

State: Arkansas **Filing Company:** Colonial Life & Accident Insurance Company
TOI/Sub-TOI: H02G Group Health - Accident Only/H02G.000 Health - Accident Only
Product Name: Group Accident 1.0
Project Name/Number: Group Accident 1.0/Group Accident 1.0

Filing at a Glance

Company: Colonial Life & Accident Insurance Company
Product Name: Group Accident 1.0
State: Arkansas
TOI: H02G Group Health - Accident Only
Sub-TOI: H02G.000 Health - Accident Only
Filing Type: Form
Date Submitted: 08/28/2012
SERFF Tr Num: UNUM-128598944
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: GACC1.0
Implementation: On Approval
Date Requested:
Author(s): Cathy Brooks, Angela Parker, Lauren Sease, Annette Smith, Tyra Marshall, Jessica Reece, Pam Childers, Amy Rish
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 09/10/2012
Disposition Status: Approved-Closed
Implementation Date:
State Filing Description:

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General Information

Project Name: Group Accident 1.0 Status of Filing in Domicile: Pending
Project Number: Group Accident 1.0 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Employer, Association Overall Rate Impact:
Filing Status Changed: 09/10/2012
State Status Changed: 09/10/2012 Deemer Date:
Created By: Jessica Reece Submitted By: Angela Parker
Corresponding Filing Tracking Number:

Filing Description:

The forms do not replace any forms currently on file with your department. These forms will be offered and marketed as supplemental insurance and not as a substitute for hospital or medical expense insurance or major medical insurance. Benefits provided are not intended to cover all medical expenses. There is no coordination of benefits. Please note all benefits are indemnity based. The level of benefits is not based on the amount of expenses incurred.

The group policy provides benefits for accidents and is designed to be sold as either off job or on job/off job coverage for the named insured. Benefits are also available for spouse and dependent children.

Coverage will be marketed in employer/employee and association or union groups by licensed Colonial Life & Accident Insurance Company agents and through relationships with insurance brokers.

Premiums may be paid 100% by named insureds or by full or partial contributions from the policyholder.

A Statement of Variability is also included with this filing and provides more detailed information regarding the plan variability. Benefits shown in the brackets are variable and will either appear in its entirety or not at all, depending on choices made by the policyholder and/or named insured. No text within the brackets will change.

The master application, enrollment form and election of portability coverage form will be used with this product. These forms are bracketed for flexibility to support the various enrollment methods, add benefits or make changes to a plan.

An Underwriting Statement of Variability is included with this filing and provides a more detailed explanation about the brackets within the Underwriting forms.

Enrollment methods include agent-assisted situations, in person or via call centers, and self-enrolled situations, using paper or electronic enrollment processes, such as web-based. In some situations where the premium is fully policyholder-paid, enrollment may be by an employee/member listing provided by the policyholder. Electronic enrollment processes may also be used in agent-assisted situations.

The forms have been submitted to our domicile state, South Carolina.

We reserve the right to alter the layout of these forms including ordering of the provisions, color, typeface and font and to change variables as requested by a specific employer or to accommodate future product design needs as long as such changes are in compliance with your state law.

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Company and Contact

Filing Contact Information

Jessica Reece, Contract Consultant jeblack@coloniallife.com
 1200 Colonial Life Boulevard 800-845-7330 [Phone] 86286 [Ext]
 Columbia, SC 29202

Filing Company Information

| | | |
|--------------------------------------------|-------------------------|-----------------------------------|
| Colonial Life & Accident Insurance Company | CoCode: 62049 | State of Domicile: South Carolina |
| 1200 Colonial Life Boulevard | Group Code: 565 | Company Type: |
| Post Office Box 1365 | Group Name: | State ID Number: |
| Columbia, SC 29202 | FEIN Number: 57-0144607 | |
| (803) 798-7000 ext. [Phone] | | |

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? No
 Fee Explanation: 5 forms x \$50 = \$250
 Per Company: No

| Company | Amount | Date Processed | Transaction # |
|--------------------------------------------|----------|----------------|---------------|
| Colonial Life & Accident Insurance Company | \$250.00 | 08/28/2012 | 62083553 |

SERFF Tracking #:

UNUM-128598944

State Tracking #:

Company Tracking #:

GACC1.0

State:

Arkansas

Filing Company:

Colonial Life & Accident Insurance Company

TOI/Sub-TOI:

H02G Group Health - Accident Only/H02G.000 Health - Accident Only

Product Name:

Group Accident 1.0

Project Name/Number:

Group Accident 1.0/Group Accident 1.0

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 09/10/2012 | 09/10/2012 |

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Disposition

Disposition Date: 09/10/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|---------------------------------------|----------------------|---------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Statements of Variability | Approved-Closed | Yes |
| Form | Group Accident Policy | Approved-Closed | Yes |
| Form | Group Accident Certificate | Approved-Closed | Yes |
| Form | Policyholder Application | Approved-Closed | Yes |
| Form | Enrollment Form | Approved-Closed | Yes |
| Form | Election of Portability Coverage Form | Approved-Closed | Yes |

State: Arkansas

Filing Company:

Colonial Life & Accident Insurance Company

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Form Schedule

Lead Form Number: GACC1.0-P

| Item No. | Schedule Item Status | Form Number | Form Type | Form Name | Action/ Action Specific Data | Readability Score | Attachments |
|----------|-------------------------------|--------------|-----------|---------------------------------------|------------------------------|-------------------|-------------------|
| 1 | Approved-Closed 09/10/2012 | GACC1.0-P-AR | POL | Group Accident Policy | Initial: | 50.500 | GACC1.0-P-AR.pdf |
| 2 | Approved-Closed 09/10/2012 | GACC1.0-C-AR | CER | Group Accident Certificate | Initial: | 50.100 | GACC1.0-C-AR.pdf |
| 3 | Approved-Closed 09/10/2012 | GACC - App | AEF | Policyholder Application | Initial: | | GACC - App.pdf |
| 4 | Approved-Closed 09/10/2012 | GACC-Enroll | AEF | Enrollment Form | Initial: | | GACC - Enroll.pdf |
| 5 | Approved-Closed 09/10/2012 | GACC - Port | OTH | Election of Portability Coverage Form | Initial: | | GACC - Port.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 |

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com]
A Stock Company

GROUP ACCIDENT INSURANCE POLICY

Please Read This Policy Carefully

This policy is a legal contract between the policyholder and us. To understand the coverage, this policy must be read as a whole.

Throughout this policy, the word **policyholder** refers to the organization shown on the Policy Rate Schedule. **You** or **your** refers to a named insured who is covered under this coverage. **Named insured** refers to the person who is a member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom the policyholder remits premium. **Covered person** refers to any person covered under this policy as described on the Certificate Schedule. **We, us, our** or **company** refer to Colonial Life & Accident Insurance Company. The male pronoun includes the female whenever used.

[This policy is delivered in and is governed by the laws of the governing jurisdiction shown on the Policy Rate Schedule and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, we have discretionary authority to determine the named insured's eligibility for benefits and to interpret the terms and provisions of the policy.]

This policy is issued in consideration of the application of the policyholder, a copy of which is attached to and made a part of this policy, and the payment of premium when due. This policy takes effect at 12:01 a.m. Standard Time at the policyholder's address on the Policy Effective Date shown on the Policy Rate Schedule.

We agree to pay, in accordance with the terms of this policy, the benefit amounts of the policy to the named insureds. Details of the benefits are shown in the certificate.

Right to Return This Policy

If, for any reason, you are not satisfied with this policy, you can return it to us at our home office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this policy as if it never existed. Any premium paid will be refunded.

Signed for Colonial Life & Accident Insurance Company:

[



Secretary



President and Chief Executive Officer]

**THIS IS A LIMITED BENEFIT POLICY.
PLEASE READ IT CAREFULLY.**

**THE POLICY IS CANCELLABLE AT THE OPTION OF THE COMPANY.
PLEASE READ THE "TERMINATION OF THIS CONTRACT" PROVISION.
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

If you should have any questions, need information about your coverage or assistance in resolving complaints, please contact your agent or Colonial Life at 1.800.325.4368. In the event that we fail to provide you with reasonable and adequate service, feel free to contact the Insurance Department.

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
1.501.371.2640

SECTION 2 – POLICY GUIDE

SECTION 1 – FACE PAGE

SECTION 2 – POLICY GUIDE

SECTION 3 – POLICY RATE SCHEDULE

SECTION 4 – POLICYHOLDER PROVISIONS

SECTION 5 – PREMIUM PAYMENTS

SECTION 6 – TERMINATION

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

SECTION 3 – POLICY RATE SCHEDULE

Policyholder: [ABC Employer] Policy Number: [987654321]
Policyholder Address: [123 Any Street Attn: Any Town, SC 99999-9999] Billing Control Number: [E123456]
Policy Effective Date: [01/01/2013] Governing Jurisdiction: [Any State]

Description of Eligible Classes

[All employees in active employment working a minimum of [15] hours per week. Temporary and seasonal workers are excluded from coverage.

Active Employment means the named insured is working for the policyholder at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. The named insured will not be considered in active employment if employment status is being continued under a severance or termination agreement. The worksite must be:

- the policyholder’s usual place of business;
an alternative work site at the direction of the policyholder; or
a location to which the named insured’s job requires him to travel.

Material and substantial duties means duties that are normally required for the performance of the named insured’s regular occupation, and cannot be reasonably omitted or modified.

Regular occupation means the occupation the named insured routinely performs on his job.]

Eligibility Period: [31 days]

This policy may include enrollment, risk management and other support services related to the policyholder’s benefit program.

Initial Monthly Rates:

Table with 2 columns: Category and Rate. Rows include Named Insured, Named Insured and Spouse, One-Parent Family, and Two-Parent Family, all with rates in the format \$[XX.XX].

Rate Guarantee Period: A change in the initial monthly rates will not take effect before [two years] after the policy effective date.

[Divisions, subsidiaries or affiliated companies include: Name/location (city and state)]

SECTION 4 – POLICYHOLDER PROVISIONS

Ownership

The policyholder is the owner of this policy and may agree with us to change it without the consent of or notice to the covered persons or their assignees.

Entire Contract

The entire contract consists of:

- this policy;
- the application of the policyholder attached to this policy;
- each named insured's enrollment form and evidence of insurability, if applicable;
- certificates issued under this policy; and
- riders, endorsements or amendments to the policy or certificates.

Changes to the Contract

Riders, endorsements and amendments add provisions to or change the terms of the policy.

Any changes to this policy, other than a change in the premium we charge, must be in writing and evidenced by endorsement on this policy, or by amendment to this policy signed by the policyholder and one of our executive officers at our home office. No agent or anyone else can change this policy or waive any of its provisions.

Furnishing Certificates

The company will provide a certificate for each named insured. The certificate will provide a description of the insurance provided by this policy and will state:

- the benefits provided under the policy;
- to whom benefits are payable;
- the limitations, exclusions and requirements that apply to coverage under the policy; and
- how to file a claim against the coverage.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy, the provisions of this policy govern.

Contestability

After two years from the Policy Effective Date, no misstatements made by the policyholder in the application, will be used to void this policy or to deny a claim for loss incurred after the expiration of the two-year period.

Conformity with State Statutes

Any provision of this policy that is in conflict with the applicable state laws of the state in which the named insured resides when he becomes insured is amended to conform to the minimum requirements of those laws.

Our Right to Change Premiums

We have the right to change the premium we charge after notifying the policyholder in writing at least 45 days in advance. A change in the initial monthly rates will not take effect before the end of the rate guarantee period shown on the Policy Rate Schedule except for reasons which affect the risk assumed, including, but not limited to those reasons shown below:

- a change occurs in this policy;
- a division, subsidiary, or affiliated company is added or deleted;
- the number of insureds changes by 25% or more; or
- a new law or a change in any existing law is enacted which applies to this policy.

After the rate guarantee period, we can change premium rates at any time. A change may take effect on an earlier date when both we and the policyholder agree in writing.

New Entrants

Any member of an eligible class, as described on the Policy Rate Schedule, and the eligible dependents of those members will become insured when they satisfy the requirements set forth in the certificate.

Information to Be Furnished By the Policyholder

The policyholder must keep a record of the named insureds and the particulars of the insurance on each and their covered spouse and dependent children, if applicable. As changes occur, the policyholder should provide us, on forms acceptable to us, information relative to any persons:

- who are eligible to enroll;
- who are insured by the coverage;
- whose status changes; and/or
- whose coverage terminates pursuant to the "Termination of Insurance" provision.

The policyholder should also provide us with any other information about the coverage that may be reasonably required, such as named insureds on leave of absence, including named insureds who are on leave under the Family and Medical Leave Act.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time. We may inspect these records at any time while this policy is in force and within one year after the termination of this policy.

All statements made in any application are considered representations and not warranties (absolute guarantees). No representation by the policyholder in applying for insurance under this policy will make it void unless the representation is contained in the application of the policyholder.

Clerical error or omission by us will not:

- prevent a covered person from receiving coverage;
- affect the amount of a covered person's coverage; or
- cause a covered person's coverage to begin or continue when the coverage would not otherwise be effective.

Electronic Transactions

Any transaction relating to this policy may be conducted by electronic means if performance of the transaction is consistent with applicable state and federal law. Any notice required by the provisions of this policy given by written, electronic and telephonic, as applicable, means will have the same force and effect as notice given in writing.

SECTION 5 – PREMIUM PAYMENTS

Premium Payments

The initial premium for each type of coverage under this policy is based on the initial monthly rates shown on the Policy Rate Schedule.

Premium Amount

To ensure accurate premium calculations, the policyholder is responsible for reporting to us the following information during the stated time periods:

- individuals who are eligible to enroll are to be reported during the month prior to or during the month the coverage becomes effective;
- covered persons whose coverage has terminated are to be reported within a month of the date coverage terminated; and
- changes in named insureds' class are to be reported within a month of the date that the change in insurance class took place.

When and Where to Pay Premiums

The premiums for each certificate must be paid to us at our home office when they are due.

The premium due dates are based on:

- the coverage effective dates shown on the Certificate Schedules; and
- the premium frequency.

The premium frequency is how often the premiums are paid. The policyholder will be liable to us for all unpaid premiums for any period, including the grace period, during which coverage under the policy was in force as to any covered person.

Premium increases or decreases which take effect during an insurance month are due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Grace Period (If Premiums Are Not Paid When Due)

After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. During the grace period this coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate at the end of the grace period.

SECTION 6 – TERMINATION

Termination of This Contract

This policy can be terminated:

- by the policyholder; or
- by us.

If the premium is not paid when it is due or during the grace period, this policy will terminate automatically at the end of the grace period.

Except for nonpayment of the required premium or the failure to meet continued underwriting standards, we may not cancel the policy prior to the first anniversary date of the policy effective date as specified on the Policy Rate Schedule. After the first anniversary date, we may cancel this policy for any reason.

If we cancel this policy for reasons other than the policyholder's failure to remit premium, a written notice will be delivered to the policyholder by certified mail at least 60 days prior to the cancellation date.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. This policy can be cancelled on an earlier date if we and the policyholder both agree. Coverage will end at 12:00 midnight Standard Time at the policyholder's address on the cancellation date.

If the policy is cancelled, the cancellation will not affect a claim for which we are liable under the terms of this policy.

Policyholder Responsibility to Named Insureds

If this policy terminates for any reason, the policyholder must:

- notify each named insured of the effective date of the termination; and
- refund or otherwise account to each named insured all contributions received or withheld from them for premiums not actually paid to us.

Workers' Compensation

This policy is not in lieu of, and does not affect, any requirement for coverage by workers' compensation insurance.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
[1200 Colonial Life Boulevard, P. O. Box 1365, Columbia, South Carolina 29202
1.800.325.4368 coloniallife.com]
A Stock Company

GROUP ACCIDENT INSURANCE CERTIFICATE
THIS CERTIFICATE EXPLAINS THE BENEFITS PROVIDED UNDER
THE GROUP ACCIDENT INSURANCE POLICY.

THIS IS A LIMITED BENEFIT CERTIFICATE.

Please Read This Certificate Carefully

This is your certificate of coverage as long as you are insured under the policy. You will want to read it carefully and keep it in a safe place.

Throughout this certificate, the word **you** or **your** refers to the named insured shown on the Certificate Schedule who is a member of an eligible class as described on the Policy Rate Schedule, who holds a certificate of coverage and for whom premiums are remitted. **Covered person** refers to any person covered under the policy as described on the Certificate Schedule. **We, us, our** or **company** refers to Colonial Life & Accident Insurance Company. **Policyholder** refers to the organization shown on the Policy Rate Schedule. It includes any division, subsidiary or affiliated company named in the Policy Rate Schedule. **Policy** means the group contract owned by the policyholder and available for review by you. The male pronoun includes the female whenever used. If the terms of your certificate of coverage and the policy differ, the policy will govern.

The policy and this certificate may be changed in whole or in part or cancelled as stated in the policy. Such an action may be taken without the consent of or notice to any covered person. Only an executive officer at our home office can approve a change. The approval must be in writing and evidenced by endorsement on the policy or certificate or an amendment signed by the policyholder and one of our executive officers at our home office. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes. This Certificate replaces any and all Certificates previously issued for the eligible classes under the Policy.

[The policy and this certificate are delivered in and are governed by the laws of the governing jurisdiction shown on the Policy Rate Schedule and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, we have discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.]

Right to Return This Certificate

If, for any reason, you are not satisfied with this certificate, you can return it to us at our home office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this certificate as if it never existed. Any premium paid will be refunded.

Signed for Colonial Life & Accident Insurance Company:

[



Secretary



President and Chief Executive Officer]

Please read this certificate carefully.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Guide To Health Insurance for People with Medicare available from the company.

If you should have any questions, need information about your coverage or assistance in resolving complaints, please contact your agent or Colonial Life at 1.800.325.4368. In the event that we fail to provide you with reasonable and adequate service, feel free to contact the Insurance Department.

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201
1.501.371.2640

SECTION 2 – CERTIFICATE GUIDE

SECTION 1 – FACE PAGE

SECTION 2 – CERTIFICATE GUIDE

SECTION 3 – CERTIFICATE SCHEDULE

SECTION 4 – GENERAL DEFINITIONS

SECTION 5 – ELIGIBILITY AND EFFECTIVE DATE

SECTION 6 – BENEFITS

[SECTION [7] – GENERAL EXCLUSIONS AND LIMITATIONS]

SECTION [8] – TERMINATION OF INSURANCE

[SECTION [9] – PORTABILITY]

SECTION [10] – GENERAL PROVISIONS

SECTION [11] – CLAIM PROVISIONS

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

SECTION 3 – CERTIFICATE SCHEDULE

| | | | |
|--------------------------|-------------------------------|-------------------------|--------------|
| Policyholder: | [ABC Employer] | Policy Number: | [123456] |
| Named Insured: | [John A. Doe] | Certificate Number: | [0000000000] |
| Coverage Type: | [Two-Parent Family] | Governing Jurisdiction: | [Any State] |
| Coverage Effective Date: | [03/01/2013] | Billing Control Number: | [E123456] |
| Accident Type: | [On & Off Job] [Off Job Only] | | |

**All benefits are payable once per covered person per covered accident unless specified otherwise.
We will pay these benefits for any covered person who receives injuries as the result of a covered accident:**

| | |
|----------------------------------------------------------------------------------------|-----------------------|
| [Accident Emergency Treatment] | \$[25-450] |
| Maximum of [1-10] visit(s) per covered person per calendar year | |
| [Accident Follow Up Doctor Visit] | \$[25-250] |
| Maximum of [1-8] visit(s) per covered person per covered accident | |
| Maximum of [1-40] visits(s) per covered person per calendar year | |
| [Accidental Death] | |
| Named Insured | \$[5,000-500,000] |
| [Spouse] | \$[5,000-500,000]] |
| [Dependent Child(ren)] | \$[1,000-100,000]]] |
| [Accidental Death – Common Carrier] | |
| Named Insured | \$[20,000-1,000,000] |
| [Spouse] | \$[20,000-1,000,000]] |
| [Dependent Child(ren)] | \$[4,000-200,000]]] |
| [Accidental Dismemberment (Loss of Finger, Toe, Hand, Foot or Sight of an Eye)] | |
| Loss of one finger or one toe | \$[150-3,000] |
| Loss of two or more fingers; or two or more toes | \$[300-6,000] |
| Any combination of two or more fingers or toes | \$[300-6,000] |
| Loss of one hand or one foot; or sight of one eye | \$[1,500-30,000] |
| Loss of both hands or both feet; or sight of both eyes | \$[3,000-60,000] |
| Any combination of two or more hands, feet or sight of an eye | \$[3,000-60,000]] |
| [Air Ambulance] | \$[100-4,800]] |
| [Ambulance] | \$[50-1,000]] |
| [Appliance] | \$[25-600]] |
| [Blood/Plasma/Platelets] | \$[50-900]] |
| [Burn] | |
| 2nd degree burns | |
| Covering a total of at least 36% of the body surface | \$[250-3,000] |

3rd degree burns

| | |
|-----------------------------------------------------------------------------------|------------------|
| Covering a total of: at least 9 square inches, but less than 18 square inches; or | \$[500-6,000] |
| At least 18 square inches, but less than 35 square inches; or | \$[1,000-12,000] |
| 35 or more square inches of the body surface | \$[3,000-36,000] |

Burn – Skin Graft

Skin graft for 2nd or 3rd degree burns [25-100]% of applicable Burn benefit]]

[Catastrophic Accident

| | |
|---------------------------------------------------------|--------------------|
| Named Insured | \$[5,000-200,000] |
| [Spouse | \$[5,000-200,000]] |
| [Dependent Child(ren) | \$[2,500-100,000]] |
| Subject to a 365-day elimination period | |
| Maximum of one benefit per lifetime per covered person] | |

[Coma \$[2,500-30,000]]

[Concussion \$[25-500]]

[Dislocation (Separated Joint)

| Joint | Closed Reduction | Open Reduction |
|-----------------------------------------------------|-------------------------|-----------------------|
| Hip | \$[200-8,000] | \$[400-16,000] |
| Knee (except patella) | \$[100-4,000] | \$[200-8,000] |
| Ankle – Bone or Bones of the Foot (other than toes) | \$[80-3,200] | \$[160-6,400] |
| Collarbone (sternoclavicular) | \$[50-2,000] | \$[100-4,000] |
| Lower Jaw | \$[30-1,200] | \$[60-2,400] |
| Shoulder (glenohumeral) | \$[30-1,200] | \$[60-2,400] |
| Elbow | \$[30-1,200] | \$[60-2,400] |
| Wrist | \$[30-1,200] | \$[60-2,400] |
| Bone or Bones of the Hand (other than fingers) | \$[30-1,200] | \$[60-2,400] |
| Collarbone (acromioclavicular and separation) | \$[10-400] | \$[20-800] |
| One Toe or Finger | \$[10-400] | \$[20-800] |

Incomplete Dislocation or dislocation reduction without anesthesia – 25% of the applicable amount for closed reduction of joint involved.]

[Emergency Dental Work

| | |
|----------------------------------|--------------|
| Dental Crown, Denture or Implant | \$[50-1,350] |
| Dental Extraction | \$[25-450]] |

[Eye Injury with surgical repair \$[50-800]]

[Fracture (Broken Bone)

| Bone | Closed Reduction | Open Reduction |
|---------------------------------------------------------------------------|-------------------------|-----------------------|
| Skull, Depressed Skull fracture (except bones of face or nose) | \$[250-10,000] | \$[500-20,000] |
| Skull, Simple Non-depressed Skull fracture (except bones of face or nose) | \$[100-4,000] | \$[200-8,000] |
| Hip, Thigh (femur) | \$[150-6,000] | \$[300-12,000] |
| Vertebrae, Body of (excluding vertebral processes) | \$[75-3,750] | \$[150-7,500] |
| Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx) | \$[75-3,750] | \$[150-7,500] |
| Leg (tibia and/or fibula) | \$[75-3,750] | \$[150-7,500] |
| Bones of Face or Nose (except mandible or maxilla) | \$[35-1,400] | \$[70-2,800] |
| Upper Jaw, Maxilla (except alveolar process) | \$[35-1,400] | \$[70-2,800] |

| | | |
|------------------------------------------------------------|--------------|--------------|
| Upper Arm between Elbow and Shoulder (humerus) | [\$35-1,400] | [\$70-2,800] |
| Lower Jaw, Mandible (except alveolar process) | [\$30-1,200] | [\$60-2,400] |
| Shoulder Blade (scapula), Collarbone (clavicle, sternum) | [\$30-1,200] | [\$60-2,400] |
| Vertebral Processes | [\$30-1,200] | [\$60-2,400] |
| Forearm (radius and/or ulna), Hand, Wrist (except fingers) | [\$30-1,200] | [\$60-2,400] |
| Kneecap (patella) | [\$30-1,200] | [\$60-2,400] |
| Foot (except toes) | [\$30-1,200] | [\$60-2,400] |
| Ankle | [\$30-1,200] | [\$60-2,400] |
| Rib | [\$25-1,000] | [\$50-2,000] |
| Coccyx | [\$20-800] | [\$40-1,600] |
| Finger, Toe | [\$10-200] | [\$20-400] |

Chip Fracture – 25% of the applicable amount for closed reduction of the bone listed above.
Maximum of one Chip Fracture benefit per covered person per covered accident.]

[Hospital Admission] \$[250-4,500]]

[Hospital Confinement] \$[25-1,200]
Maximum of [30-365] days per covered person per covered accident]

[Hospital Intensive Care Unit Admission] \$[250-6,000]]

[Hospital Intensive Care Unit Confinement] \$[50-2,400]
Maximum of [0-90] days per covered person per covered accident]

[Knee Cartilage – Torn] \$[250-2,000]]

[Laceration]

Repaired by stitches:

Total of all lacerations is less than two inches long (less than 5.08 centimeters) \$[5-300]

Total of all lacerations is at least two but less than six inches long (5.08 to 15.23 centimeters) \$[25-1,200]

Total of all lacerations is six inches or longer (15.24 centimeters or longer) \$[25-2,400]

Laceration(s) with no repair: \$[5-100]]

[Lodging] \$[50-400]

Maximum of [0-90] days per covered person per covered accident]

[Medical Imaging Study] \$[25-1,200]

Maximum of one benefit per covered person per covered accident and one benefit per covered person per calendar year]

[Occupational or Physical Therapy] \$[5-125]

Maximum of [5-20] days per covered person per covered accident]

[Pain Management] \$[50-300]]

[Prosthetic Device/Artificial Limb]

One \$[250-2,000]

More than one \$[500-4,000]]

[Rehabilitation Unit Confinement] \$[25-300]

Maximum of [10-20] days per covered person per covered accident not to exceed [30-90] days per covered person per calendar year]

[Ruptured Disc with Surgical Repair] \$[100-1,500]]

| | |
|----------------------------------------------------------------------------|----------------|
| [Surgery – Cranial, Open Abdominal and Thoracic/Hernia | |
| Cranial, Open Abdominal and Thoracic surgery | \$[500-4,000] |
| Hernia with surgical repair | \$[50-400]] |
| [Surgery – Exploratory and Arthroscopic | \$[25-500]] |
| [Tendon/Ligament/Rotator Cuff | |
| One with surgical repair | \$[100-2,000] |
| Two or more with surgical repair | \$[150-3,000]] |
| [Transportation | \$[100-1,000] |
| Maximum of [3-5] round trips per covered person per covered accident] | |
| [X-Ray | \$[10-100]] |
| [Additional Benefit Information | |
| [Health Screening | \$[25-150] |
| [Subject to a [0-365] day waiting period] | |
| Maximum of one health screening test per covered person per calendar year] | |
| [Hospital Confinement due to Covered Sickness | \$[50-5,000] |
| Maximum of [10-60] days per covered person per covered sickness]] | |

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SECTION 4 – GENERAL DEFINITIONS

Additional definitions may be contained in other certificate benefit provisions or any endorsement, amendment or rider.

Accident means an unintended or unforeseen bodily injury sustained by a covered person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

Calendar Year means the period beginning on the coverage effective date shown on the Certificate Schedule and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Certificate means a document that provides a description of the insurance provided by the policy and states:

- the benefits provided under the policy;
- to whom benefits are payable;
- the limitations, exclusions and requirements that apply to coverage under the policy; and
- how to file a claim against the coverage.

Confined or Confinement means the assignment to a bed as a resident inpatient in a hospital on the advice of a doctor or, for the purposes of the hospital confinement benefit only, confinement in an observation unit within a hospital for a period of no less than 20 continuous hours on the advice of a doctor.

Coverage Effective Date means the date coverage begins as shown in the Certificate Schedule. The coverage effective date of this certificate is not the date you signed the application for coverage.

Covered Accident means an accident which:

- occurs on or after the coverage effective date shown on the Certificate Schedule;
- occurs while this certificate is in force;
- is of the Accident Type listed on the Certificate Schedule; and
- is not excluded by name or specific description in this certificate.

Dependent Children means your natural children, your step-children, your legally adopted children, under your charge, care and control for whom you have filed a petition to adopt or children for whom you are ordered by a court to provide coverage [who are][:]

- [unmarried;] [and]
- [under 26 years of age].

Doctor or Physician means a person who:

- is licensed by the state to practice a healing art; and
- performs services for a covered person which are allowed by his license.

For purposes of this definition, Doctor or Physician does not include any covered person or anyone related to any covered person by blood or marriage, a business or professional partner of any covered person, or any person who has a financial affiliation or a business interest with any covered person.

Emergency Room means a specified area within a hospital which is designated for the emergency care of accidental injuries or sicknesses. This area must:

- be staffed and equipped to handle trauma;
- be supervised and provide treatment by physicians; and
- provide care seven days per week, 24 hours per day.

Enrollment Period means a period of time determined by us and the policyholder during which you are eligible to enroll for or change your coverage. This period of time may be limited.

Evidence of Insurability means a statement of your medical history which we will use to determine if you are approved for coverage.

Hospital means a place that:

- is an institution licensed as a hospital and operated pursuant to law on a full-time basis;
- provides overnight care of injured and sick people;
- is supervised by a doctor;
- has full-time nurses supervised by a registered nurse; and
- has at its locations or uses on a pre-arranged basis: X-ray equipment, a laboratory and an operating room where surgical operations take place.

Notwithstanding the above, a hospital is not:

- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a rehabilitation center;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Hospital Intensive Care Unit means a place which:

- is a specifically designated area of the hospital that is reserved for patients who are critically ill or injured and who require intensive comprehensive observation and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has a doctor assigned to the intensive care unit on a full-time basis.

A hospital intensive care unit that meets the definition may include, but not limited to, hospital units with the following names:

- Intensive Care Unit;
- Coronary Care Unit;
- Pediatric Intensive Care Unit;
- Pulmonary Care Unit;
- Burn Unit; or
- Transplant Unit.

A hospital intensive care unit is not any of the following step down units:

- a progressive care unit;
- an intermediate care unit;
- a private monitored room;
- sub-acute intensive care unit;
- an observation unit; or
- any facility not meeting the definition of a hospital intensive care unit as defined in this certificate.

Hospital Sub-Acute Intensive Care Unit means a place which:

- is a specifically designated area of the hospital that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and
- is under constant and continuous observation by a specially trained nursing staff.

A hospital sub-acute intensive care unit may be referred to by other names such as progressive care, intermediate care, or a step-down unit, but it is not a regular private or semi-private room, or a ward with or without monitoring equipment.

Injury means a wound to a covered person's body that is caused solely by or is the result of a covered accident.

Observation Unit means a specified area within a hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a doctor and which:

- is under the direct supervision of a doctor or registered nurse;
- is staffed by nurses assigned specifically to that unit; and
- provides care seven days per week, 24 hours per day.

Occupational Therapist is a person who:

- possesses the designation “Occupational Therapist Registered (OTR)”;
- is licensed by the state to practice occupational therapy;
- performs services which are allowed by his license; and
- performs services for which benefits are provided by this certificate.

For purposes of this definition, occupational therapist does not include any covered person or anyone related to any covered person by blood or marriage.

Off-Job Accident means an accident that occurs while a covered person is not working at any job for pay or benefits.

On-Job Accident means an accident that occurs while a covered person is working at any job for pay or benefits.

Physical Therapist is a person who:

- is licensed by the state to practice physical therapy;
- performs services which are allowed by his license;
- performs services for which benefits are provided by this certificate; and
- practices according to the Code of Ethics of the American Physical Therapy Association.

For purposes of this definition, physical therapist does not include any covered person or anyone related to any covered person by blood or marriage.

[**Pre-existing Condition** means a sickness or physical condition, whether diagnosed or not, for which a covered person was treated, had medical testing, received medical advice or had taken medication within 12 months before the coverage effective date.]

Rehabilitation Unit means an appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by accidental injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of physicians. The rehabilitation unit may be part of a hospital or a freestanding facility.

A rehabilitation unit is not:

- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Spouse means a person who is married to you on the day we issue your certificate.

Temporary Layoff or Leave of Absence means the named insured is temporarily absent from active employment for a period of time that has been agreed to in advance in writing by the employer. Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Urgent Care Facility means a place other than a doctor’s office, hospital or emergency room that provides emergency care and treatment for injured people.

SECTION 5 – ELIGIBILITY AND EFFECTIVE DATE

Coverage Effective Date

Your coverage under the policy will start at 12:01 a.m. Standard Time in the time zone where you live on the coverage effective date shown on your Certificate Schedule.

Enrollment

An individual who is a member of an eligible class may enroll in coverage during the eligibility period, as shown on the Policy Rate Schedule, that follows the later of:

- the policy effective date as shown on the Policy Rate Schedule;
- the date the individual first becomes a member of an eligible class;
- the date the individual completes the policyholder probationary period shown on the application of the policyholder, if applicable;
- the date the individual meets evidence of insurability requirements, if any.

An individual who fails to enroll during the eligibility period may enroll only during an open enrollment period. Evidence of insurability may be required. The policyholder and the company will determine when an open enrollment period begins and ends.

After the coverage effective date, the named insured cannot make any changes to the coverage type under the certificate until an open enrollment period, unless the named insured has a qualifying event. A **qualifying event**, for the purposes of this provision, means:

- birth or adoption of a child;
- issuance of a court order requiring coverage of a child;
- marriage;
- divorce; or
- death of a covered person.

The named insured will have 31 days from the date of occurrence of a qualifying event in which to:

- notify us he wishes to make a change;
- complete any required enrollment form; and
- pay any additional premium, if applicable.

Delayed Coverage Effective Date

The effective date of your coverage will be delayed if you are not a member of an eligible class on the coverage effective date shown on the Certificate Schedule. The coverage will be effective on the date that you return to status as a member of an eligible class. If this is named insured and spouse coverage, one-parent family or two-parent family coverage, coverage on the spouse and/or dependent children will be effective on the date that you return to status as a member of an eligible class.

Who is Covered By This Certificate

If this is named insured coverage as shown on the Certificate Schedule, we insure you, the named insured.

If this is named insured and spouse coverage as shown on the Certificate Schedule, we insure you and your spouse.

If this is one-parent family coverage as shown on the Certificate Schedule, we insure you and your dependent children.

If this is two-parent family coverage as shown on the Certificate Schedule, we insure you, your spouse and your dependent children.

You may not apply for coverage for your spouse if your spouse is covered as a named insured.

Coverage on newborn children begins from the moment of live birth. If the coverage is named insured coverage or named insured and spouse coverage, the coverage on the newborn will end on the later of 90 days from the date of birth or the next premium due date following the date of birth.

Coverage for adopted children begins with the earlier of the date you have filed a petition to adopt or from the moment of birth if the petition for adoption is filed within 60 days after the birth of the child.

If the coverage is named insured coverage or named insured and spouse coverage, the coverage on the adopted child will end 60 days from the date of the filing of the petition for adoption or from the date of birth of the child if you do not request a change in coverage type as provided in the Enrollment provision.

Coverage for adopted children begins with the date of placement into your custody for adoption. If the coverage is named insured coverage or named insured and spouse coverage, the coverage on the newborn or newly adopted child will end 90 days later if you do not request a change in coverage type as provided in the Enrollment provision above.

SECTION 6 – BENEFITS

[Accident Emergency Treatment

We will pay the amount and up to the maximum number of visits shown on the Certificate Schedule for Accident Emergency Treatment if any covered person is injured as the result of a covered accident and incurs a charge for and requires examination and treatment by a doctor in a hospital emergency room, urgent care facility or doctor's office (other than acupuncture or occupational or physical therapy) within 72 hours after the covered accident.

We will pay this amount once per covered person per covered accident. We will not pay the Accident Emergency Treatment and the Accident Follow-Up Doctor Visit benefits for visits on the same day.]

[Accident Follow-Up Doctor Visit

We will pay the amount and up to the maximum number of visits shown on the Certificate Schedule for Accident Follow-Up Doctor Visit if any covered person incurs a charge for and receives follow-up treatment (other than occupational or physical therapy). We will also pay this benefit if any covered person incurs a charge for and receives initial treatment more than 72 hours after the covered accident.

Treatment must:

- be provided by a doctor for injuries received as the result of a covered accident;
- begin within 60 days and be completed within 365 days of the accident;
- be due to injuries received as the result of a covered accident;
- occur in a doctor's office, urgent care facility or emergency room; and
- not be for routine examinations or preventive testing.

We will pay this amount and up to the maximum number of visits per covered person per covered accident. We will not pay the Accident Emergency Treatment and the Accident Follow-Up Doctor Visit benefits for visits on the same day.]

[Accidental Death

We will pay the amount shown on the Certificate Schedule for Accidental Death if any covered person is injured as the result of a covered accident, and the injury causes the covered person to die within 90 days after the covered accident.

Benefits will be paid to the named insured or his beneficiary. If a beneficiary is not named, we will pay the death benefit subject to the Payment of Claim provision.

If we pay this benefit, we will not pay the Accidental Death – Common Carrier benefit.]

[Accidental Death – Common Carrier

We will pay the amount shown on the Certificate Schedule for Accidental Death – Common Carrier if any covered person is injured as the result of a covered accident while a fare paying passenger on a common carrier and the injury causes the covered person to die within 90 days after the covered accident. **Common carrier** means commercial airplanes, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis and privately chartered vehicles are not common carriers.

Benefits will be paid to the named insured or his beneficiary. If a beneficiary is not named, we will pay the death benefit subject to the Payment of Claim provision.

If we pay this benefit, we will not pay the Accidental Death benefit.]

[Accidental Dismemberment (Loss of Finger, Toe, Hand, Foot or Sight of an Eye)

We will pay the amount shown on the Certificate Schedule for Accidental Dismemberment (Loss of Finger, Toe, Hand, Foot or Sight of an Eye) if a charge is incurred for loss of a finger, toe, hand, foot or sight of an eye received as the result of a covered accident and which occurs within 90 days after the covered accident.

For purposes of this benefit, the following definitions apply. **Loss of a hand** means that the hand is cut off through or above the wrist joint or the use of the hand is permanently lost. **Loss of a foot** means that the foot is cut off through or above the ankle joint or the use of the foot is permanently lost. **Loss of a finger** means that the finger is cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand. **Loss of a toe** means that the toe is cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot. **Loss of sight of an eye** means that at least 80 percent of vision is permanently lost.

If the covered person loses a finger or toe and later loses a hand or foot within 90 days on the same side of the body as the result of the same covered accident, we will subtract the amount we paid for that loss of a finger or toe from the benefit we paid for the loss of a hand or foot.]

[Air Ambulance

We will pay the amount shown on the Certificate Schedule for Air Ambulance if a charge is incurred and a licensed professional air ambulance company transports by air any covered person to or from a hospital or between medical facilities where treatment for injuries is received as the result of a covered accident. The air ambulance transportation must be within 48 hours after the covered accident. We will pay this amount once per covered person per covered accident.]

[Ambulance

We will pay the amount shown on the Certificate Schedule for Ambulance if a charge is incurred and a licensed professional ambulance company transports any covered person by ground transportation to or from a hospital or between medical facilities, where treatment for injuries is received as the result of a covered accident. The ambulance transportation must be within 90 days after the covered accident. We will pay this amount once per covered person per covered accident.]

[Appliance

We will pay the amount shown on the Certificate Schedule for Appliance if any covered person is injured as the result of a covered accident, a doctor prescribes the use of a medical appliance as an aid in personal locomotion or mobility and a charge is incurred for the appliance. For purposes of this benefit, **appliance** means a walking boot that extends above the ankle, brace for the neck, back or leg, cane, crutches, walker and wheelchair. The use of an appliance must begin within 90 days after the covered accident. We will pay this amount once per covered person per covered accident.]

[Blood/Plasma/Platelets

We will pay the amount shown on the Certificate Schedule for Blood/Plasma/Platelets if any covered person is injured as the result of a covered accident and incurs a charge for and requires the transfusion of blood/plasma/platelets as the result of the injury. The blood/plasma/platelets must be administered within 90 days after the covered accident. We will pay this amount once per covered person per covered accident.]

[Burn

We will pay the amount shown on the Certificate Schedule for Burn if any covered person receives burns as described on the Certificate Schedule as the result of a covered accident which are treated by a doctor within 72 hours after the covered accident. A charge must be incurred for treatment. We will pay this amount once per covered person per covered accident. If any covered person receives both second and third degree burns in a covered accident, we will pay the highest applicable burn benefit based on the measurement and type of burn, but not both the Second Degree Burn and Third Degree Burn benefits.

Burn – Skin Graft

We will pay the amount shown on the Certificate Schedule for Burn Skin Graft if any covered person incurs a charge for and receives a skin graft for a burn for which a benefit was received under the Burn benefit of this certificate. This benefit will be payable only once per covered person per covered accident. This benefit will not be paid for elective procedures and/or cosmetic surgery that are not the result of a covered accident.]

[Catastrophic Accident

We will pay the amount shown on the Certificate Schedule for Catastrophic Accident at the end of the elimination period if any covered person:

- sustains a catastrophic loss as the result of a covered accident;
- is under the appropriate care of a doctor during the elimination period; and
- remains alive at the end of the elimination period.

For purposes of this benefit, **elimination period** means the period of 365 days after the date of a covered accident.

For purposes of this benefit, **catastrophic loss** means an injury that within 365 days of the covered accident results in total and irrecoverable:

- loss of both hands or both feet; or
- loss or loss of use of both arms or both legs; or
- loss of one hand and one foot; or
- loss or loss of use of one arm and one leg; or
- loss of the sight of both eyes; or
- loss of the hearing of both ears; or
- loss of the ability to speak.

For purposes of this benefit, the following definitions apply. **Loss of a hand** means that the hand is cut off through or above the wrist joint. **Loss of a foot** means that the foot is cut off through or above the ankle joint. **Loss of an arm** means the arm is cut off above the elbow. **Loss of a leg** means the leg is cut off above the knee. **Loss of use of an arm** means the loss of function of the entire arm from the shoulder to the hand. **Loss of use of a leg** means the loss of function of the entire leg from the hip to the foot. **Loss of sight of both eyes** means at least 80 percent of vision is permanently lost in both eyes, such that it cannot be corrected to any functional degree by any procedure, aid or device. **Loss of hearing of both ears** means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device. **Loss of the ability to speak** means loss of audible communication, such that it cannot be corrected to any functional degree by any procedure, aid or device.

The Catastrophic Accident benefit will be payable once per lifetime for each covered person in this certificate.]

[Coma

We will pay the amount shown on the Certificate Schedule for Coma if any covered person incurs a charge for and is diagnosed with or treated for a coma lasting for a period of 14 or more consecutive days resulting from a severe traumatic brain injury due to a covered accident. The condition must require intubation for respiratory assistance and be diagnosed or treated by a doctor within 90 days after the covered accident.

For purposes of this benefit, **coma** means a continuous state of profound unconsciousness characterized by the absence of:

- eye opening,
- motor response, and
- verbal response.

The term “coma” does not include any medically induced coma.

This benefit will be payable once per covered person per covered accident.]

[Concussion

We will pay the amount shown on the Certificate Schedule for Concussion if any covered person sustains a concussion as the result of a covered accident and incurs a charge for and is diagnosed by a doctor within 72 hours from the date of the covered accident. This benefit will be payable once per covered person per covered accident.]

[Dislocation (Separated Joint)

We will pay the amount shown on the Certificate Schedule for Dislocation (Separated Joint) if any covered person receives a dislocation as the result of a covered accident. A **dislocation** is a completely separated joint. It must be diagnosed as a dislocation by a doctor within 90 days after the covered accident. The dislocation must require correction with anesthesia by a doctor, and a charge must be incurred for the correction. It can be corrected by open (surgical) or closed (non-surgical)

reduction. After all of these things occur, we will pay the applicable amount shown on the Certificate Schedule for Dislocation (Separated Joint) for the joint involved.

If any covered person receives more than one dislocation in a covered accident, and he requires open or closed reduction, we will pay for all dislocations. However, we will pay no more than two times the amount for the joint involved which has the highest benefit amount.

If the dislocation requires reduction without anesthesia by a doctor, we will pay 25 percent of the applicable amount shown on the Certificate Schedule for a closed reduction of the joint involved.

If a doctor diagnoses the dislocation as an incomplete dislocation, we will pay 25 percent of the applicable amount shown on the Certificate Schedule for a closed reduction of the joint involved. An **incomplete dislocation** is a dislocation in which the joint is not completely separated.

If any covered person receives a fracture and a dislocation in the same covered accident, we will pay for both. However, we will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

We will pay this benefit only for the first dislocation of a joint after the coverage effective date shown on the Certificate Schedule. Subsequent dislocations of the same joint after the coverage effective date shown on the Certificate Schedule will not be covered under this benefit.

We will pay either the Dislocation (Separated Joint) benefit or the Surgery – Exploratory and Arthroscopic benefit for the same covered accident if treatment occurs on the same date. When treatment occurs on the same date, we will pay the benefit with the highest benefit amount.]

[Emergency Dental Work

We will pay the amount shown on the Certificate Schedule for Emergency Dental Work for specified dental services required by a covered person as the result of injuries received in a covered accident. The dental services must begin within 60 days of the covered accident, and a charge must be incurred for the services.

For purposes of this benefit, **specified dental services** means repair of a broken sound natural tooth with a crown, denture or implant and extraction of a broken sound natural tooth.

Each Emergency Dental Work benefit shown on the Certificate Schedule is payable only once per covered accident per covered person regardless of the number of teeth involved.]

[Eye Injury

We will pay the amount shown on the Certificate Schedule for Eye Injury if any covered person receives an eye injury as the result of a covered accident. The eye injury must require surgery or the removal of a foreign object by a doctor within 90 days after the covered accident, and a charge must be incurred for the surgery or removal.

After all of these things occur, we will pay this amount once per covered person per covered accident. An examination with anesthesia will not be considered surgery.]

[Fracture (Broken Bone)

We will pay the amount shown on the Certificate Schedule for Fracture (Broken Bone) if any covered person receives a fracture as the result of a covered accident. A **fracture** is a break in a bone which can be seen by x-ray. It must be diagnosed as a fracture by a doctor within 90 days after the covered accident. The fracture must require open (surgical) or closed (non-surgical) reduction by a doctor, and a charge must be incurred for the reduction. After all of these things occur, we will pay the applicable amount listed on the Certificate Schedule for Fracture (Broken Bone) for the bone involved and the type of reduction.

If any covered person receives more than one fracture in a covered accident, and he requires open or closed reduction, we will pay for all fractures. However, we will pay no more than two times the amount listed on the Certificate Schedule for Fracture (Broken Bone) for the bone involved which has the highest benefit amount.

If a doctor diagnoses the fracture as a chip fracture, we will pay 25 percent of the applicable amount listed on the Certificate Schedule for Fracture (Broken Bone) for the closed reduction for the bone involved. A **chip fracture** is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

If any covered person receives a fracture and a dislocation in the same accident, we will pay for both. However, we will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

We will pay either the Fracture (Broken Bone) benefit or the Surgery – Exploratory and Arthroscopic benefit for the same covered accident if treatment occurs on the same date. When treatment occurs on the same date, we will pay the benefit with the highest benefit amount.]

[Hospital Admission

We will pay the amount shown on the Certificate Schedule for Hospital Admission if any covered person incurs a charge for and is confined to a hospital as the result of injuries received in a covered accident. The covered person must initially become confined within six months after the covered accident.

We will pay this amount once per covered person per covered accident.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or
- a stay of less than 20 hours in an observation unit.

We will not pay the Hospital Admission benefit and the Hospital Intensive Care Unit Admission benefit for the same covered accident concurrently.]

[Hospital Confinement

We will pay the amount shown on the Certificate Schedule for Hospital Confinement for each day any covered person incurs a charge for and is confined in a hospital or a hospital sub-acute intensive care unit as the result of injuries received in a covered accident. The covered person must initially become confined in a hospital or a sub-acute intensive care unit within six months after the covered accident. We will pay benefits for only one hospital confinement at a time even it is caused by more than one covered accident.

We will pay this amount up to the maximum number of days shown on the Certificate Schedule per covered person per covered accident.

We will not pay this benefit for:

- emergency room treatment;
- for outpatient treatment; or
- confinement of less than 20 hours to an observation unit.

If any covered person is confined in a hospital intensive care unit for more than [15] days, the Hospital Confinement benefit will begin on the [16th] day. The total amount payable per covered accident will not exceed [365] days for hospital confinement and [15] days for hospital intensive care unit confinement.

We will not pay the Hospital Confinement benefit and the Hospital Intensive Care Unit Confinement benefit concurrently.]

[Hospital Intensive Care Unit Admission

We will pay the amount shown on the Certificate Schedule for Hospital Intensive Care Unit Admission if any covered person incurs a charge for and is admitted directly to a hospital intensive care unit as the result of injuries received in a covered accident. The initial admission to a hospital intensive care unit must occur within 30 days after the covered accident.

We will pay this amount once per covered person per covered accident.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or

- a stay of less than 20 hours in an observation unit.

If any covered person is admitted directly to the hospital, we will pay the Hospital Admission benefit. If any covered person is admitted directly to the hospital intensive care unit, we will pay the Hospital Intensive Care Unit Admission benefit. If any covered person is admitted to a hospital intensive care unit that does not meet the definition in this certificate of a hospital intensive care unit, we will pay the Hospital Admission benefit.

We will not pay the Hospital Intensive Care Unit Admission benefit and the Hospital Admission benefit for the same covered accident concurrently.]

[Hospital Intensive Care Unit Confinement

We will pay the amount shown on the Certificate Schedule for Hospital Intensive Care Unit Confinement for each day any covered person incurs a charge for and is confined to a hospital intensive care unit as the result of injuries received in a covered accident. The initial confinement in a hospital intensive care unit must begin within 30 days after the covered accident.

If any covered person is confined in a hospital intensive care unit for more than [15] days, the Hospital Confinement benefit will begin on the [16th] day. The total amount payable per covered accident will not exceed [365] days for hospital confinement and [15] days for hospital intensive care unit confinement.

We will pay this amount up to the maximum number of days shown on the Certificate Schedule per covered person per covered accident.

If any covered person is confined to a hospital intensive care unit that does not meet the definition in this certificate of a hospital intensive care unit, we will pay the Hospital Confinement benefit up to the maximum benefit per covered accident.

We will not pay the Hospital Intensive Care Unit Confinement benefit and the Hospital Confinement benefit concurrently.]

[Knee Cartilage – Torn

We will pay the amount shown on the Certificate Schedule for Knee Cartilage – Torn if any covered person tears, ruptures or severs knee cartilage (meniscus) as the result of a covered accident and requires surgical repair. The injury must be treated by a doctor within 60 days after the covered accident. It must be repaired through surgery by a doctor within 12 months after the covered accident and a charge must be incurred for the repair. After all of these things occur, we will pay this amount for each covered accident. If exploratory or arthroscopic surgery is performed and no repair is done, or if the cartilage is shaved (debridement), we will pay under the Surgery – Exploratory and Arthroscopic benefit.

We will pay this amount once per covered person per covered accident.

We will pay either the Knee Cartilage – Torn benefit or the Surgery – Exploratory and Arthroscopic benefit for the same covered accident if treatment occurs on the same date. When treatment occurs on the same date, we will pay the benefit with the highest benefit amount.]

[Laceration

We will pay the amount shown on the Certificate Schedule for Laceration if any covered person receives a laceration as the result of a covered accident. A **laceration** is a cut. The laceration must be repaired by a doctor within 72 hours after the covered accident, and a charge must be incurred for the repair. After all of these things occur, we will pay this amount for each covered accident. The amount we pay will be based on the total length of all lacerations received in any one covered accident that require repair. If the laceration is severe enough to require stitches but the doctor chooses to repair it in another way, we will pay it as a laceration repaired with stitches.

We will pay this amount once per covered person per covered accident.

If any covered person receives a laceration on a finger, toe, hand, foot, or eye and later loses that finger, toe, hand, foot or eye as the result of the same covered accident, we will subtract the amount we paid under the laceration benefit from the Accidental Dismemberment (Loss of Finger, Toe, Hand, Foot or Sight of an Eye) benefit.]

[Lodging

We will pay the amount shown on the Certificate Schedule for Lodging if a charge is incurred for one motel/hotel room for a companion to accompany the covered person. We will pay this benefit for any day the covered person is confined in a hospital

more than 50 miles from the residence of the covered person as the result of a covered accident, up to the maximum number of days shown on the Certificate Schedule per covered accident.]

[Medical Imaging Study

We will pay the amount shown on the Certificate Schedule for Medical Imaging Study if any covered person incurs a charge for and receives one of the following imaging studies as the result of a covered accident:

- Computed Tomography (CT) imaging or Computed Axial Tomography (CAT Scan);
- Electroencephalogram (EEG); or
- Magnetic Resonance (MR) or Magnetic Resonance Imaging (MRI).

The study must be prescribed by a doctor and performed in a medical facility within 180 days of the covered accident.

This benefit will be payable once per covered person per covered accident and one benefit per covered person per calendar year.]

[Occupational or Physical Therapy

We will pay the amount shown on the Certificate Schedule for Occupational or Physical Therapy for any day a covered person incurs a charge for and requires occupational or physical therapy treatment as the result of a covered accident. We will pay this benefit up to the maximum number of days shown on the Certificate Schedule per covered person per covered accident.

The therapy must begin within 90 days after the covered accident and must be completed within one year after the covered accident. All services must be prescribed by a doctor and rendered by a licensed occupational or physical therapist and performed in an office or in a hospital on an inpatient or outpatient basis.]

[Pain Management

We will pay the amount shown on the Certificate Schedule for Pain Management if a covered person is injured as a result of a covered accident and receives Epidural Anesthesia. **Epidural Anesthesia** means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a covered accident, and does not include treatment for childbirth or diseases. The epidural anesthesia must be administered within [0-365] days after the covered accident. For purposes of this certificate, epidural anesthesia does not include epidural steroid injections. This benefit will be payable once per covered person per covered accident. A charge must be incurred for the epidural anesthesia.]

[Prosthetic Device/Artificial Limb

We will pay the amount shown on the Certificate Schedule for Prosthetic Device/Artificial Limb for a prosthetic device/artificial limb which is prescribed by a doctor for functional use when the covered person loses a hand, foot or sight of an eye due to a covered accident. The prosthetic device/artificial limb must be received within one year of the covered accident, and a charge must be incurred for the device/limb.

We will pay this benefit once per covered person per covered accident. This benefit is not payable for hearing aids, dental aids, including false teeth, eye glasses or for cosmetic prosthesis such as hair wigs. We will not pay for joint replacement such as an artificial hip or knee.]

[Rehabilitation Unit Confinement

We will pay the amount shown on the Certificate Schedule for Rehabilitation Unit Confinement if any covered person incurs a charge for and is transferred to a rehabilitation unit immediately after a period of hospital confinement due to a covered accident. We will pay this amount for each day of confinement in a rehabilitation unit, up to the maximum number of days shown on the Certificate Schedule per covered person per covered accident.

We will not pay both the Rehabilitation Unit Confinement benefit and the Hospital Confinement benefit concurrently.]

[Ruptured Disc with Surgical Repair

We will pay the amount shown on the Certificate Schedule for Ruptured Disc with Surgical Repair if any covered person receives a ruptured disc in his spine as the result of a covered accident. It must be treated by a doctor within 60 days after the covered accident. It must be repaired through surgery by a doctor within one year after the accident, and a charge must be incurred for this surgery. After all of these things occur, we will pay this amount once per covered person per covered accident.

We will pay either the Ruptured Disc with Surgical Repair benefit or the Surgery – Exploratory and Arthroscopic benefit for the same covered accident if treatment occurs on the same date. When treatment occurs on the same date, we will pay the benefit with the highest benefit amount.]

[Surgery – Cranial, Open Abdominal and Thoracic/Hernia

We will pay the amount shown on the Certificate Schedule for Cranial, Open Abdominal and Thoracic surgery, if any covered person incurs a charge for and undergoes cranial, open abdominal, or thoracic surgery other than hernia repair. The surgery must be performed within 72 hours of the covered accident to repair internal injuries received as the result of a covered accident.

We will pay the amount shown on the Certificate Schedule for Hernia if any covered person incurs a charge for and undergoes hernia surgery. The hernia must be diagnosed within 30 days of the covered accident, and surgery must be performed within 60 days of the covered accident to repair a hernia received as a result of a covered accident.

We will pay this benefit once per covered person per covered accident. If any covered person has both cranial, open abdominal, or thoracic (other than hernia repair) surgery and hernia surgery as a result of the same covered accident, we will only pay the Surgery – Cranial, Open Abdominal and Thoracic benefit.

We will pay either the Surgery – Cranial, Open Abdominal and Thoracic/Hernia benefit or the Surgery – Exploratory and Arthroscopic benefit for the same covered accident if treatment occurs on the same date. When treatment occurs on the same date, we will pay the benefit with the highest benefit amount.]

[Surgery – Exploratory and Arthroscopic

We will pay the amount shown on the Certificate Schedule for Surgery – Exploratory and Arthroscopic, if any covered person incurs a charge for and undergoes exploratory or arthroscopic surgery within 60 days of the covered accident to explore or repair injuries received as the result of a covered accident.

Hernia repair is not covered under this benefit.

We will pay either the Surgery – Exploratory and Arthroscopic benefit or one of the following benefits for the same covered accident if treatment occurs on the same date:

- Dislocation (Separated Joint) benefit; or
- Fracture (Broken Bone) benefit; or
- Knee Cartilage – Torn benefit; or
- Ruptured Disc with Surgical Repair benefit; or
- Surgery – Cranial, Open Abdominal and Thoracic/Hernia benefit; or
- Tendon/Ligament/Rotator Cuff benefit.

When treatment occurs on the same date, we will pay the benefit with the highest benefit amount.

We will pay this benefit once per covered person per covered accident.]

[Tendon/Ligament/Rotator Cuff

We will pay the amount shown on the Certificate Schedule for Tendon/Ligament/Rotator Cuff if any covered person receives an injured tendon/ligament/rotator cuff as the result of a covered accident. It must be torn, ruptured or severed. It must be treated by a doctor within 60 days after the covered accident. It must be repaired through surgery by a doctor within one year after the accident, and a charge must be incurred for this surgery. We will pay this benefit once per covered person per covered accident.

We will pay either the Tendon/Ligament/Rotator Cuff benefit or the Surgery – Exploratory and Arthroscopic benefit for the same covered accident if treatment occurs on the same date. When treatment occurs on the same date, we will pay the benefit with the highest benefit amount.]

[Transportation

We will pay the amount shown on the Certificate Schedule for Transportation if any covered person incurs a charge and must travel from their residence more than 50 miles one way to receive special treatment and confinement in a hospital for injuries received as the result of a covered accident. Treatment must be:

- prescribed by a doctor; and
- not available locally.

We will pay this benefit for each round trip, up to the maximum number of round trips shown on the Certificate Schedule per covered person per covered accident.

This benefit is not payable for transportation by ambulance or air ambulance.]

[X-Ray

We will pay the amount shown on the Certificate Schedule for X-Ray if any covered person incurs a charge for and receives an x-ray as the result of a covered accident. The test must be prescribed by a doctor and performed in a doctor’s office or in a hospital on an inpatient or outpatient basis and performed within 90 days of the covered accident.

This benefit is not payable for exams listed in the Medical Imaging Study benefit.

We will pay this benefit once per covered person per covered accident.]

[ADDITIONAL BENEFIT INFORMATION

[Health Screening

We will pay the amount shown on the Certificate Schedule for Health Screening if any covered person incurs charges for and has one of the health screening tests listed below performed [after the waiting period] and while this certificate is in force. The covered health screening tests include:

| | | |
|----------------------------------------------------------|----------------------------------------|-------------------------------------------------------|
| Stress test on a bicycle or treadmill | Skin cancer biopsy | Hemoccult stool analysis |
| Fasting blood glucose test | Breast ultrasound | Mammography |
| Blood test for triglycerides | CA 15-3 (blood test for breast cancer) | Pap smear |
| Serum Cholesterol test to determine level of HDL and LDL | CA 125 (blood test for ovarian cancer) | PSA (blood test for prostate cancer) |
| Bone marrow testing | CEA (blood test for colon cancer) | Serum protein electrophoresis(blood test for myeloma) |
| Carotid Doppler | Chest x-ray | Thermography |
| Electrocardiogram (EKG, ECG) | Colonoscopy | ThinPrep pap test |
| Echocardiogram (ECHO) | Flexible sigmoidoscopy | Virtual colonoscopy |

We will pay the maximum of one health screening test per covered person per calendar year.

[For purposes of this benefit, **waiting period** means the first [0-365] days following any covered person’s coverage effective date during which time this benefit is not payable.]]

[Hospital Confinement due to Covered Sickness

We will pay the amount shown on the Certificate Schedule for Hospital Confinement due to Covered Sickness for each day any covered person incurs a charge for and is confined in a hospital, up to the maximum number of days shown on the Certificate Schedule for Hospital Confinement due to Covered Sickness.

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

- occurs on or after the coverage effective date shown on the Certificate Schedule;
- occurs while this certificate is in force; and
- is not excluded by name or specific description in this certificate.

Covered sickness also includes care for a covered newborn child in a hospital nursery following the birth of the child.

We will pay benefits for only one hospital confinement at a time due to covered sickness even if it is caused by more than one covered sickness. We will not pay this benefit for emergency room treatment, for outpatient treatment or for a stay of less than 20 hours in an observation unit.

If any covered person is confined in a hospital and becomes confined again within 90 days for the same or related covered sickness, we will treat the confinement as a continuation of the prior confinement. If more than 90 days have passed between the periods of hospital confinement, we will treat this confinement as a new confinement.

[Exclusions and Limitations for Hospital Confinement due to Covered Sickness:

We will not pay any benefits for a hospital confinement that is caused by, contributed to by or occurs as a result of the covered person's:

[Accidental Injuries

Having injuries received in an accident;]

[Alcoholism or Drug Addiction

Treatment for alcoholism or drug addiction unless the covered person is addicted to a narcotic taken on the advice of a doctor;]

[Dental Care

Treatment for dental care or dental care procedures;]

[Elective Procedures

Having elective procedures and/or cosmetic surgery or reconstructive surgery unless it is a result of trauma, infection, or other diseases;]

[Pre-existing Conditions

Having a pre-existing condition as described and limited by this benefit;] [or]

[Psychiatric or Psychological Conditions

Having a psychiatric or psychological condition including, but not limited to, affective disorders, neuroses, anxiety, stress and adjustment reactions. However, Alzheimer's Disease and other organic senile dementias are covered.]

[War or Armed Conflict

Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.]

[Giving Birth Limitation

We will not pay benefits for hospital confinement due to any covered person giving birth within the first nine (9) months after the coverage effective date of this certificate as a result of a normal pregnancy, including Cesarean. Complications of pregnancy will be covered to the same extent as any other covered sickness.]

[Pre-existing Condition Limitation for Hospital Confinement due to Covered Sickness

After this certificate has been in force for [12] months from the coverage effective date of this certificate, we will pay benefits for any pre-existing condition not otherwise excluded by name or specific description if the covered confinement began more than [12] months after the coverage effective date of this certificate.]

[Continuity of Coverage for Hospital Confinement due to Covered Sickness

If this coverage replaces another accident policy, or you become insured under this coverage due to a merger, acquisition or affiliation, this coverage shall not limit or exclude benefits for a pre-existing condition that would have been provided under the policy being replaced. Time periods applicable to pre-existing conditions will be waived to the extent that similar exclusions or limitations were satisfied under the policy being replaced.]]]]

[SECTION [7] – GENERAL EXCLUSIONS AND LIMITATIONS

We will not pay any benefits for losses that are caused by, contributed to by or occur as a result of a covered person's:

[Felonies or Illegal Occupations

Committing or attempting to commit a felony or engaging in an illegal occupation.]

[Hazardous Avocations

Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting; or operating, learning to operate, or serving as a crew member of any aircraft or hot air balloon; or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven, or any similar activities. This does not include flying as a fare paying passenger.]

[Racing

Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.]

[Semi-professional or Professional Sports

Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.]

[Sickness

Having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. We also will not pay benefits to diagnose or treat the sickness. **Sickness** means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.]

[Suicide or Injuries Which Any Covered Person Intentionally Does to Himself

Committing or trying to commit suicide or his injuring himself intentionally, whether he is sane or not.]

[War or Armed Conflict

Being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.]

[In addition to the exclusions listed above, we also will not pay the Catastrophic Accident benefit for injuries that are caused by or are the result of:

[Birth

Injuries to a dependent child received during his birth.]

[Intoxicants and Narcotics

Any covered person's being intoxicated or under the influence of any narcotics unless administered on the advice of his doctor.]]]

SECTION [8] – TERMINATION OF INSURANCE

Termination of The Named Insured's Coverage

The coverage on a named insured under the policy will terminate on the earliest of the following dates:

- the date the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for the named insured; or
- the date the named insured is no longer in an eligible class; or
- the date the named insured's class is no longer included for insurance; or
- the date the next premium is due after the named insured asks us to end his coverage.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while you are covered.

When Coverage Ends on Your Spouse and Dependent Children

If this is a named insured and spouse coverage or two-parent family coverage, coverage on your spouse will end on the earliest of the following dates:

- the date your coverage under the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your spouse; or
- the date the next premium is due after you ask us to end your spouse's coverage; or
- the date you die; or
- the date the next premium is due after you divorce your spouse or your marriage is annulled. If this is a named insured and spouse coverage or two-parent family coverage and you divorce your spouse or your marriage is annulled and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which he did not qualify.

If this is a one-parent family or two-parent family coverage, coverage on your dependent children will end on the earliest of the following dates:

- the date your coverage under the policy terminates; or
- the end of the grace period following the premium due date we fail to receive the required premium for your dependent children; or
- the date the next premium is due after you ask us to end your dependent children's coverage; or
- the date you die.

We will provide coverage for a claim for which we are liable under the terms of this certificate if the loss occurs while your spouse and/or dependent child is covered.

Coverage will end on each child when he no longer qualifies as a dependent child as defined in this certificate. A dependent child who reaches age 26 may remain covered if that child is and continues to be mentally or physically handicapped and is dependent on you for support and maintenance. Upon our request and at our expense, you must submit proof of incapacity for dependency to us for a child whose coverage would otherwise terminate if not incapacitated or dependent. We will continue to charge any appropriate premium for that child as long as he meets the definition of a dependent child. It is your responsibility to notify us if any dependent child no longer qualifies as an eligible dependent. If this is one-parent family or two-parent family coverage and all of your dependent children no longer qualify as eligible dependents and you do not notify us, the extent of our liability will be to refund premium paid for the time period for which they did not qualify.

Leave of Absence Under the Family and Medical Leave Act

A named insured may continue his coverage during absences for family or medical leave. If a named insured is on a family or medical leave of absence, coverage will continue under this certificate as if the named insured were in active employment, if the following conditions are met:

- the premiums are paid in accordance with the policy's provisions; and
- the policyholder has approved the named insured's leave in writing.

Coverage will be continued for up to the greater of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, upon the named insured's return to active employment, no evidence of insurability will be required to reinstate the coverage which was in effect before the leave began.

In order for these conditions to apply, the policyholder must notify us and commence paying premiums for the named insured's coverage within 31 days following a named insured's return to active employment following a leave of absence for family or medical leave.

Leave of Absence – Other

If the named insured is on a temporary layoff or leave of absence other than for family or medical leave and premium is paid in accordance with the policy's provisions, he will be covered through the premium due date immediately following the date the temporary layoff or leave of absence begins.

If premium is remitted beyond the premium due date referenced above, our only liability will be to return the premium.

[SECTION [9] PORTABILITY

Portability Privilege

We will provide accident insurance portability coverage, subject to these provisions.

Such coverage will not be available for a named insured, unless:

- that named insured accident insurance under the policy terminates under the provision, Termination of the Named Insured's Coverage for one of the following reasons:
 - the named insured is no longer in an eligible class; or
 - the named insured's class is no longer included for insurance;
- we receive a written request by the named insured and payment of all premiums due for the portability coverage not later than 63 days after such termination; and
- the request is made on a form we furnish or approve for that purpose.

Portability Privilege for Covered Spouse

We will provide portability coverage for a covered spouse in the case of annulment, divorce from or death of the named insured. Such coverage will provide the same rights and conditions as portable coverage available to a named insured.

Your spouse is not eligible to apply to continue coverage under this provision if your spouse was not covered under this certificate on the date of your annulment, divorce or death.

Coverage

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy when the named insured's insurance terminated. Portability coverage may include any eligible family members who were covered under the policy. Any change made to the policy after a named insured is insured under the portability privilege will not apply to that named insured unless it is required by law.

Portability coverage will be effective on the day after coverage under the policy terminates.

Premiums

Premiums are due and payable in advance to us at our home office. The premium rates are based on the portability rates in effect on any premium due date. We have the right to change the portability premium we charge on any premium due date. Written notice will be given at least 45 days before the change is to take effect.

Grace Period (If Premiums Are Not Paid When Due)

After the first premium, if the premium is not paid when it is due, it can be paid during the next 31 days. These 31 days are called the grace period. During the grace period this coverage will stay in force. If the premium is not paid before the grace period ends, the coverage provided by this certificate will terminate at the end of the grace period.

Termination of Insurance

Insurance under this portability privilege will automatically end on the earliest of the following dates:

- The date the named insured again becomes eligible for accident insurance under the policy.
- The last day for which premiums have been paid, if the named insured fails to pay premiums when due, subject to the Grace Period provision.
- The date insurance under this portability provision is cancelled by us for any reason upon 31 days notice.

With respect to insurance for your spouse and dependent children, insurance under this portability privilege will automatically end on the earliest of the following dates:

- the date the named insured's insurance terminates; or
- as to your dependent children, the date the dependent child ceases to qualify as a dependent child as defined in this certificate; or
- as to your spouse, the date the next premium is due after you divorce your spouse or your marriage is annulled except as provided under the Portability Privilege for Covered Spouse provision.

Once insurance under this portability provision is cancelled, it cannot be reinstated.

Termination of the Policy

Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits, terms and conditions for portability coverage will be determined as if the policy had remained in full force and effect.]

SECTION [10] – GENERAL PROVISIONS

Misstatement of Age

If the age of the named insured has been misstated, we will make any equitable adjustment of premiums. We will refund any excess premium payment over the amount due based on your correct age. We will request payment for any overdue premium based on your correct age. If the misstatement is discovered after a payment is due and payable, we will reduce or increase the benefit amount payable by the amount of excess or overdue premium due to the misstatement. If a named insured is not eligible because of age we will refund all premiums paid.

Contestability

No statement made by any named insured relating to his insurability or the insurability of his dependents shall be used to contest the validity of the insurance after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made and unless the statement is contained in a written instrument signed by the named insured making the statement, unless the statement was fraudulent.

Contest means that we question the validity of coverage under the policy through a letter to the policyholder or the named insured. This contest is effective on the date we mail the letter and refund premiums.

All statements made by the policyholder or any named insured shall be deemed representations and not warranties. No written statement made by the policyholder or any named insured shall be used in any contest unless a copy of the statement is furnished to the policyholder or the named insured.

Policyholder as Agent

For purposes of the policy and this certificate, the policyholder acts on its own behalf or as your agent. Under no circumstances will the policyholder be deemed our agent.

SECTION [11] – CLAIM PROVISIONS

Notice of Claim

If a covered person has a covered accident that may result in a claim for benefits under the policy, written notice must be given to us at our home office. This must be done within 90 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as is reasonably possible. The notice must contain enough information to identify the covered person.

Claim Forms

When we receive written or verbal notice of a claim, claim forms will be sent with which to file Proof of Loss. If these forms are not given to you within 15 days, you will be excused from filing the forms as long as you send us Proof of Loss as described below.

Proof of Loss

We must receive a written proof of loss within 90 days after the covered loss begins. If you are not able to give us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.

Written proof of loss must include one or more of the following: a doctor's bill, a hospital bill or other proof of charges.

[Proof of Loss for Catastrophic Accident

You must give us written proof of loss within 90 days after the catastrophic accident elimination period ends. Written proof of loss for the catastrophic accident, provided at your expense and in English or Spanish, includes the following:

- an attending doctor's statement verifying the extent of injury; and
- a completed catastrophic accident claim form.

If you are not able to give us written proof of loss within 90 days, it will not have a bearing on your claim if proof is given to us as soon as it is reasonably possible. In any event, proof must be given no later than one year from the time stated unless you are legally unable to do so.]

Time of Payment of Claim

After we receive written proof of loss and process your claim, we will immediately pay any benefits due.

Payment of Claim

Benefits will be paid to you unless we receive your written authorization to pay them elsewhere, such as to a hospital or a doctor's office. This is called assignment.

You have the right to name a beneficiary. If one is not named, and we still owe you benefits at your death, benefits due will be paid in this order to your:

- spouse; or
- children; or
- parents; or
- brothers and sisters; or
- estate.

If benefits are payable to your estate, we can pay benefits up to \$1,000 to someone related to you by blood or marriage who we feel is fairly entitled to them. If we do this, we will have no responsibility for this payment because we made it in good faith.

Unpaid Premium

When a claim is paid under the policy, any premium then due and unpaid for your certificate may be deducted by us from the claim payment.

Overpaid Claim

We have the right to recover any overpayments due to:

- fraud; and
- any error made during the processing of a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

Questions Concerning the Named Insured's Claim

If you have questions concerning your claim, you can call us at our home office. We are open Monday through Friday from 8:30 a.m. until 5:00 p.m. Eastern Time.

Physical Exam and Autopsy

We can require that any covered person be examined by a doctor of our choice as often as it is reasonably necessary while his claim is pending. We can also require an autopsy in the event of the death of any covered person in those states where this is allowed. Either or both of these will be done at our expense.

Legal Action

We cannot be sued for benefits under the policy:

- until 60 days after we are sent written proof of loss; or
- more than three years after the time has passed in which we require written proof of loss.

Claim Review

If a claim is denied, we will give written notice of:

- the reason for denial; and
- the policy provision that relates to the denial;
- the right to ask for a review of the claims; and

- the right to submit any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports.

Appeals Procedure

Prior to filing any lawsuit and within 60 days after denial of a claim, you or your estate must appeal any denial of benefits under the policy by making a written request for review of the denial.

Workers' Compensation Not Affected

The policy does not replace or change any requirement for coverage under Workers' Compensation insurance.

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365, COLUMBIA, SC 29202
APPLICATION FOR GROUP ACCIDENT INSURANCE**

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| Policyholder Section | | | |
| Policyholder Name ABC Company | | Billing Control Number E5555555 | Situs State |
| Policyholder (or Corporate) Address Street City State Zip Code 123 Any Street Any City Any State 12345 | | Policyholder Phone Number 555-555-5555 | |
| Do you have [employees] located in other states? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | | If "Yes," please list states here: | |
| Plan Administrator Name: Betty Plan Admin | | Plan Administrator Email Address: anyemail@anyemail.com | |
| Nature of Business Any | | Effective Date of Coverage (mm/dd/yyyy) 11/1/2011 | |
| Are any divisions, subsidiaries or affiliated companies to be covered under this policy? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | If "yes," provide the name/location (city/state) | |
| Enrollment Information | | | |
| Initial Enrollment Dates (mm/dd/yyyy) Start Date Stop Date 10/1/2011 11/1/2011 | | Subsequent Open Enrollment Dates, if any, are subject to the agreement of the Policyholder and Colonial Life & Accident Insurance Company each year. | |
| Eligible Class | | | |
| <input checked="" type="checkbox"/> [All employees in active employment working a minimum of [15] regularly scheduled hours per week. Temporary and seasonal workers are excluded from coverage.] Active employees are those who are working at the worksite for earnings that are paid regularly, and they are performing the material and substantial duties of their regular occupation. The worksite must be the employer's usual place of business; an alternative worksite at the direction of the employer; or a location to which the named insured's job requires him to travel. | | | |
| <input type="checkbox"/> Other: | | | |
| Number of Eligible [Employees]: [XX] | | New Hire Waiting Period: [XX days] | New Hire Eligibility Period : [31 days] |
| Policyholder Contribution | | | |
| Is there any policyholder contribution? If yes, indicate appropriate contribution type and amount below. | | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| <input type="checkbox"/> Policyholder Contribution: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% <input type="checkbox"/> Other _____ | | | |
| Who does the policyholder contribution apply to? <input type="checkbox"/> Named Insured <input type="checkbox"/> Named Insured, Spouse, Dependent Children | | | |
| <input type="checkbox"/> Flat Dollar Amount Contribution: A Flat Dollar Amount of \$_____ toward monthly premium. | | | |
| Replacement Section | | | |
| Is this a replacement of similar coverage? | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| Previous Company Name | | Termination Date of Prior Plan | |
| | | | |
| Plan Option Applied For | | | |
| 1. Choose 1 Option <input checked="" type="checkbox"/> On/Off job <input type="checkbox"/> Off job only | | 2. Choose up to 2 Benefit Levels <input type="checkbox"/> Value Plan <input checked="" type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 | |
| 3. Choose 1 Health Screening Benefit Option <input checked="" type="checkbox"/> None <input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 | | 4. Choose 1 Sickness Hospital Confinement Benefit Option <input checked="" type="checkbox"/> None <input type="checkbox"/> \$50 - \$5000 | |
| Agreement Section | | | |
| All statements and information found in the application are deemed representations and not warranties. With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby confirm that the answers and statements above are true and have been completed to the best of my knowledge and belief. It is understood and agreed that this application shall be attached as a part of the Policy applied for and that no Insurance shall be effective until approved by Colonial Life & Accident Insurance Company at its Home Office. | | | |
| Signed at: City _____ Any City _____ State _Any State_____ Date ___09/30/2012_____ | | | |
| mm/dd/yyyy | | | |
| (x) <u>Jack R. Employer</u> | | _____jackemployer@anyemail.com_____ | |
| Signature of Authorizing Officer | | Authorizing Officer Email Address | |

Agent Section

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

(x) Joe R Agent Date 09/30/2012
Signature of Licensed Agent (if applicable) mm/dd/yyyy

Agent Name Joe R Agent License No. 12345 Code No. 67890

Fraud Warning Notice

| | |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| For all states except those listed below: | Any person who knowingly and with the 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. |
| Alabama | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. |
| Arkansas, Louisiana, Rhode Island and West Virginia | Any person who knowingly presents a false or fraudulent claim for payment for 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. |
| 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 and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. |
| District of Columbia | WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant. |
| Florida | Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. |
| Kentucky Kansas North Carolina | Any person who knowingly and with the 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 may subject such person to criminal and civil penalties. |
| Maine and 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 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. |
| New Jersey | Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. |
| New Mexico | ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. |
| 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 and Texas | Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law. |
| 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. If coverage is <u>contested</u> , the company's only obligation will be to refund all premiums paid. |
| Tennessee | It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. <u>Penalties include imprisonment, fines and denial of coverage.</u> |
| Virginia | Any person who, with the 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 have violated state law. |

Colonial Life & Accident Insurance Company P.O. Box 1365, Columbia, SC 29202-1365

GROUP ACCIDENT INSURANCE ENROLLMENT FORM

| | |
|------------------------------------------------------------------------------------------------------------------|--|
| Enrollment Type: <input checked="" type="checkbox"/> Initial Enrollment <input type="checkbox"/> New Hire | |
| <input type="checkbox"/> Qualifying Event: Date _____ Event: _____ | |

| Proposed Insured Section – Always complete | | | | |
|---------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------|
| Proposed Insured (First, MI, Last) John A. Doe | | Gender M <input checked="" type="checkbox"/> F <input type="checkbox"/> | Birthdate (mm/dd/yyyy) 01/01/1966 | Social Security No. 111-11-1111 |
| Home Address – Street 123 Any Street | City Any City | State Any State | Zip Code 12345 | Employee ID/Payroll No. 111-11-1111 |
| Email Address anymail@anywhere.com | | | Home Phone No. (555)555-5555 Business Phone No. (555)555-5555 | |
| Date Employed 01/01/2009 | Occupation/Job Title Any | Annual Income \$50,000 | Hrs. Worked/Week 40 | Employee Class |
| Policyholder Name ABC Company | | Policyholder Address (Street-City-State-Zip) 345 Any Street, Any City, Any State 12345 | | Section/Dept. No. |

| Eligibility Information – Always complete | |
|-------------------------------------------|---------------------------------------------------------------------|
| Are you actively working? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

| Spouse/Dependent Section – Always complete | | | | |
|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------|----------------------|---------------------------------------------------------------------|
| Is your spouse applying for coverage? If yes, provide identifying information below. | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Name of Spouse (First, MI, Last) Jane A. Doe | Gender M <input type="checkbox"/> F <input checked="" type="checkbox"/> | Birthdate (mm/dd/yyyy) 01/01/1967 | Relationship wife | Social Security No. 222-22-2222 |
| Are there any eligible dependents applying for coverage? | | | | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

| Beneficiary Information – Employee only | | | | | |
|-----------------------------------------------------|------------------------------------------------------------------------------------|-----------|------------------|------------------------------------------|------------------------------------|
| Beneficiary's Name (First, MI, Last) Jane A. Doe | Primary <input checked="" type="checkbox"/> Contingent <input type="checkbox"/> | Age 40 | Benefit % 100 | Relationship to Proposed Insured Wife | Social Security No. 222-22-2222 |
| Beneficiary's Name (First, MI, Last) | Primary <input type="checkbox"/> Contingent <input type="checkbox"/> | Age | Benefit % | Relationship to Proposed Insured | Social Security No. |

| Plan Section | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------|------------------------|--|
| Type of Coverage | Plan Code | P = Pre-Tax A = After-Tax | Monthly Premium | |
| <input type="checkbox"/> Proposed Insured <input type="checkbox"/> One Parent Family <input checked="" type="checkbox"/> Proposed Insured & Spouse <input type="checkbox"/> Two Parent Family | xxxx | P <input checked="" type="checkbox"/> A <input type="checkbox"/> | \$ xx.xx] | |

Agreement Section

I understand that if sickness hospital confinement coverage is applied for, benefits for any loss incurred during the first [12] months after the issue date for a disease or physical condition that I now have or have had in the past will not be paid. By applying for the coverage indicated above, I am requesting cancellation of existing Accident Insurance with Colonial Life & Accident Insurance Company (base plan and all applicable riders) if the coverage applied for is issued. If for any reason the coverage applied for is not issued, this request for cancellation shall be null and void. With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby certify the statements are true and have been completed to the best of my knowledge and belief.

Signed at: City Any State Any Date 07/10/2012

(x) John A. Doe
Signature of Named Insured (if applicable)

Agent Section

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

(x) Joe R Agent Date 07/10/2012
Signature of Licensed Agent (if applicable) mm/dd/yyyy

Agent Name Joe R Agent License No. 12345 Code No. 67890

Fraud Warning Notice

| | |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| For all states except those listed below: | Any person who knowingly and with the 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. |
| Alabama | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. |
| Arkansas, Louisiana, Rhode Island and West Virginia | Any person who knowingly presents a false or fraudulent claim for payment for 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. |
| 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 and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. |
| District of Columbia | WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant. |
| Florida | Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. |
| Kentucky Kansas North Carolina | Any person who knowingly and with the 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 may subject such person to criminal and civil penalties. |
| Maine and 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 may include imprisonment, fines or a denial of insurance benefits. |
| Maryland | Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| New Jersey | Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. |
| New Mexico | ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. |
| 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 <u>guilty of a felony.</u> |
| Oregon and Texas | Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law. |
| 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. If coverage is <u>contested</u> , the company's only obligation will be to refund all premiums paid. |
| Tennessee | It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. <u>Penalties include imprisonment, fines and denial of coverage.</u> |
| Virginia | Any person who, with the 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 have violated state law. |

ELECTION OF PORTABILITY COVERAGE – GROUP ACCIDENT INSURANCE
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY
PO BOX 1365, COLUMBIA, SOUTH CAROLINA 29202-1365 Phone: 1.800.325.4368

If your group coverage ends, we will provide accident insurance portability coverage, subject to the Portability Privilege provision in your Group Accident Insurance Certificate. To apply you must complete this form and it must be received by us within 63 days after your group accident coverage ends. Please obtain your portability premium rates from your Colonial Life representative or contact the Colonial Life home office and mail your initial premium payment, along with this Election of Portability Coverage form, to the address shown above. **Make your check or money order payable to Colonial Life & Accident Insurance Company.**

SECTION 1: APPLICANT/NAMED INSURED INFORMATION (to be completed by the applicant/named insured)

| | | | |
|--------------------------------------------|-------------------------------------------------------------------------------|--------------------------------------|------------------------------------|
| Insured Name (First, MI, Last) John Doe | Gender M <input checked="" type="checkbox"/> F <input type="checkbox"/> | Birthdate (mm/dd/yyyy) 01/01/1980 | Social Security No. 111-11-1111 |
| Home Address – Street 123 Any Street | City Any City | State Any State | Zip Code 12345 |
| Home Phone No. 555-555-5555 | | | Email Address jdoe@anyemail.com |
| Business Phone No. 555-555-5555 | | | |

SECTION 2: POLICYHOLDER INFORMATION (to be completed by the employer/plan administrator)

| | | |
|-------------------------------------------------------------|------------------------------------------------|------------------------------------|
| Policyholder Name ABC Company | Group Policy No. xxxxxxxxx | Billing Control No. xxxxxxxxxxx |
| Policyholder Home Office Address – Street 345 Any Street | City Any City | State Any State |
| Zip Code 12345 | | Business Phone No. 555-555-5555 |
| Reason for Termination Any reason | Date of Termination (mm/dd/yyyy) xx/xx/xxxx | |

Policyholder Signature

 (x) Jack R. Employer Date: 08/01/2012
 Employer/Plan Administrator mm/dd/yyyy

SECTION 3: COVERAGE ELECTIONS – NOTE: The named insured must port coverage for any eligible spouse or dependent children to be eligible to port. Coverage election may not be changed to add spouse or dependent children to coverage. Coverage election may only be changed to remove a spouse and/or dependent children.

I elect to port my coverage with no changes.
 I elect to remove the following insureds from my coverage: Spouse Dependent Children

Total monthly premium: \$ _____

SECTION 4: PAYMENT SECTION – you have a choice of 2 easy payment methods, please select one.

| | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. <input checked="" type="checkbox"/> Please deduct monthly premiums from my checking account. Attach a voided check and indicate one range of days for your checking account to draft. <input checked="" type="checkbox"/> 1st - 5th <input type="checkbox"/> 16th - 20th <input type="checkbox"/> 6th - 10th <input type="checkbox"/> 21st - 26th <input type="checkbox"/> 11th - 15th</p> | <p>2. <input type="checkbox"/> Please bill me directly. (Choose one of the following): <input type="checkbox"/> Quarterly (submit a payment 3 times your monthly premium) <input type="checkbox"/> Semi-Annual (submit a payment 6 times your monthly premium) <input type="checkbox"/> Annual (submit a payment 12 times your monthly premium)</p> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

- I understand and agree to the following:
- Any coverage chosen on this election form will be issued in accordance with the portability provision contained in the policyholder's Colonial Life Group Accident Insurance policy under which this coverage is offered and is subject to satisfaction of the conditions provided therein.
 - Portability coverage will become effective the day after your Group Accident Insurance coverage terminates subject to Colonial Life receiving a completed election of portability coverage form and the first premium within 63 days from the date group coverage terminates.

John E. Doe
 Applicant/Named Insured Signature

10/10/2011
 Date (mm/dd/yyyy)

SERFF Tracking #:

UNUM-128598944

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

GACC1.0

State:

Arkansas

Filing Company:

Colonial Life & Accident Insurance Company

TOI/Sub-TOI:

H02G Group Health - Accident Only/H02G.000 Health - Accident Only

Product Name:

Group Accident 1.0

Project Name/Number:

Group Accident 1.0/Group Accident 1.0

Supporting Document Schedules

| | | Item Status: | Status Date: |
|-----------------------------------------------------|----------------------|---------------------|---------------------|
| Satisfied - Item: | Flesch Certification | Approved-Closed | 09/10/2012 |
| Comments: | | | |
| Attachment(s): | | | |
| GACC1.0-AR Readability Compliance Certification.pdf | | | |

| | | Item Status: | Status Date: |
|------------------|---------------------|---------------------|---------------------|
| Bypassed - Item: | Application | Approved-Closed | 09/10/2012 |
| Bypass Reason: | N/A New application | | |
| Comments: | | | |

| | | Item Status: | Status Date: |
|--------------------------------------------------------|---------------------------|---------------------|---------------------|
| Satisfied - Item: | Statements of Variability | Approved-Closed | 09/10/2012 |
| Comments: | | | |
| Attachment(s): | | | |
| GACC1.0-AR Statement of Variability.pdf | | | |
| Group Accident - UW Statement of Variability - Reg.pdf | | | |

READABILITY COMPLIANCE CERTIFICATION

| <u>Form Number</u> | <u>Flesch Score*</u> |
|--------------------|----------------------|
| GACC1.0-P-AR | 50.5 |
| GACC1.0-C-AR | 50.1 |

*I hereby certify that the Flesch reading ease score of the above policy forms are as stated above.

DATE August 27, 2012



John J. Garrison
Vice President, Law & Compliance
Colonial Life & Accident Insurance Co.
Post Office Box 1365
Columbia, South Carolina 29202

Statement of Variability for forms: GACC1.0-P-AR and GACC1.0-C-AR

MASTER POLICY, GACC1.0-P-AR

SECTION 1 – FACE PAGE

- Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future.
- ERISA language will be included in employer accounts and will either appear as shown or not at all. No text will be changed within the brackets.
- Officer signatures and titles are subject to updates as officer's names and/or titles change.

SECTION 3 – POLICY RATE SCHEDULE

- The Policyholder, Policy Number, Policyholder Address, Billing Control Number, Policy Effective Date and Governing Jurisdiction will vary by policyholder.
- The Description of Eligible Classes will vary based on policyholder definition. Definitions such as Active Employment, Material and Substantial Duties and Regular Occupation will be included or deleted as appropriate. These definitions may alternatively include association or union terms, as appropriate.
- Minimum hours per week is policyholder specific and will usually range between: **[15-30]** hours.
- Eligibility Period: **[31-180]** days. This is determined by the Policyholder.
- Initial Monthly Rates will vary based on plan selected. Composite rates will be displayed.
- Rate Guarantee Period will display: one, two, three, four or five years.
- Divisions, subsidiaries or affiliated companies will be listed as appropriate.

CERTIFICATE, GACC1.0-C-AR

SECTION 1 – FACE PAGE

- Company address, phone number and website address may be modified on any forms included in this filing, if changes occur in the future.
- ERISA language will be included in employer accounts and will either appear as shown or not at all. No text will be changed within the brackets.
- Officer signatures and titles are subject to updates as officer's names and/or titles change.

SECTION 2 – CERTIFICATE GUIDE

- Section 7 General Exclusions and Limitations will be included or not, based on policyholder choice.
- The Termination of Insurance section number will be either 7 or 8 based on the presence of the General Exclusions and Limitations section.
- Section 9 Portability will be included or not, based on policyholder choice.
- The Portability section number will be either 8 or 9 based on the presence of the General Exclusions and Limitations section.
- The General Provisions section number will either be 8, 9 or 10 based on the presence of the General Exclusions and Limitations and Portability sections.
- The Claims Provisions section number will either be 9, 10 or 11 based on the presence of the General Exclusions and Limitations and Portability sections.

SECTION 3 – CERTIFICATE SCHEDULE

- The Policyholder, Policy Number, Named Insured, Certificate Number, Coverage Type, Governing Jurisdiction, Coverage Effective Date, Billing Control Number and Accident Type fields will vary by policyholder and named insured.
- All bracketed benefits are policyholder choice as to include them in the contract or not.
- All benefit payment ranges are displayed on the Certificate Schedule.
- Unless specified otherwise below, benefits are payable once per covered person per covered accident.
 - Accident Emergency Treatment – maximum of **[1-10]** visit(s) per covered person per calendar year

- Accident Follow Up Doctor Visit – maximum of **[1-8]** visit(s) per covered person per covered accident and maximum of **[1-40]** visit(s) per covered person per calendar year
- Catastrophic Accident – maximum of one benefit per lifetime per covered person
- Hospital Confinement – maximum of **[30-365]** days per covered person per covered accident
- Hospital Intensive Care Unit Confinement – maximum of **[0-90]** days per covered person per covered accident
- Lodging – maximum of **[0-90]** days per covered person per covered accident
- Medical Imaging Study – maximum of one benefit per covered person per covered accident and one benefit per covered person per calendar year
- Occupational or Physical Therapy – maximum of **[5-20]** days per covered person per covered accident
- Rehabilitation Unit Confinement – maximum of **[10-20]** days per covered person per covered accident not to exceed **[30-90]** days per covered person per calendar year
- Transportation – maximum of **[3-5]** round trips per covered person per covered accident
- Additional Benefits are policyholder choice as to include them in the contract or not.
 - Health Screening – Waiting Period range is **[0-365]** days' and the benefit will be included or not based on policyholder choice. Maximum of one health screening test per covered person per calendar year
 - Hospital Confinement due to Covered Sickness – Maximum of **[10-60]** days per covered person per covered sickness

SECTION 4 – GENERAL DEFINITIONS

Definitions may be added or removed according to the policyholder's plan.

- The **Dependent Children** definition may vary, if, in the future, we elect to remove some requirements for dependent children.
- The definition of **Pre-existing Condition** will appear as shown or not at all based on whether the policyholder elects to include the Hospital Confinement due to Covered Sickness benefit.

SECTION 6 – BENEFITS

Benefits will either appear as shown or not at all depending on the plan chosen by the policyholder. All benefit payment ranges are displayed on the Certificate Schedule.

- Hospital Confinement
 - "more than **[15]** days" will range from **[0-90]** days,
 - "begin on the **[16th]** day" will range from **[1-91]** days,
 - "will not exceed **[365]** days" will range from **[30-365]** days and
 - "**[15]** days for hospital intensive care unit confinement" will range from **[0-90]** days
- Hospital Intensive Care Unit Confinement
 - "more than **[15]** days" will range from **[0-90]** days,
 - "begin on the **[16th]** day" will range from **[1-91]** days,
 - "will not exceed **[365]** days" will range from **[30-365]** days and
 - "**[15]** days for hospital intensive care unit confinement" will range from **[0-90]** days
- Pain Management – epidural anesthesia must be administered within **[0-365]** days

Additional Benefit Information

- Health Screening – Waiting period range is **[0-365]** days' and the benefit will be included or not based on policyholder choice.
- Continuity of Coverage for Hospital Confinement due to Covered Sickness – This provision will be included or not, if the policyholder is transferring from a prior carrier's plan.

Limitations and Exclusions for Hospital Confinement due to Covered Sickness – All bracketed exclusions are policyholder choice as to include them in the contract or not.

- Pre-existing Condition Limitation for Hospital Confinement due to Covered Sickness: **[0-12]** months based on state requirements

SECTION 7 – GENERAL EXCLUSIONS AND LIMITATIONS

All bracketed exclusions are policyholder choice as to include them in the contract or not.

SECTION 8 – TERMINATION OF INSURANCE

The Termination of Insurance section number will be either 7 or 8 based on the presence of the General Exclusions and Limitations section.

SECTION 9 – PORTABILITY

The Portability section number will be either 8 or 9 based on the presence of the General Exclusions and Limitations section.

- This entire section, as well as all provisions listed, will be included based on policyholder choice.

SECTION 10 – GENERAL PROVISIONS

The General Provisions section number will either be 8, 9 or 10 based on the presence of the General Exclusions and Limitations and Portability sections.

SECTION 11 – CLAIM PROVISIONS

- The Claim Provisions section number will either be 9, 10 or 11 based on the presence of the General Exclusions and Limitations and Portability sections.
- The Proof of Loss for Catastrophic Accident provision will be included or not based on policyholder choice.

Underwriting Statement of Variability – Group Accident

Group Accident - Master Application, GACC - App

Page 1

1. **Policyholder Section** – Terms such as employee will be included or deleted as appropriate. These definitions may alternatively include association or union terms, as appropriate.
2. **Eligible Class** – Minimum hours per week is policyholder specific but will range between 15-30 hours.
3. **Eligible Class** - All bracketed information in this section to be determined by the Policyholder's requirements for eligibility of coverage.
4. **Plan Option Applied For** – Health Screening Benefit options will vary from "None" to \$25, \$50, or \$100 per employer choice.
5. **Plan Option Applied For** – Sickness Hospital Confinement Benefit options will vary from "None" to \$50 - \$5000 per employer choice.

Group Accident - Enrollment Form, GACC-Enroll

Page 1

1. **Plan Section** - Bracketed information will be dependent on Policyholder's selection of coverage extended to eligible members.
2. **Agreement Section** – The bracketed information in this section will vary from 0, 3, 6 or 12 months based on the state requirements for pre-existing conditions.