

State: Arkansas **Filing Company:** Boston Mutual Life Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: BMLIC-GH-CI-AR-12-01-F/BMLIC-GH-CI-AR-12-01-F

Filing at a Glance

Company: Boston Mutual Life Insurance Company
Product Name: Critical Illness
State: Arkansas
TOI: H07G Group Health - Specified Disease - Limited Benefit
Sub-TOI: H07G.001 Critical Illness
Filing Type: Form
Date Submitted: 09/04/2012
SERFF Tr Num: PERR-128639266
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: BMLIC-GH-CI-AR-12-01-F

Implementation: 10/04/2012
Date Requested:
Author(s): Neresa Torres, Olga E. Garcia, Addy Angelico
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 09/13/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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General Information

Project Name: BMLIC-GH-CI-AR-12-01-F Status of Filing in Domicile: Pending
Project Number: BMLIC-GH-CI-AR-12-01-F Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Being filed concurrently.
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Group Market Type: Employer, Association, Other Explanation for Other Group Market Type: Union
Overall Rate Impact: Filing Status Changed: 09/13/2012
State Status Changed: 09/13/2012
Deemer Date: Created By: Olga E. Garcia
Submitted By: Addy Anggelico Corresponding Filing Tracking Number:

Filing Description:

On behalf of Boston Mutual Life Insurance Company (the "Company"), we are submitting a new program filing. The forms will be offered to employer, association, and union groups to provide coverage for specified diseases. The plans offered include two options: one plan with cancer coverage and one plan without cancer coverage. The forms are new and do not replace any forms previously approved in your state.

The forms contain bracketed information in order to allow for flexibility. Statements of Variability, which explain how the bracketing will be utilized, are provided.

The referenced forms have been written in readable language and are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, positioning and format. However, printing standards will never be less than required under your law.

We respectfully request that this filing be effective on the earliest possible date according to your filing laws.

Enclosed is authorization for Perr&Knight to submit this filing on behalf of the Company. All correspondence related to this filing should be directed to Perr&Knight. If there are any requests for additional information related to items in this filing, we will forward the request immediately to the Company contact. We will submit the Company's response to your attention as soon as we receive it.

Company and Contact

Filing Contact Information

Olga E. Garcia, Filing Analyst doi@perrknight.com
401 Wilshire Blvd Suite 300 310-230-9339 [Phone] 163 [Ext]
Santa Monica, CA 90401

State: Arkansas **Filing Company:** Boston Mutual Life Insurance Company
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Filing Company Information

(This filing was made by a third party - perrandknightactuaryconsultants)

Boston Mutual Life Insurance Company	CoCode: 61476	State of Domicile:
120 Royall Street	Group Code: 581	Massachusetts
Canton, MA 02021	Group Name:	Company Type: Life
(781) 828-7000 ext. [Phone]	FEIN Number: 04-1106240	State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$650.00
 Retaliatory? No
 Fee Explanation: AR \$50 per form fee applies. (\$50*13=\$650)
 Per Company: No

Company	Amount	Date Processed	Transaction #
Boston Mutual Life Insurance Company	\$650.00	09/04/2012	62263391

SERFF Tracking #:

PERR-128639266

State Tracking #:

Company Tracking #:

BMLIC-GH-CI-AR-12-01-F

State:

Arkansas

Filing Company:

Boston Mutual Life Insurance Company

TOI/Sub-TOI:

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

Product Name:

Critical Illness

Project Name/Number:

BMLIC-GH-CI-AR-12-01-F/BMLIC-GH-CI-AR-12-01-F

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/13/2012	09/13/2012

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
Olga E. Garcia	09/12/2012	09/12/2012

SERFF Tracking #:

PERR-128639266

State Tracking #:

Company Tracking #:

BMLIC-GH-CI-AR-12-01-F

State:

Arkansas

Filing Company:

Boston Mutual Life Insurance Company

TOI/Sub-TOI:

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

Product Name:

Critical Illness

Project Name/Number:

BMLIC-GH-CI-AR-12-01-F/BMLIC-GH-CI-AR-12-01-F

Disposition

Disposition Date: 09/13/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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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	Statement of Variability	Approved-Closed	Yes
Supporting Document	Letter of Authority	Approved-Closed	Yes
Form (revised)	Group Critical Illness Master Policy	Approved-Closed	Yes
Form	Group Critical Illness Master Policy	Approved-Closed	Yes
Form (revised)	Group Critical Illness Master Policy	Approved-Closed	Yes
Form	Group Critical Illness Master Policy	Approved-Closed	Yes
Form (revised)	Certificate of Insurance for Group Critical Illness Policy	Approved-Closed	Yes
Form	Certificate of Insurance for Group Critical Illness Policy	Approved-Closed	Yes
Form (revised)	Certificate of Insurance for Group Critical Illness Policy	Approved-Closed	Yes
Form	Certificate of Insurance for Group Critical Illness Policy	Approved-Closed	Yes
Form (revised)	Dependent Children Benefit Rider	Approved-Closed	Yes
Form	Dependent Children Benefit Rider	Approved-Closed	Yes
Form	Genetic Screening Test Benefit Rider	Approved-Closed	Yes
Form	Extended Loss Benefit Rider	Approved-Closed	Yes
Form	Health Screening Benefit Rider	Approved-Closed	Yes
Form	Occupational HIV Benefit Rider	Approved-Closed	Yes
Form	Strike Waiver	Approved-Closed	Yes
Form	Application for Group Critical Illness Insurance	Approved-Closed	Yes
Form	Critical Illness Enrollment Form	Approved-Closed	Yes
Form	Critical Illness Enrollment Form	Approved-Closed	Yes

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Objection Letter

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

Dear Olga E. Garcia,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Critical Illness Master Policy, WS-CI Master Policy with Cancer 04/12 (Form)
- Group Critical Illness Master Policy, WS-CI Master Policy Without Cancer 04/12 (Form)
- Certificate of Insurance for Group Critical Illness Policy, WS-CI Cert With Cancer 04/12 AL (Form)
- Dependent Children Benefit Rider, WS-CI DC Rider 04/12 (Form)

Comments: Your attention is called to the definition of Dependent Child/Children. With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Conclusion:

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

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/12/2012
Submitted Date	09/12/2012

Dear Rosalind Minor,

Introduction:

Thank you for your correspondence dated September 10.

Response 1

Comments:

The definition of Dependent Child is revised in the policies, certificates and the Dependent Child Rider. Due to the change to the rider, the form number is also revised.

Related Objection 1

Applies To:

- Group Critical Illness Master Policy, WS-CI Master Policy with Cancer 04/12 (Form)
- Group Critical Illness Master Policy, WS-CI Master Policy Without Cancer 04/12 (Form)
- Certificate of Insurance for Group Critical Illness Policy, WS-CI Cert With Cancer 04/12 AL (Form)
- Dependent Children Benefit Rider, WS-CI DC Rider 04/12 (Form)

Comments: Your attention is called to the definition of Dependent Child/Children. With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Boston Mutual Life Insurance Company

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

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Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	WS-CI Mast Policy with Cancer 0412 AR	POL	Group Critical Illness Master Policy	Initial	0.000	WS-CI Mast Policy with Cancer 0412 AR.pdf	Date Submitted: 09/12/2012 By: Olga E. Garcia
<i>Previous Version</i>							
1	<i>WS-CI Master Policy with Cancer 04/12</i>	<i>POL</i>	<i>Group Critical Illness Master Policy</i>	<i>Initial</i>	<i>0.000</i>	<i>WS-CI Mast Policy with Cancer 0412 AR.pdf</i>	<i>Date Submitted: 09/12/2012 By: Olga E. Garcia</i>
2	WS-CI Mast Policy Without Cancer 0412 AR	POL	Group Critical Illness Master Policy	Initial	0.000	WS-CI Mast Policy Without Cancer 0412 AR.pdf	Date Submitted: 09/12/2012 By: Olga E. Garcia
<i>Previous Version</i>							
2	<i>WS-CI Master Policy Without Cancer 04/12</i>	<i>POL</i>	<i>Group Critical Illness Master Policy</i>	<i>Initial</i>	<i>0.000</i>	<i>WS-CI Mast Policy Without Cancer 0412 AR.pdf</i>	<i>Date Submitted: 09/12/2012 By: Olga E. Garcia</i>

State:

Arkansas

Filing Company:

Boston Mutual Life Insurance Company

TOI/Sub-TOI:

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

Product Name:

Critical Illness

Project Name/Number:

BMLIC-GH-CI-AR-12-01-F/BMLIC-GH-CI-AR-12-01-F

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	WS-CI Mast Policy with Cancer 0412 AR	POL	Group Critical Illness Master Policy	Initial	0.000	WS-CI Mast Policy with Cancer 0412 AR.pdf	Date Submitted: 09/12/2012 By: Olga E. Garcia
3	WS-CI Cert With Cancer 0412 AR	CER	Certificate of Insurance for Group Critical Illness Policy	Initial	0.000	WS-CI Cert With Cancer 0412 AR.pdf	Date Submitted: 09/12/2012 By: Olga E. Garcia

Previous Version

3	<i>WS-CI Cert With Cancer 04/12 AL</i>	<i>CER</i>	<i>Certificate of Insurance for Group Critical Illness Policy</i>	<i>Initial</i>	<i>0.000</i>	<i>WS-CI Cert With Cancer 0412 AR.pdf</i>	<i>Date Submitted: 09/12/2012 By: Olga E. Garcia</i>
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Form Schedule Item Changes

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1	WS-CI Mast Policy with Cancer 0412 AR	POL	Group Critical Illness Master Policy	Initial	0.000	WS-CI Mast Policy with Cancer 0412 AR.pdf	Date Submitted: 09/12/2012 By: Olga E. Garcia
4	WS-CI Cert Without Cancer 0412 AR	CER	Certificate of Insurance for Group Critical Illness Policy	Initial	0.000	WS-CI Cert Without Cancer 0412 AR.pdf	Date Submitted: 09/12/2012 By: Olga E. Garcia

Previous Version

4	<i>WS-CI Cert Without Cancer 04/12 AL</i>	<i>CER</i>	<i>Certificate of Insurance for Group Critical Illness Policy</i>	<i>Initial</i>	<i>0.000</i>	<i>WS-CI Cert Without Cancer 0412 AR.pdf</i>	<i>Date Submitted: 09/12/2012 By: Olga E. Garcia</i>
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Form Schedule Item Changes							
Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	WS-CI Mast Policy with Cancer 0412 AR	POL	Group Critical Illness Master Policy	Initial	0.000	WS-CI Mast Policy with Cancer 0412 AR.pdf	Date Submitted: 09/12/2012 By: Olga E. Garcia
5	WS-CI DC Rider 0412 AR	CERA	Dependent Children Benefit Rider	Initial	0.000	WS-CI DC Rider 0412 AR.pdf	Date Submitted: 09/12/2012 By: Olga E. Garcia
<i>Previous Version</i>							
5	<i>WS-CI DC Rider 04/12</i>	<i>CERA</i>	<i>Dependent Children Benefit Rider</i>	<i>Initial</i>	<i>0.000</i>	<i>WS-CI DC Rider 0412.pdf</i>	<i>Date Submitted: 09/12/2012 By: Olga E. Garcia</i>

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Olga E. Garcia

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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 09/13/2012	WS-CI Mast Policy with Cancer 0412 AR	POL	Group Critical Illness Master Policy	Initial:	0.000	WS-CI Mast Policy with Cancer 0412 AR.pdf
2	Approved-Closed 09/13/2012	WS-CI Mast Policy Without Cancer 0412 AR	POL	Group Critical Illness Master Policy	Initial:	0.000	WS-CI Mast Policy Without Cancer 0412 AR.pdf
3	Approved-Closed 09/13/2012	WS-CI Cert With Cancer 0412 AR	CER	Certificate of Insurance for Group Critical Illness Policy	Initial:	0.000	WS-CI Cert With Cancer 0412 AR.pdf
4	Approved-Closed 09/13/2012	WS-CI Cert Without Cancer 0412 AR	CER	Certificate of Insurance for Group Critical Illness Policy	Initial:	0.000	WS-CI Cert Without Cancer 0412 AR.pdf
5	Approved-Closed 09/13/2012	WS-CI DC Rider 0412 AR	CERA	Dependent Children Benefit Rider	Initial:	0.000	WS-CI DC Rider 0412 AR.pdf
6	Approved-Closed 09/13/2012	WS-CI GT Rider 04/12	CERA	Genetic Screening Test Benefit Rider	Initial:	0.000	WS-CI GT Rider 0412.pdf
7	Approved-Closed 09/13/2012	WS-CI EL Rider 04/12	CERA	Extended Loss Benefit Rider	Initial:	0.000	WS-CI EL Rider 0412.pdf
8	Approved-Closed 09/13/2012	WS-CI HS Rider 04/12	CERA	Health Screening Benefit Rider	Initial:	0.000	WS-CI HS Rider 0412.pdf
9	Approved-Closed 09/13/2012	WS-CI OHIV Rider 04/12	CERA	Occupational HIV Benefit Rider	Initial:	0.000	WS-CI OHIV Rider 0412.pdf

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Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
10	Approved-Closed 09/13/2012	WS-CI SW Rider 04/12	CERA	Strike Waiver	Initial:	0.000	WS-CI SW Rider 0412.pdf
11	Approved-Closed 09/13/2012	WS-CI Master Application 7/12	AEF	Application for Group Critical Illness Insurance	Initial:	0.000	228-076 Master App 07092012.pdf
12	Approved-Closed 09/13/2012	WS-GI/MI APP - CI 7/12	AEF	Critical Illness Enrollment Form	Initial:	0.000	228-071 Simplified CI App 07092012.pdf
13	Approved-Closed 09/13/2012	BML-CI-APP 7/12	AEF	Critical Illness Enrollment Form	Initial:	0.000	228-075 Full App 07092012.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



[120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521]

GROUP CRITICAL ILLNESS MASTER POLICY

Based on the Application for this Group Insurance Policy (herein called the Plan) made by

[ABC COMPANY, INC.]
(herein called the Policyholder)

and based on the payment of the premium when due, the Company agrees to pay the benefits provided on the following pages.

**THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY
THIS POLICY PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

This Plan becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown below. It may be continued in effect by the payment of premiums as provided in Section II. The Plan will terminate as provided in the provision titled "Termination of the Plan" in Section I.

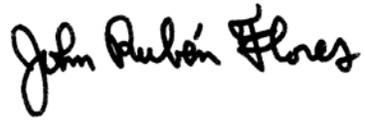
The first anniversary of this Plan will be the Anniversary Date shown below. "We", "us", and "our" refer to the Company. Subsequent anniversaries of the Plan will be the same date each year thereafter.

All matter printed or written by the Company on the following pages forms a part of this Plan as if recited over the signatures below. This Plan is a legal contract between the Company and the Policyholder. This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof the Company has caused this Plan to be executed at our Home Office in [Canton, Massachusetts] on the Effective Date.

Signed for the Company at its Home Office

[

President

Secretary
]

Countersigned by _____
Licensed Resident Agent (if required by your state)

Group Policy Number - [1234]
Effective Date - [April 1, 2012] **Anniversary Date -** [April 1, 2013]
Jurisdiction - [State Name] **Non-Participating**

GROUP POLICY PROVISIONS

- SECTION I** - Eligibility, Effective Date and Termination
- SECTION II** - Premium Provisions
- SECTION III** - General Definitions / Benefit Definitions
- SECTION IV** - Benefit Provisions
- SECTION V** - Limitations and Exclusions
- SECTION VI** - Claim Provisions
- SECTION VII** - General Provisions
- SECTION VIII** - Benefit Schedules
- SECTION IX** - Occupational Classifications

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

Certificateholder as used in this Plan, means a person insured under this Plan who is:

1. an eligible [Employee/Member] of the Policyholder, or an eligible Spouse of the [Employee/Member];
2. engaged in full-time work; and
3. included in the class of [Employees/Members] eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of this Plan is shown on Page 1 of the Master Policy.

The Effective Date for a Certificateholder is as follows:

1. A Certificateholder's insurance will be effective on the date shown on the Certificate Schedule provided the Certificateholder is then actively at work.
2. If a Certificateholder is not actively at work on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Certificateholder is first thereafter actively at work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date the Certificateholder's insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.
2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date the Certificateholder's insurance became effective.
3. For a Spouse eligible on or first acquired after the Certificateholder's Effective Date, the Effective Date will be the date we assign after approving the enrollment form for such coverage.

TERMINATION OF THE PLAN

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Plan on the day prior to the date any premium is due by giving 31 days written notice. The Plan will terminate when the number of participating Certificateholders is less than the number mutually agreed upon by the Policyholder and the Company in writing.

In these events, this Plan and all certificates issued hereunder will terminate on such date at 12:01 a.m. Standard Time at the Policyholder's address. This will be without prejudice to the rights of any Insured as respects any claim arising during the period the Plan is in force.

The Policyholder has the sole responsibility to notify Certificateholders of such termination.

TERMINATION OF A CERTIFICATEHOLDER'S INSURANCE

A Certificateholder's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date he ceases to meet the definition of [an Employee/a Member] as defined in the Plan; or
4. on the date he is no longer a member of the class eligible.

Insurance for an insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date the Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive the Certificateholder's written request to terminate coverage for his or her Spouse.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums in the Certificate. The rates can be changed annually. The Company will give the Policyholder written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid to the Company at our Home Office in [Canton, Massachusetts]. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

This Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Certificateholder must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore,

angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the enrollment form or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germinomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Fraumeni's Syndrome, Cowden Disease, Turcot Syndrome.

Cancer – means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. The following are not considered Cancer for purposes of this policy:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);
3. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;
4. Basal cell carcinoma and squamous cell carcinoma of the skin and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Cancer is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

Carcinoma in situ - means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. It also includes Stage 1 Hodgkin's Disease and Stage A Prostate Cancer. Carcinoma in situ does not include basal cell carcinoma, squamous cell carcinoma or melanoma diagnosed as Clark's Level I or II or Breslow less than .75mm. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Carcinoma in situ is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

The "first diagnosis" of Cancer/Carcinoma in situ includes a diagnosis of a recurrence of Cancer/Carcinoma in situ that was previously diagnosed before this Certificate was in force if, after the previous diagnosis and before the date of diagnosis of the recurrence, the Insured is free of any symptoms and treatment of the Cancer/Carcinoma in situ for the 12 consecutive months preceding the Certificate Application Date or any 12 consecutive months thereafter. Treatment does not include Maintenance Drug Therapy or routine follow-up visits or tests to verify that the Cancer/Carcinoma in situ has not returned.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
 - a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
 - b. there is medical evidence to support the diagnosis; and
 - c. a Doctor is treating an Insured for Cancer and/or Carcinoma in Situ.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception

and/or behavior and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date the Certificateholder signed the enrollment form for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule - This is page 3 of the certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder - means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Children - means all of the Certificateholder's children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company upon request.

Children means the Certificateholder's biological children, stepchildren, adopted children, foster children or any child for whom he or she is required by a court or administrative order to provide health coverage.

Doctor or Physician - means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include an Insured or their Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes;
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome;
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

[Employee - means the Insured as shown in the Certificate Schedule.]

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a

traumatic event, including surgical traumas. The date of diagnosis is the date that the Insured's Doctor or Physician recommends that he or she begin renal dialysis for End Stage Renal Disease.

Family Member - means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work - means the Certificateholder is spending at least [20] hours per week performing his/her occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while the Insured's coverage is in force and after any applicable Waiting Period.

Insured(s) –

1. If [Employee/Member] coverage is shown in the Certificate Schedule, we insure the [Employee/Member].
2. If coverage is for the Spouse of an eligible Certificateholder, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached rider (if applicable). Rider coverage is shown on the Certificate Page.
4. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Certificate or by the enrollment form, then such person shall not be an Insured.
5. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Loss of Sight, Speech or Hearing- means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Maintenance Drug Therapy – means ongoing hormonal treatment, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer or carcinoma in situ due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than palliative or suppression of a cancer that is still present.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

[Member - means the Insured as shown in the Certificate Schedule.]

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than the Insured or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date the Insured signed the enrollment form and indicated the specific rider(s) for which he/she is applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Skin Cancer – means basal cell carcinoma, squamous cell carcinoma and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm. It is not Skin Cancer if it has metastasized and leads to internal cancer. The date of diagnosis for Skin Cancer is the date the tissue specimen is taken.

Specified Critical Illness - means such illnesses shown in the Certificate Schedule and as defined in this Plan.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. **Meningocele** – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. **Myelomeningocele** – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured's spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If a Certificateholder dies while covered under a Certificate, then their surviving Spouse shall become the Insured if such Spouse is an Insured. If there is no surviving Spouse covered under the Certificate, then the Certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines. For Cancer or Carcinoma in Situ, Treatment does not include Maintenance Drug Therapy or routine follow-up visits and tests to verify if the Cancer/Carcinoma in Situ has not returned.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

SECTION IV - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while the Certificate is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months (12 months of no treatment for cancer or carcinoma in situ).

Skin Cancer Benefit

We will pay this benefit if an Insured person is diagnosed with Skin Cancer if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Policy.

This benefit is payable only once during the lifetime of the certificate for each Insured person.

Portability Privilege

When coverage would otherwise terminate under this Plan because an [Employee/Member] ends [employment/membership] with the [Employer/Association], they may elect to continue coverage. An [Employee/Member] must have been continuously insured for at least [0-12] months under this Plan and/or the prior Plan just before the date their [employment/membership] terminated. The coverage that may be continued is that which the [Employee/Member] had on the date their [employment/membership] terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. the Certificateholder failed to pay any required premium;
 - b. this Group Policy terminates.
2. To keep the Certificate in force the Certificateholder must:
 - a. make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date the Certificateholder fails to pay any required premium;
 - b. the date this Group Policy is terminated.

If a Certificateholder qualifies for this Portability Privilege as described, then the same Benefits, Plan Provisions, and Premium Rate as shown in their Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Plan contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, the Insured may elect to void the Certificate from the beginning and receive a full refund of premium.

PRIOR HISTORY OF CANCER

No benefits are payable for Cancer or Carcinoma in Situ if the Insured was previously diagnosed before this Certificate was in force and, after the previous diagnosis, the Insured has not gone 12 months without Treatment before a new diagnosis of Cancer/Carcinoma in situ is made.

PRE-EXISTING CONDITIONS LIMITATION (Not Applicable to Insureds with a Prior History of Cancer or Carcinoma in Situ – See PRIOR HISTORY OF CANCER)

This Plan contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021]. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When we receive a notice of claim, we will send the Claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021] within ninety (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. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send the Insured written notice of our claim decision within 30 days after we receive due proof of loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send the Insured a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send the Insured written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. The Insured will have 45 days to provide any additional information requested.

If the claim is urgent, we will notify the Insured of our decision within 72 hours. If we need more information, we will let the Insured know within 24 hours of the claim. At that time we will tell the Insured what additional information is needed to process the claim. The Insured will have 48 hours to provide any additional information requested. We will notify the Insured of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat the Insured's claim as urgent if a delay in processing the claim could seriously jeopardize his or her life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject the Insured to severe pain that cannot be managed without the care or treatment that is the subject of the claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support the claim;
4. Information concerning the Insured's right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of the Insured's right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after the Insured receives notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, the Insured may:

1. Send us written comments;
2. Review any non-privileged information relating to the claim; or
3. Provide us with other information or proof in support of the claim.

We will review the claim promptly after receiving the request. We will advise the Insured of the results of our review within 60 days after we receive the request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of the Insured's right to bring a civil action.

If the appeal arises from our denial of an urgent claim, we will consider the appeal and notify the Insured of our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All benefits will be payable to the Certificateholder unless assigned by them or by operation of law. Any accrued benefit unpaid at the Insured's death may be paid to their estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from you. If you have any questions about this Plan, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this Plan. Thank you for your loyal patronage.

Entire Contract, Changes: This Policy together with the application, enrollment forms, endorsements, benefit

agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Plan shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change this Plan or waive any of its Provisions. Any Rider, Endorsement or Application that modifies, limits or excludes coverage under this Plan must be signed by the Certificateholder to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Plan within 60 days after written Proof of Loss has been given as required by this Plan. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from an Insured's effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from an Insured's Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Clerical Error: Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

Misstatement of Age: If an age has been misstated on the enrollment form, the benefits will be those the premium paid would have purchased at the correct age.

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 it was issued is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New [Employees/Members] of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally Insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

Important Notice: For questions regarding the Policy, please contact the Company at [1-800-669-2668]. If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494

SECTION VIII

POLICY SCHEDULE

MASTER POLICYHOLDER: [ABC COMPANY INC]

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: [\$30,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

PRE-EXISTING CONDITION PERIOD: [180] Days

WAITING PERIOD: [30] Days

[IF THIS COVERAGE REPLACES EXISTING CRITICAL ILLNESS COVERAGE THE CERTIFICATEHOLDER CURRENTLY HAS WITH ANOTHER CARRIER, HE OR SHE WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME THE PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD.]

COVERED SPECIFIED CRITICAL ILLNESSES:

100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

- | | |
|--------------------------------------|--|
| Myocardial Infarction (Heart Attack) | Benign Brain Tumor |
| Stroke | Major Organ Transplant |
| Coma | End Stage Renal Disease (Kidney Failure) |
| Paralysis | Amyotrophic Lateral Sclerosis (ALS) |
| Severe Burns | Loss of Sight, Speech or Hearing |
| Alzheimer's Disease | Cancer |

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:

- Coronary Artery Bypass Surgery
- Angioplasty/Stent
- Carcinoma in situ (not including Skin Cancer)

Skin Cancer – a \$300 one-time (lifetime) benefit is payable for Skin Cancer per Insured Person.

[SPOUSE BENEFIT:

INSURED SPOUSE: [Jane Doe]

MAXIMUM BENEFIT AMOUNT: [\$15,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

[DEPENDENT CHILDREN BENEFIT RIDER:

MAXIMUM BENEFIT AMOUNT: [\$7,500]

100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: **Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida]**

[HEALTH SCREENING BENEFIT RIDER:

[\$50] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[GENETIC SCREENING TEST BENEFIT RIDER:

[\$250] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[EXTENDED LOSS BENEFIT RIDER:

MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000]

There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.]

[STRIKE WAIVER:

]

[OCCUPATIONAL HIV BENEFIT RIDER:

[\$5,000] payable one-time for the Primary Insured]

SECTION IX - OCCUPATIONAL CLASSIFICATIONS

[All Full-Time employees, who are actively at work, and have completed at least [XX] months of continuous employment with the Policyholder.]



[120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521]

GROUP CRITICAL ILLNESS MASTER POLICY

Based on the Application for this Group Insurance Policy (herein called the Plan) made by

[ABC COMPANY, INC.]
(herein called the Policyholder)

and based on the payment of the premium when due, the Company agrees to pay the benefits provided on the following pages.

**THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY
THIS POLICY PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

This Plan becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown below. It may be continued in effect by the payment of premiums as provided in Section II. The Plan will terminate as provided in the provision titled "Termination of the Plan" in Section I.

The first anniversary of this Plan will be the Anniversary Date shown below. "We", "us", and "our" refer to the Company. Subsequent anniversaries of the Plan will be the same date each year thereafter.

All matter printed or written by the Company on the following pages forms a part of this Plan as if recited over the signatures below. This Plan is a legal contract between the Company and the Policyholder. This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof the Company has caused this Plan to be executed at our Home Office in [Canton, Massachusetts] on the Effective Date.

Signed for the Company at its Home Office


President


Secretary

Countersigned by _____
Licensed Resident Agent (if required by your state)

Group Policy Number - [1234]
Effective Date - [April 1, 2012] **Anniversary Date -** [April 1, 2013]
Jurisdiction - [State Name] **Non-Participating**

GROUP POLICY PROVISIONS

- SECTION I** - Eligibility, Effective Date and Termination
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SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

Certificateholder as used in this Plan, means a person insured under this Plan who is:

1. an eligible [Employee/Member] of the Policyholder, or an eligible Spouse of the [Employee/Member];
2. engaged in full-time work; and
3. included in the class of [Employees/Members] eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of this Plan is shown on Page 1 of the Master Policy.

The Effective Date for a Certificateholder is as follows:

1. A Certificateholder's insurance will be effective on the date shown on the Certificate Schedule provided the Certificateholder is then actively at work.
2. If a Certificateholder is not actively at work on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Certificateholder is first thereafter actively at work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date the Certificateholder's insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.
2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date the Certificateholder's insurance became effective.
3. For a Spouse eligible on or first acquired after the Certificateholder's Effective Date, the Effective Date will be the date we assign after approving the application for such coverage.

TERMINATION OF THE PLAN

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Plan on the day prior to the date any premium is due by giving 31 days written notice. The Plan will terminate when the number of participating Certificateholders is less than the number mutually agreed upon by the Policyholder and the Company in writing.

In these events, this Plan and all certificates issued hereunder will terminate on such date at 12:01 a.m. Standard Time at the Policyholder's address. This will be without prejudice to the rights of any Insured as respects any claim arising during the period the Plan is in force.

The Policyholder has the sole responsibility to notify Certificateholders of such termination.

TERMINATION OF A CERTIFICATEHOLDER'S INSURANCE

A Certificateholder's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date he ceases to meet the definition of [an Employee/a Member] as defined in the Plan; or
4. on the date he is no longer a member of the class eligible.

Insurance for an insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date the Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive the Certificateholder's written request to terminate coverage for his or her Spouse.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums in the Certificate. The rates can be changed annually. The Company will give the Policyholder written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid to the Company at our Home Office in [Canton, Massachusetts]. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

This Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Certificateholder must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore,

angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the enrollment form or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germinomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Fraumeni's Syndrome, Cowden Disease, Turcot Syndrome.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date the Certificateholder signed the enrollment form for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule - This is page 3 of the certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder – means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stents or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Children - means all of the Certificateholder's children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company upon request.

Children means the Certificateholder's biological children, stepchildren, adopted children, foster children or any child for whom he or she is required by a court or administrative order to provide health coverage.

Doctor or Physician - means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include an Insured or their Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes;
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome;
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

[Employee - means the Insured as shown in the Certificate Schedule.]

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas. The date of diagnosis is the date that the Insured's Doctor or Physician recommends that he or she begin renal dialysis for End Stage Renal Disease.

Family Member - means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work - means the Certificateholder is spending at least [20] hours per week performing his/her occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while the Insured's coverage is in force and after any applicable Waiting Period.

Insured(s) -

1. If [Employee/Member] coverage is shown in the Certificate Schedule, we insure the [Employee/Member].
2. If coverage is for the Spouse of an eligible Certificateholder, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached rider (if applicable). Rider coverage is shown on the Certificate Page. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Certificate or by the enrollment form, then such person shall not be an Insured.
4. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Loss of Sight, Speech or Hearing- means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

[**Member** – means the Insured as shown in the Certificate Schedule.]

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than the Insured or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date the Insured signed the enrollment form and indicated the specific rider(s) for which he/she is applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Specified Critical Illness - means such illnesses shown in the Certificate Schedule and as defined in this Plan.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. Meningocele – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. Myelomeningocele – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured's spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive

evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If a Certificateholder dies while covered under a Certificate, then their surviving Spouse shall become the Insured if such Spouse is an Insured. If there is no surviving Spouse covered under the Certificate, then the Certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

SECTION IV - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while the Certificate is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months.

Portability Privilege

When coverage would otherwise terminate under this Plan because an [Employee/Member] ends [employment/membership] with the [Employer/Association], they may elect to continue coverage. An [Employee/Member] must have been continuously insured for at least [XX] months under this Plan and/or the prior Plan just before the date their [employment/membership] terminated. The coverage that may be continued is that which the [Employee/Member] had on the date their [employment/membership] terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. the Certificateholder failed to pay any required premium;
 - b. this Group Policy terminates.
2. To keep the Certificate in force the Certificateholder must:
 - a. make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date the Certificateholder fails to pay any required premium;
 - b. the date this Group Policy is terminated.

If a Certificateholder qualifies for this Portability Privilege as described, then the same Benefits, Plan Provisions, and Premium Rate as shown in their Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Plan contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, the Insured may elect to void the Certificate from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS LIMITATION

This Plan contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021]. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When we receive a notice of claim, we will send the Claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021] within ninety (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. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send the Insured written notice of our claim decision within 30 days after we receive due proof of loss. If there are special circumstances that require more time (such as the need to hold a

hearing), we will send the Insured a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send the Insured written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. The Insured will have 45 days to provide any additional information requested.

If the claim is urgent, we will notify the Insured of our decision within 72 hours. If we need more information, we will let the Insured know within 24 hours of the claim. At that time we will tell the Insured what additional information is needed to process the claim. The Insured will have 48 hours to provide any additional information requested. We will notify the Insured of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat the Insured's claim as urgent if a delay in processing the claim could seriously jeopardize his or her life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject the Insured to severe pain that cannot be managed without the care or treatment that is the subject of the claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support the claim;
4. Information concerning the Insured's right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of the Insured's right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after the Insured receives notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, the Insured may:

1. Send us written comments;
2. Review any non-privileged information relating to the claim; or
3. Provide us with other information or proof in support of the claim.

We will review the claim promptly after receiving the request. We will advise the Insured of the results of our review within 60 days after we receive the request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of the Insured's right to bring a civil action.

If the appeal arises from our denial of an urgent claim, we will consider the appeal and notify the Insured of our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All benefits will be payable to the Certificateholder unless assigned by them or by operation of law. Any accrued benefit unpaid at the Insured's death may be paid to their estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from you. If you have any questions about this Plan, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this Plan. Thank you for your loyal patronage.

Entire Contract, Changes: This Policy together with the application, enrollment forms, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Plan shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change this Plan or waive any of its Provisions. Any Rider, Endorsement or

Application that modifies, limits or excludes coverage under this Plan must be signed by the Certificateholder to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Plan within 60 days after written Proof of Loss has been given as required by this Plan. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from an Insured's effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from an Insured's Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Clerical Error: Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

Misstatement of Age: If an age has been misstated on the enrollment form, the benefits will be those the premium paid would have purchased at the correct age.

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 it was issued is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New [Employees/Members] of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

Important Notice: For questions regarding the Policy, please contact the Company at [1-800-669-2668]. If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494

SECTION VIII

POLICY SCHEDULE

MASTER POLICYHOLDER: [ABC COMPANY INC]

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: [\$30,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

PRE-EXISTING CONDITION PERIOD: [180] Days

WAITING PERIOD: [30] Days

[IF THIS COVERAGE REPLACES EXISTING CRITICAL ILLNESS COVERAGE THE CERTIFICATEHOLDER CURRENTLY HAS WITH ANOTHER CARRIER, HE OR SHE WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME THE PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD.]

COVERED SPECIFIED CRITICAL ILLNESSES:

100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

- | | |
|--------------------------------------|--|
| Myocardial Infarction (Heart Attack) | Benign Brain Tumor |
| Stroke | Major Organ Transplant |
| Coma | End Stage Renal Disease (Kidney Failure) |
| Paralysis | Amyotrophic Lateral Sclerosis (ALS) |
| Severe Burns | Loss of Sight, Speech or Hearing |
| Alzheimer's Disease | |

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:

- Coronary Artery Bypass Surgery
- Angioplasty/Stent

[SPOUSE BENEFIT:

MAXIMUM BENEFIT AMOUNT: [\$15,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

[DEPENDENT CHILDREN BENEFIT RIDER:

MAXIMUM BENEFIT AMOUNT: [\$7,500]

100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida]

[HEALTH SCREENING BENEFIT RIDER:

[\$50] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[GENETIC SCREENING TEST BENEFIT RIDER:

[\$250] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[EXTENDED LOSS BENEFIT RIDER:

MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000]

There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.]

[STRIKE WAIVER:

]

[OCCUPATIONAL HIV BENEFIT RIDER:

[\$5,000] payable one-time for the Primary Insured]

SECTION IX - OCCUPATIONAL CLASSIFICATIONS

[All Full-Time employees, who are actively at work, and have completed at least [XX] months of continuous employment with the Policyholder.]



CERTIFICATE OF INSURANCE FOR GROUP CRITICAL ILLNESS POLICY

**THIS CERTIFICATE PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare.

PLEASE READ YOUR CERTIFICATE CAREFULLY

We certify that You are insured under the Critical Illness Policy (herein called the Plan) issued to the Policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from Specified Critical Illness. Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in Your Certificate or not, apply to the insurance referred to by the Certificate.

The Effective Date of Your Certificate is as shown in the Certificate Schedule if You are on that date actively at work [for the Policyholder]. If not, this Certificate will become effective on the next date You are actively at work [as an eligible Employee]. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate is issued in consideration of the payment in advance of the required premium and of Your statements and representations in the enrollment form. This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to You under the Plan. "You" and "Your" refer to the Certificateholder or any other Insured under Family Coverage. "We", "Us", and "Our" refer to the Company.

NO RECOVERY FOR PRE-EXISTING CONDITIONS—PLEASE READ CAREFULLY. Your Certificate Schedule reflects the period of time this coverage is in force during which no benefits will be provided for conditions diagnosed within the 180 day period prior to the Effective Date shown in the Certificate Schedule.

Signed for the Company at its Home Office

President

Secretary

TEN DAY RIGHT TO EXAMINE CERTIFICATE

You have the right to return the Certificate within ten (10) days of its delivery and have the premium refunded if, after examination of the Certificate, You are not satisfied for any reason.

CERTIFICATE INDEX

Eligibility, Effective Date and Termination	Section I
Premium Provisions	Section II
General Definitions / Benefit Definitions	Section III
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Limitations and Exclusions.....	Section V
Claim Provisions	Section VI
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CERTIFICATE SCHEDULE

MASTER POLICYHOLDER: [ABC COMPANY INC]
PRIMARY INSURED: [John Doe]
EFFECTIVE DATE: [May 1, 2012]

CERTIFICATE NUMBER: [123456]

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: [\$30,000] [\$xx.xx]
[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

PRE-EXISTING CONDITION PERIOD: [180] Days

WAITING PERIOD: [30] Days

[IF THIS COVERAGE REPLACES EXISTING CRITICAL ILLNESS COVERAGE YOU CURRENTLY HAVE WITH ANOTHER CARRIER, YOU WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME YOUR PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD.]

COVERED SPECIFIED CRITICAL ILLNESSES:

100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

Myocardial Infarction (Heart Attack)	Benign Brain Tumor
Stroke	Major Organ Transplant
Coma	End Stage Renal Disease (Kidney Failure)
Paralysis	Amyotrophic Lateral Sclerosis (ALS)
Severe Burns	Loss of Sight, Speech or Hearing
Alzheimer's Disease	Cancer

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:

Coronary Artery Bypass Surgery
Angioplasty/Stent
Carcinoma in situ (not including Skin Cancer)

Skin Cancer – a \$300 one-time (lifetime) benefit is payable for Skin Cancer per Insured Person.

[SPOUSE BENEFIT: [\$x.xx]

INSURED SPOUSE: [Jane Doe]

MAXIMUM BENEFIT AMOUNT: [\$15,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

[DEPENDENT CHILDREN BENEFIT RIDER: [\$x.xx]

MAXIMUM BENEFIT AMOUNT: [\$7,500]

100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida]

[HEALTH SCREENING BENEFIT RIDER: [\$x.xx]

[\$50] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[GENETIC SCREENING TEST BENEFIT RIDER: [\$x.xx]

[\$250] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[EXTENDED LOSS BENEFIT RIDER: [\$x.xx]

MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000]

There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.]

[STRIKE WAIVER: [\$x.xx]]

[OCCUPATIONAL HIV BENEFIT RIDER: [\$x.xx]

[\$5,000] payable one-time for the Primary Insured]

TOTAL MONTHLY PREMIUM: [\$xx.xx]

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

You as used in this Certificate, means a person insured under this Certificate who is:

1. an eligible [Employee/Member] of the Policyholder, or an eligible Spouse of the [Employee/Member];
2. engaged in full-time work; and
3. included in the class of [Employees/Members] eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of the Plan is shown on Page 1 of the Master Policy.

The Effective Date for You is as follows:

1. Your insurance will be effective on the date shown on the Certificate Schedule provided You are Actively At Work.
2. If you are not Actively At Work on the date coverage would otherwise become effective, the Effective Date of Your coverage will be the date on which You are first thereafter Actively At Work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date Your insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.
2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date that Your insurance became effective.
3. For a Spouse eligible on or first acquired after Your Effective Date, the Effective Date will be the date We assign after approving the application for such coverage.

TERMINATION OF YOUR INSURANCE

Your insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date You cease to meet the definition of [an Employee/a Member] as defined in the Plan; or
4. on the date You are no longer a member of the class eligible.

Insurance for insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date a Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive Your written request to terminate coverage for Your Spouse.

Termination of the insurance on any Insured shall be without prejudice to an Insured's rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums. The rates shown in this Schedule can be changed annually. The Company will give the Policyholder written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid by the Policyholder to the Company at Our Home Office. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

The Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, this Certificate will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Insured must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore, angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the application or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germinomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Frauman's Syndrome, Cowden Disease, Turcot Syndrome.

Cancer – means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. The following are not considered Cancer for purposes of this policy:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);

3. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;
4. Basal cell carcinoma and squamous cell carcinoma of the skin and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Cancer is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

Carcinoma in situ - means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. It also includes Stage 1 Hodgkin's Disease and Stage A Prostate Cancer. Carcinoma in situ does not include basal cell carcinoma, squamous cell carcinoma or melanoma diagnosed as Clark's Level I or II or Breslow less than .75mm. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Carcinoma in situ is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

The "first diagnosis" of Cancer/Carcinoma in situ includes a diagnosis of a recurrence of Cancer/Carcinoma in situ that was previously diagnosed before this Certificate was in force if, after the previous diagnosis and before the date of diagnosis of the recurrence, the Insured is free of any symptoms and treatment of the Cancer/Carcinoma in situ for the 12 consecutive months preceding the Certificate Application Date or any 12 consecutive months thereafter. Treatment does not include Maintenance Drug Therapy or routine follow-up visits or tests to verify that the Cancer/Carcinoma in situ has not returned.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
 - a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
 - b. there is medical evidence to support the diagnosis; and
 - c. a Doctor is treating You for Cancer and/or Carcinoma in Situ.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date you sign the application for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule – This is page 3 of your certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder – means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Child/Children - All of Your children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company upon request.

Children means Your biological children, stepchildren, adopted children, foster children or any child for whom You are required by a court or administrative order to provide health coverage.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include You or a Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas. The date of diagnosis is the date that Your Doctor or Physician recommends that You begin renal dialysis for End Stage Renal Disease.

Family Member means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work means spending at least [20] hours per week performing your occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while this Certificate is in force and after any applicable Waiting Period.

Insured(s) –

1. If coverage is issued to You, We insure You as the Primary Insured as shown on the Certificate Schedule.
2. If you elect Spouse coverage, We insure You and Your Spouse. Spouse coverage is shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached Rider (if applicable). Rider coverage is shown on the Certificate Schedule.

Loss of Sight, Speech or Hearing means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Maintenance Drug Therapy – means ongoing hormonal treatment, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer or carcinoma in situ due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than palliative or suppression of a cancer that is still present.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than Yourself or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date you sign the application and indicate the specific rider(s) for which you are applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Skin Cancer – means basal cell carcinoma, squamous cell carcinoma and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm. It is not Skin Cancer if it has metastasized and leads to internal cancer. The date of diagnosis for Skin Cancer is the date the tissue specimen is taken.

Specified Critical Illness - means such Illnesses shown in the Certificate Schedule and as defined in this Certificate.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. Meningocele – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. Myelomeningocele – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured’s spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Verterbrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If You die while covered under this certificate, then Your surviving Spouse shall become the Insured if Your Spouse is an Insured. If there is no surviving Spouse covered under this certificate, then this certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines. For Cancer or Carcinoma in Situ, Treatment does not include Maintenance Drug Therapy or routine follow-up visits and tests to verify if the Cancer/Carcinoma in Situ has not returned.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won’t pay benefits for a Specified Critical Illness that begins during the Waiting Period.

You or Your - means the Insured(s) as shown on the Certificate Schedule.

SECTION IV – BENEFIT PROVISIONS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate’s Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months (12 months of no Treatment for Cancer/Carcinoma in situ).

Skin Cancer Benefit

We will pay this benefit if an Insured person is diagnosed with Skin Cancer if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Policy.

This benefit is payable only once during the lifetime of the certificate for each Insured person.

Portability Privilege

When Your coverage would otherwise terminate under this Plan because You end [employment/membership] with the Policyholder, You may elect to keep Your certificate in force. You must have been continuously insured for at least [xx] months under this Plan and/or the prior Plan just before the date Your [employment/membership] terminated. The coverage You may continue is that which You had on the date Your [employment/membership] terminated, including Spouse and Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. You failed to pay any required premium;
 - b. the Group Policy terminates.
2. To keep Your insurance in force You must:
 - a. make written Application to the Company within 31 days after the date Your insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date Your insurance would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date You failed to pay any required premium;
 - b. the date the Group Policy is terminated.

If you qualify for this Portability Privilege as described, then the same benefits, plan provisions, and premium rate as shown in your Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This certificate contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, you may elect to void the Certificate from the beginning and receive a full refund of premium.

PRIOR HISTORY OF CANCER

No benefits are payable for Cancer or Carcinoma in Situ if the Insured was previously diagnosed before this Certificate was in force and, after the previous diagnosis, the Insured has not gone 12 months without Treatment before a new diagnosis of Cancer/Carcinoma in situ is made.

PRE-EXISTING CONDITIONS LIMITATION (Not Applicable to Insureds with a Prior History of Cancer or Carcinoma in Situ – See PRIOR HISTORY OF CANCER)

This certificate contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021]. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021] within ninety (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. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send You written notice of Our claim decision within 30 days after We receive due proof of Your loss. If there are special circumstances that require more time (such as the need to hold a hearing), We will send You a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, We will send You written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If Your claim is urgent, We will notify You of Our decision within 72 hours. If We need more information, We will let You know within 24 hours of Your claim. At that time We will tell You what additional information is needed to process Your claim. You will have 48 hours to provide any additional information requested. We will notify You of Our decision within 48 hours after We receive the requested information. Our response to an urgent care claim may be oral; if it is, We will confirm Our decision in writing.

We will treat Your claim as urgent if a delay in processing Your claim could seriously jeopardize Your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject You to severe pain that cannot be managed without the care or treatment that is the subject of Your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy or certificate provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support Your claim;
4. Information concerning Your right to request that we review Our decision; and
5. A description of Our review procedures, time limits and notice of Your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by Us no more than 180 days after You receive notice of Our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, You may:

1. Send Us written comments;
2. Review any non-privileged information relating to Your claim; or
3. Provide Us with other information or proof in support of Your claim.

We will review Your claim promptly after receiving Your request. We will advise You of the results of Our review within 60 days after We receive Your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of Your right to bring a civil action.

If Your appeal arises from Our denial of an urgent claim, We will consider Your appeal and notify You of Our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All Benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefit unpaid at Your death may be paid to Your estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from You. If You have any questions about this certificate, its benefits, the filing of claims, a complaint or a compliment, please call us or write to Us. Thank you for your loyal patronage.

Entire Contract, Changes: The Master Policy together with the application, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Certificate shall be valid until approved in writing by an executive officer of the Company. Any change must be noted on or attached hereto. No agent may change this Certificate or waive any of its provisions.

Physical Examination and Autopsy: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending. In the case of death, We may also have an autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Certificate within 60 days after written proof of loss has been given as required by this Certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from the Effective Date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from the Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

Conformity with State Statutes: Any Provision of this Certificate which, on its "Effective Date", is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New Employees of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

Important Notice: For questions regarding the Policy, please contact the Company at [1-800-669-2668]. If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division

1200 West Third Street
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494



CERTIFICATE OF INSURANCE FOR GROUP CRITICAL ILLNESS POLICY

**THIS CERTIFICATE PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare.

PLEASE READ YOUR CERTIFICATE CAREFULLY

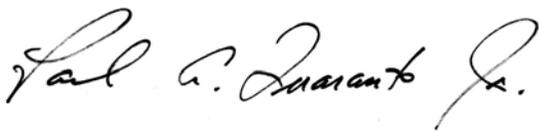
We certify that You are insured under the Critical Illness Policy (herein called the Plan) issued to the Policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from Specified Critical Illness. Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in Your Certificate or not, apply to the insurance referred to by the Certificate.

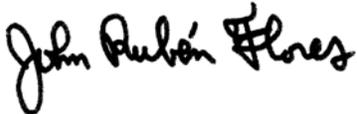
The Effective Date of Your Certificate is as shown in the Certificate Schedule if You are on that date actively at work [for the Policyholder]. If not, this Certificate will become effective on the next date You are actively at work [as an eligible Employee]. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate is issued in consideration of the payment in advance of the required premium and of Your statements and representations in the enrollment form. This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to You under the Plan. "You" and "Your" refer to the Certificateholder or any other Insured under Family Coverage. "We", "Us", and "Our" refer to the Company.

NO RECOVERY FOR PRE-EXISTING CONDITIONS—PLEASE READ CAREFULLY. Your Certificate Schedule reflects the period of time this coverage is in force during which no benefits will be provided for conditions diagnosed within the 180 day period prior to the Effective Date shown in the Certificate Schedule.

Signed for the Company at its Home Office


President


Secretary

TEN DAY RIGHT TO EXAMINE CERTIFICATE

You have the right to return the Certificate within ten (10) days of its delivery and have the premium refunded if, after examination of the Certificate, You are not satisfied for any reason.

CERTIFICATE INDEX

Eligibility, Effective Date and Termination	Section I
Premium Provisions	Section II
General Definitions / Benefit Definitions	Section III
Benefit Provisions	Section IV
Limitations and Exclusions.....	Section V
Claim Provisions	Section VI
General Provisions.....	Section VII

CERTIFICATE SCHEDULE

MASTER POLICYHOLDER: [ABC COMPANY INC]
PRIMARY INSURED: [John Doe]
EFFECTIVE DATE: [May 1, 2012]

CERTIFICATE NUMBER: [123456]

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: [\$30,000] [\$xx.xx]
[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

PRE-EXISTING CONDITION PERIOD: [180] Days

WAITING PERIOD: [30] Days

[IF THIS COVERAGE REPLACES EXISTING CRITICAL ILLNESS COVERAGE YOU CURRENTLY HAVE WITH ANOTHER CARRIER, YOU WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME YOUR PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD.]

COVERED SPECIFIED CRITICAL ILLNESSES:

100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

Myocardial Infarction (Heart Attack)	Benign Brain Tumor
Stroke	Major Organ Transplant
Coma	End Stage Renal Disease (Kidney Failure)
Paralysis	Amyotrophic Lateral Sclerosis (ALS)
Severe Burns	Loss of Sight, Speech or Hearing
Alzheimer's Disease	

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:

Coronary Artery Bypass Surgery
Angioplasty/Stent

[SPOUSE BENEFIT: [\$x.xx]

INSURED SPOUSE: [Jane Doe]

MAXIMUM BENEFIT AMOUNT: [\$15,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

[DEPENDENT CHILDREN BENEFIT RIDER: [\$x.xx]

MAXIMUM BENEFIT AMOUNT: [\$7,500]

100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: **Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida**

[HEALTH SCREENING BENEFIT RIDER: [\$x.xx]

[\$50] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[GENETIC SCREENING TEST BENEFIT RIDER: [\$x.xx]

[\$250] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[EXTENDED LOSS BENEFIT RIDER: [\$x.xx]

MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000]

There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.]

[STRIKE WAIVER: [\$x.xx]]

[OCCUPATIONAL HIV BENEFIT RIDER: [\$x.xx]

[\$5,000] payable one-time for the Primary Insured]

TOTAL MONTHLY PREMIUM: [\$xx.xx]

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

You as used in this Certificate, means a person insured under this Certificate who is:

1. an eligible [Employee/Member] of the Policyholder, or an eligible Spouse of the [Employee/Member];
2. engaged in full-time work; and
3. included in the class of [Employees/Members] eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of the Plan is shown on Page 1 of the Master Policy.

The Effective Date for You is as follows:

1. Your insurance will be effective on the date shown on the Certificate Schedule provided You are Actively At Work.
2. If you are not Actively At Work on the date coverage would otherwise become effective, the Effective Date of Your coverage will be the date on which You are first thereafter Actively At Work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date Your insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.
2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date that Your insurance became effective.
3. For a Spouse eligible on or first acquired after Your Effective Date, the Effective Date will be the date We assign after approving the application for such coverage.

TERMINATION OF YOUR INSURANCE

Your insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date You cease to meet the definition of [an Employee/a Member] as defined in the Plan; or
4. on the date You are no longer a member of the class eligible.

Insurance for insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date the Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive Your written request to terminate coverage for Your Spouse.

Termination of the insurance on any Insured shall be without prejudice to an Insured's rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums. The rates shown in this Schedule can be changed annually. The Company will give the Policyholder written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid by the Policyholder to the Company at Our Home Office. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

The Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, this Certificate will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Insured must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore, angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the application or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germinomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Frauman's Syndrome, Cowden Disease, Turcot Syndrome.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date you sign the application for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule – This is page 3 of your certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder – means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Child/Children - All of Your children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company upon request.

Children means Your biological children, stepchildren, adopted children, foster children or any child for whom You are required by a court or administrative order to provide health coverage.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include You or a Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes;
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome;
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas. The date of diagnosis is the date that Your Doctor or Physician recommends that You begin renal dialysis for End Stage Renal Disease.

Family Member means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work means spending at least [20] hours per week performing your occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while this Certificate is in force and after any applicable Waiting Period.

Insured(s) –

1. If coverage is issued to You, We insure You as the Primary Insured as shown on the Certificate Schedule.
2. If you elect Spouse coverage, We insure You and Your Spouse. Spouse coverage is shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached Rider (if applicable). Rider coverage is shown on the Certificate Schedule.

Loss of Sight, Speech or Hearing means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than Yourself or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date you sign the application and indicate the specific rider(s) for which you are applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Specified Critical Illness - means such Illnesses shown in the Certificate Schedule and as defined in this Certificate.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. Meningocele – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. Myelomeningocele – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured's spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Verterbrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If You die while covered under this certificate, then Your surviving Spouse shall become the Insured if Your Spouse is an Insured. If there is no surviving Spouse covered under this certificate, then this certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

You or Your - means the Insured(s) as shown on the Certificate Schedule.

SECTION IV – BENEFIT PROVISIONS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.

3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months.

Portability Privilege

When Your coverage would otherwise terminate under this Plan because You end [employment/membership] with the Policyholder, You may elect to keep Your certificate in force. You must have been continuously insured for at least [xx] months under this Plan and/or the prior Plan just before the date Your [employment/membership] terminated. The coverage You may continue is that which You had on the date Your [employment/membership] terminated, including Spouse and Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. You failed to pay any required premium;
 - b. the Group Policy terminates.
2. To keep Your insurance in force You must:
 - a. make written Application to the Company within 31 days after the date Your insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date Your insurance would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date You failed to pay any required premium;
 - b. the date the Group Policy is terminated.

If you qualify for this Portability Privilege as described, then the same benefits, plan provisions, and premium rate as shown in your Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This certificate contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, you may elect to void the Certificate from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS LIMITATION

This certificate contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021]. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021] within ninety (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. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send You written notice of Our claim decision within 30 days after We receive due proof of Your loss. If there are special circumstances that require more time (such as the need to hold a hearing), We will send You a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, We will send You written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If Your claim is urgent, We will notify You of Our decision within 72 hours. If We need more information, We will let You know within 24 hours of Your claim. At that time We will tell You what additional information is needed to process Your claim. You will have 48 hours to provide any additional information requested. We will notify You of Our decision within 48 hours after We receive the requested information. Our response to an urgent care claim may be oral; if it is, We will confirm Our decision in writing.

We will treat Your claim as urgent if a delay in processing Your claim could seriously jeopardize Your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject You to severe pain that cannot be managed without the care or treatment that is the subject of Your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy or certificate provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support Your claim;
4. Information concerning Your right to request that we review Our decision; and
5. A description of Our review procedures, time limits and notice of Your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by Us no more than 180 days after You receive notice of Our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, You may:

1. Send Us written comments;
2. Review any non-privileged information relating to Your claim; or
3. Provide Us with other information or proof in support of Your claim.

We will review Your claim promptly after receiving Your request. We will advise You of the results of Our review within 60 days after We receive Your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of Your right to bring a civil action.

If Your appeal arises from Our denial of an urgent claim, We will consider Your appeal and notify You of Our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All Benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefit unpaid at Your death may be paid to Your estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from You. If You have any questions about this certificate, its benefits, the filing of claims, a complaint or a compliment, please call us or write to Us. Thank you for your loyal patronage.

Entire Contract, Changes: The Master Policy together with the application, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Certificate shall be valid until approved in writing by an executive officer of the Company. Any change must be noted on or attached hereto. No agent may change this Certificate or waive any of its provisions.

Physical Examination and Autopsy: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending. In the case of death, We may also have an autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Certificate within 60 days after written proof of loss has been given as required by this Certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from the Effective Date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from the Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

Conformity with State Statutes: Any Provision of this Certificate which, on its "Effective Date", is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New Employees of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

Important Notice: For questions regarding the Policy, please contact the Company at [1-800-669-2668]. If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494



DEPENDENT CHILDREN BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SPECIFIED CRITICAL ILLNESS

This Rider is a part of the Certificate to which it is attached. We have issued this Rider to you because: (1) you paid the additional premium for this Rider (when applicable); and (2) we relied on the application you made. Unless amended by this Rider, certificate definitions, other provisions and terms apply to this Rider.

Effective Date - If issued at the same time as the certificate, this Rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this Rider will have a later Effective Date, which will be shown in a revised Certificate Schedule Page. Refer to the Effective Date and Termination provision as stated herein.

DEFINITIONS

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

Dependent Children - means all of the Certificateholder's children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company upon request.

Children means Your biological children, stepchildren, adopted children, foster children or any child for whom You are required by a court or administrative order to provide health coverage.

BENEFITS

If a Dependent Child is diagnosed with a Specified Critical Illness, subject to the provisions, limitations and exclusions in the Certificate and this Rider and while this Rider is in force, we will provide the benefits for the Specified Critical Illnesses shown on the Certificate Schedule Page. The appropriate benefit amount we will pay for the Dependent Child is shown on the Certificate Schedule Page.

GENERAL PROVISIONS

If your Dependent Child's coverage is terminated because of attainment of the maximum age, we will still pay benefits for any covered condition that was diagnosed while the Dependent was covered under this Rider.

EFFECTIVE DATE

Coverage for Dependent Children is subject to the following:

1. Newborn children of a Certificateholder and/or his or her Spouse shall automatically be covered from birth provided that we receive notification within thirty-one (31) days after the birth of the child. Foster children shall be eligible for coverage on the same basis upon placement in the foster home.
2. Adopted children will be covered the later of the date of birth or the date a decree of adoption is entered by the Certificateholder and/or his or her Spouse. A decree of adoption must be

entered within one year from the date proceedings were instituted, unless extended by order of the court, and the Certificateholder and/or his or her Spouse must continue to have custody pursuant to the decree of the court.

TERMINATION – Coverage for the Dependent Children or Dependent Child will end on the earliest of the following:

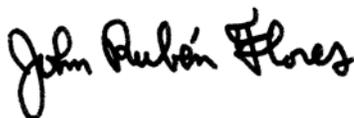
1. When the Certificate terminates;
2. The date We receive Your written request to cancel the Rider (in which case the grace period will not apply);
3. When the Dependent Children or Dependent Child does not qualify as a dependent of You or Your Spouse as defined in this Rider.

CONTRACT -This Rider is part of the Certificate, and will terminate when the certificate terminates, or when premiums are no longer paid for this Rider. This Rider is subject to all of the terms of the certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office



President



Secretary



GENETIC SCREENING TEST BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SPECIFIED CRITICAL ILLNESS

This rider is a part of the certificate to which it is attached. We have issued this rider to you because (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, certificate definitions and other provisions and terms apply to this rider.

Effective Date – If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later Effective Date, which will be shown on a revised Certificate Schedule Page.

BENEFIT

We will pay this benefit for genetic screening tests performed and recommended by a physician for the purpose of determining your risk of an illness or condition covered under your certificate. The genetic test must be performed by a Physician and while this Rider is in force. We will pay the amount shown on the certificate Schedule Page. This benefit is payable once per calendar year.

This benefit is payable in addition to the Health Screening benefit, if any. This benefit is not payable for Dependent Children. Payment of this benefit will not reduce the Maximum Benefit Amount of the certificate.

LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Rider contains a Waiting Period. This means no benefits are payable for any insured person who has genetic screening test during the Waiting Period. If coverage is approved and premiums are paid, the Waiting Period begins from the Rider Application Date. The Waiting Period is shown on the Certificate Schedule Page.

GENERAL PROVISIONS

This Rider is part of the certificate and will terminate when that certificate terminates, or when premiums are no longer paid for this Rider. The premium for this Rider is shown on the Certificate Schedule Page.

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

Signed for the Company at its Home Office

President

Secretary



EXTENDED LOSS BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SPECIFIED CRITICAL ILLNESS

This rider is a part of the certificate to which it is attached. We have issued this rider to you because (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, certificate definitions and other provisions and terms apply to this rider.

Effective Date – If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later effective date, which will be shown on a revised Certificate Schedule Page.

BENEFIT

We will pay the Extended Loss benefit amount shown on the Certificate Schedule Page if an Insured is admitted and confined on an inpatient basis in a Hospital for a period of 30 or more consecutive days for treatment of a Covered Sickness or Covered Injury.

LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Rider contains a Waiting Period. This means no benefits are payable for any Insured who has an Extended Loss which begins during the Waiting Period. The Waiting Period begins from the Rider Application Date. The Waiting Period is shown on the Certificate Schedule Page.

PRE-EXISTING CONDITIONS LIMITATION

This Rider contains a Pre-existing Condition Limitation. "Pre-existing Condition" means a sickness, accident or physical condition which, within 12 months prior to the Rider Application Date, resulted in medical advice or treatment.

We will not pay benefits for an accident or sickness resulting from a Pre-existing Condition during the first 12 months after this Rider is in force. The Pre-existing limitation period begins from the Rider Application Date. A claim for benefits for loss starting after 12 months from the Rider Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

We won't pay for loss due to:

1. Intentionally self inflicted injury or action;
2. Suicide or attempted suicide while sane or insane;
3. Illegal activities or participation in an illegal occupation;
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or
5. Substance Abuse.

DEFINITIONS

Covered Sickness - means an illness, infection, disease or any other abnormal physical condition or an injury which:

1. begins after the Rider Effective Date;
2. begins while this Rider is in force;
3. is not the result of a Pre-Existing Condition;

4. is not for a Specified Critical Illness already eligible for benefit under the certificate. This benefit will not be paid when the Specified Critical Illness benefit is payable for the same or related sickness; and
5. is not for the treatment of alcoholism, drug addiction or mental or nervous disorders.

Covered Injury - means bodily injury solely due to an accident and not contributed to by any other cause which:

1. begins after the Rider Effective Date;
2. begins while this Rider is in force; and
3. is not the result of a Pre-Existing Condition.

Hospital - means a primary care Hospital operated pursuant to law. The Hospital has organized facilities to provide first level treatment of sick and injured persons on an inpatient basis for which a charge is made. Organized facilities include emergency services, admissions services, clinical laboratory, diagnostic X-ray and an operating room.

Treatment facilities for emergency, medical and surgical services must be provided within the Hospital. The Hospital must provide 24 hour nursing services by or under the supervision of an R.N. (graduate registered Nurse), and be supervised by a staff of one or more Physicians. The Hospital also maintains on its premises the patient's written history and medical records.

Not included is a Hospital or institution or part of such Hospital or institution which is licensed or used principally as: (a) a hospice unit (including any beds designated as a hospice bed); (b) a swing bed; (c) a convalescent home; (d) a rest or nursing facility; (e) a skilled nursing facility; (f) a psychiatric unit; (g) a rehabilitation unit or facility; or (h) a facility primarily affording custodial care, educational care or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, drug addicts or alcoholics.

GENERAL PROVISIONS

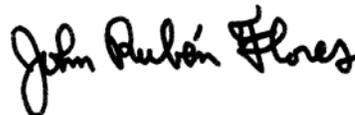
This Rider is part of the certificate and will terminate when that certificate terminates, or when premiums are no longer paid for this Rider. The premium for this Rider is shown on the Certificate Schedule Page.

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

Signed for the Company at its Home Office



President



Secretary



HEALTH SCREENING BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SPECIFIED CRITICAL ILLNESS

This rider is a part of the certificate to which it is attached. We have issued this rider to you because (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, certificate definitions and other provisions and terms apply to this rider.

Effective Date – If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later Effective Date, which will be shown on a revised Certificate Schedule Page.

Health Screening Benefit (Calendar Year Limit)

We will pay this benefit for the following Health Screening Tests performed after the Waiting Period and while this Rider is in force. We will pay the Health Screening Benefit amount shown on the Certificate Schedule Page for any one of the following Health Screening Tests. This benefit is payable once per Calendar Year. Payment of this benefit will not reduce the Maximum Benefit Amount of the Certificate. This benefit is not paid for Dependent Children. There is no limit to the number of years you can receive benefits for Health Screening Tests, as long as this Rider is in force. We will pay this benefit regardless of the results of the test.

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides
4. Lipid Panel (total cholesterol count)
5. Bone marrow testing,
6. CA 15-3 (blood test for breast cancer),
7. CA 125 (blood test for ovarian cancer),
8. CEA (blood test for colon cancer),
9. Chest X-ray,
10. Electrocardiogram (EKG)
11. Colonoscopy
12. Flexible sigmoidoscopy
13. Hemocult stool analysis,
14. Mammography/Breast Ultrasound
15. Pap smear (including ThinPrep Pap Test)
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography
19. Oral Cancer screening using ViziLite OraTest or other similar test
20. Biopsy for Skin Cancer

LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Rider contains a Waiting Period. This means no benefits are payable for any insured person who has a Health Screening Test during the Waiting Period. If coverage is approved and premiums are paid, the Waiting Period begins from the Rider Application Date. The Waiting Period is shown on the Certificate Schedule Page.

GENERAL PROVISIONS

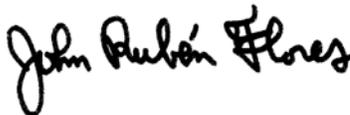
This Rider is part of the certificate and will terminate when that certificate terminates, or when premiums are no longer paid for this Rider. The premium for this Rider is shown on the Certificate Schedule Page.

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

Signed for the Company at its Home Office



President



Secretary



OCCUPATIONAL HIV BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SPECIFIED CRITICAL ILLNESS

This rider is a part of the certificate to which it is attached. We have issued this rider to you because (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, certificate definitions and other provisions and terms apply to this rider.

Effective Date – If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later effective date, which will be shown on a revised Certificate Schedule Page.

BENEFITS

We will pay the amount shown on the Certificate Schedule if the Insured is initially diagnosed as HIV Positive for Occupational HIV due to a Covered Injury while this Rider is in force. This benefit is only payable once.

DEFINITIONS

The terms used in this Rider are as defined in the Policy (“DEFINITIONS”) section. The following definitions are added to this Rider:

Covered Injury - means an accidental:

1. cutaneous exposure through abraded skin;
2. percutaneous exposure; or
3. mucocutaneous exposure

that occurs while the Insured is covered by this benefit, actively at work and performing all the regular duties of his or her occupation on a full-time basis.

HIV - means human immunodeficiency virus.

HIV Positive - means the presence of HIV antibodies in the blood of an Insured as substantiated through both a positive screening test enzyme-linked immunosorbent assay (ELISA), and a positive supplement test such as the Western Blot. All such tests must be approved by the Food and Drug Administration (FDA) with the interpretation of positive results as specified by the manufacturer(s).

Occupational HIV - means an Insured , as a direct result of a Covered Injury, tests HIV Positive, subject to the following:

1. an incident report (notice of exposure) on a form acceptable to Us, which describes the nature of the exposure to HIV, must be filed with the Insured’s employer within 48 hours and be sent to Us as soon as reasonably possible, after the accident;
2. the Insured must not have previously tested positive for HIV, or if he or she had previously tested positive for HIV, the Insured subsequently tested negative for HIV prior to the date of the accident;
3. the Insured must have a preliminary screening test, such as ELISA or other appropriate Food and Drug Administration (FDA) approved test (other than saliva or urine testing), for HIV within 48 hours of the Injury at an authorized laboratory other than the laboratory of his or her employer. We must receive notification: 1) of the results of that test as soon as reasonably possible; and 2) that the results are negative; and thereafter, the Insured must test HIV positive within 26 weeks of the date of the Injury reported in item a. above. We must receive notification of HIV Positive test results as soon as reasonably possible.

EXCLUSIONS

The following Exclusions are added to this Rider:

1. No benefits will be paid for Occupational HIV resulting from a needle stick or sharp injury or a mucous membrane exposure to blood or blood-stained bodily fluid which occurred prior to the effective date of this Rider.
2. We will not pay for any cost incurred for HIV tests or any related testing or treatment.

LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Rider contains a Waiting Period. This means no benefits are payable for a diagnosis of Occupational HIV during the Waiting Period. The Waiting Period begins from the Rider Application Date. The Waiting Period is shown on the Certificate Schedule Page.

GENERAL PROVISIONS

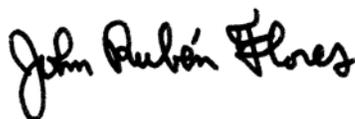
This Rider is part of the certificate. This rider will terminate when that certificate terminates, or when premiums are no longer paid for this Rider. This rider will also terminate once the benefit for this rider has been paid. The premium for this Rider is shown on the Certificate Schedule Page.

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

Signed for the Company at its Home Office



President



Secretary



STRIKE WAIVER

This rider is a part of the certificate to which it is attached. We have issued this rider to you because (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, certificate definitions and other provisions and terms apply to this rider.

Effective Date – If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later effective date, which will be shown on a revised Certificate Schedule Page.

TEMPORARILY NOT WORKING: We will continue Your coverage if we receive written notice that You are on Strike. Coverage will be continued for six (6) months following the last day of the month in which You are not engaged in full-time work due to a Strike. During the Strike, we will not require payment of premiums. If the Strike continues beyond the stated six (6) month period, you will be required to resume paying premiums for your certificate and any riders, including this rider, for coverage to remain in force.

Strike means a lawful primary strike authorized as provided by the union's constitution and by-laws.

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

Signed for the Company at its Home Office

A handwritten signature in black ink that reads "Paul A. Zucanto Jr." in a cursive style.

President

A handwritten signature in black ink that reads "John Rubén Flores" in a cursive style.

Secretary



120 Royall Street
Canton, MA 02021
800-669-2668

APPLICATION FOR GROUP CRITICAL ILLNESS INSURANCE

by : _____
Employer/Union Name

of : _____
Home Office Location (City & State)

for a Plan of Group Critical Illness Insurance, and representations are made as follows:

1. Class of Employees/Members eligible for coverage:

- Number of regular full-time employees/members: _____
- Other: _____

A full-time employee/member is defined as one who works [twenty (20)] hours or more per week. An employee/member must be Actively at Work on the date he/she applies for insurance, and on the date his/her Insurance is to become effective. An employee/member must have completed _____ months of continuous service before being eligible.

2. The minimum number of enrolled employees/members necessary to keep the Group Policy in force is: _____

3. Effective Date – The requested effective date of the Group Master Policy is: _____

4. Optional Features: _____

5. Will this Group Critical Illness Policy replace any existing group critical illness policy?

- Yes
- No

6. General Agreement:

The applicant agrees to transmit the total premiums under the group policy to the Insurer named below at its home office when due. No agent or other person except an officer can make or change any contract or agreement on behalf of the Insurer named below.

Refer to the attached list for the appropriate State Fraud Warning.

Signature of Employer/Union Representative

Date

Title

Underwritten by:



□ FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

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

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

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

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



CRITICAL ILLNESS ENROLLMENT FORM

Proposed Insured <i>(First, MI, Last)</i>		S.S.N./ITIN	Gender	Date of Birth
Residential Address		City	State	Zip Code
Employer/Union		I am actively at work at least [20] hours a week. <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Hire
Spouse's Name <i>(if applying for coverage)</i>	Gender	Spouse Date of Birth	[Has your spouse been hospitalized or treated at a medical facility on an in or outpatient basis within the past six months? <input type="checkbox"/> Yes <input type="checkbox"/> No]	
[Have you or your spouse used tobacco products in the last 12 months?]		Proposed Insured <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No

Critical Illness Options: 1-3 (select only 1 option)

OPTION 1 - Critical Illness [with Cancer]	
PROPOSED INSURED FACE AMOUNT	[SPOUSE FACE AMOUNT]
[\$10,000] [Weekly] premium - [\$10.00]	[\$5,000] [Weekly] premium - [\$5.00]
Total [Weekly] Premium - [\$15.00]	

OPTION 2 - Critical Illness [with Cancer]	
PROPOSED INSURED FACE AMOUNT	[SPOUSE FACE AMOUNT]
[\$15,000] [Weekly] premium - [\$12.00]	[\$2,500] [Weekly] premium - [\$5.00]
Total [Weekly] Premium - [\$17.00]	

I elect Option: _____ Total [Weekly] Premium: _____

OPTION 3 I elect to Waive Coverage

Agreement and Declaration – Read Carefully Before Signing: I represent that the statements and answers written in this enrollment form are complete and true to the best of my/our knowledge and belief, and it is agreed that:

- A. This enrollment form shall form the basis for and become a part of any certificate issued.
- B. The agent has no authority to waive the answers to any questions or modify the enrollment form.
- C. The insurance applied for shall be in force on the date of the enrollment form signed by me, provided that the Company approves the coverage applied for without any modification, as to plan, amount of premium, and further, provided that the Company receives the first premium payment within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance shall take effect until the certificate has been delivered to and accepted by me.
- D. I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.
- E. I understand that the beneficiary will be my Estate unless otherwise indicated in the Special Request section.
- F. I acknowledge that I have received a copy of Boston Mutual Life Insurance Company's Notice of Information Privacy Practices and any Outline of Coverage that is required by the State.
- G. The proposed insured will be the owner unless otherwise stated in the Special Request Section.

Refer to the attached list for the State Fraud Warning.

Special Request: _____

Date _____ State Signed at: _____

Signature of Proposed Insured _____

Agent of Record _____ Agent NPN _____

FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET • CANTON, MA 02021

CRITICAL ILLNESS ENROLLMENT FORM

PART A

Proposed Insured <i>(First, Middle, Last)</i>		Social Security/ITIN	Gender	Date of Birth	Age
Residential Address <i>(no P.O. Box)</i>		City	State	Zip	
Mailing Address		Occupation	Hours Worked	Date of Hire	
Employer/Union	Daytime Phone No.	Beneficiary Name for Proposed Insured/Relationship <i>(estate unless designated otherwise)</i>			
Spouse's Name <i>(if applying for coverage)</i>			Gender	Spouse Date of Birth	Age
Special Request			Proposed Insured	Spouse	
Are you actively at work?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Has your spouse received medical advice or treatment or has been advised to receive medical tests, but has not received the results of those tests within the past six months?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you used any tobacco products in the last 12 months?			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
As of the date of this application, is there any other specified disease, disability, or accident insurance in force or applied for on any proposed insured? If "Yes", list company name, person covered, policy number, type and amount of coverage and the specified disease(s) covered.			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CRITICAL ILLNESS: <input type="checkbox"/> with Cancer <input type="checkbox"/> without Cancer					
<input type="checkbox"/> Proposed Insured: Benefit Amount \$ _____		Premium Amount \$ _____			
<input type="checkbox"/> Spouse: Benefit Amount \$ _____		Premium Amount \$ _____			
Riders: <input type="checkbox"/> Dependent Children's Rider Premium \$ _____		<input type="checkbox"/> Genetic Screening Rider Premium \$ _____			
<input type="checkbox"/> Health Screening Rider Premium \$ _____		<input type="checkbox"/> Extended Loss Rider Premium \$ _____			
<input type="checkbox"/> Occupational HIV Benefit Rider \$ _____		Total weekly premium: \$ _____			
To the best of your knowledge and belief:			Proposed Insured	Spouse	
1. Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you ever been told by a physician that you needed an organ transplant, or been diagnosed or treated by a physician for a) a stroke or transient ischemic attack (TIA), b) heart attack or other heart condition, or any abnormality of the heart or circulatory system; c) diabetes except gestational diabetes; d) Any disease of disorder of the liver or pancreas; e) kidney (renal) failure or end stage kidney (renal) disease; f) emphysema or lung disease; g) Alzheimer's Disease; h) Lupus, Cystic Fibrosis, or Sickle Cell Anemia; i) paralysis of at least two limbs; or j) disease or disorder of the nervous system.			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Within the last 2 years have any proposed insured taken 3 or more medications for high blood pressure or been diagnosed or treated for alcohol or drug abuse?			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Answer only if cancer coverage is being selected: in the last 5 years have any proposed insured been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

AGREEMENT & DECLARATION – Read Carefully Before Signing: I represent that the statements and answers written in this enrollment form parts A & B and any supplements are complete and true to the best of my/our knowledge and belief, and it is agree that:

- A. This enrollment form and any supplement shall form the basis for and become a part of any certificate issued.
- B. The agent has no authority to waive the answers to any question in, or modify the application.
- C. The insurance applied for shall be in force on the date of the enrollment form signed by me, provided that the Company approves the enrollment form without any modification, as to plan, amount of premium, and, further provided that the Company receives the first premium payment within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance shall take effect until the policy has been delivered to and accepted by me and shall not take effect if there has been a change in the health of any person to be insured as stated since the date of the application.
- D. The proposed insured will be the owner unless otherwise stated in the Special Request section.
- E. I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.
- F. I have received a copy of Boston Mutual Life Insurance Company's Notice of Information Privacy Practices and any outline of coverage that is required by the state.
- G. **Refer to the attached list for the State Fraud Warning.**

Date	Signature of Proposed Insured	Signed at
Date	Signature of Agent	Agent NPN Number

Underwritten by: Boston Mutual Life Insurance Company

CRITICAL ILLNESS ENROLLMENT FORM

PART B

To be completed for any proposed insured who is applying for Benefit Amounts in excess of \$50,000:

Name of Proposed Insured	Height	Weight
A.		
B.		
C.		
D.		
E.		

To the best of your knowledge and belief:

1. Have any 2 natural parents or siblings been diagnosed with heart disease, stroke, diabetes, cancer, kidney disease, or Multiple Sclerosis before age 60. YES NO

Details: _____

2. Please list all prescription drugs any proposed insured is currently taking.

Proposed Insured A _____

Proposed Insured B _____

Proposed Insured C _____

Proposed Insured D _____

Proposed Insured E _____

HOME OFFICE USE ONLY

Guarantee Issue Amount _____

Proposed Insured _____

Spouse _____

FRAUD WARNING NOTICES

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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

FRAUD WARNING NOTICES . . . *cont.*

PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

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SERFF Tracking #:

PERR-128639266

State Tracking #:

Company Tracking #:

BMLIC-GH-CI-AR-12-01-F

State:

Arkansas

Filing Company:

Boston Mutual Life Insurance Company

TOI/Sub-TOI:

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

Product Name:

Critical Illness

Project Name/Number:

BMLIC-GH-CI-AR-12-01-F/BMLIC-GH-CI-AR-12-01-F

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/13/2012
Comments:			
Attachment(s):			
AR Readability.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	09/13/2012
Comments:	Acknowledged		
		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	09/13/2012
Comments:			
Attachment(s):			
SOV no outline.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Letter of Authority	Approved-Closed	09/13/2012
Comments:			
Attachment(s):			
Signed Authorization Letter Perr & Knight.pdf			

CERTIFICATE OF READABILITY Arkansas

FORM NAME	FORM NUMBER	FLESCH SCORE
Group Critical Illness Master Policy	WS-CI Master Policy with Cancer 04/12 AR	62.17
Group Critical Illness Master Policy	WS-CI Master Policy Without Cancer 04/12 AR	62.16
Certificate of Insurance for Group Critical Illness Policy	WS-CI Cert With Cancer 04/12 AR	63.21
Certificate of Insurance for Group Critical Illness Policy	WS-CI Cert Without Cancer 04/12 AR	63.4
Dependent Children Benefit Rider	WS-CI DC Rider 04/12	62.52
Genetic Screening Test Benefit Rider	WS-CI GT Rider 04/12	67.08
Extended Loss Benefit Rider	WS-CI EL Rider 04/12	64.57
Health Screening Benefit Rider	WS-CI HS Rider 04/12	73.45
Occupational HIV Benefit Rider	WS-CI OHIV Rider 04/12	69.06
Strike Waiver	WS-CI SW Rider 04/12	67.06
Application for Group Critical Illness Insurance	WS-CI Master Application 7/12	57.51
Critical Illness Enrollment Form	WS-GI/MI APP – CI 7/12	66.61
Critical Illness Enrollment Form	BML-CI-APP 7/12	67.55

The text was Flesch scored by computer.

I certify that to the best of my knowledge and belief, the above referenced forms meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations.


(Signature of Company Officer)

Mary T Tillson, Vice President Product & Field Support
800-669-2668 X249
Mary_tillson@bostonmutual.com

(Officer's Contact Information)

**BOSTON MUTUAL LIFE INSURANCE COMPANY
EXPLANATION OF VARIABLES
GROUP CRITICAL ILLNESS POLICY**

GENERAL POLICY AND CERTIFICATE VARIABLES

Unless otherwise noted, all bracketed text in the forms and within this statement of variability is variable only to the extent that it may be included or omitted according to a policyholder's plan of insurance.

When bracketed text is deleted, paragraphs may be moved to suit the needs of a particular policyholder.

Titles of specific Acts or Laws may be modified as appropriate.

Letters and numbers as they appear in a list, punctuation or words such as "and" or "or" will be included or omitted as needed in order to make the statement or list read correctly.

Within the contract, the term "employee" or "member" will be used depending on the type of organization that the master contract is issued to.

SPECIFIC VARIABLES

POLICY

FACE PAGE: All "John Doe" and case specific information will vary as requested for each specific case, and as agreed to by the policyholder and **us**.

The company address and the signatures of our officers have been bracketed to allow for future changes. Any change in the officers of the company will be filed with the commissioner before the signatures are changed.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION:

"Employee" will be used when issued to employer groups, and "Member" will be used when issued to associations or unions.

DEFINITIONS:

The definition of full time work can vary based on the minimum number of hours worked defined for the case [12-40].

"Employee" will be used when issued to employer groups, and "Member" will be used when issued to associations or unions.

BENEFIT PROVISIONS:

"Employee" and "employment" will be used when issued to employer groups, and "Member" and "membership" will be used when issued to associations or unions.

GENERAL PROVISIONS:

"Employee" will be used when issued to employer groups, and "Member" will be used when issued to associations or unions.

CERTIFICATE OF COVERAGE

FACE PAGE: All "John Doe" and case specific information will vary as requested for each specific case, and as agreed upon between the policyholder and **us**.

The address of the company and signatures of our officers have been bracketed to allow for future changes. Any change in the officers of the company will be filed with the commissioner before the signatures are changed.

**BOSTON MUTUAL LIFE INSURANCE COMPANY
EXPLANATION OF VARIABLES
GROUP CRITICAL ILLNESS POLICY**

CERTIFICATE SCHEDULE:

MAXIMUM BENEFIT AMOUNT: [\$2000 - \$100,000]
Benefits may be reduced at age 70 based on policyholder specifics.

PRE-EXISTING CONDITION PERIOD: [0 or 180] Days
WAITING PERIOD: [30] Days
Credit may be given for prior coverage based on policyholder specifics.

SPOUSE BENEFIT:
INSURED SPOUSE: [Jane Doe]
MAXIMUM BENEFIT AMOUNT: [\$1000 - \$50,000]

Benefits may be reduced at age 70 based on policyholder specifics.

DEPENDENT CHILDREN BENEFIT RIDER:
MAXIMUM BENEFIT AMOUNT: [\$500 - \$25,000]

HEALTH SCREENING BENEFIT RIDER: [\$50 - \$500]
This benefit amount is per Primary Insured. If Spouse coverage is elected the benefit is per calendar year.

GENETIC SCREENING TEST BENEFIT RIDER: [\$250 or \$500]
per Primary Insured and Spouse if Spouse coverage is elected, per calendar year.

EXTENDED LOSS BENEFIT RIDER:
MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000 - \$10,000]
There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.

OCCUPATIONAL HIV BENEFIT RIDER: [\$500 - \$5000]
This benefit is payable one-time for the Primary Insured

TOTAL MONTHLY PREMIUM: [\$xx.xx]
Contract specific - Varies by policyholder or certificateholder choices

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION:
“Employee” will be used when issued to employer groups, and “Member” will be used when issued to associations or unions.

DEFINITIONS:
The definition of full time work can vary based on the minimum number of hours worked defined for the case [12-40]

GENERAL PROVISIONS:
All references to the address of Boston Mutual Life insurance have been bracketed to allow for future address or administrative office changes.

PORTABILITY:
The number of months that an insured must be continuously insured will vary by case [0-12]
An Employee must have been continuously insured for at least [XX] months under this Plan and/or the prior Plan just before the date their employment terminated.

“Employee” and “employment” will be used when issued to employer groups, and “Member” and “membership” will be used when issued to associations or unions.

**BOSTON MUTUAL LIFE INSURANCE COMPANY
EXPLANATION OF VARIABLES
GROUP CRITICAL ILLNESS POLICY**

RIDERS

The address of the company and signatures of our officers have been bracketed to allow for future changes. Any change in the officers of the company will be filed with the commissioner before the signatures are changed.



June 18, 2012

To Whom It May Concern:

The firm of Perr & Knight, located at 401 Wilshire Blvd., Santa Monica California, is hereby authorized to submit forms for approval to the Department of Insurance on behalf of Boston Mutual Life Insurance Company. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Sincerely,

A handwritten signature in cursive script, reading "Mary Tillson". The signature is written in black ink and is positioned to the left of the typed name.

Mary Tillson
Vice President, Product - Field Support
Boston Mutual Life Insurance Co.
Phone: 781 770 0249
Fax: 781 770 0521

State: Arkansas **Filing Company:** Boston Mutual Life Insurance Company
TOI/Sub-TOI: H07G Group Health - Specified Disease - Limited Benefit/H07G.001 Critical Illness
Product Name: Critical Illness
Project Name/Number: BMLIC-GH-CI-AR-12-01-F/BMLIC-GH-CI-AR-12-01-F

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)
08/31/2012	Form	Group Critical Illness Master Policy	09/12/2012	WS-CI Mast Policy with Cancer 0412 AR.pdf (Superseded)
08/31/2012	Form	Group Critical Illness Master Policy	09/12/2012	WS-CI Mast Policy Without Cancer 0412 AR.pdf (Superseded)
08/31/2012	Form	Certificate of Insurance for Group Critical Illness Policy	09/12/2012	WS-CI Cert With Cancer 0412 AR.pdf (Superseded)
08/31/2012	Form	Certificate of Insurance for Group Critical Illness Policy	09/12/2012	WS-CI Cert Without Cancer 0412 AR.pdf (Superseded)
08/31/2012	Form	Dependent Children Benefit Rider	09/12/2012	WS-CI DC Rider 0412.pdf (Superseded)



[120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521]

GROUP CRITICAL ILLNESS MASTER POLICY

Based on the Application for this Group Insurance Policy (herein called the Plan) made by

[ABC COMPANY, INC.]
(herein called the Policyholder)

and based on the payment of the premium when due, the Company agrees to pay the benefits provided on the following pages.

**THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY
THIS POLICY PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

This Plan becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown below. It may be continued in effect by the payment of premiums as provided in Section II. The Plan will terminate as provided in the provision titled "Termination of the Plan" in Section I.

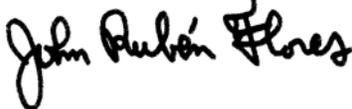
The first anniversary of this Plan will be the Anniversary Date shown below. "We", "us", and "our" refer to the Company. Subsequent anniversaries of the Plan will be the same date each year thereafter.

All matter printed or written by the Company on the following pages forms a part of this Plan as if recited over the signatures below. This Plan is a legal contract between the Company and the Policyholder. This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof the Company has caused this Plan to be executed at our Home Office in [Canton, Massachusetts] on the Effective Date.

Signed for the Company at its Home Office

[

President

Secretary
]

Countersigned by _____
Licensed Resident Agent (if required by your state)

Group Policy Number - [1234]
Effective Date - [April 1, 2012] **Anniversary Date -** [April 1, 2013]
Jurisdiction - [State Name] **Non-Participating**

GROUP POLICY PROVISIONS

- SECTION I** - Eligibility, Effective Date and Termination
- SECTION II** - Premium Provisions
- SECTION III** - General Definitions / Benefit Definitions
- SECTION IV** - Benefit Provisions
- SECTION V** - Limitations and Exclusions
- SECTION VI** - Claim Provisions
- SECTION VII** - General Provisions
- SECTION VIII** - Benefit Schedules
- SECTION IX** - Occupational Classifications

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

Certificateholder as used in this Plan, means a person insured under this Plan who is:

1. an eligible [Employee/Member] of the Policyholder, or an eligible Spouse of the [Employee/Member];
2. engaged in full-time work; and
3. included in the class of [Employees/Members] eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of this Plan is shown on Page 1 of the Master Policy.

The Effective Date for a Certificateholder is as follows:

1. A Certificateholder's insurance will be effective on the date shown on the Certificate Schedule provided the Certificateholder is then actively at work.
2. If a Certificateholder is not actively at work on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Certificateholder is first thereafter actively at work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date the Certificateholder's insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.
2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date the Certificateholder's insurance became effective.
3. For a Spouse eligible on or first acquired after the Certificateholder's Effective Date, the Effective Date will be the date we assign after approving the enrollment form for such coverage.

TERMINATION OF THE PLAN

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Plan on the day prior to the date any premium is due by giving 31 days written notice. The Plan will terminate when the number of participating Certificateholders is less than the number mutually agreed upon by the Policyholder and the Company in writing.

In these events, this Plan and all certificates issued hereunder will terminate on such date at 12:01 a.m. Standard Time at the Policyholder's address. This will be without prejudice to the rights of any Insured as respects any claim arising during the period the Plan is in force.

The Policyholder has the sole responsibility to notify Certificateholders of such termination.

TERMINATION OF A CERTIFICATEHOLDER'S INSURANCE

A Certificateholder's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date he ceases to meet the definition of [an Employee/a Member] as defined in the Plan; or
4. on the date he is no longer a member of the class eligible.

Insurance for an insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date the Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive the Certificateholder's written request to terminate coverage for his or her Spouse.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums in the Certificate. The rates can be changed annually. The Company will give the Policyholder written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid to the Company at our Home Office in [Canton, Massachusetts]. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

This Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Certificateholder must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore,

angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the enrollment form or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germinomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Fraumeni's Syndrome, Cowden Disease, Turcot Syndrome.

Cancer – means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. The following are not considered Cancer for purposes of this policy:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);
3. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;
4. Basal cell carcinoma and squamous cell carcinoma of the skin and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Cancer is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

Carcinoma in situ - means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. It also includes Stage 1 Hodgkin's Disease and Stage A Prostate Cancer. Carcinoma in situ does not include basal cell carcinoma, squamous cell carcinoma or melanoma diagnosed as Clark's Level I or II or Breslow less than .75mm. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Carcinoma in situ is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

The "first diagnosis" of Cancer/Carcinoma in situ includes a diagnosis of a recurrence of Cancer/Carcinoma in situ that was previously diagnosed before this Certificate was in force if, after the previous diagnosis and before the date of diagnosis of the recurrence, the Insured is free of any symptoms and treatment of the Cancer/Carcinoma in situ for the 12 consecutive months preceding the Certificate Application Date or any 12 consecutive months thereafter. Treatment does not include Maintenance Drug Therapy or routine follow-up visits or tests to verify that the Cancer/Carcinoma in situ has not returned.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
 - a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
 - b. there is medical evidence to support the diagnosis; and
 - c. a Doctor is treating an Insured for Cancer and/or Carcinoma in Situ.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception

and/or behavior and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date the Certificateholder signed the enrollment form for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule - This is page 3 of the certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder - means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Children - means all of the Certificateholder's children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday.

Children means the Certificateholder's biological children, stepchildren, adopted children, foster children or any child for whom he or she is required by a court or administrative order to provide health coverage.

Doctor or Physician - means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include an Insured or their Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes;
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome;
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

[Employee - means the Insured as shown in the Certificate Schedule.]

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a

traumatic event, including surgical traumas. The date of diagnosis is the date that the Insured's Doctor or Physician recommends that he or she begin renal dialysis for End Stage Renal Disease.

Family Member - means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work - means the Certificateholder is spending at least [20] hours per week performing his/her occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while the Insured's coverage is in force and after any applicable Waiting Period.

Insured(s) –

1. If [Employee/Member] coverage is shown in the Certificate Schedule, we insure the [Employee/Member].
2. If coverage is for the Spouse of an eligible Certificateholder, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached rider (if applicable). Rider coverage is shown on the Certificate Page.
4. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Certificate or by the enrollment form, then such person shall not be an Insured.
5. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Loss of Sight, Speech or Hearing- means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Maintenance Drug Therapy – means ongoing hormonal treatment, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer or carcinoma in situ due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than palliative or suppression of a cancer that is still present.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

[Member - means the Insured as shown in the Certificate Schedule.]

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than the Insured or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date the Insured signed the enrollment form and indicated the specific rider(s) for which he/she is applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Skin Cancer – means basal cell carcinoma, squamous cell carcinoma and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm. It is not Skin Cancer if it has metastasized and leads to internal cancer. The date of diagnosis for Skin Cancer is the date the tissue specimen is taken.

Specified Critical Illness - means such illnesses shown in the Certificate Schedule and as defined in this Plan.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. Meningocele – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. Myelomeningocele – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured's spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If a Certificateholder dies while covered under a Certificate, then their surviving Spouse shall become the Insured if such Spouse is an Insured. If there is no surviving Spouse covered under the Certificate, then the Certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines. For Cancer or Carcinoma in Situ, Treatment does not include Maintenance Drug Therapy or routine follow-up visits and tests to verify if the Cancer/Carcinoma in Situ has not returned.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

SECTION IV - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while the Certificate is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months (12 months of no treatment for cancer or carcinoma in situ).

Skin Cancer Benefit

We will pay this benefit if an Insured person is diagnosed with Skin Cancer if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Policy.

This benefit is payable only once during the lifetime of the certificate for each Insured person.

Portability Privilege

When coverage would otherwise terminate under this Plan because an [Employee/Member] ends [employment/membership] with the [Employer/Association], they may elect to continue coverage. An [Employee/Member] must have been continuously insured for at least [0-12] months under this Plan and/or the prior Plan just before the date their [employment/membership] terminated. The coverage that may be continued is that which the [Employee/Member] had on the date their [employment/membership] terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. the Certificateholder failed to pay any required premium;
 - b. this Group Policy terminates.
2. To keep the Certificate in force the Certificateholder must:
 - a. make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date the Certificateholder fails to pay any required premium;
 - b. the date this Group Policy is terminated.

If a Certificateholder qualifies for this Portability Privilege as described, then the same Benefits, Plan Provisions, and Premium Rate as shown in their Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Plan contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, the Insured may elect to void the Certificate from the beginning and receive a full refund of premium.

PRIOR HISTORY OF CANCER

No benefits are payable for Cancer or Carcinoma in Situ if the Insured was previously diagnosed before this Certificate was in force and, after the previous diagnosis, the Insured has not gone 12 months without Treatment before a new diagnosis of Cancer/Carcinoma in situ is made.

PRE-EXISTING CONDITIONS LIMITATION (Not Applicable to Insureds with a Prior History of Cancer or Carcinoma in Situ – See PRIOR HISTORY OF CANCER)

This Plan contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021]. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When we receive a notice of claim, we will send the Claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021] within ninety (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. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send the Insured written notice of our claim decision within 30 days after we receive due proof of loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send the Insured a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send the Insured written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. The Insured will have 45 days to provide any additional information requested.

If the claim is urgent, we will notify the Insured of our decision within 72 hours. If we need more information, we will let the Insured know within 24 hours of the claim. At that time we will tell the Insured what additional information is needed to process the claim. The Insured will have 48 hours to provide any additional information requested. We will notify the Insured of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat the Insured's claim as urgent if a delay in processing the claim could seriously jeopardize his or her life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject the Insured to severe pain that cannot be managed without the care or treatment that is the subject of the claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support the claim;
4. Information concerning the Insured's right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of the Insured's right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after the Insured receives notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, the Insured may:

1. Send us written comments;
2. Review any non-privileged information relating to the claim; or
3. Provide us with other information or proof in support of the claim.

We will review the claim promptly after receiving the request. We will advise the Insured of the results of our review within 60 days after we receive the request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of the Insured's right to bring a civil action.

If the appeal arises from our denial of an urgent claim, we will consider the appeal and notify the Insured of our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All benefits will be payable to the Certificateholder unless assigned by them or by operation of law. Any accrued benefit unpaid at the Insured's death may be paid to their estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from you. If you have any questions about this Plan, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this Plan. Thank you for your loyal patronage.

Entire Contract, Changes: This Policy together with the application, enrollment forms, endorsements, benefit

agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Plan shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change this Plan or waive any of its Provisions. Any Rider, Endorsement or Application that modifies, limits or excludes coverage under this Plan must be signed by the Certificateholder to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Plan within 60 days after written Proof of Loss has been given as required by this Plan. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from an Insured's effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from an Insured's Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Clerical Error: Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

Misstatement of Age: If an age has been misstated on the enrollment form, the benefits will be those the premium paid would have purchased at the correct age.

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 it was issued is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New [Employees/Members] of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally Insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

Important Notice: For questions regarding the Policy, please contact the Company at [1-800-669-2668]. If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494

SECTION VIII

POLICY SCHEDULE

MASTER POLICYHOLDER: [ABC COMPANY INC]

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: [\$30,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

PRE-EXISTING CONDITION PERIOD: [180] Days

WAITING PERIOD: [30] Days

[IF THIS COVERAGE REPLACES EXISTING CRITICAL ILLNESS COVERAGE THE CERTIFICATEHOLDER CURRENTLY HAS WITH ANOTHER CARRIER, HE OR SHE WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME THE PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD.]

COVERED SPECIFIED CRITICAL ILLNESSES:

100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

- | | |
|--------------------------------------|--|
| Myocardial Infarction (Heart Attack) | Benign Brain Tumor |
| Stroke | Major Organ Transplant |
| Coma | End Stage Renal Disease (Kidney Failure) |
| Paralysis | Amyotrophic Lateral Sclerosis (ALS) |
| Severe Burns | Loss of Sight, Speech or Hearing |
| Alzheimer's Disease | Cancer |

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:

- Coronary Artery Bypass Surgery
- Angioplasty/Stent
- Carcinoma in situ (not including Skin Cancer)

Skin Cancer – a \$300 one-time (lifetime) benefit is payable for Skin Cancer per Insured Person.

[SPOUSE BENEFIT:

INSURED SPOUSE: [Jane Doe]

MAXIMUM BENEFIT AMOUNT: [\$15,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

[DEPENDENT CHILDREN BENEFIT RIDER:

MAXIMUM BENEFIT AMOUNT: [\$7,500]

100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: **Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida]**

[HEALTH SCREENING BENEFIT RIDER:

[\$50] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[GENETIC SCREENING TEST BENEFIT RIDER:

[\$250] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[EXTENDED LOSS BENEFIT RIDER:

MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000]

There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.]

[STRIKE WAIVER:

]

[OCCUPATIONAL HIV BENEFIT RIDER:

[\$5,000] payable one-time for the Primary Insured]

SECTION IX - OCCUPATIONAL CLASSIFICATIONS

[All Full-Time employees, who are actively at work, and have completed at least [XX] months of continuous employment with the Policyholder.]



[120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521]

GROUP CRITICAL ILLNESS MASTER POLICY

Based on the Application for this Group Insurance Policy (herein called the Plan) made by

[ABC COMPANY, INC.]
(herein called the Policyholder)

and based on the payment of the premium when due, the Company agrees to pay the benefits provided on the following pages.

**THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY
THIS POLICY PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

This Plan becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown below. It may be continued in effect by the payment of premiums as provided in Section II. The Plan will terminate as provided in the provision titled "Termination of the Plan" in Section I.

The first anniversary of this Plan will be the Anniversary Date shown below. "We", "us", and "our" refer to the Company. Subsequent anniversaries of the Plan will be the same date each year thereafter.

All matter printed or written by the Company on the following pages forms a part of this Plan as if recited over the signatures below. This Plan is a legal contract between the Company and the Policyholder. This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof the Company has caused this Plan to be executed at our Home Office in [Canton, Massachusetts] on the Effective Date.

Signed for the Company at its Home Office


President


Secretary

Countersigned by _____
Licensed Resident Agent (if required by your state)

Group Policy Number - [1234]
Effective Date - [April 1, 2012] **Anniversary Date -** [April 1, 2013]
Jurisdiction - [State Name] **Non-Participating**

GROUP POLICY PROVISIONS

- SECTION I** - Eligibility, Effective Date and Termination
- SECTION II** - Premium Provisions
- SECTION III** - General Definitions / Benefit Definitions
- SECTION IV** - Benefit Provisions
- SECTION V** - Limitations and Exclusions
- SECTION VI** - Claim Provisions
- SECTION VII** - General Provisions
- SECTION VIII** - Policy Schedule
- SECTION IX** - Occupational Classifications

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

Certificateholder as used in this Plan, means a person insured under this Plan who is:

1. an eligible [Employee/Member] of the Policyholder, or an eligible Spouse of the [Employee/Member];
2. engaged in full-time work; and
3. included in the class of [Employees/Members] eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of this Plan is shown on Page 1 of the Master Policy.

The Effective Date for a Certificateholder is as follows:

1. A Certificateholder's insurance will be effective on the date shown on the Certificate Schedule provided the Certificateholder is then actively at work.
2. If a Certificateholder is not actively at work on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Certificateholder is first thereafter actively at work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date the Certificateholder's insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.
2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date the Certificateholder's insurance became effective.
3. For a Spouse eligible on or first acquired after the Certificateholder's Effective Date, the Effective Date will be the date we assign after approving the application for such coverage.

TERMINATION OF THE PLAN

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Plan on the day prior to the date any premium is due by giving 31 days written notice. The Plan will terminate when the number of participating Certificateholders is less than the number mutually agreed upon by the Policyholder and the Company in writing.

In these events, this Plan and all certificates issued hereunder will terminate on such date at 12:01 a.m. Standard Time at the Policyholder's address. This will be without prejudice to the rights of any Insured as respects any claim arising during the period the Plan is in force.

The Policyholder has the sole responsibility to notify Certificateholders of such termination.

TERMINATION OF A CERTIFICATEHOLDER'S INSURANCE

A Certificateholder's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date he ceases to meet the definition of [an Employee/a Member] as defined in the Plan; or
4. on the date he is no longer a member of the class eligible.

Insurance for an insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date the Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive the Certificateholder's written request to terminate coverage for his or her Spouse.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums in the Certificate. The rates can be changed annually. The Company will give the Policyholder written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid to the Company at our Home Office in [Canton, Massachusetts]. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

This Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Certificateholder must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore,

angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the enrollment form or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germinomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Fraumeni's Syndrome, Cowden Disease, Turcot Syndrome.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date the Certificateholder signed the enrollment form for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule - This is page 3 of the certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder – means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stents or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Children - means all of the Certificateholder's children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday.

Children means the Certificateholder's biological children, stepchildren, adopted children, foster children or any child for whom he or she is required by a court or administrative order to provide health coverage.

Doctor or Physician - means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include an Insured or their Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes;
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome;
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

[**Employee** - means the Insured as shown in the Certificate Schedule.]

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas. The date of diagnosis is the date that the Insured's Doctor or Physician recommends that he or she begin renal dialysis for End Stage Renal Disease.

Family Member - means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work - means the Certificateholder is spending at least [20] hours per week performing his/her occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while the Insured's coverage is in force and after any applicable Waiting Period.

Insured(s) -

1. If [Employee/Member] coverage is shown in the Certificate Schedule, we insure the [Employee/Member].
2. If coverage is for the Spouse of an eligible Certificateholder, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached rider (if applicable). Rider coverage is shown on the Certificate Page. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Certificate or by the enrollment form, then such person shall not be an Insured.
4. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Loss of Sight, Speech or Hearing- means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

[**Member** – means the Insured as shown in the Certificate Schedule.]

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than the Insured or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date the Insured signed the enrollment form and indicated the specific rider(s) for which he/she is applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Specified Critical Illness - means such illnesses shown in the Certificate Schedule and as defined in this Plan.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. Meningocele – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. Myelomeningocele – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured's spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive

evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If a Certificateholder dies while covered under a Certificate, then their surviving Spouse shall become the Insured if such Spouse is an Insured. If there is no surviving Spouse covered under the Certificate, then the Certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

SECTION IV - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while the Certificate is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months.

Portability Privilege

When coverage would otherwise terminate under this Plan because an [Employee/Member] ends [employment/membership] with the [Employer/Association], they may elect to continue coverage. An [Employee/Member] must have been continuously insured for at least [XX] months under this Plan and/or the prior Plan just before the date their [employment/membership] terminated. The coverage that may be continued is that which the [Employee/Member] had on the date their [employment/membership] terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. the Certificateholder failed to pay any required premium;
 - b. this Group Policy terminates.
2. To keep the Certificate in force the Certificateholder must:
 - a. make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date the Certificateholder fails to pay any required premium;
 - b. the date this Group Policy is terminated.

If a Certificateholder qualifies for this Portability Privilege as described, then the same Benefits, Plan Provisions, and Premium Rate as shown in their Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This Plan contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, the Insured may elect to void the Certificate from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS LIMITATION

This Plan contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021]. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When we receive a notice of claim, we will send the Claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021] within ninety (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. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send the Insured written notice of our claim decision within 30 days after we receive due proof of loss. If there are special circumstances that require more time (such as the need to hold a

hearing), we will send the Insured a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send the Insured written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. The Insured will have 45 days to provide any additional information requested.

If the claim is urgent, we will notify the Insured of our decision within 72 hours. If we need more information, we will let the Insured know within 24 hours of the claim. At that time we will tell the Insured what additional information is needed to process the claim. The Insured will have 48 hours to provide any additional information requested. We will notify the Insured of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat the Insured's claim as urgent if a delay in processing the claim could seriously jeopardize his or her life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject the Insured to severe pain that cannot be managed without the care or treatment that is the subject of the claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support the claim;
4. Information concerning the Insured's right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of the Insured's right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after the Insured receives notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, the Insured may:

1. Send us written comments;
2. Review any non-privileged information relating to the claim; or
3. Provide us with other information or proof in support of the claim.

We will review the claim promptly after receiving the request. We will advise the Insured of the results of our review within 60 days after we receive the request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of the Insured's right to bring a civil action.

If the appeal arises from our denial of an urgent claim, we will consider the appeal and notify the Insured of our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All benefits will be payable to the Certificateholder unless assigned by them or by operation of law. Any accrued benefit unpaid at the Insured's death may be paid to their estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from you. If you have any questions about this Plan, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this Plan. Thank you for your loyal patronage.

Entire Contract, Changes: This Policy together with the application, enrollment forms, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Plan shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change this Plan or waive any of its Provisions. Any Rider, Endorsement or

Application that modifies, limits or excludes coverage under this Plan must be signed by the Certificateholder to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Plan within 60 days after written Proof of Loss has been given as required by this Plan. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from an Insured's effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from an Insured's Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Clerical Error: Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

Misstatement of Age: If an age has been misstated on the enrollment form, the benefits will be those the premium paid would have purchased at the correct age.

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 it was issued is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New [Employees/Members] of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

Important Notice: For questions regarding the Policy, please contact the Company at [1-800-669-2668]. If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494

SECTION VIII

POLICY SCHEDULE

MASTER POLICYHOLDER: [ABC COMPANY INC]

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: [\$30,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

PRE-EXISTING CONDITION PERIOD: [180] Days

WAITING PERIOD: [30] Days

[IF THIS COVERAGE REPLACES EXISTING CRITICAL ILLNESS COVERAGE THE CERTIFICATEHOLDER CURRENTLY HAS WITH ANOTHER CARRIER, HE OR SHE WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME THE PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD.]

COVERED SPECIFIED CRITICAL ILLNESSES:

100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

- | | |
|--------------------------------------|--|
| Myocardial Infarction (Heart Attack) | Benign Brain Tumor |
| Stroke | Major Organ Transplant |
| Coma | End Stage Renal Disease (Kidney Failure) |
| Paralysis | Amyotrophic Lateral Sclerosis (ALS) |
| Severe Burns | Loss of Sight, Speech or Hearing |
| Alzheimer's Disease | |

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:

- Coronary Artery Bypass Surgery
- Angioplasty/Stent

[SPOUSE BENEFIT:

MAXIMUM BENEFIT AMOUNT: [\$15,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

[DEPENDENT CHILDREN BENEFIT RIDER:

MAXIMUM BENEFIT AMOUNT: [\$7,500]

100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida]

[HEALTH SCREENING BENEFIT RIDER:

[\$50] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[GENETIC SCREENING TEST BENEFIT RIDER:

[\$250] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[EXTENDED LOSS BENEFIT RIDER:

MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000]

There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.]

[STRIKE WAIVER:

]

[OCCUPATIONAL HIV BENEFIT RIDER:

[\$5,000] payable one-time for the Primary Insured]

SECTION IX - OCCUPATIONAL CLASSIFICATIONS

[All Full-Time employees, who are actively at work, and have completed at least [XX] months of continuous employment with the Policyholder.]



CERTIFICATE OF INSURANCE FOR GROUP CRITICAL ILLNESS POLICY

**THIS CERTIFICATE PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare.

PLEASE READ YOUR CERTIFICATE CAREFULLY

We certify that You are insured under the Critical Illness Policy (herein called the Plan) issued to the Policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from Specified Critical Illness. Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in Your Certificate or not, apply to the insurance referred to by the Certificate.

The Effective Date of Your Certificate is as shown in the Certificate Schedule if You are on that date actively at work [for the Policyholder]. If not, this Certificate will become effective on the next date You are actively at work [as an eligible Employee]. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate is issued in consideration of the payment in advance of the required premium and of Your statements and representations in the enrollment form. This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to You under the Plan. "You" and "Your" refer to the Certificateholder or any other Insured under Family Coverage. "We", "Us", and "Our" refer to the Company.

NO RECOVERY FOR PRE-EXISTING CONDITIONS—PLEASE READ CAREFULLY. Your Certificate Schedule reflects the period of time this coverage is in force during which no benefits will be provided for conditions diagnosed within the 180 day period prior to the Effective Date shown in the Certificate Schedule.

Signed for the Company at its Home Office

President

Secretary

TEN DAY RIGHT TO EXAMINE CERTIFICATE

You have the right to return the Certificate within ten (10) days of its delivery and have the premium refunded if, after examination of the Certificate, You are not satisfied for any reason.

CERTIFICATE INDEX

Eligibility, Effective Date and Termination	Section I
Premium Provisions	Section II
General Definitions / Benefit Definitions	Section III
Benefit Provisions	Section IV
Limitations and Exclusions.....	Section V
Claim Provisions	Section VI
General Provisions.....	Section VII

CERTIFICATE SCHEDULE

MASTER POLICYHOLDER: [ABC COMPANY INC]
PRIMARY INSURED: [John Doe]
EFFECTIVE DATE: [May 1, 2012]

CERTIFICATE NUMBER: [123456]

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: [\$30,000] [\$xx.xx]
[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

PRE-EXISTING CONDITION PERIOD: [180] Days

WAITING PERIOD: [30] Days

[IF THIS COVERAGE REPLACES EXISTING CRITICAL ILLNESS COVERAGE YOU CURRENTLY HAVE WITH ANOTHER CARRIER, YOU WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME YOUR PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD.]

COVERED SPECIFIED CRITICAL ILLNESSES:

100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

Myocardial Infarction (Heart Attack)	Benign Brain Tumor
Stroke	Major Organ Transplant
Coma	End Stage Renal Disease (Kidney Failure)
Paralysis	Amyotrophic Lateral Sclerosis (ALS)
Severe Burns	Loss of Sight, Speech or Hearing
Alzheimer's Disease	Cancer

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:

Coronary Artery Bypass Surgery
Angioplasty/Stent
Carcinoma in situ (not including Skin Cancer)

Skin Cancer – a \$300 one-time (lifetime) benefit is payable for Skin Cancer per Insured Person.

[SPOUSE BENEFIT: [\$x.xx]

INSURED SPOUSE: [Jane Doe]

MAXIMUM BENEFIT AMOUNT: [\$15,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

[DEPENDENT CHILDREN BENEFIT RIDER: [\$x.xx]

MAXIMUM BENEFIT AMOUNT: [\$7,500]

100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida]

[HEALTH SCREENING BENEFIT RIDER: [\$x.xx]

[\$50] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[GENETIC SCREENING TEST BENEFIT RIDER: [\$x.xx]

[\$250] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[EXTENDED LOSS BENEFIT RIDER: [\$x.xx]

MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000]

There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.]

[STRIKE WAIVER: [\$x.xx]]

[OCCUPATIONAL HIV BENEFIT RIDER: [\$x.xx]

[\$5,000] payable one-time for the Primary Insured]

TOTAL MONTHLY PREMIUM: [\$xx.xx]

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

You as used in this Certificate, means a person insured under this Certificate who is:

1. an eligible [Employee/Member] of the Policyholder, or an eligible Spouse of the [Employee/Member];
2. engaged in full-time work; and
3. included in the class of [Employees/Members] eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of the Plan is shown on Page 1 of the Master Policy.

The Effective Date for You is as follows:

1. Your insurance will be effective on the date shown on the Certificate Schedule provided You are Actively At Work.
2. If you are not Actively At Work on the date coverage would otherwise become effective, the Effective Date of Your coverage will be the date on which You are first thereafter Actively At Work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date Your insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.
2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date that Your insurance became effective.
3. For a Spouse eligible on or first acquired after Your Effective Date, the Effective Date will be the date We assign after approving the application for such coverage.

TERMINATION OF YOUR INSURANCE

Your insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date You cease to meet the definition of [an Employee/a Member] as defined in the Plan; or
4. on the date You are no longer a member of the class eligible.

Insurance for insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date a Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive Your written request to terminate coverage for Your Spouse.

Termination of the insurance on any Insured shall be without prejudice to an Insured's rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums. The rates shown in this Schedule can be changed annually. The Company will give the Policyholder written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid by the Policyholder to the Company at Our Home Office. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

The Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, this Certificate will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Insured must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore, angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the application or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germinomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Frauman's Syndrome, Cowden Disease, Turcot Syndrome.

Cancer – means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. The following are not considered Cancer for purposes of this policy:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasive);

3. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;
4. Basal cell carcinoma and squamous cell carcinoma of the skin and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Cancer is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

Carcinoma in situ - means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. It also includes Stage 1 Hodgkin's Disease and Stage A Prostate Cancer. Carcinoma in situ does not include basal cell carcinoma, squamous cell carcinoma or melanoma diagnosed as Clark's Level I or II or Breslow less than .75mm. The date of diagnosis is the day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Carcinoma in situ is based; or, in the case where a pathological case cannot be made, the date of clinical diagnosis.

The "first diagnosis" of Cancer/Carcinoma in situ includes a diagnosis of a recurrence of Cancer/Carcinoma in situ that was previously diagnosed before this Certificate was in force if, after the previous diagnosis and before the date of diagnosis of the recurrence, the Insured is free of any symptoms and treatment of the Cancer/Carcinoma in situ for the 12 consecutive months preceding the Certificate Application Date or any 12 consecutive months thereafter. Treatment does not include Maintenance Drug Therapy or routine follow-up visits or tests to verify that the Cancer/Carcinoma in situ has not returned.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:
 - a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
 - b. there is medical evidence to support the diagnosis; and
 - c. a Doctor is treating You for Cancer and/or Carcinoma in Situ.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date you sign the application for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule – This is page 3 of your certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder – means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Child/Children - All of Your children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday.

Children means Your biological children, stepchildren, adopted children, foster children or any child for whom You are required by a court or administrative order to provide health coverage.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include You or a Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas. The date of diagnosis is the date that Your Doctor or Physician recommends that You begin renal dialysis for End Stage Renal Disease.

Family Member means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work means spending at least [20] hours per week performing your occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while this Certificate is in force and after any applicable Waiting Period.

Insured(s) –

1. If coverage is issued to You, We insure You as the Primary Insured as shown on the Certificate Schedule.
2. If you elect Spouse coverage, We insure You and Your Spouse. Spouse coverage is shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached Rider (if applicable). Rider coverage is shown on the Certificate Schedule.

Loss of Sight, Speech or Hearing means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Maintenance Drug Therapy – means ongoing hormonal treatment, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer or carcinoma in situ due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than palliative or suppression of a cancer that is still present.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than Yourself or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date you sign the application and indicate the specific rider(s) for which you are applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Skin Cancer – means basal cell carcinoma, squamous cell carcinoma and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm. It is not Skin Cancer if it has metastasized and leads to internal cancer. The date of diagnosis for Skin Cancer is the date the tissue specimen is taken.

Specified Critical Illness - means such Illnesses shown in the Certificate Schedule and as defined in this Certificate.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. Meningocele – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. Myelomeningocele – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured’s spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If You die while covered under this certificate, then Your surviving Spouse shall become the Insured if Your Spouse is an Insured. If there is no surviving Spouse covered under this certificate, then this certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines. For Cancer or Carcinoma in Situ, Treatment does not include Maintenance Drug Therapy or routine follow-up visits and tests to verify if the Cancer/Carcinoma in Situ has not returned.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won’t pay benefits for a Specified Critical Illness that begins during the Waiting Period.

You or Your - means the Insured(s) as shown on the Certificate Schedule.

SECTION IV – BENEFIT PROVISIONS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate’s Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months (12 months of no Treatment for Cancer/Carcinoma in situ).

Skin Cancer Benefit

We will pay this benefit if an Insured person is diagnosed with Skin Cancer if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Policy.

This benefit is payable only once during the lifetime of the certificate for each Insured person.

Portability Privilege

When Your coverage would otherwise terminate under this Plan because You end [employment/membership] with the Policyholder, You may elect to keep Your certificate in force. You must have been continuously insured for at least [xx] months under this Plan and/or the prior Plan just before the date Your [employment/membership] terminated. The coverage You may continue is that which You had on the date Your [employment/membership] terminated, including Spouse and Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. You failed to pay any required premium;
 - b. the Group Policy terminates.
2. To keep Your insurance in force You must:
 - a. make written Application to the Company within 31 days after the date Your insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date Your insurance would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date You failed to pay any required premium;
 - b. the date the Group Policy is terminated.

If you qualify for this Portability Privilege as described, then the same benefits, plan provisions, and premium rate as shown in your Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This certificate contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, you may elect to void the Certificate from the beginning and receive a full refund of premium.

PRIOR HISTORY OF CANCER

No benefits are payable for Cancer or Carcinoma in Situ if the Insured was previously diagnosed before this Certificate was in force and, after the previous diagnosis, the Insured has not gone 12 months without Treatment before a new diagnosis of Cancer/Carcinoma in situ is made.

PRE-EXISTING CONDITIONS LIMITATION (Not Applicable to Insureds with a Prior History of Cancer or Carcinoma in Situ – See PRIOR HISTORY OF CANCER)

This certificate contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.

4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021]. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021] within ninety (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. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send You written notice of Our claim decision within 30 days after We receive due proof of Your loss. If there are special circumstances that require more time (such as the need to hold a hearing), We will send You a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, We will send You written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If Your claim is urgent, We will notify You of Our decision within 72 hours. If We need more information, We will let You know within 24 hours of Your claim. At that time We will tell You what additional information is needed to process Your claim. You will have 48 hours to provide any additional information requested. We will notify You of Our decision within 48 hours after We receive the requested information. Our response to an urgent care claim may be oral; if it is, We will confirm Our decision in writing.

We will treat Your claim as urgent if a delay in processing Your claim could seriously jeopardize Your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject You to severe pain that cannot be managed without the care or treatment that is the subject of Your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy or certificate provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support Your claim;
4. Information concerning Your right to request that we review Our decision; and
5. A description of Our review procedures, time limits and notice of Your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by Us no more than 180 days after You receive notice of Our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, You may:

1. Send Us written comments;
2. Review any non-privileged information relating to Your claim; or
3. Provide Us with other information or proof in support of Your claim.

We will review Your claim promptly after receiving Your request. We will advise You of the results of Our review within 60 days after We receive Your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific

policy provisions, rules or guidelines on which the decision was based, and notice of Your right to bring a civil action.

If Your appeal arises from Our denial of an urgent claim, We will consider Your appeal and notify You of Our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All Benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefit unpaid at Your death may be paid to Your estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from You. If You have any questions about this certificate, its benefits, the filing of claims, a complaint or a compliment, please call us or write to Us. Thank you for your loyal patronage.

Entire Contract, Changes: The Master Policy together with the application, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Certificate shall be valid until approved in writing by an executive officer of the Company. Any change must be noted on or attached hereto. No agent may change this Certificate or waive any of its provisions.

Physical Examination and Autopsy: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending. In the case of death, We may also have an autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Certificate within 60 days after written proof of loss has been given as required by this Certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from the Effective Date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from the Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

Conformity with State Statutes: Any Provision of this Certificate which, on its "Effective Date", is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New Employees of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

Important Notice: For questions regarding the Policy, please contact the Company at [1-800-669-2668]. If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494



CERTIFICATE OF INSURANCE FOR GROUP CRITICAL ILLNESS POLICY

**THIS CERTIFICATE PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare.

PLEASE READ YOUR CERTIFICATE CAREFULLY

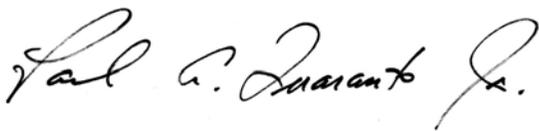
We certify that You are insured under the Critical Illness Policy (herein called the Plan) issued to the Policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from Specified Critical Illness. Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in Your Certificate or not, apply to the insurance referred to by the Certificate.

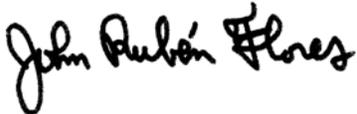
The Effective Date of Your Certificate is as shown in the Certificate Schedule if You are on that date actively at work [for the Policyholder]. If not, this Certificate will become effective on the next date You are actively at work [as an eligible Employee]. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate is issued in consideration of the payment in advance of the required premium and of Your statements and representations in the enrollment form. This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to You under the Plan. "You" and "Your" refer to the Certificateholder or any other Insured under Family Coverage. "We", "Us", and "Our" refer to the Company.

NO RECOVERY FOR PRE-EXISTING CONDITIONS—PLEASE READ CAREFULLY. Your Certificate Schedule reflects the period of time this coverage is in force during which no benefits will be provided for conditions diagnosed within the 180 day period prior to the Effective Date shown in the Certificate Schedule.

Signed for the Company at its Home Office


President


Secretary

TEN DAY RIGHT TO EXAMINE CERTIFICATE

You have the right to return the Certificate within ten (10) days of its delivery and have the premium refunded if, after examination of the Certificate, You are not satisfied for any reason.

CERTIFICATE INDEX

Eligibility, Effective Date and Termination	Section I
Premium Provisions	Section II
General Definitions / Benefit Definitions	Section III
Benefit Provisions	Section IV
Limitations and Exclusions.....	Section V
Claim Provisions	Section VI
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CERTIFICATE SCHEDULE

MASTER POLICYHOLDER: [ABC COMPANY INC]
PRIMARY INSURED: [John Doe]
EFFECTIVE DATE: [May 1, 2012]

CERTIFICATE NUMBER: [123456]

SCHEDULE OF BENEFITS

MAXIMUM BENEFIT AMOUNT: [\$30,000] [\$xx.xx]
[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

PRE-EXISTING CONDITION PERIOD: [180] Days

WAITING PERIOD: [30] Days

[IF THIS COVERAGE REPLACES EXISTING CRITICAL ILLNESS COVERAGE YOU CURRENTLY HAVE WITH ANOTHER CARRIER, YOU WILL BE GIVEN CREDIT FOR THE PERIOD OF TIME YOUR PRIOR COVERAGE WAS IN FORCE TOWARD THE PRE-EXISTING CONDITION PERIOD AND THE WAITING PERIOD.]

COVERED SPECIFIED CRITICAL ILLNESSES:

100% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illnesses:

Myocardial Infarction (Heart Attack)	Benign Brain Tumor
Stroke	Major Organ Transplant
Coma	End Stage Renal Disease (Kidney Failure)
Paralysis	Amyotrophic Lateral Sclerosis (ALS)
Severe Burns	Loss of Sight, Speech or Hearing
Alzheimer's Disease	

30% of the applicable Maximum Benefit Amount is payable for the following Specified Critical Illness:

Coronary Artery Bypass Surgery
Angioplasty/Stent

[SPOUSE BENEFIT: [\$x.xx]

INSURED SPOUSE: [Jane Doe]

MAXIMUM BENEFIT AMOUNT: [\$15,000]

[THE MAXIMUM BENEFIT AMOUNT PAYABLE IS REDUCED BY 50% STARTING AT AGE 70.]

[DEPENDENT CHILDREN BENEFIT RIDER: [\$x.xx]

MAXIMUM BENEFIT AMOUNT: [\$7,500]

100% of the applicable Maximum Benefit Amount is payable for these additional Specified Critical Illness Conditions for Children: **Cerebral Palsy, Cleft Lip or Palate, Down Syndrome, Cystic Fibrosis and Spina Bifida]**

[HEALTH SCREENING BENEFIT RIDER: [\$x.xx]

[\$50] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[GENETIC SCREENING TEST BENEFIT RIDER: [\$x.xx]

[\$250] per Primary Insured (and Spouse if Spouse coverage is elected) per calendar year.]

[EXTENDED LOSS BENEFIT RIDER: [\$x.xx]

MAXIMUM BENEFIT AMOUNT PER INSURED: [\$1,000]

There is no credit given toward the pre-existing condition limitation on this rider for prior coverage.]

[STRIKE WAIVER: [\$x.xx]]

[OCCUPATIONAL HIV BENEFIT RIDER: [\$x.xx]

[\$5,000] payable one-time for the Primary Insured]

TOTAL MONTHLY PREMIUM: [\$xx.xx]

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

You as used in this Certificate, means a person insured under this Certificate who is:

1. an eligible [Employee/Member] of the Policyholder, or an eligible Spouse of the [Employee/Member];
2. engaged in full-time work; and
3. included in the class of [Employees/Members] eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of the Plan is shown on Page 1 of the Master Policy.

The Effective Date for You is as follows:

1. Your insurance will be effective on the date shown on the Certificate Schedule provided You are Actively At Work.
2. If you are not Actively At Work on the date coverage would otherwise become effective, the Effective Date of Your coverage will be the date on which You are first thereafter Actively At Work.

The Effective Date for a Spouse is the date shown on the Certificate Schedule subject to the following:

1. The date Your insurance is effective for a Spouse who is eligible on that date; for whom coverage is applied for and premium paid; and who is not hospital confined.
2. At 12:01 a.m. Standard Time, on the day a Spouse is no longer hospital confined if the Spouse was otherwise eligible for coverage on the date that Your insurance became effective.
3. For a Spouse eligible on or first acquired after Your Effective Date, the Effective Date will be the date We assign after approving the application for such coverage.

TERMINATION OF YOUR INSURANCE

Your insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. on the date You cease to meet the definition of [an Employee/a Member] as defined in the Plan; or
4. on the date You are no longer a member of the class eligible.

Insurance for insured Spouse will terminate the earliest of:

1. the date the Plan is terminated;
2. on the 31st day after the premium due date if the required premium has not been paid;
3. the premium due date following the date the Spouse ceases to meet the definition of Spouse as defined in this contract;
4. the premium due date following the date we receive Your written request to terminate coverage for Your Spouse.

Termination of the insurance on any Insured shall be without prejudice to an Insured's rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums. The rates shown in this Schedule can be changed annually. The Company will give the Policyholder written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

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

Aggregate premiums for this Plan are to be paid by the Policyholder to the Company at Our Home Office. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

The Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, this Certificate will stay in force, unless the Policyholder has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Actively at Work - to be considered "actively at work", the Insured must perform for a full normal workday the regular duties of his employment at the regular place of business or at a location to which he may be required to travel to perform the regular duties of his employment.

Alzheimer's Disease – means a progressive degenerative disease of the brain that is diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The diagnosis must be supported by medical evidence that the Insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment results in a significant reduction in mental and social functioning, resulting in the Insured's inability to permanently perform 2 or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition. Activities of Daily Living include 1) Bathing, 2) Continence, 3) Dressing, 4) Eating, 5) Toileting and 6) Transferring. The date of diagnosis is the date determined by a psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the Insured's medical records.

Amyotrophic Lateral Sclerosis (ALS) – means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. The date of diagnosis of ALS is the date a physician makes a diagnosis based upon generally accepted principles of medicine in the United States at the time the diagnosis is made.

Angioplasty/Stent - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore, angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit. The date of diagnosis is the date of the surgery.

Beneficiary - means the person named in the application or any subsequent change of Beneficiary form recorded at Our home office. A Beneficiary is either a primary Beneficiary or a contingent Beneficiary.

Benign Brain Tumor – means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including but not limited to loss of vision, loss of hearing or balance disruption. The date of diagnosis is the date of the biopsy or surgical excision or specific neurological exam which results in a diagnosis of a Benign Brain Tumor.

The following are not considered Benign Brain Tumors: tumors of the skull, pituitary adenomas and germinomas. We will not pay for benign brain tumors diagnosed with any of the following conditions prior to the Insured's Certificate Application Date: Neurofibromatosis I, Neurofibromatosis II, Tuberous Sclerosis, Li Frauman's Syndrome, Cowden Disease, Turcot Syndrome.

Cerebral Palsy – means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder. The date of diagnosis of Cerebral Palsy is the first date after live birth where a licensed Pediatrician or neurologist diagnoses Cerebral Palsy.

Certificate Application Date - means the date you sign the application for this coverage. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Certificate Schedule – This is page 3 of your certificate. This page lists the Insured(s) covered under the certificate, the conditions covered and their associated benefit amounts.

Certificateholder – means the primary Insured as shown in the Certificate Schedule.

Cleft Lip or Palate – means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity. Includes clefts occurring on one side of the mouth or both sides. The date of diagnosis of the cleft lip or palate is the first date after live birth where a Pediatrician or licensed Physician diagnoses a Cleft Lip or Palate.

Coma - means a state of unconsciousness for 30 consecutive days with no reaction to external stimuli, no reaction to internal needs; and the use of life support systems. The diagnosis of coma must indicate that permanent neurological deficit is present. The date of diagnosis for Coma is the date the Insured fell into a state of unconsciousness.

Coronary Artery Bypass Surgery - means undergoing open heart surgery for treatment of a heart condition to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures. The date of diagnosis is the date of the surgery.

Cystic Fibrosis – means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test is based upon sweat chloride concentrations greater than 60 mmol/L. The date of diagnosis is the first date after live birth where Cystic Fibrosis has been definitively confirmed and established via this sweat test.

Dependent Child/Children - All of Your children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday.

Children means Your biological children, stepchildren, adopted children, foster children or any child for whom You are required by a court or administrative order to provide health coverage.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include You or a Family Member.

Down Syndrome – means a diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another physician familiar with Down Syndrome Diagnosis. Down Syndrome includes:

1. Trisomy – an individual has three instead of two number 21 chromosomes;
2. Translocation – an extra part of the 21st chromosome is attached to another chromosome;
3. Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

The date of diagnosis for Down Syndrome is the first date after live birth when the chromosome test was completed which revealed Trisomy or Mosaicism.

End Stage Renal Disease (Kidney Failure) - means the chronic, irreversible failure of both of the Insured's kidneys to function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas. The date of diagnosis is the date that Your Doctor or Physician recommends that You begin renal dialysis for End Stage Renal Disease.

Family Member means an Insured's Spouse, son, daughter, mother, father, sister, or brother.

Full-time Work means spending at least [20] hours per week performing your occupational duties.

Illness - means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury - means bodily Injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while this Certificate is in force and after any applicable Waiting Period.

Insured(s) –

1. If coverage is issued to You, We insure You as the Primary Insured as shown on the Certificate Schedule.
2. If you elect Spouse coverage, We insure You and Your Spouse. Spouse coverage is shown on the Certificate Schedule.
3. Coverage for Dependent Children will be included in an attached Rider (if applicable). Rider coverage is shown on the Certificate Schedule.

Loss of Sight, Speech or Hearing means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes.

The date of diagnosis is the date determined by the physician when the loss became total, permanent and/or irreversible.

Major Organ Transplant - means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas which is medically necessary for the treatment of a disease of the heart, lung, liver, kidney or pancreas. The date of diagnosis is the date of the transplant surgery.

Maximum Benefit Amount – means the amount is shown on the Certificate Schedule. It is the greatest amount of benefit payable for a covered occurrence of each Specified Critical Illness, subject to the percentages shown on the Certificate Schedule.

Myocardial Infarction (Heart Attack) - means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or Injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include **all** of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal; in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

The date of diagnosis is the date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed above.

Paralysis - means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence. The date of diagnosis is the date, as determined by the physician, when the permanent, total and irreversible paralysis began.

Pathologist - means a Doctor, other than Yourself or a Family Member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Rider Application Date means the date you sign the application and indicate the specific rider(s) for which you are applying. Coverage is contingent upon issuance of the certificate and the payment of the premium.

Severe Burns – means full-thickness or third-degree burn, as determined by a Physician covering at least 25% of the body. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation. The date of diagnosis is the date the injury occurred.

Specified Critical Illness - means such Illnesses shown in the Certificate Schedule and as defined in this Certificate.

Spina Bifida – means a confirmed diagnosis of either of the following types of Spina Bifida:

1. Meningocele – The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities and new problems can develop later in life.
2. Myelomeningocele – This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida which causes nerve damage and more severe disabilities.

This does not include Spina Bifida Occulta. Spina Diagnosis must be made by a licensed Physician familiar with Spina Bifida. The date of diagnosis of Spina Bifida is the first date after live birth where a Pediatrician or licensed Physician diagnoses Spina Bifida.

Spouse – means the person recognized as the Insured's spouse under the laws of the state in which the Insured resides.

Stroke - means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Verterbrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI). Stroke does not mean head Injury, transient ischemic attack or chronic cerebrovascular insufficiency. The date of diagnosis is the date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

Successor Insured - If You die while covered under this certificate, then Your surviving Spouse shall become the Insured if Your Spouse is an Insured. If there is no surviving Spouse covered under this certificate, then this certificate shall terminate on the next premium due date.

Treatment - means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

Waiting Period - means the number of days after the Certificate Application Date before We will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

You or Your - means the Insured(s) as shown on the Certificate Schedule.

SECTION IV – BENEFIT PROVISIONS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate is in force; and
3. It is not excluded by name or specific description in this Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Maximum Benefit Amount is shown on the Certificate Schedule. Benefits will be based on the Maximum Benefit Amount in effect when the loss begins.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.

3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 6 months.

Portability Privilege

When Your coverage would otherwise terminate under this Plan because You end [employment/membership] with the Policyholder, You may elect to keep Your certificate in force. You must have been continuously insured for at least [xx] months under this Plan and/or the prior Plan just before the date Your [employment/membership] terminated. The coverage You may continue is that which You had on the date Your [employment/membership] terminated, including Spouse and Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. You failed to pay any required premium;
 - b. the Group Policy terminates.
2. To keep Your insurance in force You must:
 - a. make written Application to the Company within 31 days after the date Your insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date Your insurance would otherwise terminate.
3. Insurance will cease on the earliest of these dates:
 - a. the date You failed to pay any required premium;
 - b. the date the Group Policy is terminated.

If you qualify for this Portability Privilege as described, then the same benefits, plan provisions, and premium rate as shown in your Certificate as previously issued will apply.

SECTION V - LIMITATIONS AND EXCLUSIONS

WAITING PERIOD

This certificate contains a Waiting Period. This means no benefits are payable for any Insured who has been diagnosed with a Specified Critical Illness during the Waiting Period. The Waiting Period starts on the Certificate Application Date. The Waiting Period is shown on the Certificate Schedule. If an Insured is first diagnosed during the Waiting Period, you may elect to void the Certificate from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS LIMITATION

This certificate contains a Pre-existing Condition Limitation. If a Pre-existing Condition results in a Specified Critical Illness claim during the number of days shown on the Certificate Schedule under Pre-existing Condition Period, starting from the Certificate Application Date, no benefits will be payable for that claim.

Pre-existing Condition means a sickness or physical condition which, within 180 days prior to the Certificate Application Date, resulted in medical advice or Treatment.

We will not pay benefits for any condition or Illness starting within the Pre-existing Condition Period from the Certificate Application Date which is caused by, contributed to, or resulting from a Pre-existing Condition. A claim for benefits for loss starting after the Pre-existing Condition Period from the Application Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition. A condition will no longer be considered Pre-existing at the end of the Pre-existing Condition Period.

There are no benefits payable for any Specified Critical Illness where the date of diagnosis is prior to the Effective Date of this policy or diagnosed during the 30 day waiting period.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted Injury or action while sane or insane.
2. Suicide or attempted suicide while sane or insane.
3. Substance Abuse, except for substance abuse innocently sustained at the hands of a Doctor.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to: Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021]. Notice should include the name of the Insured and the Certificate number. Notice given by or on behalf of the Insured to any authorized agent of the Company within this state, with particulars sufficient to identify the Policy, is considered notice to the Company.

Claim Forms: When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not given within 15 days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at Boston Mutual Life Insurance Company, [120 Royall Street, Canton MA 02021] within ninety (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. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send You written notice of Our claim decision within 30 days after We receive due proof of Your loss. If there are special circumstances that require more time (such as the need to hold a hearing), We will send You a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, We will send You written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If Your claim is urgent, We will notify You of Our decision within 72 hours. If We need more information, We will let You know within 24 hours of Your claim. At that time We will tell You what additional information is needed to process Your claim. You will have 48 hours to provide any additional information requested. We will notify You of Our decision within 48 hours after We receive the requested information. Our response to an urgent care claim may be oral; if it is, We will confirm Our decision in writing.

We will treat Your claim as urgent if a delay in processing Your claim could seriously jeopardize Your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject You to severe pain that cannot be managed without the care or treatment that is the subject of Your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy or certificate provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support Your claim;
4. Information concerning Your right to request that we review Our decision; and
5. A description of Our review procedures, time limits and notice of Your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by Us no more than 180 days after You receive notice of Our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, You may:

1. Send Us written comments;
2. Review any non-privileged information relating to Your claim; or
3. Provide Us with other information or proof in support of Your claim.

We will review Your claim promptly after receiving Your request. We will advise You of the results of Our review within 60 days after We receive Your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of Your right to bring a civil action.

If Your appeal arises from Our denial of an urgent claim, We will consider Your appeal and notify You of Our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately upon receipt of acceptable Proof of Loss, but not later than 30 days after receipt of acceptable Proof of Loss.

Payment of Claims: All Benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefit unpaid at Your death may be paid to Your estate.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from You. If You have any questions about this certificate, its benefits, the filing of claims, a complaint or a compliment, please call us or write to Us. Thank you for your loyal patronage.

Entire Contract, Changes: The Master Policy together with the application, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. In the absence of fraud, statements made by the Policyholder or by an Insured are deemed representations and not warranties. No change in this Certificate shall be valid until approved in writing by an executive officer of the Company. Any change must be noted on or attached hereto. No agent may change this Certificate or waive any of its provisions.

Physical Examination and Autopsy: We, at Our expense, have the right to have You examined as often as reasonably necessary while a claim is pending. In the case of death, We may also have an autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Certificate within 60 days after written proof of loss has been given as required by this Certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from the Effective Date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from the Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

Conformity with State Statutes: Any Provision of this Certificate which, on its "Effective Date", is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Certificates: An individual Certificate will be issued for delivery to the Insured. The Certificate will describe:

1. the benefits under the Policy;
2. to whom benefits will be paid; and
3. the limitations and terms of the Policy.

If there is a conflict between the Policy and the Certificate, the Policy will control.

New Entrants: New Employees of the Policyholder and their Spouse or Dependent Children will be added to the applicable class originally insured under the Policy provided they apply for such coverage and meet the requirements for eligibility as stated in the Policy.

Important Notice: For questions regarding the Policy, please contact the Company at [1-800-669-2668]. If discussions with the Company have failed to produce a satisfactory resolution to a problem, the Arkansas Department of Insurance may be contacted at:

Arkansas Department of Insurance
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Telephone: 1-800-852-5494



DEPENDENT CHILDREN BENEFIT RIDER TO CERTIFICATE OF INSURANCE FOR SPECIFIED CRITICAL ILLNESS

This Rider is a part of the Certificate to which it is attached. We have issued this Rider to you because: (1) you paid the additional premium for this Rider (when applicable); and (2) we relied on the application you made. Unless amended by this Rider, certificate definitions, other provisions and terms apply to this Rider.

Effective Date - If issued at the same time as the certificate, this Rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this Rider will have a later Effective Date, which will be shown in a revised Certificate Schedule Page. Refer to the Effective Date and Termination provision as stated herein.

DEFINITIONS

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

Dependent Children - means all of the Certificateholder's children who are less than twenty-six (26) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-six (26) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 26th birthday.

Children means Your biological children, stepchildren, adopted children, foster children or any child for whom You are required by a court or administrative order to provide health coverage.

BENEFITS

If a Dependent Child is diagnosed with a Specified Critical Illness, subject to the provisions, limitations and exclusions in the Certificate and this Rider and while this Rider is in force, we will provide the benefits for the Specified Critical Illnesses shown on the Certificate Schedule Page. The appropriate benefit amount we will pay for the Dependent Child is shown on the Certificate Schedule Page.

GENERAL PROVISIONS

If your Dependent Child's coverage is terminated because of attainment of the maximum age, we will still pay benefits for any covered condition that was diagnosed while the Dependent was covered under this Rider.

EFFECTIVE DATE

Coverage for Dependent Children is subject to the following:

1. Newborn children of a Certificateholder and/or his or her Spouse shall automatically be covered from birth provided that we receive notification within thirty-one (31) days after the birth of the child. Foster children shall be eligible for coverage on the same basis upon placement in the foster home.
2. Adopted children will be covered the later of the date of birth or the date a decree of adoption is entered by the Certificateholder and/or his or her Spouse. A decree of adoption must be

entered within one year from the date proceedings were instituted, unless extended by order of the court, and the Certificateholder and/or his or her Spouse must continue to have custody pursuant to the decree of the court.

TERMINATION – Coverage for the Dependent Children or Dependent Child will end on the earliest of the following:

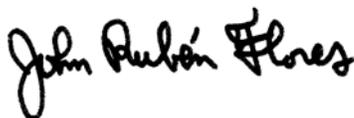
1. When the Certificate terminates;
2. The date We receive Your written request to cancel the Rider (in which case the grace period will not apply);
3. When the Dependent Children or Dependent Child does not qualify as a dependent of You or Your Spouse as defined in this Rider.

CONTRACT -This Rider is part of the Certificate, and will terminate when the certificate terminates, or when premiums are no longer paid for this Rider. This Rider is subject to all of the terms of the certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office



President



Secretary