APPENDIX 1.A.(2) which states that..."No policy issued pursuant to this Section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes							
Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	H-0186.AR	POL	Policy	Initial	41.300	H-0186.AR.pdf	Date Submitted: 09/14/2012 By: John Mays
<i>Previous Version</i>							
1	H-0186.AR	POL	Policy	Initial	41.300	H-0186.AR.pdf	Date Submitted: 09/14/2012 By: John Mays
2	H-0186.OC	OUT	Outline of Covera ge	Initial	40.800	H-0186.OC.AR.pdf	Date Submitted: 09/14/2012 By: John Mays
<i>Previous Version</i>							
2	H-0186.OC	OUT	Outline of Covera ge	Initial	40.800	H-0186.OC.pdf	Date Submitted: 09/14/2012 By: John Mays

No Rate/Rule Schedule items changed.

Conclusion:

Thanks!

Sincerely,

John Mays

SERFF Tracking #:

NELI-128652362

State Tracking #:

Company Tracking #:

H-0186

State: Arkansas

Filing Company:

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: H-0186

Project Name/Number: H-0186/H-0186

Amendment Letter

Submitted Date: 09/14/2012

Comments:

"non-perscription" was removed from question 6 on both applications.

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
H-0186.AP	Application/Enrollment Form	Application	Initial				40.000	H-0186.AP.pdf
H-0186.CB.AP	Application/Enrollment Form	Combination Application	Initial				40.200	H-0186.CB.AP.pdf

Submitted Date: 09/14/2012

Comments:

Amendment for the correction of the numbering in the application.

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
H-0186.AP	Application/Enrollment Form	Application	Initial				40.000	H-0186.AP.pdf

State: Arkansas

Filing Company:

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: H-0186

Project Name/Number: H-0186/H-0186

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/14/2012	H-0186.AR	POL	Policy	Initial:	41.300	H-0186.AR.pdf
2	Approved-Closed 09/14/2012	H-0186.AP	AEF	Application	Initial:	40.000	H-0186.AP.pdf
3	Approved-Closed 09/14/2012	H-0186.CB.AP	AEF	Combination Application	Initial:	40.200	H-0186.CB.AP.pdf
4	Approved-Closed 09/14/2012	H-0186.OC	OUT	Outline of Coverage	Initial:	40.800	H-0186.OC.AR.pdf

Form Type Legend:

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

PREMIUM RATES MAY BE CHANGED ON A CLASS BASIS
GUARANTEED RENEWABLE TO AGE 75



P. O. Box 4884 • Houston, Texas 77210-4884 • 1-800-552-7879

CRITICAL ILLNESS POLICY

Philadelphia American Life Insurance Company will be referred to in this Policy as "Company", "We", "Us", and/or "Our". The individual(s) as shown in the Application are referred to in this Policy as "Insured", "You" and/or "Your".

This Policy is issued in consideration of the statements made in the Application and the payment of the premiums specified herein. We hereby insure the Applicant, first named on the Policy Schedule, and all dependent members of the Insured's family, if any, named in the Policy Schedule and Application (copy of which is attached to and made a part of this Policy), coverage for Covered Conditions, as defined herein, while this Policy is in force, subject to all provisions of this Policy.

The first premium is due on the Effective Date. Renewal premiums are due on the same date of each calendar month after the Effective Date.

THIS IS A LIMITED POLICY – PLEASE READ YOUR POLICY CAREFULLY

This Policy is a legal contract between You and Us.

SPECIAL NOTICE TO THE APPLICANT

This Policy is issued based on Your answers to questions in the Application for this Policy. If any information shown on it is not correct and complete, or if any past medical history has been left out, write to Us immediately. A copy of Your Application is enclosed. If to Your knowledge, there is any fraudulent misstatement in Your Application or if any relevant part of Your medical history has been omitted, Your Policy may not be a valid contract. The best time to determine this matter is now, before a claim arises. If for any reason any such situation exists, contact Us at Our Home Office shown above.

NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY

If this Policy for any reason is unsatisfactory, and within 10 days following receipt thereof it is returned to the Company's Home Office in Houston, Texas, the premium paid will be refunded. If returned, this Policy will be canceled and declared null and void from the Effective Date.

RENEWAL AND PREMIUM PAYMENT PROVISIONS

PREMIUM PAYING PERIOD: This Policy is guaranteed renewable to age 75 by the timely payment of premiums. It must be paid on or before its due date, or within the 31 days that follow. When an Insured's coverage terminates at age 75, coverage for other Insured persons, if any, shall continue under this Policy. The payment of a premium will not continue this Policy in force beyond the next premium due date. We cannot refuse to renew this Policy or place any restrictions on it if the premium is paid on time.

After the first 12 months, We reserve the right, subject to 60 days prior written notice to You at Your last known address, to establish a new schedule of premium rates; such schedule of rates will be effective on the following renewal date for all or any class of Insured's covered by this Policy. Premiums are scheduled to change annually based upon each Insured's attained age. Attained age means the age of the Insured on the Policy Effective Date of coverage and any subsequent Policy anniversary.

IN WITNESS THEREOF, We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 A.M. at Your residence on its Effective Date. This Policy terminates at 12:01 A.M. on the date any renewal premium is due and not paid, subject to the Grace Period.

SECRETARY

PRESIDENT

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any Company, makes any claim for the proceeds of an insurance Policy containing any false, incomplete or misleading information may be guilty of a crime as determined by a court of law.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

MAXIMUM CRITICAL ILLNESS BENEFITS REDUCE 50% AT AGE 65.

WAITING PERIOD: The benefits of this Policy are payable for loss that begins more than 30 days after the Effective Date of coverage.

POLICY SCHEDULE

INSURED: [DOE, JOHN]
 POLICY NUMBER: [12345678]
 EFFECTIVE DATE: [07/01/12]

ISSUE AGE: [49]
 MODE OF PAYMENT: [MONTHLY; QUARTERLY; SEMI ANNUAL; ANNUAL]
 FIRST RENEWAL DATE: [08/01/12]
 INITIAL PREMIUM: [40.00]

INSURED PERSON(S)	MAXIMUM CRITICAL ILLNESS BENEFIT (for each Benefit Section)
[JOHN DOE], Insured	[\$1,000-\$50,000]
[], Spouse	[\$1,000-\$50,000]
[], Dependent Child	[\$1,000-\$10,000]

Coverage for an Insured person terminates when that Insured person's Maximum Critical Illness Benefit has been paid under Benefit Sections I and II.

COVERED CONDITIONS	Percentage Benefit Payable
Benefit Section I	
Cancer (Internal Cancer)*	100%
Non-Invasive Carcinoma In-Situ (if metastasized, balance will be paid)	25%
Benefit Section II	
Heart Attack	100%
Stroke	100%
Coronary Artery Bypass Surgery**	25%
Angioplasty	10%
Pacemaker Implant (single chambered / double chambered)	30% / 40%
End Stage Renal Failure	100%
Organ Transplant (heart, lung, liver, pancreas)	100%
Organ Transplant (kidney)	50%

* Excludes pre-malignant conditions or conditions with malignant potential; cervical intraepithelial neoplasia (CIN) stages I and II; Carcinoma in Situ; and Skin Cancer.

** Payable for one Coronary Artery Bypass Surgery only.

Maximum Critical Illness Benefits reduce 50% at age 65.

Waiting Period: The benefits of this Policy are payable for loss that begins more than 30 days after the Effective Date of coverage for each Insured person. If the Diagnosis is made within the first 30 days, benefits will not be payable at any time for that condition.

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DEFINITIONS

CHILD OR CHILDREN: Unless excluded from coverage, means Your unmarried Children, stepchildren, foster and adopted Children who are dependent on You. They must also be:

- (1) under age 19; or
- (2) under age 25 and enrolled as a full-time student in an accredited school or college.

Children also include any Children for whom You must provide medical support under a court order. A Child is considered Your Child if You are a party in a suit in which adoption of the Child by You is sought and such Child is ultimately adopted by You. Also included as Children are grandchildren whom You claim as dependents for federal income tax purposes.

COVERED CONDITION(S): One of the medical conditions, diseases or procedures listed in paragraphs A. through J. below.

A. Cancer (Internal Cancer)

A disease that is identified by the uncontrolled and abnormal growth of malignant cells. This includes Hodgkin's Disease, leukemia, lymphoma, carcinoma, sarcoma, malignant melanoma that is Diagnosed as Clark's Level III or above or Breslow greater than .75mm and malignant tumors. Diagnosis must be made by a Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system unless medically inappropriate. A clinical diagnosis will be accepted in lieu thereof.

For purposes of this Policy, the following are not considered Cancer (Internal Cancer): pre-malignant conditions or conditions with malignant potential, cervical intraepithelial neoplasia (CIN) stages I and II, Carcinoma in Situ, Non-Invasive Carcinoma In-Situ, Leukoplakia, hyperplasia, polycythemia, moles, lesions, Skin Cancer.

B. Non-Invasive Carcinoma In-Situ

A localized malignant tumor, which contains one or several cells that have the potential to invade or metastasize but have not yet done so. This excludes Skin Cancer. Diagnosis must be made by a licensed Pathologist unless medically inappropriate. A clinical diagnosis will be accepted in lieu thereof.

C. Heart Attack

The death (infarction) of a portion of the heart muscle as a result of inadequate blood supply. Diagnosis of a Heart Attack must be made by a Legally Qualified Physician who is a board certified Cardiologist. Diagnosis of a Heart Attack must be based on all of the following criteria:

- (1) associated new EKG changes consistent with Injury;
- (2) elevation of cardiac enzymes above generally accepted laboratory levels of normal (a diagnostic elevation of Troponin I or in the case of CPK, a CPK-MB measurement must be used); and
- (3) confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

The following are not considered a Heart Attack: an EKG change consistent with transient ischemic change, angina, or chance finding of EKG changes suggestive of a previous Heart Attack, or death of the heart muscle coincident with death of an Insured from other causes.

In the event of death, an autopsy confirmation and death certificate identifying Heart Attack as the cause of death will be accepted.

D. Stroke

A cerebrovascular event resulting in permanent neurological damage, including infarction of, hemorrhage of, or embolization to brain tissue from an extracranial source. Diagnosis of Stroke must be made by a Legally Qualified Physician who is a board certified Neurologist. Diagnosis of a Stroke must be based on the following criteria:

- (1) documented neurological impairment or deficits; and
- (2) confirming neuroimaging studies.

Stroke does not mean a cerebrovascular event resulting from a head Injury, transient ischemic attack, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.

E. Coronary Artery Bypass Surgery (surgical treatment)

The first ever heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a Legally Qualified Physician who is a board certified Cardiothoracic Surgeon. Payable for one Coronary Artery Bypass Surgery per Insured person.

F. Angioplasty

The undergoing of angioplasty, atherectomy or laser treatment for coronary artery disease, which cannot be adequately controlled by medical therapy, following a recommendation by a cardiologist. Angiographic evidence of the underlying disease must be provided.

G. Pacemaker Implant

The procedure to insert an artificial pacemaker. A pacemaker is a device that sends small electrical impulses to the heart muscle to maintain a suitable heart rate or to stimulate the lower chambers of the heart (ventricles). A pacemaker may also be used to treat fainting spells (syncope), congestive heart failure and hypertrophic cardiomyopathy.

H. End Stage Renal Failure

Diagnosis by a Legally Qualified Physician who is a board certified Nephrologist, of End Stage Renal disease which:

- (1) results in chronic irreversible failure of both kidneys to function; and
- (2) requires an Insured person to undergo regular renal dialysis at least weekly.

I. Organ Transplant (heart, lung, liver, pancreas)

The actual undergoing, as a recipient, of a transplant due to failure of one of the following organs: heart, lung, liver or pancreas.

J. Organ Transplant (kidney)

The actual undergoing, as a recipient, of a transplant due to failure of the kidney.

DIAGNOSIS or DIAGNOSED: Diagnosis or Diagnosed means a written diagnosis by a Legally Qualified Physician of the Insured person's Covered Condition. We reserve the right to request that any Covered Condition Diagnosis be reviewed by a physician of Our choice. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, We shall have the right to request either an examination of the Insured person or that the evidence used in making the Diagnosis in dispute be reviewed by an independent acknowledged expert selected by Us in the applicable field of medicine. The opinion of such expert as to such Diagnosis shall be binding on both the Insured person and Us.

EFFECTIVE DATE: Effective date is the Policy Effective Date shown on the Policy Schedule page. If a Dependent is added to the Policy after the original Policy Effective Date, that Dependents Effective Date will be shown on an endorsement.

INJURY or INJURIES: Injury or Injuries means accidental bodily injuries sustained by an Insured person which are the direct cause of the loss independent of disease, bodily infirmity, or any other cause and occurs while the policy is in force. (See Pre-Existing Sickness or Injury Provision)

INSURED: "Insured" means the Insured's named on the Policy Schedule. "Insured" also means the following provided they are named on the Policy Schedule or added later as provided in the section "Additional Dependents": (1) the Insured; (2) the Insured's spouse; (3) the Insured's unmarried dependent Children who are under age 19 or under age 25 and enrolled as a full-time student in an accredited school or college; (4) a grandchild who is Your dependent for federal income tax purposes; and (5) a Child for whom You must provide medical support under a court order enforceable in this state. Coverage shall be provided for an adopted or foster Child of the Insured to the same extent as the coverage provided by this Policy for the Insured's dependent Children.

A Child born to the Insured while this Policy is in force will be covered from the moment of birth, subject to written notice and payment of the applicable premium which must be received by Us within 31 days after such Child's birth.

LEGALLY QUALIFIED PHYSICIAN: A practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or Injuries. Such person must not be the Insured, Insured's spouse or Insured's Child(ren) or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist as required by this Policy. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Legally Qualified Physicians.

SICKNESS: Sickness means illness or disease of an Insured person which first manifested itself after the Effective Date of coverage and while this Policy is in force. (See Pre-Existing Sickness or Injury Provision)

SKIN CANCER: Any of the following:

- (1) basal cell carcinoma, basal cell epithelioma or squamous cell carcinoma of the skin; or
- (2) Kaposi's Sarcoma; or
- (3) melanoma that is Diagnosed as Clark's Level I or II or Breslow less than .75mm.

BENEFITS

While this Policy is in force, We will pay the amount shown in the Policy Schedule, less any partial payment(s) previously paid per Benefit Section, provided for a Covered Condition subject to Covered Condition definitions, Exclusions and Limitations and other terms and conditions of this Policy.

REDUCTION OF BENEFITS DUE TO AGE: Any benefits remaining at age 65 or older will reduce 50%.

Except as otherwise set forth in this Policy, coverage for each Insured person terminates when an Insured person's Maximum Critical Illness Benefit has been paid in full under Benefit Sections I and II as shown in the Policy Schedule.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS: Benefits will not be payable for any such loss resulting from or in connection with:

- (1) suicide, attempted suicide or intentional self-inflicted Injury, whether sane or insane;
- (2) war or any act of war (whether declared or undeclared) or participating in a riot or felony;
- (3) being intoxicated (as determined by the laws governing the operation of motor vehicles in the jurisdiction where the loss or cause of loss occurs) or under the influence of an illegal substance or a narcotic (except for narcotics used as prescribed to an Insured person by a physician);
- (4) the Insured person's commission or attempt to commit a felony or to which a contributing cause was the Insured person's being engaged in an illegal occupation;
- (5) loss that begins prior to the Effective Date of coverage.

WAITING PERIOD: The benefits of this Policy are payable for loss that begins more than 30 days after the Effective Date of coverage for each Insured, including Insured dependents. If the Diagnosis is made within the first 30 days, benefits will not be payable under this Policy at anytime for that condition. The loss must result from Covered Conditions as they are defined in this Policy.

PRE-EXISTING SICKNESS OR INJURY PROVISION: The benefits of this Policy will not be payable during the first 12 months that coverage is in force with respect to an Insured person for a loss caused by a Pre-Existing Sickness or Injury disclosed or not disclosed in the Application. This 12 month period is measured from the Effective Date of coverage for each Insured person. A Pre-Existing Sickness or Injury means a Sickness or Injury which is Diagnosed by a Legally Qualified Physician or for which medical advice or treatment was recommended or received from a Legally Qualified Physician within 12 months prior to the Effective Date of coverage for each Insured person.

TERMINATION

This contract is made with the Insured who has signed the Application heretofore. In the event of death of the Insured, the spouse, if an Insured person, shall automatically become the Insured and beneficiary of all Insured persons.

The spouse of the Insured shall cease to be an Insured person at the end of the term during which the spouse becomes divorced or legally separated from the Insured. The spouse shall be eligible for a conversion policy, at attained age and without evidence of insurability, then in use by the Company which most closely approximates the coverage provided by this Policy. Written request for conversion and payment of the first premium must be made within 31 days after termination of insurance under this Policy.

The dependent Children of the Insured shall cease to be Insured persons when they have reached the limiting age or marry.

The attainment of the limiting age for an Insured dependent will not cause coverage to terminate while that person is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on You for support and maintenance. Chiefly dependent means the Insured dependent receives the majority of his/her financial support from You.

You must provide proof that the dependent is in fact a disabled and dependent person. We may request such proof no more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

We shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

GENERAL PROVISIONS

ENTIRE CONTRACT: This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the Effective Date of this Policy, no misstatement, except fraudulent misstatements, made by the Applicant in the Application for such Policy shall be used to void this Policy or to deny a claim for loss incurred commencing after the expiration of such 2 year period.

GRACE PERIOD: A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period this Policy shall continue in force.

REINSTATEMENT: If any renewal premium is not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy provided, however, that if the Company or such agent requires an application for reinstatement, this Policy will be reinstated upon approval of such Application by the Company or, lacking such approval, upon the 45th day following the date of such Application, unless the Company has previously notified the Insured in writing of its disapproval of such Application. The reinstated Policy shall cover only loss resulting from an Injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In all other respects the Insured and Company shall have the same rights thereunder as they had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement may be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

NOTICE OF CLAIM: Written Notice of Claim must be given to the Company or authorized agent within 20 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or the beneficiary to the Company at Houston, Texas, or to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS: The Company, upon receipt of a Notice of Claim, will furnish to the claimant such forms as are usually furnished by it for filing Proof of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS: Written Proof of Loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as is reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured. Any other accrued indemnities unpaid at the Insured's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000.00 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

PHYSICAL EXAMINATION AND AUTOPSY: The Company at its own expense shall have the right and opportunity to examine the Insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

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 written 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.

CHANGE OF BENEFICIARY: Unless the Insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured and the consent of beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

MISSTATEMENT OF AGE: If the age of the Insured has been misstated, the amounts payable under this Policy are the amounts the premium paid would have purchased at the correct age.

ADDITIONAL DEPENDENTS: Anyone who becomes a spouse or dependent Child of the Insured after the Effective Date of this Policy may be added by making written Application, providing evidence of eligibility and insurability satisfactory to the Company and upon payment of any required premium. The acceptance of additional dependents will be shown by an endorsement affixed to this Policy and the date of such endorsement shall be the Effective Date under this Policy with respect to such additional dependents.

With respect to a newborn Child, coverage is effective from the moment of birth for a period of 31 days without evidence of insurability or acceptance by the Company. After 31 days, such Child will remain a named dependent only if written notice of birth is received by the Company before the next premium due date, or within the Grace Period, and any required premium is paid for such dependent.

An adopted or foster Child's coverage is effective on the date of the filing of the petition to adopt, subject to written notice and payment of any required premium which must be received by Us within 60 days after placement. For purposes of this provision, placement means the assumption by the Insured of physical custody of the adopted child and the financial support and care of the Child.

OTHER INSURANCE IN THIS COMPANY: Insurance effective at any one time on the Insured under a like Policy or policies in this Company is limited to one such Policy elected by the insured, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

UNPAID PREMIUM: Upon payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

UNEARNED PREMIUM: In the event of cancellation by the Insured or death of the Insured, any portion of unearned premium will be returned. Unearned Premium is that portion of the premium representing the unexpired portion of the Policy term.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Insured resides on such date, is hereby amended to conform to the minimum requirements of such state.

CANCELLATION BY INSURED: The Insured may cancel this Policy at any time by written notice delivered or mailed to the Company effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, We shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.



**PHILADELPHIA
AMERICAN**
LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

**APPLICATION
CRITICAL ILLNESS INSURANCE POLICY
(Form H-0186)**

REQUESTED EFFECTIVE DATE: _____

ELECTRONIC APPLICATION YES NO

PAYMENT MODE: Monthly Quarterly
 Semi-Annual Annual

PAYMENT TYPE: Monthly Bank Draft Direct Bill
 List Bill

Plan Type: Applicant Spouse Dependent Children - how many? _____
Tobacco User-Applicant: Yes No Tobacco User-Spouse: Yes No
Benefit Amount: Applicant \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Spouse \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Dependent Children \$10,000 (each child)

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION TO APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HT.	WT.	PREMIUM
1.										
2.			SPOUSE							
3.			DEP. 1							
4.			DEP. 2							
5.			DEP. 3							
6.			DEP. 4							
7.			DEP. 5							
8.			DEP. 6							

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (If different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT: APPLICANT: _____ SPOUSE: _____ CRITICAL ILLNESS TOTAL PREMIUM DUE	\$ _____
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CRITICAL ILLNESS INSURANCE (Answer Questions 1-10)

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
IF THE ANSWER TO ANY OF QUESTIONS 1-6 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.								
1. Has any Applicant ever been diagnosed with or received treatment, tested positive or taken medication for any of the following conditions: Liver cirrhosis, Hepatitis B or C, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Parkinson's, cystic fibrosis, cerebral palsy, sickle cell or aplastic anemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, emphysema, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
2. Within the past 10 years has any Applicant tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
3. Within the past 10 years has any Applicant been diagnosed with, taken medication or received treatment for heart attack, coronary artery disease, or been advised to have any diagnostic tests relating to the heart or circulatory system which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 2 years has any Applicant been treated, tested or taken medication for mitral valve prolapse, tachycardia-bradycardia or arrhythmia?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
5. Within the past 5 years has any Applicant been diagnosed with, taken medication or received treatment for internal cancer, leukemia, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
6. Within the past 4 years has any Applicant used drugs, been diagnosed with or received any medical treatment, taken medication for or been advised to have a medical test for alcohol or drug abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
<u>THE FOLLOWING QUESTION APPLIES TO THE PRIMARY APPLICANT OR SPOUSE THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.</u>								
7. Within the past 24 months has any Applicant used any form of tobacco (including cigars, pipe or chewing tobacco)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

STATEMENT OF OTHER INSURANCE AND BENEFICIARY

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
8. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of Insurance: _____	<input type="radio"/> <input type="radio"/>							
9. Is there any other health, accident or disability insurance in force on the Applicants? If YES, give name of Company and type of insurance: _____	<input type="radio"/> <input type="radio"/>							

10. List both Primary and Secondary Beneficiary

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS

APPLICANT #1'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP

AUTHORIZATION TO MY BANK

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

_____ X _____
Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____
Name Name of Employer
to deduct from my salary and pay to Philadelphia American Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____, \$ _____ each month.

_____ Date Signature of Employee

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Philadelphia American Life Insurance Company, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information or correct information regarding the tobacco use of any applicant may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Philadelphia American Life Insurance Company.

APPLICANT'S STATEMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I acknowledge receipt of the Outline of Coverage and Disclosure Notice and have read the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance if this is a replacement.

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

Dated at _____ on _____, 20____.
City, State & Zip Month & Day

Signature of Applicant #1 _____ Signature of Spouse: _____

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: YES NO

2. Did you personally meet with each Applicant? (If No, explain) YES NO

3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members. YES NO

4. I have left or made available an Outline of Coverage and a Disclosure Notice. YES NO

5. Was the application solicited by: PAPER ELECTRONIC

6. Mail Policy to: AGENT INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT * _____	AGENT NUMBER	MONTH	DAY	YEAR
SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %		
1.				
2.				
3.				

Agent Notes



**PHILADELPHIA
AMERICAN**
LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

APPLICATION
CRITICAL ILLNESS INSURANCE (Form H-0186)
ACCIDENT EXPENSE INSURANCE (Form H-0089)

REQUESTED EFFECTIVE DATE: _____

ELECTRONIC APPLICATION YES NO

PAYMENT MODE: Monthly Quarterly
 Semi-Annual Annual

PAYMENT TYPE: Monthly Bank Draft Direct Bill
 List Bill

CRITICAL ILLNESS POLICY

Plan Type: Applicant Spouse Dependent Children - how many? _____
Tobacco User-Applicant: Yes No Tobacco User-Spouse: Yes No
Benefit Amount: Applicant \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Spouse \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Dependent Children \$10,000 (each child)

ACCIDENT EXPENSE POLICY

Benefit Amount 1 Unit 2 Units
Plan Type: Individual Individual & Spouse Single Parent
 Family Child Only (per Child)
Accident Expense Optional Benefits:
Disability Income Benefit Rider: Occ. Type 1 Occ. Type 2
Number of Units: 1 Unit 2 Units
Benefit Period: 12 Months 24 Months

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION TO APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HT.	WT.	PREMIUM
1.										
2.			SPOUSE							
3.			DEP. 1							
4.			DEP. 2							
5.			DEP. 3							
6.			DEP. 4							
7.			DEP. 5							
8.			DEP. 6							
9.			DEP. 7							
10.			DEP. 9							
11.			DEP. 10							
12.			DEP. 11							
13.			DEP. 12							

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (if different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:	
APPLICANT: _____	
SPOUSE: _____	
CRITICAL ILLNESS INSURANCE PREMIUM	\$ _____
ACCIDENT EXPENSE INSURANCE PREMIUM.....	\$ _____
ACCIDENT DISABILITY RIDER PREMIUM	\$ _____
TOTAL PAYMENT DUE	\$ _____

CRITICAL ILLNESS INSURANCE (Answer Questions 1-7 and 10-12)

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
IF THE ANSWER TO ANY OF QUESTIONS 1-6 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.								
1. Has any Applicant ever been diagnosed with or received treatment, tested positive or taken medication for any of the following conditions: Liver cirrhosis, Hepatitis B or C, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Parkinson's, cystic fibrosis, cerebral palsy, sickle cell or aplastic anemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, emphysema, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
2. Within the past 10 years has any Applicant tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
3. Within the past 10 years has any Applicant been diagnosed with, taken medication or received treatment for heart attack, coronary artery disease, or been advised to have any diagnostic tests relating to the heart or circulatory system which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 2 years has any Applicant been treated, tested or taken medication for mitral valve prolapse, tachycardia-bradycardia or arrhythmia?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
5. Within the past 5 years has any Applicant been diagnosed with, taken medication or received treatment for internal cancer, leukemia, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
6. Within the past 4 years has any Applicant used drugs, been diagnosed with or received any medical treatment, taken medication for or been advised to have a medical test for alcohol or drug abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
<u>THE FOLLOWING QUESTION APPLIES TO THE PRIMARY APPLICANT OR SPOUSE THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.</u>								
7. Within the past 24 months has any Applicant used any form of tobacco (including cigars, pipe or chewing tobacco)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

ACCIDENT EXPENSE INSURANCE (Answer Questions 8-12)

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
IF AN ANSWER TO QUESTION 8 OR 9 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.								
8. Within the past 12 months has any Applicant engaged in or had intentions to engage in any hazardous sports or activities including motorcycle or automobile racing, parachuting, rodeo riding, mountain climbing or scuba diving to depths greater than 60 feet (18 meters)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
9. Within the past 3 years has any Applicant been under treatment for excessive drug or alcohol abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

STATEMENT OF OTHER INSURANCE AND BENEFICIARY FOR BOTH CRITICAL ILLNESS AND ACCIDENT EXPENSE INSURANCE

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
10. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of Insurance: _____	<input type="radio"/> <input type="radio"/>							
11. Is there any other health, accident or disability insurance in force on the Applicants? If YES, give name of Company and type of insurance: _____	<input type="radio"/> <input type="radio"/>							

12. List both Primary and Secondary Beneficiary

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS

APPLICANT #1'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP

AUTHORIZATION TO MY BANK

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

_____ X _____
Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____
Name Name of Employer
to deduct from my salary and pay to Philadelphia American Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____, \$ _____ each month.

_____ Date Signature of Employee

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Philadelphia American Life Insurance Company, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information or correct information regarding the tobacco use of any applicant may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Philadelphia American Life Insurance Company.

APPLICANT'S STATEMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I understand that if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income. I acknowledge receipt of the Outline of Coverage and Disclosure Notice and have read the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance if this is a replacement.

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

Dated at _____ on _____ 20_____.
City, State & Zip Month & Day

Signature of Applicant #1 _____ Signature of Spouse: _____

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: YES NO

2. Did you personally meet with each Applicant? (If No, explain) YES NO

3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members. YES NO

4. I have left or made available an Outline of Coverage and a Disclosure Notice. YES NO

5. Was the application solicited by: PAPER ELECTRONIC

6. Mail Policy to: AGENT INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT *	AGENT NUMBER	MONTH	DAY	YEAR
SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %		
1.				
2.				
3.				

Agent Notes



P. O. Box 4884 • Houston, Texas 77210-4884 • 1-800-552-7879

**CRITICAL ILLNESS INSURANCE POLICY
FORM H-0186.AR**

OUTLINE OF COVERAGE

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 provisions 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.**

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions for one of the specific diseases, health conditions or procedures named in the policy.

BENEFITS

We will pay the amount described below, less any partial payment(s) previously paid per Benefit Section, provided for a Covered Condition subject to Covered Condition definitions, Exclusions and Limitations and other terms and conditions of the policy.

Except as otherwise set forth in the policy, coverage for each insured terminates when an insured's Maximum Critical Illness Benefit has been paid in full under Benefit Sections I and II as shown below.

MAXIMUM CRITICAL ILLNESS BENEFIT

Insured and/or Spouse: \$10,000 / \$20,000 / \$30,000 / \$40,000 / \$50,000
 Dependent Child(ren): \$10,000

COVERED CONDITIONS

Percentage Benefit Payable

Benefit Section I	
Cancer (Internal Cancer)*	100%
Non-Invasive Carcinoma In-Situ (if metastasized, balance will be paid)	25%
Benefit Section II	
Heart Attack	100%
Stroke	100%
Coronary Artery Bypass Surgery**	25%
Angioplasty	10%
Pacemaker Implant (single chambered / double chambered)	30% / 40%
End Stage Renal Failure	100%
Organ Transplant (heart, lung, liver, pancreas)	100%
Organ Transplant (kidney)	50%

* Excludes pre-malignant conditions or conditions with malignant potential; cervical intraepithelial neoplasia (CIN) stages I and II; Carcinoma in Situ; and Skin Cancer.

** Payable for one Coronary Artery Bypass Surgery only.

WAITING PERIOD: The benefits of this Policy are payable for loss that begins more than 30 days after the Effective Date of coverage for each Insured, including Insured dependents. If the Diagnosis is made within the first 30 days, benefits will not be payable under this Policy at anytime for that condition. The loss must result from Covered Conditions as they are defined in this Policy.

REDUCTION OF BENEFITS DUE TO AGE: Any benefits remaining at age 65 or older will reduce 50%.

DEFINITIONS

COVERED CONDITION(S): One of the medical conditions, diseases or procedures listed in paragraphs A. through J. below.

A. Cancer (Internal Cancer)

A disease that is identified by the uncontrolled and abnormal growth of malignant cells. This includes Hodgkin's Disease, leukemia, lymphoma, carcinoma, sarcoma, malignant melanoma that is Diagnosed as Clark's Level III or above or Breslow greater than .75mm and malignant tumors. Diagnosis must be made by a Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system unless medically inappropriate. A clinical diagnosis will be accepted in lieu thereof.

For purposes of the policy, the following are not considered Cancer (Internal Cancer): pre-malignant conditions or conditions with malignant potential, cervical intraepithelial neoplasia (CIN) stages I and II, Carcinoma in Situ, Non-Invasive Carcinoma In-Situ, Leukoplakia, hyperplasia, polycythemia, moles, lesions, Skin Cancer.

B. Non-Invasive Carcinoma In-Situ

A localized malignant tumor, which contains one or several cells that have the potential to invade or metastasize but have not yet done so. This excludes Skin Cancer. Diagnosis must be made by a licensed Pathologist unless medically inappropriate. A clinical diagnosis will be accepted in lieu thereof.

C. Heart Attack

The death (infarction) of a portion of the heart muscle as a result of inadequate blood supply. Diagnosis of a Heart Attack must be made by a Legally Qualified Physician who is a board certified Cardiologist. Diagnosis of a Heart Attack must be based on all of the following criteria:

- (1) associated new EKG changes consistent with Injury;
- (2) elevation of cardiac enzymes above generally accepted laboratory levels of normal (a diagnostic elevation of Troponin I or in the case of CPK, a CPK-MB measurement must be used); and
- (3) confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

The following are not considered a Heart Attack: an EKG change consistent with transient ischemic change, angina, or chance finding of EKG changes suggestive of a previous Heart Attack, or death of the heart muscle coincident with death of an insured from other causes.

In the event of death, an autopsy confirmation and death certificate identifying Heart Attack as the cause of death will be accepted.

D. Stroke

A cerebrovascular event resulting in permanent neurological damage, including infarction of, hemorrhage of, or embolization to brain tissue from an extracranial source. Diagnosis of Stroke must be made by a Legally Qualified Physician who is a board certified Neurologist. Diagnosis of a Stroke must be based on the following criteria:

- (1) documented neurological impairment or deficits; and
- (2) confirming neuroimaging studies.

Stroke does not mean a cerebrovascular event resulting from a head Injury, transient ischemic attack, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.

E. Coronary Artery Bypass Surgery (surgical treatment)

The first ever heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a Legally Qualified Physician who is a board certified Cardiothoracic Surgeon. Payable for one Coronary Artery Bypass Surgery per insured person.

F. Angioplasty

The undergoing of angioplasty, atherectomy or laser treatment for coronary artery disease, which cannot be adequately controlled by medical therapy, following a recommendation by a cardiologist. Angiographic evidence of the underlying disease must be provided.

G. Pacemaker Implant

The procedure to insert an artificial pacemaker. A pacemaker is a device that sends small electrical impulses to the heart muscle to maintain a suitable heart rate or to stimulate the lower chambers of the heart (ventricles). A pacemaker may also be used to treat fainting spells (syncope), congestive heart failure and hypertrophic cardiomyopathy.

H. End Stage Renal Failure

Diagnosis by a Legally Qualified Physician who is a board certified Nephrologist, of End Stage Renal disease which:

- (1) results in chronic irreversible failure of both kidneys to function; and
- (2) requires an insured person to undergo regular renal dialysis at least weekly.

I. Organ Transplant (heart, lung, liver, pancreas)

The actual undergoing, as a recipient, of a transplant due to failure of one of the following organs: heart, lung, liver or pancreas.

J. Organ Transplant (kidney)

The actual undergoing, as a recipient, of a transplant due to failure of the kidney.

DIAGNOSIS or DIAGNOSED: Diagnosis or Diagnosed means a written diagnosis by a legally qualified physician of the insured person's Covered Condition. We reserve the right to request that any Covered Condition Diagnosis be reviewed by a physician of our choice. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, we shall have the right to request either an examination of the insured person or that the evidence used in making the Diagnosis in dispute be reviewed by an independent acknowledged expert selected by us in the applicable field of medicine. The opinion of such expert as to such Diagnosis shall be binding on both the insured person and us.

SKIN CANCER: Any of the following:

- (1) basal cell carcinoma, basal cell epithelioma or squamous cell carcinoma of the skin; or
- (2) Kaposi's Sarcoma; or
- (3) melanoma that is Diagnosed as Clark's Level I or II or Breslow less than .75mm.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS: Benefits will not be payable for any such loss resulting from or in connection with: (1) suicide, attempted suicide or intentional self-inflicted Injury, whether sane or insane; (2) war or any act of war (whether declared or undeclared) or participating in a riot or felony; (3) being intoxicated (as determined by the laws governing the operation of motor vehicles in the jurisdiction where the loss or cause of loss occurs) or under the influence of an illegal substance or a narcotic (except for narcotics used as prescribed to an insured person by a physician); (4) the insured person's commission or attempt to commit a felony or to which a contributing cause was the insured person's being engaged in an illegal occupation; (5) loss that begins prior to the effective date of coverage.

PRE-EXISTING SICKNESS OR INJURY PROVISION: The benefits of the policy will not be payable during the first 12 months that coverage is in force with respect to an insured person for a loss caused by a Pre-Existing Sickness or Injury disclosed or not disclosed in the application. This 12 month period is measured from the effective date of coverage for each insured person. A Pre-Existing Sickness or Injury means a Sickness or Injury which is Diagnosed by a legally qualified physician or for which medical advice or treatment was recommended or received from a legally qualified physician within 12 months prior to the effective date of coverage for each insured person.

RENEWABILITY

The policy is Guaranteed Renewable to age 75.

PREMIUM

Your premium for the policy is \$_____ annually. If your premium is not annual, it is \$_____ for _____ months. The policy provides a 31-day grace period during which period the policy will remain in force. Premiums are subject to change.

SERFF Tracking #:

NELI-128652362

State Tracking #:

Company Tracking #:

H-0186

State: Arkansas

Filing Company:

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: H-0186

Project Name/Number: H-0186/H-0186

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: %

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Philadelphia American Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

NELI-128652362

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

H-0186

State: Arkansas**Filing Company:**

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness**Product Name:** H-0186**Project Name/Number:** H-0186/H-0186

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action*	Rate Action Information	Attachments
1	Approved-Closed 09/14/2012	Rates	H-0186.AR	New		Rates.pdf

Proposed Critical Illness Policy Form (H-0186)

Monthly Premiums - 9/1/12

Benefit Amount - \$1,000

Attained Age	NTU		STD	
	Male	Female	Male	Female
Dependent Child	0.140	0.140	0.140	0.140
18 - 25	0.378	0.302	0.491	0.393
26	0.391	0.313	0.508	0.406
27	0.403	0.322	0.524	0.419
28	0.416	0.333	0.541	0.433
29	0.428	0.342	0.557	0.445
30	0.454	0.363	0.590	0.473
31	0.486	0.383	0.676	0.527
32	0.519	0.403	0.762	0.582
33	0.551	0.423	0.848	0.636
34	0.584	0.443	0.935	0.691
35	0.617	0.463	1.021	0.746
36	0.687	0.506	1.107	0.800
37	0.756	0.549	1.193	0.855
38	0.825	0.592	1.279	0.909
39	0.895	0.635	1.365	0.964
40	0.966	0.676	1.449	1.014
41	1.036	0.726	1.592	1.114
42	1.107	0.775	1.735	1.214
43	1.177	0.824	1.877	1.314
44	1.247	0.874	2.020	1.413
45	1.317	0.922	2.163	1.513
46	1.391	0.974	2.306	1.613
47	1.466	1.026	2.449	1.713
48	1.540	1.078	2.591	1.812
49	1.615	1.131	2.734	1.912
50	1.692	1.184	2.876	2.014
51	1.789	1.231	3.043	2.107
52	1.887	1.277	3.210	2.201
53	1.985	1.323	3.377	2.294
54	2.082	1.369	3.544	2.388
55	2.178	1.415	3.711	2.481
56	2.276	1.479	3.878	2.575
57	2.375	1.544	4.045	2.668
58	2.474	1.608	4.212	2.762
59	2.573	1.673	4.379	2.855
60	2.671	1.737	4.541	2.953
61	2.798	1.819	4.758	3.093
62	2.925	1.902	4.974	3.234
63	3.052	1.985	5.190	3.375
64	3.179	2.066	5.406	3.515
65	3.308	2.150	5.623	3.656
66	3.447	2.241	5.860	3.809
67	3.587	2.331	6.097	3.963
68	3.726	2.422	6.335	4.118
69	3.866	2.513	6.572	4.271
70	4.006	2.604	6.810	4.427
71	4.092	2.660	6.956	4.521
72	4.178	2.715	7.102	4.616
73	4.264	2.772	7.249	4.712
74	4.350	2.828	7.395	4.807
75	4.436	2.883	7.542	4.901

NTU - Non Tobacco User Rates, STD - Tobacco User Rates

Policy fee per month: \$2.00

Premium modal factors:

Monthly (1.0), Quarterly (3.0), Semiannual (6.0), Annual (12.0)

SERFF Tracking #:

NELI-128652362

State Tracking #:

Company Tracking #:

H-0186

State: Arkansas

Filing Company:

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: H-0186

Project Name/Number: H-0186/H-0186

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/14/2012
Comments:			
Attachment(s):			
Readability Certification.pdf			

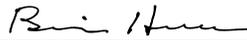
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/14/2012
Bypass Reason:	Application is included with forms.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/14/2012
Bypass Reason:	Outline of Coverage is included with the forms.		
Comments:			

READABILITY CERTIFICATION

I hereby certify that the forms listed below meet the minimum reading ease score on a Flesch test basis:

<u>Form Number</u>	<u>Readability Score</u>
H-0186.....	41.3
H-0186.OC.....	40.8
H-0186.AP.....	40.0
H-0186.AP.CB.....	40.2



Brian Hull, AIRC
Vice President
Product Development and Compliance
Philadelphia American Life Insurance Company

SERFF Tracking #:

NELI-128652362

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

H-0186

State: Arkansas**Filing Company:**

Philadelphia American Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness**Product Name:** H-0186**Project Name/Number:** H-0186/H-0186

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)
09/14/2012	Form	Application	09/14/2012	H-0186.AP.pdf (Superseded)
08/21/2012	Form	Policy	09/14/2012	H-0186.AR.pdf (Superseded)
08/21/2012	Form	Application	09/14/2012	H-0186.AP.pdf (Superseded)
08/21/2012	Form	Combination Application	09/14/2012	H-0186.CB.AP.pdf (Superseded)
08/21/2012	Form	Outline of Coverage	09/14/2012	H-0186.OC.pdf (Superseded)



**PHILADELPHIA
AMERICAN**
LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

**APPLICATION
CRITICAL ILLNESS INSURANCE POLICY
(Form H-0186)**

REQUESTED EFFECTIVE DATE: _____

ELECTRONIC APPLICATION YES NO

PAYMENT MODE: Monthly Quarterly
 Semi-Annual Annual

PAYMENT TYPE: Monthly Bank Draft Direct Bill
 List Bill

Plan Type: Applicant Spouse Dependent Children - how many? _____
Tobacco User-Applicant: Yes No Tobacco User-Spouse: Yes No
Benefit Amount: Applicant \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Spouse \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Dependent Children \$10,000 (each child)

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION TO APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HT.	WT.	PREMIUM
1.										
2.			SPOUSE							
3.			DEP. 1							
4.			DEP. 2							
5.			DEP. 3							
6.			DEP. 4							
7.			DEP. 5							
8.			DEP. 6							

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (If different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT: APPLICANT: _____ SPOUSE: _____ CRITICAL ILLNESS TOTAL PREMIUM DUE \$ _____	
-----------------------------------------------------------------------------------------------------------------------------------------------------------------	--

CRITICAL ILLNESS INSURANCE (Answer Questions 1-10)

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO	
IF THE ANSWER TO ANY OF QUESTIONS 1-6 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.									
1. Has any Applicant ever been diagnosed with or received treatment, tested positive or taken medication for any of the following conditions: Liver cirrhosis, Hepatitis B or C, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Parkinson's, cystic fibrosis, cerebral palsy, sickle cell or aplastic anemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, emphysema, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure?	<input type="radio"/> <input type="radio"/>								
2. Within the past 10 years has any Applicant tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="radio"/> <input type="radio"/>								
3. Within the past 10 years has any Applicant been diagnosed with, taken medication or received treatment for heart attack, coronary artery disease, or been advised to have any diagnostic tests relating to the heart or circulatory system which have not been completed or for which results have not been received?	<input type="radio"/> <input type="radio"/>								
4. Within the past 2 years has any Applicant been treated, tested or taken medication for mitral valve prolapse, tachycardia-bradycardia or arrhythmia?	<input type="radio"/> <input type="radio"/>								
5. Within the past 5 years has any Applicant been diagnosed with, taken medication or received treatment for internal cancer, leukemia, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	<input type="radio"/> <input type="radio"/>								
6. Within the past 4 years has any Applicant used non-prescription drugs, been diagnosed with or received any medical treatment, taken medication for or been advised to have a medical test for alcohol or drug abuse?	<input type="radio"/> <input type="radio"/>								
<u>THE FOLLOWING QUESTION APPLIES TO THE PRIMARY APPLICANT OR SPOUSE THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.</u>									
7. Within the past 24 months has any Applicant used any form of tobacco (including cigars, pipe or chewing tobacco)?	<input type="radio"/> <input type="radio"/>								

STATEMENT OF OTHER INSURANCE AND BENEFICIARY

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
8. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of Insurance: _____	<input type="radio"/> <input type="radio"/>							
9. Is there any other health, accident or disability insurance in force on the Applicants? If YES, give name of Company and type of insurance: _____	<input type="radio"/> <input type="radio"/>							

10. List both Primary and Secondary Beneficiary

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS

APPLICANT #1'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP

AUTHORIZATION TO MY BANK

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

**If Bank
Draft
Authorization,
ATTACH
VOIDED
CHECK HERE
and sign
authorization
at right.**

_____ X _____
Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____
Name Name of Employer
to deduct from my salary and pay to Philadelphia American Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____, \$ _____ each month.

_____ Date Signature of Employee

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Philadelphia American Life Insurance Company, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information or correct information regarding the tobacco use of any applicant may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Philadelphia American Life Insurance Company.

APPLICANT'S STATEMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I acknowledge receipt of the Outline of Coverage and Disclosure Notice and have read the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance if this is a replacement.

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

Dated at _____ on _____ 20____.
City, State & Zip Month & Day

Signature of Applicant #1 _____ Signature of Spouse: _____

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: YES NO

2. Did you personally meet with each Applicant? (If No, explain) YES NO

3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members. YES NO

4. I have left or made available an Outline of Coverage and a Disclosure Notice. YES NO

5. Was the application solicited by: PAPER ELECTRONIC

6. Mail Policy to: AGENT INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT * _____	AGENT NUMBER	MONTH	DAY	YEAR
SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %		
1.				
2.				
3.				

Agent Notes

PREMIUM RATES MAY BE CHANGED ON A CLASS BASIS
GUARANTEED RENEWABLE TO AGE 75



P. O. Box 4884 • Houston, Texas 77210-4884 • 1-800-552-7879

CRITICAL ILLNESS POLICY

Philadelphia American Life Insurance Company will be referred to in this Policy as "Company", "We", "Us", and/or "Our". The individual(s) as shown in the Application are referred to in this Policy as "Insured", "You" and/or "Your".

This Policy is issued in consideration of the statements made in the Application and the payment of the premiums specified herein. We hereby insure the Applicant, first named on the Policy Schedule, and all dependent members of the Insured's family, if any, named in the Policy Schedule and Application (copy of which is attached to and made a part of this Policy), coverage for Covered Conditions, as defined herein, while this Policy is in force, subject to all provisions of this Policy.

The first premium is due on the Effective Date. Renewal premiums are due on the same date of each calendar month after the Effective Date.

THIS IS A LIMITED POLICY – PLEASE READ YOUR POLICY CAREFULLY

This Policy is a legal contract between You and Us.

SPECIAL NOTICE TO THE APPLICANT

This Policy is issued based on Your answers to questions in the Application for this Policy. If any information shown on it is not correct and complete, or if any past medical history has been left out, write to Us immediately. A copy of Your Application is enclosed. If to Your knowledge, there is any fraudulent misstatement in Your Application or if any relevant part of Your medical history has been omitted, Your Policy may not be a valid contract. The best time to determine this matter is now, before a claim arises. If for any reason any such situation exists, contact Us at Our Home Office shown above.

NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY

If this Policy for any reason is unsatisfactory, and within 10 days following receipt thereof it is returned to the Company's Home Office in Houston, Texas, the premium paid will be refunded. If returned, this Policy will be canceled and declared null and void from the Effective Date.

RENEWAL AND PREMIUM PAYMENT PROVISIONS

PREMIUM PAYING PERIOD: This Policy is guaranteed renewable to age 75 by the timely payment of premiums. It must be paid on or before its due date, or within the 31 days that follow. When an Insured's coverage terminates at age 75, coverage for other Insured persons, if any, shall continue under this Policy. The payment of a premium will not continue this Policy in force beyond the next premium due date. We cannot refuse to renew this Policy or place any restrictions on it if the premium is paid on time.

After the first 12 months, We reserve the right, subject to 60 days prior written notice to You at Your last known address, to establish a new schedule of premium rates; such schedule of rates will be effective on the following renewal date for all or any class of Insured's covered by this Policy. Premiums are scheduled to change annually based upon each Insured's attained age. Attained age means the age of the Insured on the Policy Effective Date of coverage and any subsequent Policy anniversary.

IN WITNESS THEREOF, We have caused this Policy to be signed by Our President and Our Secretary. This Policy takes effect at 12:01 A.M. at Your residence on its Effective Date. This Policy terminates at 12:01 A.M. on the date any renewal premium is due and not paid, subject to the Grace Period.

SECRETARY

PRESIDENT

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any Company, makes any claim for the proceeds of an insurance Policy containing any false, incomplete or misleading information may be guilty of a crime as determined by a court of law.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

MAXIMUM CRITICAL ILLNESS BENEFITS REDUCE 50% AT AGE 65.

REDUCED BENEFITS FOR THE FIRST 90 DAYS AS DESCRIBED IN THE POLICY SCHEDULE.

POLICY SCHEDULE

INSURED: [DOE, JOHN]
 POLICY NUMBER: [12345678]
 EFFECTIVE DATE: [07/01/12]

ISSUE AGE: [49]
 MODE OF PAYMENT: [MONTHLY; QUARTERLY; SEMI ANNUAL; ANNUAL]
 FIRST RENEWAL DATE: [08/01/12]
 INITIAL PREMIUM: [40.00]

INSURED PERSON(S)	MAXIMUM CRITICAL ILLNESS BENEFIT (for each Benefit Section)
[JOHN DOE], Insured	[\$1,000-\$50,000]
[, Spouse]	[\$1,000-\$50,000]
[, Dependent Child]	[\$1,000-\$10,000]

Coverage for an Insured person terminates when that Insured person's Maximum Critical Illness Benefit has been paid under Benefit Sections I and II.

In order to be eligible for a full benefit under both Benefit Section I and Benefit Section II, the Covered Condition(s) under each section must be separated by at least 90 consecutive days. This is based on the date of first occurrence of the Covered Condition(s) for each Insured. If the Covered Conditions are not separated by at least 90 days, Reduced Benefits will apply.

Reduced Benefits, (First 90 Days): Benefits will be reduced during the first 90 days following:

- (1) the Effective Date of coverage; or
- (2) the Reinstatement date of the policy; or
- (3) the date of first occurrence of a Covered Condition.

Reduced Benefits will be 25% of the Percentage Benefits Payable listed below.

COVERED CONDITIONS	Percentage Benefit Payable
Benefit Section I	
Cancer (Internal Cancer)*	100%
Non-Invasive Carcinoma In-Situ (if metastasized, balance will be paid)	25%
Benefit Section II	
Heart Attack	100%
Stroke	100%
Coronary Artery Bypass Surgery**	25%
Angioplasty	10%
Pacemaker Implant (single chambered / double chambered)	30% / 40%
End Stage Renal Failure	100%
Organ Transplant (heart, lung, liver, pancreas)	100%
Organ Transplant (kidney)	50%

* Excludes pre-malignant conditions or conditions with malignant potential; cervical intraepithelial neoplasia (CIN) stages I and II; Carcinoma in Situ; and Skin Cancer.

** Payable for one Coronary Artery Bypass Surgery only.

Maximum Critical Illness Benefits reduce 50% at age 65.

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DEFINITIONS

CHILD OR CHILDREN: Unless excluded from coverage, means Your unmarried Children, stepchildren, foster and adopted Children who are dependent on You. They must also be:

- (1) under age 19; or
- (2) under age 25 and enrolled as a full-time student in an accredited school or college.

Children also include any Children for whom You must provide medical support under a court order. A Child is considered Your Child if You are a party in a suit in which adoption of the Child by You is sought and such Child is ultimately adopted by You. Also included as Children are grandchildren whom You claim as dependents for federal income tax purposes.

COVERED CONDITION(S): One of the medical conditions, diseases or procedures listed in paragraphs A. through J. below.

A. Cancer (Internal Cancer)

A disease that is identified by the uncontrolled and abnormal growth of malignant cells. This includes Hodgkin's Disease, leukemia, lymphoma, carcinoma, sarcoma, malignant melanoma that is Diagnosed as Clark's Level III or above or Breslow greater than .75mm and malignant tumors. Diagnosis must be made by a Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system.

For purposes of this Policy, the following are not considered Cancer (Internal Cancer): pre-malignant conditions or conditions with malignant potential, cervical intraepithelial neoplasia (CIN) stages I and II, Carcinoma in Situ, Non-Invasive Carcinoma In-Situ, Leukoplakia, hyperplasia, polycythemia, moles, lesions, Skin Cancer.

B. Non-Invasive Carcinoma In-Situ

A localized malignant tumor, which contains one or several cells that have the potential to invade or metastasize but have not yet done so. This excludes Skin Cancer. Diagnosis must be made by a licensed Pathologist.

C. Heart Attack

The death (infarction) of a portion of the heart muscle as a result of inadequate blood supply. Diagnosis of a Heart Attack must be made by a Legally Qualified Physician who is a board certified Cardiologist. Diagnosis of a Heart Attack must be based on all of the following criteria:

- (1) associated new EKG changes consistent with Injury;
- (2) elevation of cardiac enzymes above generally accepted laboratory levels of normal (a diagnostic elevation of Troponin I or in the case of CPK, a CPK-MB measurement must be used); and
- (3) confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

The following are not considered a Heart Attack: an EKG change consistent with transient ischemic change, angina, or chance finding of EKG changes suggestive of a previous Heart Attack, or death of the heart muscle coincident with death of an Insured from other causes.

In the event of death, an autopsy confirmation and death certificate identifying Heart Attack as the cause of death will be accepted.

D. Stroke

A cerebrovascular event resulting in permanent neurological damage, including infarction of, hemorrhage of, or embolization to brain tissue from an extracranial source. Diagnosis of Stroke must be made by a Legally Qualified Physician who is a board certified Neurologist. Diagnosis of a Stroke must be based on the following criteria:

- (1) documented neurological impairment or deficits; and
- (2) confirming neuroimaging studies.

Stroke does not mean a cerebrovascular event resulting from a head Injury, transient ischemic attack, chronic

cerebrovascular insufficiency and reversible ischemic neurological deficits.

E. Coronary Artery Bypass Surgery (surgical treatment)

The first ever heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a Legally Qualified Physician who is a board certified Cardiothoracic Surgeon. Payable for one Coronary Artery Bypass Surgery per Insured person.

F. Angioplasty

The undergoing of angioplasty, atherectomy or laser treatment for coronary artery disease, which cannot be adequately controlled by medical therapy, following a recommendation by a cardiologist. Angiographic evidence of the underlying disease must be provided.

G. Pacemaker Implant

The procedure to insert an artificial pacemaker. A pacemaker is a device that sends small electrical impulses to the heart muscle to maintain a suitable heart rate or to stimulate the lower chambers of the heart (ventricles). A pacemaker may also be used to treat fainting spells (syncope), congestive heart failure and hypertrophic cardiomyopathy.

H. End Stage Renal Failure

Diagnosis by a Legally Qualified Physician who is a board certified Nephrologist, of End Stage Renal disease which:
(1) results in chronic irreversible failure of both kidneys to function; and
(2) requires an Insured person to undergo regular renal dialysis at least weekly.

I. Organ Transplant (heart, lung, liver, pancreas)

The actual undergoing, as a recipient, of a transplant due to failure of one of the following organs: heart, lung, liver or pancreas.

J. Organ Transplant (kidney)

The actual undergoing, as a recipient, of a transplant due to failure of the kidney.

DIAGNOSIS or DIAGNOSED: Diagnosis or Diagnosed means a written diagnosis by a Legally Qualified Physician of the Insured person's Covered Condition. We reserve the right to request that any Covered Condition Diagnosis be reviewed by a physician of Our choice. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, We shall have the right to request either an examination of the Insured person or that the evidence used in making the Diagnosis in dispute be reviewed by an independent acknowledged expert selected by Us in the applicable field of medicine. The opinion of such expert as to such Diagnosis shall be binding on both the Insured person and Us.

EFFECTIVE DATE: Effective date is the Policy Effective Date shown on the Policy Schedule page. If a Dependent is added to the Policy after the original Policy Effective Date, that Dependents Effective Date will be shown on an endorsement.

INJURY or INJURIES: Injury or Injuries means accidental bodily injuries sustained by an Insured person which are the direct cause of the loss independent of disease, bodily infirmity, or any other cause and occurs while the policy is in force. (See Pre-Existing Sickness or Injury Provision)

INSURED: "Insured" means the Insured's named on the Policy Schedule. "Insured" also means the following provided they are named on the Policy Schedule or added later as provided in the section "Additional Dependents": (1) the Insured; (2) the Insured's spouse; (3) the Insured's unmarried dependent Children who are under age 19 or under age 25 and enrolled as a full-time student in an accredited school or college; (4) a grandchild who is Your dependent for federal income tax purposes; and (5) a Child for whom You must provide medical support under a court order enforceable in this state. Coverage shall be provided for an adopted or foster Child of the Insured to the same extent as the coverage provided by this Policy for the Insured's dependent Children.

A Child born to the Insured while this Policy is in force will be covered from the moment of birth, subject to written notice and payment of the applicable premium which must be received by Us within 31 days after such Child's birth.

LEGALLY QUALIFIED PHYSICIAN: A practitioner of the healing arts duly licensed, practicing in the United States and legally qualified to treat Sickness or Injuries. Such person must not be the Insured, Insured's spouse or Insured's Child(ren) or a business associate. He or she must be providing services within the scope of his or her license, and must be a board certified specialist as required by this Policy. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Legally Qualified Physicians.

SICKNESS: Sickness means illness or disease of an Insured person which first manifested itself after the Effective Date of coverage and while this Policy is in force. (See Pre-Existing Sickness or Injury Provision)

SKIN CANCER: Any of the following:

- (1) basal cell carcinoma, basal cell epithelioma or squamous cell carcinoma of the skin; or
- (2) Kaposi's Sarcoma; or
- (3) melanoma that is Diagnosed as Clark's Level I or II or Breslow less than .75mm.

BENEFITS

While this Policy is in force, We will pay the amount shown in the Policy Schedule, less any partial payment(s) previously paid per Benefit Section, provided for a Covered Condition subject to Covered Condition definitions, Exclusions and Limitations and other terms and conditions of this Policy. In order to be eligible for a full benefit under both Benefit Section I and Benefit Section II, the Covered Condition(s) under each section must be separated by at least 90 consecutive days. This is based on the date of first occurrence of the Covered Condition(s) for each Insured. If the Covered Condition is not separated by at least 90 days, Reduced Benefits will apply.

REDUCED BENEFITS (FIRST 90 DAYS): Benefits will be reduced during the first 90 days following:

- (1) the Effective Date of coverage; or
- (2) the Reinstatement date of the policy; or
- (3) the date of first occurrence of a Covered Condition.

The reduced benefits will be 25% of the Percentage Benefits Payable listed in the Policy Schedule.

REDUCTION OF BENEFITS DUE TO AGE: Any benefits remaining at age 65 or older will reduce 50%.

Except as otherwise set forth in this Policy, coverage for each Insured person terminates when an Insured person's Maximum Critical Illness Benefit has been paid in full under Benefit Sections I and II as shown in the Policy Schedule.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS: Benefits will not be payable for any such loss resulting from or in connection with:

- (1) suicide, attempted suicide or intentional self-inflicted Injury, whether sane or insane;
- (2) war or any act of war (whether declared or undeclared) or participating in a riot or felony;
- (3) being intoxicated (as determined by the laws governing the operation of motor vehicles in the jurisdiction where the loss or cause of loss occurs) or under the influence of an illegal substance or a narcotic (except for narcotics used as prescribed to an Insured person by a physician);
- (4) the Insured person's commission or attempt to commit a felony or to which a contributing cause was the Insured person's being engaged in an illegal occupation;
- (5) loss that begins prior to the Effective Date of coverage.

PRE-EXISTING SICKNESS OR INJURY PROVISION: The benefits of this Policy will not be payable during the first 12 months that coverage is in force with respect to an Insured person for a loss caused by a Pre-Existing Sickness or Injury disclosed or not disclosed in the Application. This 12 month period is measured from the Effective Date of coverage for each Insured person. A Pre-Existing Sickness or Injury means a Sickness or Injury which is Diagnosed by a Legally Qualified Physician or for which medical advice or treatment was recommended or received from a Legally Qualified Physician within 12 months prior to the Effective Date of coverage for each Insured person.

TERMINATION

This contract is made with the Insured who has signed the Application heretofore. In the event of death of the Insured, the spouse, if an Insured person, shall automatically become the Insured and beneficiary of all Insured persons.

The spouse of the Insured shall cease to be an Insured person at the end of the term during which the spouse becomes divorced or legally separated from the Insured. The spouse shall be eligible for a conversion policy, at attained age and without evidence of insurability, then in use by the Company which most closely approximates the coverage provided by this Policy. Written request for conversion and payment of the first premium must be made within 31 days after termination of insurance under this Policy.

The dependent Children of the Insured shall cease to be Insured persons when they have reached the limiting age or marry.

The attainment of the limiting age for an Insured dependent will not cause coverage to terminate while that person is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent on You for support and maintenance. Chiefly dependent means the Insured dependent receives the majority of his/her financial support from You.

You must provide proof that the dependent is in fact a disabled and dependent person. We may request such proof no more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

We shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

GENERAL PROVISIONS

ENTIRE CONTRACT: This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After 2 years from the Effective Date of this Policy, no misstatement, except fraudulent misstatements, made by the Applicant in the Application for such Policy shall be used to void this Policy or to deny a claim for loss incurred commencing after the expiration of such 2 year period.

GRACE PERIOD: A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period this Policy shall continue in force.

REINSTATEMENT: If any renewal premium is not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy provided, however, that if the Company or such agent requires an application for reinstatement, this Policy will be reinstated upon approval of such Application by the Company or, lacking such approval, upon the 45th day following the date of such Application, unless the Company has previously notified the Insured in writing of its disapproval of such Application. The reinstated Policy shall cover only loss resulting from an Injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In all other respects the Insured and Company shall have the same rights thereunder as they had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement may be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement. Benefits are reduced during the first 90 days after Reinstatement.

NOTICE OF CLAIM: Written Notice of Claim must be given to the Company or authorized agent within 20 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or the beneficiary to the Company at Houston, Texas, or to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS: The Company, upon receipt of a Notice of Claim, will furnish to the claimant such forms as are usually furnished by it for filing Proof of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in this Policy for filing Proof of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS: Written Proof of Loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as is reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured. Any other accrued indemnities unpaid at the Insured's death may, at the option of the Company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured. If any indemnity of this Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity, up to an amount not exceeding \$1,000.00 to any relative by blood or connection by marriage to the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

PHYSICAL EXAMINATION AND AUTOPSY: The Company at its own expense shall have the right and opportunity to examine the Insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

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 written 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.

CHANGE OF BENEFICIARY: Unless the Insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured and the consent of beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

MISSTATEMENT OF AGE: If the age of the Insured has been misstated, the amounts payable under this Policy are the amounts the premium paid would have purchased at the correct age.

ADDITIONAL DEPENDENTS: Anyone who becomes a spouse or dependent Child of the Insured after the Effective Date of this Policy may be added by making written Application, providing evidence of eligibility and insurability satisfactory to the Company and upon payment of any required premium. The acceptance of additional dependents will be shown by an endorsement affixed to this Policy and the date of such endorsement shall be the Effective Date under this Policy with respect to such additional dependents.

With respect to a newborn Child, coverage is effective from the moment of birth for a period of 31 days without evidence of insurability or acceptance by the Company. After 31 days, such Child will remain a named dependent only if written notice of birth is received by the Company before the next premium due date, or within the Grace Period, and any required premium is paid for such dependent.

An adopted or foster Child's coverage is effective on the date of the filing of the petition to adopt, subject to written notice and payment of any required premium which must be received by Us within 60 days after placement. For purposes of this provision, placement means the assumption by the Insured of physical custody of the adopted child and the financial support and care of the Child.

OTHER INSURANCE IN THIS COMPANY: Insurance effective at any one time on the Insured under a like Policy or policies in this Company is limited to one such Policy elected by the insured, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

UNPAID PREMIUM: Upon payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

UNEARNED PREMIUM: In the event of cancellation by the Insured or death of the Insured, any portion of unearned premium will be returned. Unearned Premium is that portion of the premium representing the unexpired portion of the Policy term.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Insured resides on such date, is hereby amended to conform to the minimum requirements of such state.

CANCELLATION BY INSURED: The Insured may cancel this Policy at any time by written notice delivered or mailed to the Company effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, We shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.



**PHILADELPHIA
AMERICAN**
LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

**APPLICATION
CRITICAL ILLNESS INSURANCE POLICY
(Form H-0186)**

REQUESTED EFFECTIVE DATE: _____

ELECTRONIC APPLICATION YES NO

PAYMENT MODE: Monthly Quarterly
 Semi-Annual Annual

PAYMENT TYPE: Monthly Bank Draft Direct Bill
 List Bill

Plan Type: Applicant Spouse Dependent Children - how many? _____
Tobacco User-Applicant: Yes No Tobacco User-Spouse: Yes No
Benefit Amount: Applicant \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Spouse \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Dependent Children \$10,000 (each child)

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION TO APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HT.	WT.	PREMIUM
1.										
2.			SPOUSE							
3.			DEP. 1							
4.			DEP. 2							
5.			DEP. 3							
6.			DEP. 4							
7.			DEP. 5							
8.			DEP. 6							
9.			DEP. 7							
10.			DEP. 8							
11.			DEP. 9							
12.			DEP. 10							

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (If different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT: APPLICANT: _____ SPOUSE: _____ CRITICAL ILLNESS TOTAL PREMIUM DUE	\$ _____
--------------------------------------------------------------------------------------------------------------------------------------------------------	----------

CRITICAL ILLNESS INSURANCE (Answer Questions 1-7 and 10-12)

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
IF THE ANSWER TO ANY OF QUESTIONS 1-6 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.								
1. Has any Applicant ever been diagnosed with or received treatment, tested positive or taken medication for any of the following conditions: Liver cirrhosis, Hepatitis B or C, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Parkinson's, cystic fibrosis, cerebral palsy, sickle cell or aplastic anemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, emphysema, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
2. Within the past 10 years has any Applicant tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
3. Within the past 10 years has any Applicant been diagnosed with, taken medication or received treatment for heart attack, coronary artery disease, or been advised to have any diagnostic tests relating to the heart or circulatory system which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 2 years has any Applicant been treated, tested or taken medication for mitral valve prolapse, tachycardia-bradycardia or arrhythmia?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
5. Within the past 5 years has any Applicant been diagnosed with, taken medication or received treatment for internal cancer, leukemia, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
6. Within the past 4 years has any Applicant used non-prescription drugs, been diagnosed with or received any medical treatment, taken medication for or been advised to have a medical test for alcohol or drug abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
<u>THE FOLLOWING QUESTION APPLIES TO THE PRIMARY APPLICANT OR SPOUSE THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.</u>								
7. Within the past 24 months has any Applicant used any form of tobacco (including cigars, pipe or chewing tobacco)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

STATEMENT OF OTHER INSURANCE AND BENEFICIARY

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
10. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of Insurance: _____	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
11. Is there any other health, accident or disability insurance in force on the Applicants? If YES, give name of Company and type of insurance: _____	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

12. List both Primary and Secondary Beneficiary

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS

APPLICANT #1'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP

AUTHORIZATION TO MY BANK

**If Bank
Draft
Authorization,
ATTACH
VOIDED
CHECK HERE
and sign
authorization
at right.**

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

_____ X _____
Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____
Name Name of Employer

to deduct from my salary and pay to Philadelphia American Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____, \$ _____ each month.

_____ Date _____ Signature of Employee

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Philadelphia American Life Insurance Company, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information or correct information regarding the tobacco use of any applicant may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Philadelphia American Life Insurance Company.

APPLICANT'S STATEMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I acknowledge receipt of the Outline of Coverage and Disclosure Notice and have read the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance if this is a replacement.

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

Dated at _____ on _____ 20____.
City, State & Zip Month & Day

Signature of Applicant #1 _____ Signature of Spouse: _____

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: YES NO

2. Did you personally meet with each Applicant? (If No, explain) YES NO

3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members. YES NO

4. I have left or made available an Outline of Coverage and a Disclosure Notice. YES NO

5. Was the application solicited by: PAPER ELECTRONIC

6. Mail Policy to: AGENT INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT *	AGENT NUMBER	MONTH	DAY	YEAR
SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %		
1.				
2.				
3.				

Agent Notes



**PHILADELPHIA
AMERICAN**
LIFE INSURANCE COMPANY®

P.O. BOX 4884, HOUSTON, TX. 77210-4884

**APPLICATION
CRITICAL ILLNESS INSURANCE (Form H-0186)
ACCIDENT EXPENSE INSURANCE (Form H-0089)**

REQUESTED EFFECTIVE DATE: _____

ELECTRONIC APPLICATION YES NO

PAYMENT MODE: Monthly Quarterly
 Semi-Annual Annual

PAYMENT TYPE: Monthly Bank Draft Direct Bill
 List Bill

CRITICAL ILLNESS POLICY

Plan Type: Applicant Spouse Dependent Children - how many? _____
Tobacco User-Applicant: Yes No Tobacco User-Spouse: Yes No
Benefit Amount: Applicant \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Spouse \$10,000 \$20,000 \$30,000
 \$40,000 \$50,000
Benefit Amount: Dependent Children \$10,000 (each child)

ACCIDENT EXPENSE POLICY

Benefit Amount 1 Unit 2 Units
Plan Type: Individual Individual & Spouse Single Parent
 Family Child Only (per Child)
Accident Expense Optional Benefits:
Disability Income Benefit Rider: Occ. Type 1 Occ. Type 2
Number of Units: 1 Unit 2 Units
Benefit Period: 12 Months 24 Months

PRINT APPLICANT'S NAMES (LAST, FIRST, MI, MAIDEN)	SOCIAL SECURITY	SEX	RELATION TO APPL.	DATE OF BIRTH	FTS Y/N	AGE	BIRTH STATE	HT.	WT.	PREMIUM
1.										
2.			SPOUSE							
3.			DEP. 1							
4.			DEP. 2							
5.			DEP. 3							
6.			DEP. 4							
7.			DEP. 5							
8.			DEP. 6							
9.			DEP. 7							
10.			DEP. 9							
11.			DEP. 10							
12.			DEP. 11							
13.			DEP. 12							

APPLICANT'S ADDRESS (Actual Address. We cannot use a P.O. Box)	CITY	STATE	ZIP	COUNTY
PREMIUM PAYOR ADDRESS (if different than Applicant's Address)	CITY	STATE	ZIP	COUNTY
BUSINESS NAME AND ADDRESS	CITY	STATE	ZIP	
HOME PHONE	BUSINESS PHONE	EMAIL		

DESCRIBE THE OCCUPATION AND SPECIFIC DUTIES FOR EACH ADULT APPLICANT:	
APPLICANT: _____	
SPOUSE: _____	
CRITICAL ILLNESS INSURANCE PREMIUM	\$ _____
ACCIDENT EXPENSE INSURANCE PREMIUM.....	\$ _____
ACCIDENT DISABILITY RIDER PREMIUM	\$ _____
TOTAL PAYMENT DUE	\$ _____

CRITICAL ILLNESS INSURANCE (Answer Questions 1-7 and 10-12)

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
IF THE ANSWER TO ANY OF QUESTIONS 1-6 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.								
1. Has any Applicant ever been diagnosed with or received treatment, tested positive or taken medication for any of the following conditions: Liver cirrhosis, Hepatitis B or C, insulin-diabetes and/or neuropathy, ulcerative colitis or Crohn's, Down's syndrome, Rheumatoid Arthritis, ALS (Lou Gehrig's Disease), Parkinson's, cystic fibrosis, cerebral palsy, sickle cell or aplastic anemia, transplant recipient, multiple sclerosis, muscular dystrophy, lupus, COPD, emphysema, suicide attempt, Stroke or TIA, paraplegia or quadriplegia, kidney or renal failure?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
2. Within the past 10 years has any Applicant tested positive or been diagnosed with or treated as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
3. Within the past 10 years has any Applicant been diagnosed with, taken medication or received treatment for heart attack, coronary artery disease, or been advised to have any diagnostic tests relating to the heart or circulatory system which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
4. Within the past 2 years has any Applicant been treated, tested or taken medication for mitral valve prolapse, tachycardia-bradycardia or arrhythmia?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
5. Within the past 5 years has any Applicant been diagnosed with, taken medication or received treatment for internal cancer, leukemia, malignant melanoma or any other malignancy or been advised to have any diagnostic tests relating to cancer which have not been completed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
6. Within the past 4 years has any Applicant used non-prescription drugs, been diagnosed with or received any medical treatment, taken medication for or been advised to have a medical test for alcohol or drug abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
<u>THE FOLLOWING QUESTION APPLIES TO THE PRIMARY APPLICANT OR SPOUSE THAT ARE ABLE TO QUALIFY FOR COVERAGE BASED ON THE ANSWERS ABOVE, OTHERWISE DO NOT CONTINUE.</u>								
7. Within the past 24 months has any Applicant used any form of tobacco (including cigars, pipe or chewing tobacco)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

ACCIDENT EXPENSE INSURANCE (Answer Questions 8-12)

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
IF AN ANSWER TO QUESTION 8 OR 9 IS "YES" THEN THAT APPLICANT IS <u>NOT</u> ELIGIBLE FOR COVERAGE.								
8. Within the past 12 months has any Applicant engaged in or had intentions to engage in any hazardous sports or activities including motorcycle or automobile racing, parachuting, rodeo riding, mountain climbing or scuba diving to depths greater than 60 feet (18 meters)?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○
9. Within the past 3 years has any Applicant been under treatment for excessive drug or alcohol abuse?	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○	○ ○

STATEMENT OF OTHER INSURANCE AND BENEFICIARY FOR BOTH CRITICAL ILLNESS AND ACCIDENT EXPENSE INSURANCE

	Applicant YES/NO	Spouse YES/NO	Child 1 YES/NO	Child 2 YES/NO	Child 3 YES/NO	Child 4 YES/NO	Child 5 YES/NO	Child 6 YES/NO
10. Will the insurance applied for replace or change any existing insurance? If YES, give name of Company and type of Insurance:	<input type="radio"/> <input type="radio"/>							
11. Is there any other health, accident or disability insurance in force on the Applicants? If YES, give name of Company and type of insurance:	<input type="radio"/> <input type="radio"/>							

12. List both Primary and Secondary Beneficiary

Primary: _____ Relationship: _____

Secondary: _____ Relationship: _____

FAMILY DOCTOR OR DOCTOR OF EACH APPLICANT WHO HAS CURRENT AND COMPLETE MEDICAL RECORDS

APPLICANT #1'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
SPOUSE'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP
CHILDREN'S DOCTOR NAME:		Phone Number	
ADDRESS	CITY	STATE	ZIP

AUTHORIZATION TO MY BANK

If Bank Draft Authorization, ATTACH VOIDED CHECK HERE and sign authorization at right.

As a convenience to me, I hereby request and authorize you to pay and charge my account, checks drawn on my account by and payable to the order of the Philadelphia American Life Insurance Company, Houston, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks be dishonored whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. A photocopy of my signature should be honored as if it were original.

_____ X _____
Date Signature (as it appears on bank records)

AUTHORIZATION FOR PAYROLL DEDUCTION

Employee _____ I hereby authorize _____
Name Name of Employer
to deduct from my salary and pay to Philadelphia American Life Insurance Company, Houston, Texas, the monthly deposits as set forth below. Beginning with the month of _____, \$ _____ each month.

_____ Date Signature of Employee

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you intend to lapse or otherwise terminate existing insurance and replace it with a new plan from Philadelphia American Life Insurance Company, you should be aware of and seriously consider certain factors that may affect your coverage under the new plan.

1. Health conditions that you now have may not be immediately or fully covered under the new plan. This could result in a claim for benefits being denied, reduced, or delayed under the new plan, whereas a similar claim might have been payable under your present plan.
2. If after due consideration, you still wish to terminate your present insurance and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information or correct information regarding the tobacco use of any applicant may cause the company to deny a future claim and to void your coverage as though it has never been in force. After you have completed the application and before you sign it, reread it carefully. Be certain that all information has been properly recorded.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of or addition to your present plan. You should be certain that you understand all the relevant factors involved in replacing or adding to your present coverage.
4. Finally, we recommend that you not terminate your present plan until you are certain that your application for the new plan has been accepted by Philadelphia American Life Insurance Company.

APPLICANT'S STATEMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby apply to Philadelphia American Life Insurance Company for coverage under a Policy to be issued in reliance upon the written answers to the questions in this Application which I have answered to the best of my knowledge and belief. I understand and agree that (1) the coverage shall not take effect unless the Application has been accepted and approved in writing by the Company and until the Effective Date of my coverage under the Policy and (2) my coverage will not become effective until all necessary underwriting information has been received and reviewed by the Home Office and that the requested Effective Date may be delayed if the Home Office requires additional medical information to process my Application and (3) the agent does not have the authority to waive a complete answer to any question in the Application, pass on insurability, make or alter any part of the contract, or waive any of the Company's other rights or requirements. I understand and agree that the falsity of any answer or statement in this Application may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed by the Company. The Company may rely upon this Application and all of the information contained herein.

I hereby authorize and request any physician, hospital, dentist, pharmacy, pharmacy benefit manager, individual, employer, insurance company, law enforcement agency, governmental agency or other entity to permit bearer or representative of Philadelphia American Life Insurance Company to view, copy, be furnished a copy or be given details of all record information in connection with any past or present illnesses, financial records, employment records and/or police records. This authorization is to include, but is not limited to information pertaining to diagnosis, care or treatment for psychiatric disorder, drug and alcohol abuse, treatment or prescriptions, testing and/or treatment of HIV (AIDS virus) and/or sexually transmitted diseases. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules. The results of an HIV-related test shall be confidential and we cannot release or disclose this information except in certain circumstances permitted by law. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, my employer or consumer reporting agency or insurance company who possesses information of care, treatment or advice of me, my family, or our health may furnish such information to Philadelphia American Life Insurance Company or it's representative or it's reinsurers upon presenting this authorization or a photocopy. Philadelphia American Life Insurance Company or its reinsurers may make a brief report available regarding me or my dependents to other companies to whom I have applied or may apply. I understand that I may revoke this authorization at any time by writing to Philadelphia American Life Insurance Company and that I or my representative is entitled to receive a copy of this authorization form upon request. This authorization shall remain in effect for twenty four (24) months from the date this authorization is signed.

I understand that if the Accident Disability Income Benefit Rider is elected, the maximum benefit per month will not exceed 60% of my gross monthly income. I acknowledge receipt of the Outline of Coverage and Disclosure Notice and have read the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance if this is a replacement.

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

Dated at _____ on _____ 20_____.
City, State & Zip Month & Day

Signature of Applicant #1 _____ Signature of Spouse: _____

AGENT USE ONLY

1. Will this coverage applied for replace or effect a change of any coverage with this or any other company? Please Explain: YES NO

2. Did you personally meet with each Applicant? (If No, explain) YES NO

3. I have truly and accurately recorded the information as herein supplied by the Applicant #1 for all family members. YES NO

4. I have left or made available an Outline of Coverage and a Disclosure Notice. YES NO

5. Was the application solicited by: PAPER ELECTRONIC

6. Mail Policy to: AGENT INSURED

AGENT NAME (Please print first and last name)	ADDRESS	CITY	STATE	ZIP
SIGNATURE OF AGENT *	AGENT NUMBER	MONTH	DAY	YEAR
SPLIT AGENT LAST NAME	SPLIT AGENT NUMBER	SPLIT AGENT %		
1.				
2.				
3.				

Agent Notes



P. O. Box 4884 • Houston, Texas 77210-4884 • 1-800-552-7879

CRITICAL ILLNESS INSURANCE POLICY FORM H-0186

OUTLINE OF COVERAGE

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 provisions 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**.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions for one of the specific diseases, health conditions or procedures named in the policy.

BENEFITS

We will pay the amount described below, less any partial payment(s) previously paid per Benefit Section, provided for a Covered Condition subject to Covered Condition definitions, Exclusions and Limitations and other terms and conditions of the policy. In order to be eligible for a full benefit under both Benefit Section I and Benefit Section II, the Covered Condition(s) under each section must be separated by at least 90 consecutive days. This is based on the date of first occurrence of the Covered Condition(s) for each insured. If the Covered Condition is not separated by at least 90 days, Reduced Benefits will apply. See Reduced Benefits below.

Except as otherwise set forth in the policy, coverage for each insured terminates when an insured's Maximum Critical Illness Benefit has been paid in full under Benefit Sections I and II as shown below.

MAXIMUM CRITICAL ILLNESS BENEFIT

Insured and/or Spouse: \$10,000 / \$20,000 / \$30,000 / \$40,000 / \$50,000
Dependent Child(ren): \$10,000

COVERED CONDITIONS

Percentage Benefit Payable

Benefit Section I	
Cancer (Internal Cancer)*	100%
Non-Invasive Carcinoma In-Situ (if metastasized, balance will be paid)	25%
Benefit Section II	
Heart Attack	100%
Stroke	100%
Coronary Artery Bypass Surgery**	25%
Angioplasty	10%
Pacemaker Implant (single chambered / double chambered)	30% / 40%
End Stage Renal Failure	100%
Organ Transplant (heart, lung, liver, pancreas)	100%
Organ Transplant (kidney)	50%

* Excludes pre-malignant conditions or conditions with malignant potential; cervical intraepithelial neoplasia (CIN) stages I and II; Carcinoma in Situ; and Skin Cancer.

** Payable for one Coronary Artery Bypass Surgery only.

REDUCED BENEFITS (FIRST 90 DAYS): Benefits will be reduced during the first 90 days following: (1) the effective date of coverage; or (2) the Reinstatement date of the policy; or (3) the date of first occurrence of a Covered Condition. The reduced benefits will be 25% of the Percentage Benefits Payable listed in the policy schedule.

REDUCTION OF BENEFITS DUE TO AGE: Any benefits remaining at age 65 or older will reduce 50%.

DEFINITIONS

COVERED CONDITION(S): One of the medical conditions, diseases or procedures listed in paragraphs A. through J. below.

A. Cancer (Internal Cancer)

A disease that is identified by the uncontrolled and abnormal growth of malignant cells. This includes Hodgkin's Disease, leukemia, lymphoma, carcinoma, sarcoma, malignant melanoma that is Diagnosed as Clark's Level III or above or Breslow greater than .75mm and malignant tumors. Diagnosis must be made by a Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system.

For purposes of the policy, the following are not considered Cancer (Internal Cancer): pre-malignant conditions or conditions with malignant potential, cervical intraepithelial neoplasia (CIN) stages I and II, Carcinoma in Situ, Non-Invasive Carcinoma In-Situ, Leukoplakia, hyperplasia, polycythemia, moles, lesions, Skin Cancer.

B. Non-Invasive Carcinoma In-Situ

A localized malignant tumor, which contains one or several cells that have the potential to invade or metastasize but have not yet done so. This excludes Skin Cancer. Diagnosis must be made by a licensed Pathologist.

C. Heart Attack

The death (infarction) of a portion of the heart muscle as a result of inadequate blood supply. Diagnosis of a Heart Attack must be made by a Legally Qualified Physician who is a board certified Cardiologist. Diagnosis of a Heart Attack must be based on all of the following criteria:

- (1) associated new EKG changes consistent with Injury;
- (2) elevation of cardiac enzymes above generally accepted laboratory levels of normal (a diagnostic elevation of Troponin I or in the case of CPK, a CPK-MB measurement must be used); and
- (3) confirmatory imaging studies such as thallium scans, MUGA scans or stress echocardiograms.

The following are not considered a Heart Attack: an EKG change consistent with transient ischemic change, angina, or chance finding of EKG changes suggestive of a previous Heart Attack, or death of the heart muscle coincident with death of an insured from other causes.

In the event of death, an autopsy confirmation and death certificate identifying Heart Attack as the cause of death will be accepted.

D. Stroke

A cerebrovascular event resulting in permanent neurological damage, including infarction of, hemorrhage of, or embolization to brain tissue from an extracranial source. Diagnosis of Stroke must be made by a Legally Qualified Physician who is a board certified Neurologist. Diagnosis of a Stroke must be based on the following criteria:

- (1) documented neurological impairment or deficits; and
- (2) confirming neuroimaging studies.

Stroke does not mean a cerebrovascular event resulting from a head Injury, transient ischemic attack, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.

E. Coronary Artery Bypass Surgery (surgical treatment)

The first ever heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a Legally Qualified Physician who is a board certified Cardiothoracic Surgeon. Payable for one Coronary Artery Bypass Surgery per insured person.

F. Angioplasty

The undergoing of angioplasty, atherectomy or laser treatment for coronary artery disease, which cannot be adequately controlled by medical therapy, following a recommendation by a cardiologist. Angiographic evidence of the underlying disease must be provided.

G. Pacemaker Implant

The procedure to insert an artificial pacemaker. A pacemaker is a device that sends small electrical impulses to the heart muscle to maintain a suitable heart rate or to stimulate the lower chambers of the heart (ventricles). A pacemaker may also be used to treat fainting spells (syncope), congestive heart failure and hypertrophic cardiomyopathy.

H. End Stage Renal Failure

Diagnosis by a Legally Qualified Physician who is a board certified Nephrologist, of End Stage Renal disease which:

- (1) results in chronic irreversible failure of both kidneys to function; and
- (2) requires an insured person to undergo regular renal dialysis at least weekly.

I. Organ Transplant (heart, lung, liver, pancreas)

The actual undergoing, as a recipient, of a transplant due to failure of one of the following organs: heart, lung, liver or pancreas.

J. Organ Transplant (kidney)

The actual undergoing, as a recipient, of a transplant due to failure of the kidney.

DIAGNOSIS or DIAGNOSED: Diagnosis or Diagnosed means a written diagnosis by a legally qualified physician of the insured person's Covered Condition. We reserve the right to request that any Covered Condition Diagnosis be reviewed by a physician of our choice. In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, we shall have the right to request either an examination of the insured person or that the evidence used in making the Diagnosis in dispute be reviewed by an independent acknowledged expert selected by us in the applicable field of medicine. The opinion of such expert as to such Diagnosis shall be binding on both the insured person and us.

SKIN CANCER: Any of the following:

- (1) basal cell carcinoma, basal cell epithelioma or squamous cell carcinoma of the skin; or
- (2) Kaposi's Sarcoma; or
- (3) melanoma that is Diagnosed as Clark's Level I or II or Breslow less than .75mm.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS: Benefits will not be payable for any such loss resulting from or in connection with: (1) suicide, attempted suicide or intentional self-inflicted Injury, whether sane or insane; (2) war or any act of war (whether declared or undeclared) or participating in a riot or felony; (3) being intoxicated (as determined by the laws governing the operation of motor vehicles in the jurisdiction where the loss or cause of loss occurs) or under the influence of an illegal substance or a narcotic (except for narcotics used as prescribed to an insured person by a physician); (4) the insured person's commission or attempt to commit a felony or to which a contributing cause was the insured person's being engaged in an illegal occupation; (5) loss that begins prior to the effective date of coverage.

PRE-EXISTING SICKNESS OR INJURY PROVISION: The benefits of the policy will not be payable during the first 12 months that coverage is in force with respect to an insured person for a loss caused by a Pre-Existing Sickness or Injury disclosed or not disclosed in the application. This 12 month period is measured from the effective date of coverage for each insured person. A Pre-Existing Sickness or Injury means a Sickness or Injury which is Diagnosed by a legally qualified physician or for which medical advice or treatment was recommended or received from a legally qualified physician within 12 months prior to the effective date of coverage for each insured person.

RENEWABILITY

The policy is Guaranteed Renewable to age 75.

PREMIUM

Your premium for the policy is \$_____ annually. If your premium is not annual, it is \$_____ for _____ months. The policy provides a 31-day grace period during which period the policy will remain in force. Premiums are subject to change.