
State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.002 Short Term
Product Name: Short Term Disability C50000
Project Name/Number: Short Term Disability 50000/

Filing at a Glance

Company: Continental American Insurance Company
Product Name: Short Term Disability C50000
State: Arkansas
TOI: H11G Group Health - Disability Income
Sub-TOI: H11G.002 Short Term
Filing Type: Form
Date Submitted: 01/04/2013
SERFF Tr Num: CAIC-128834455
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 9312

Implementation: On Approval
Date Requested:
Author(s): Sara McCormick
Reviewer(s): Donna Lambert (primary)
Disposition Date: 01/15/2013
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.002 Short Term
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General Information

Project Name: Short Term Disability 50000 Status of Filing in Domicile: Pending
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Group
 Submission Type: New Submission Group Market Size: Small and Large
 Group Market Type: Employer, Other Explanation for Other Group Market Type: Union
 Overall Rate Impact: Filing Status Changed: 01/15/2013
State Status Changed: 01/15/2013
 Deemer Date: Created By: Sara McCormick
 Submitted By: Sara McCormick Corresponding Filing Tracking Number:
 Filing Description:
 Please see the Cover Letter.

Company and Contact

Filing Contact Information

Sara McCormick, Regulatory Analyst smccormick@caicworksite.com
 2801 Devine Street 803-354-4952 [Phone]
 Columbia, SC 29205

Filing Company Information

Continental American Insurance Company	CoCode: 71730	State of Domicile: South Carolina
2801 Devine Street	Group Code: 370	Company Type: LAH
Columbia, SC 29205	Group Name: Continental Amer Ins Co	State ID Number:
(803) 256-6265 ext. [Phone]	FEIN Number: 57-0514130	

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? Yes
 Fee Explanation: South Carolina's retaliatory fee is zero dollars; therefore, we are submitting the following:
 One policy = \$50
 One certificate = \$50
 Two applications = \$100
 Total: \$200.00
 Per Company: No

Company	Amount	Date Processed	Transaction #
Continental American Insurance Company	\$200.00	01/04/2013	66271923

SERFF Tracking #:

CAIC-128834455

State Tracking #:

Company Tracking #:

9312

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.002 Short Term

Product Name:

Short Term Disability C50000

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/15/2013	01/15/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	01/14/2013	01/14/2013

Response Letters

Responded By	Created On	Date Submitted
Sara McCormick	01/14/2013	01/14/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Master Policy	Sara McCormick	01/07/2013	01/07/2013
Form	Certificate of Insurance	Sara McCormick	01/07/2013	01/07/2013

State: Arkansas
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Filing Company: Continental American Insurance Company

Disposition

Disposition Date: 01/15/2013

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Cover Letter	Approved	Yes
Form (revised)	Master Policy	Approved	Yes
Form	Master Policy	Replaced	Yes
Form (revised)	Certificate of Insurance	Approved	Yes
Form	Certificate of Insurance	Replaced	Yes
Form	Certificate of Insurance	Replaced	Yes
Form	Master Application	Approved	Yes
Form	Employee Application	Approved	Yes

State: Arkansas **Filing Company:** Continental American Insurance Company
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.002 Short Term
Product Name: Short Term Disability C50000
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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/14/2013
Submitted Date	01/14/2013
Respond By Date	02/14/2013

Dear Sara McCormick,

Introduction:

This will acknowledge receipt of the captioned filing.

Please add to the certificate the information required by Bulletin 15-2009.

Conclusion:

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

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 01/14/2013
 Submitted Date 01/14/2013

Dear Donna Lambert,

Introduction:

Response 1

Comments:

We have added the information required by Bulletin 15-2009 to the Certificate.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Certificate of Insurance	C50101AR	CER	Initial		40.700	C50101AR STD Certificate.pdf	Date Submitted: 01/14/2013 By: Sara McCormick
<i>Previous Version</i>								
1	Certificate of Insurance	C50101AR	CER	Initial		40.700	C50101AR STD Certificate.pdf	Date Submitted: 01/07/2013 By:
<i>Previous Version</i>								
1	Certificate of Insurance	C50101AR	CER	Initial		40.700	C50101AR STD Certificate.pdf	Date Submitted: 01/04/2013 By: Sara McCormick

SERFF Tracking #:

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9312

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.002 Short Term

Product Name:

Short Term Disability C50000

Project Name/Number:

Short Term Disability 50000/

No Rate/Rule Schedule items changed.

Conclusion:

Thank you for your continued review of this filing.

Sincerely,

Sara McCormick

State: Arkansas
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.002 Short Term
Product Name: Short Term Disability C50000
Project Name/Number: Short Term Disability 50000/

Filing Company: Continental American Insurance Company

Amendment Letter

Submitted Date: 01/07/2013

Comments:

We have revised the Master Policy and Certificate; please accept the new forms.

Thank you.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Master Policy	C50100AR	POL	Initial		40.000	C50100AR STD Master Policy.pdf	Date Submitted: 01/07/2013 By:
<i>Previous Version</i>								
1	Master Policy	C50100AR	POL	Initial		40.000	C50100AR STD Master Policy.pdf	Date Submitted: 01/04/2013 By: Sara McCormick
2	Certificate of Insurance	C50101AR	CER	Initial		40.700	C50101AR STD Certificate.pdf	Date Submitted: 01/07/2013 By:
<i>Previous Version</i>								
2	Certificate of Insurance	C50101AR	CER	Initial		40.700	C50101AR STD Certificate.pdf	Date Submitted: 01/04/2013 By: Sara McCormick

No Rate Schedule Items Changed.

SERFF Tracking #:

CAIC-128834455

State Tracking #:

Company Tracking #:

9312

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.002 Short Term

Product Name:

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No Supporting Documents Changed.

State: Arkansas
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Form Schedule

Lead Form Number: C50100AR								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 01/14/2013	Master Policy	C50100AR	POL	Initial		40.000	C50100AR STD Master Policy.pdf
2	Approved 01/15/2013	Certificate of Insurance	C50101AR	CER	Initial		40.700	C50101AR STD Certificate.pdf
3	Approved 01/10/2013	Master Application	C50201AR	AEF	Initial		0.000	C50201AR Master Application.pdf
4	Approved 01/10/2013	Employee Application	C50202AR	AEF	Initial		0.000	C50202AR STD Application.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



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205

800.433.3036]

GROUP SHORT-TERM DISABILITY INSURANCE POLICY

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Policy. Benefits are paid for short-term Disability caused by Sickness or Off-the-Job Injury [or On-the-Job Injury]. This Policy does not provide benefits for any other Sickness or condition.

IF THE INSURED HAS ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

ANY POLICIES ISSUED IN THE STATE OF ARKANSAS ARE GOVERNED BY THE STATE OF ARKANSAS

[ABC COMPANY, INC.] (the "Policyholder") applied for coverage under this Group Short-Term Disability Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "we," "us," or "our"). Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as *he*, *him*, and *his*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

This is a limited Plan. Please read it carefully.

This Plan becomes effective on the Effective Date at 12:01 a.m., as determined by the Policyholder's address. Plan Termination is governed by Section I. The Plan continues to be effective while premiums are paid, as provided in Section II.

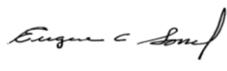
The Plan's first Anniversary Date appears below. Subsequent anniversaries will be the same date each following year.

The Policyholder may add new [Employees] from time to time, according to the Plan's terms.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown below.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

[]

[Eugene C. Sorrel, President]

Group Policy Number [1234]

Effective Date [January 1, 2012]

Jurisdiction [State Name]

Anniversary Date [January 1, 2013]

Non-Participating

Notice of Non-Insured Benefits

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services.
- Educational services.
- Benefit statement services.
- Payroll or plan administration services.

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers (such as pharmacies, optometrists, dentists, and accountants) to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

Table of Contents

Section I	-	Eligibility, Effective Date, Termination, and Portability
Section II	-	Premium Provisions
Section III	-	Definitions
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Section V	-	Limitations & Exclusions Provisions
Section VI	-	Claim Provisions
Section VII	-	General Provisions
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[Section X	-	Incorporation of Rider Provisions]

Section I – Eligibility, Effective Date, Termination, and Portability

Eligibility

A person is an eligible [Employee] under this Plan if he meets **all** the following requirements:

- He is [An Employee] of the Policyholder.
- He is engaged in [full; part]-time work.
- He is included in the class of [Employees] eligible for coverage, as shown on the Application.

Effective Date

The Plan's Effective Date is shown on Page 1.

[An Employee's] Effective Date is the date his insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if the [Employee] is Actively at Work on that date.
- The date the [Employee] returns to an Actively-at-Work status if he is not Actively at Work on the date that is shown on the Certificate Schedule.

Plan Termination

The Plan may terminate for any of the following reasons.

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the [first] Policy year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application.

The Policyholder has the sole responsibility to notify [Employees] of the Plan's termination. If the Plan terminates, it—and all Certificates [and Riders] issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

If the Plan ends, we will provide coverage for claims arising from Disabilities that were first diagnosed while the Plan was in force.

Termination of [an Employee's] Insurance

[An Employee's] insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The [31]st day after the premium due date, if the premium has not been paid.
- The date he no longer meets the Plan's definition of [an Employee].
- The date he no longer belongs to an eligible class.

If an Insured's coverage ends, we will provide coverage for claims arising from short-term Disability that was first diagnosed while his coverage was in force.

Portability Privilege

When [an Employee] [ends employment with the employer] and his coverage would otherwise end, that [Employee] may choose to continue his coverage under this Plan. The [Employee] may continue the coverage that he had on the date his [employment] ended.

To keep his Certificate in force, the [Employee] must meet the following three requirements:

- He must apply to the Company in writing within 31 days after the date his insurance would otherwise terminate.
- He must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- He must be engaged in [full; part]-time work.

Coverage will end:

- 31 days after the date the [Employee] fails to pay any required premium, **or**
- The date this Group Plan is terminated, whichever occurs first.

If [an Employee] qualifies for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.]

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount payable on any premium due date. [The rates shown in this Schedule can be changed each year] [after the rate guarantee period has expired]. The Company will give the Policyholder written notice [31] days before any change in rates becomes effective.

Premium Payments

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

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

Grace Period

This Plan has a [31-day] Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next [31] days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

Section III – Definitions

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

Actively at Work refers to an Insured's ability to perform his regular employment duties for a full normal workday. The Insured may perform these activities either at his employer's regular place of business or at a location where the Insured may be required to travel to perform the regular duties of his employment.

Base Annual Pay is the [Employee's] annual income from his [Full-Time] Job with the Policyholder. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which the Insured can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions requiring Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - Acute nephritis,
 - Nephrosis,
 - Cardiac decompensation,
 - Missed abortion,
 - Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - Ectopic pregnancy that is terminated, and
 - Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- multiple gestation pregnancy.
- false labor.
- occasional spotting.
- morning sickness.

Other similar conditions associated with a difficult pregnancy are not considered Complications of Pregnancy.

Cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit shown on the Benefit Schedule.

Disability

- **Total Disability** refers to the Insured's being under the care and attendance of a Doctor due to a condition that causes his inability to perform the material and substantial duties of his [Full-Time] Job with the employer. To qualify as Total Disability, the Insured may not be working at any job.

- **[Partial Disability]** refers to the Insured's being under the care and attendance of a Doctor due to a condition that causes his inability to perform the material and substantial duties of his [Full-Time] Job. To qualify as Partial Disability, the Insured is able to work at any job earning less than [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80] percent of the Base Annual Pay of his [Full-Time] Job at the time he became disabled.]

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.
- A person who is licensed to treat the type of condition for which a claim is made.

A Doctor does **not** include the Insured or the Insured's Family Member.

Elimination Period is the number of [continuous] days at the beginning of the Insured's Period of Disability for which no benefits are payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

[Employee] is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The [Employee] is the Insured under this Plan.

Family Member includes anyone related to the Insured in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law; and spouses, as applicable.

Full-Time Job refers to a job at which the Insured works, performing his occupational duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job [or On-the-Job] bodily injury not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective. The Insured is named on his Certificate Schedule. The Insured is always the covered eligible [Employee] under an employer group Policy.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders and adjustment disorders. It also includes any other condition usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

Off-the-Job Injury means an Injury that occurs while the Insured is not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while the Insured is working at any job for pay or benefits.

Period of Disability means the length of time the Insured is either Totally Disabled or [Partially Disabled] from one or more causes. It starts the first full day of Total Disability [Partial Disability] after the Insured ceases to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date the Insured ceases to be Totally Disabled [Partially Disabled].
- The date the Insured returns to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition. Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- [It first manifested and was first treated after the Effective Date of coverage.]
- It occurs while coverage is in force.

Treatment or Medical Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Section IV – Benefit Provisions

The benefit amounts payable under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if the Insured’s Disability is caused by a covered Sickness or covered Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with the Insured while a claim is pending, or to use an independent consultant and Doctor’s statement to determine whether the Insured is qualified to receive Disability benefits.**

The Insured must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of the Insured’s death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by [30, 60, 90, 120, 150, 180] days or more.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, the Insured will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to the **same condition or a related condition**, until [30, 60, 90, 120, 150, **180**] days after **all** the following conditions are met:

- He has been released by a Doctor from the prior Disability.
- He is no longer disabled.
- He is no longer qualified to receive any Disability benefits under this Policy.

After his Disability Benefit Period, the Insured may continue his coverage if **all** the following conditions are met:

- He returns to work within [90] days after his Benefit Period ends.
- Premium payments for his coverage resumes upon his return to work.
- The group Policy is still in force upon his return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability if they are not separated by the Insured's returning to work at a [Full-Time] Job for [1, 7, 14, 30] consecutive days, during which he is performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, the Insured will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to an **unrelated cause**, until [1, 7, 14, 30] consecutive days after **all** the following conditions are met:

- He has been released by a Doctor from a prior Disability.
- He is no longer disabled.
- He is no longer qualified to receive any Disability benefits under this Policy.

After his Disability Benefit Period, the Insured may continue his coverage if **all** the following conditions are met:

- He returns to work within [90] days after his Benefit Period ends.
- Premium payments for his coverage resumes upon his return to work.
- The group Policy is still in force upon his return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* [or a new *Partial Disability Benefit Period* (a maximum of [3] months)], subject to a new Elimination Period.

[The Partial Disability Benefit has its own Benefit Period; it is not subject to the Total Disability Benefit Period. An insured may be eligible for the Partial Disability Benefit even if he had not received the Total Disability Benefit.]

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If the Insured has a [Full-Time] Job at the time of his Sickness or Off-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Total Disability within [30, 60, **90**] days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay him the Daily Disability Benefit for each day of his Total Disability. This benefit is payable up to the Total Disability Benefit Period and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of his pre-Disability Base Annual Pay.

[PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If the Insured has a [Full-Time] Job at the time of his Sickness or Off-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Partial Disability within [30, 60, **90**] days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay [30, 35, 40, 45, **50**, 55, 60, 65, 70, 75, 80] percent of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months) and is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination Period appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after the Insured returns to work earning less than [80]% of the Base Annual Pay of his [Full-Time] job.

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of his pre-Disability Annual Income.]

[TOTAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If the Insured has a [Full-Time] Job at the time of his On-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered On-the-Job Injury causes his Total Disability within [30, 60, **90**] days of his last Treatment for his covered On-the-Job Injury, we will pay him the Daily Disability Benefit for each day of his Total Disability. This benefit is payable up to the Total Disability Benefit Period and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his Full-Time Job, or (2) working at any job.]

[PARTIAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If the Insured has a [Full-Time] Job at the time of his On-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered On-the-Job Injury causes his Partial Disability within [30, 60, **90**] days of his last Treatment for his covered On-the-Job Injury, we will pay [30, 35, 40, 45, **50**, 55, 60, 65, 70, 75, 80] percent of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months) and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of his pre-Disability Base Annual Pay.]

[MENTAL ILLNESS LIMITED BENEFIT]

If the Insured is Totally Disabled due to a Mental Illness, (see **Section III – Definitions**) Disability benefits will be paid for the Period of Disability shown in the Benefit Schedule, provided that the Insured is under the regular care and attendance of a Doctor.

The Mental Illness Limited Benefit is subject to the lifetime maximum shown in the Benefit Schedule.]

[ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT]

If the Insured is Totally Disabled due to alcoholism or drug addiction, Disability benefits will be paid for the Period of Disability shown in the Benefit Schedule.

The Alcoholism and Drug Addiction Limited Benefit is subject to the lifetime maximum shown in the Benefit Schedule.]

[PRE-EXISTING CONDITIONS BENEFIT]

We will pay a [25; 50; 75]% benefit for any Disability occurring after the effective date which is caused by, resulting from — or affected by — a Pre-existing Condition if the Disability occurs within the [3; 6; 12]-month period prior to the Insured's Effective Date.

The Company will not reduce a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after the Insured's Effective Date.]

[WAIVER OF PREMIUM BENEFIT

If the Insured's covered Sickness or covered Off-the-Job Injury [or covered On-the-Job Injury] causes his Total Disability [or Partial Disability] [for more than [90, 60, 30] consecutive days] while this coverage is in force, we will waive, from month to month, the premium for the Certificate and any applicable rider(s) for as long as he remains disabled, up to the applicable Benefit Period shown in the Benefit Schedule.

For premiums to be waived, we will require an employer's statement and a Doctor's statement certifying the Insured's inability to perform his customary duties or activities, and may each month thereafter require a Doctor's statement that his inability to perform those duties or activities continues. We may ask for and use an independent consultant to determine the Insured's Disability when this benefit is in force.

All premiums must be paid to keep an Insured's Certificate and any applicable rider(s) in force until we approve his claim for this Waiver of Premium Benefit. Premium payments for the Insured must resume the earlier of his returning to work or within [90] days after he no longer qualifies for Disability benefits.

[The Waiver of Premium Benefit is not available with a three-month Total Disability Benefit Period.]

Section V – Limitations & Exclusions Provisions

[Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, [pregnancy], or injury that existed within the [3; 6; 12]-month period before the Insured's Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated the Insured[.], **or**
- symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.]

[We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability was diagnosed within the [3; 6; 12]-month period after the Insured's Effective Date.]

The Company will not reduce or deny a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after the Insured's Effective Date.]

[Pregnancy Limitation

Within the first [nine months] of the Effective Date of coverage, we will *not* pay benefits for a Disability that is caused by, or occurs as a result of, the Insured's Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for [nine months] from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery** and **eight weeks for cesarean delivery**, less the Elimination Period, unless the Insured furnishes proof that her Disability continues beyond these time frames due to Complications of Pregnancy.]

[Continuity of Coverage Upon Transfer of Insurance Carriers]

When we replace another carrier's plan, we provide the following Continuity of Coverage protection. We provide this coverage for loss due to a Pre-existing Condition for covered [Employees] who were insured under the prior plan at the time of transfer.

Benefits may be payable for a loss due to a pre-existing condition for [an Employee] if **all** of the following conditions are met:

- He was insured by the prior carrier at the time of transfer.
- He was actively employed and insured under this Plan on its Effective Date.
- His Benefit Period and Elimination Period under his prior coverage is the same as, or less than, his Benefit Period and Elimination Period under this Plan.

The benefits will be determined as follows:

- We will apply this Plan's Pre-existing Conditions Limitation. If the [Employee] qualifies for benefits, he will be paid according to his Certificate's Benefit Schedule.
- If the [Employee] cannot satisfy this Plan's Pre-existing Conditions Limitation, the prior carrier's pre-existing condition limitation will be applied:
 - If the [Employee] satisfies the prior carrier's pre-existing condition limitation, giving consideration towards continuous time insured under both policies, he will be paid according to the prior carrier's benefit schedule (including benefit period, elimination period, and maximum monthly benefit).
 - If he cannot satisfy the Pre-existing Conditions Limitation of this Policy, or that of the prior carrier, no benefit will be paid.]

Limitations and Exclusions

A. We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

B. We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which the Insured received benefits that were not lawfully due and that fraudulently induced payment.

C. We will not pay benefits for a Disability that is caused by or occurs as a result of:

1. [Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.]
2. [Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.]
3. [An intentionally self-inflicted Injury.]
4. [A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.]
5. [Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.]
6. [Mental Illness as defined in **Section III – Definitions.**]
7. [Alcoholism or drug addiction.]
8. [An Injury arising from any employment.]
9. [Injury or Sickness covered by Worker's Compensation.]
10. [Sickness or Injury for which the [Employee] is eligible to receive benefits under any sick leave (sick days) plan.]
11. [Loss of a professional license, occupational license, or certification.]
12. [Having cosmetic surgery or other elective procedures that are not Medically Necessary.]

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

The Insured must give written notice of claim:

- Within 60 days after a diagnosis of Disability **or**
- As soon as reasonably possible.

Notice must include the Insured's name and the Certificate number. Notice can be mailed to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202.

Claim Forms

When the Company receives notice of a claim, we will send the Insured forms so that he can file Proof of Loss (details included in the **Proof of Loss** section below).

If the Company does not provide the forms within 15 working days, the Insured can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. The Insured will also need to provide a statement by the treating Doctor. The Insured must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to all documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). The Insured must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202.

The Insured must provide Proof of Loss documentation within 90 days after the date of diagnosis of the Disability. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for the Insured to provide this proof within the required time.

The Insured must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of the Insured's legal mental capacity.

Claims Payment Timeframe

Once we receive the required Proof of Loss, the Company will pay, deny, or settle each submitted claim within 30 calendar days.

Payment of Claims

We will pay all benefits to the Insured unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

1. To any approved assignee.
2. To the Insured's beneficiary.
3. To the Insured's surviving spouse.
4. To the Insured's estate.

Changing of Beneficiary

The Insured can ask us to change his beneficiary at any time. The request must be in writing, and the change must be approved by us. If approved, it will go into effect the day the Insured signs the request. The change will not have any bearing on payments made before we approved the request.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Physical Examination and Autopsy

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Legal Action

The Insured cannot take legal action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of the Insured's benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that the Insured has specifically assigned the benefits of his Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If the Insured is covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by the Insured or the Insured's estate, as the case may be, will be effective. We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- the Policyholder, **or**
- the Insured, **or**
- the Insured's beneficiary.

This will ensure that Policyholders or Insureds have an opportunity to review the information they have provided in their Applications. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- will not be valid unless approved in writing by an executive officer of the Company.
- must be noted on or attached to the Contract.
- may not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Insured to be valid.

Time Limit on Certain Defenses

After two years from the Effective Date of the Insured's coverage, no misstatements, except fraudulent misstatements, made by the Insured in the Application shall be used to void his coverage or to deny a claim for Disability commencing after the expiration of such two-year period.

[No claim for loss incurred or Disability commencing after [12] months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the Insured's coverage has been in force [12] months.]

Misstatement of Age

If the Insured's age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if the Insured's misstated age at the time of Application was outside the age limits for his coverage.

Misstatement of Occupation or Income

If the Insured's occupation has been misstated, the benefits will be those that the premiums paid would have purchased for his correct occupation. If his income has been misstated, the benefit payable will be that which would have been allowed for his true income level, and any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, we will make a premium adjustment.

Individual Certificates

We will give the Policyholder a Certificate for each [Employee]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

Required Information

The Policyholder will furnish all information and proofs which we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII – Benefit Schedule

ELIGIBILITY

[All [Full-Time] [Employees] working at least [19] hours or more weekly, who are Actively at Work[, and have completed at least [6] months of continuous employment with the Policyholder].]

BENEFIT PERIOD

Benefit	Benefit Period
Total Disability (Non-Occupational)	[3, 6, 12] Months
[Partial Disability	[3] Months]
[Total Disability (24-Hour)	[3, 6, 12] Months]
[Mental Illness Limited Benefit	[90] Days per [12-]month period], lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit	[90] Days per [12-]month period], lifetime maximum]

ELIMINATION PERIOD

Total and/or Partial Disability	Elimination Period
Injury	[0, 7, 14, 30, 60, 90] Days
Sickness	[7, 14, 30, 60, 90] Days

Section IX – Schedule of Premiums

The Monthly Benefit Amount for Total Disability issued is subject to [60%] of the eligible [Employee's] Base Annual Pay.*

BENEFIT AMOUNTS

Minimum	[5] units (\$500/Month)
Maximum	[60] units (\$6,000/Month)
The percentage of income replacement may vary for state-sponsored disability programs for [Employees] who reside in: California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island	

***Base Annual Pay** is the [Employee's] annual income from his [Full-Time] Job with his employer. This pay excludes overtime pay, bonuses, or any other special pay.

[The maximum benefit for which the [Employee] is eligible to apply will be reduced by any other group, individual, or franchise Disability Income coverage to be continued.]

Any increase in the Monthly Disability Benefit due to an increase in earnings is subject to written Application to and acceptance by Continental American Insurance Company. Evidence of insurability may be required.

PREMIUMS

The table below shows the premiums applicable to the Plan on the Effective Date. The rates shown are for each \$100.00 of monthly benefit amount [and include the rate for Partial Disability Benefits]. Rates can be changed [annually].

Ages	Units	Monthly Rate per \$100 of Monthly Benefit
[[18-49]	\$100	\$xx.xx]
[[50-59]	\$100	\$xx.xx]
[[60-74]	\$100	\$xx.xx]

[Section X – Incorporation of Rider Provisions

The attached listed Certificate Riders are made a part of this Plan.

Rider Name

[rider name

Form Number

form number]]



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205

800.433.3036]

GROUP SHORT-TERM DISABILITY INSURANCE CERTIFICATE

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Certificate. Benefits are paid for short-term Disability that is caused by Sickness or Off-the-Job Injury [or On-the-Job Injury]. This Certificate does not provide benefits for any other Sickness or condition.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

ANY CERTIFICATES ISSUED IN THE STATE OF ARKANSAS ARE GOVERNED BY THE STATE OF ARKANSAS

[ABC COMPANY, INC.] (“the Policyholder”) applied for coverage under this Group Short-Term Disability Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “we,” “us,” or “our”). For the purpose of this Plan, “you” (including “your” and “yours”) refers to you. Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. Your Application is maintained on file and made part of this Certificate. (Please note that male pronouns—such as *you*, *you*, and *your*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

Please read your Certificate carefully.

We certify that you are insured under the Group Short-Term Disability Insurance Policy (the “Plan”). The Plan was issued to your [Employer], the Policyholder. This coverage provides benefits for loss resulting from short-term disability. The Certificate is subject to the definitions, exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

Notice of Non-Insured Benefits

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or who become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services.
- Educational services.
- Benefit statement services.
- Payroll or plan administration services.

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, as well as related services.

In addition, CAIC may arrange for third-party service providers (such as pharmacies, optometrists, dentists, and accountants) to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

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Section I – Eligibility, Effective Date, Termination, and Portability

Eligibility

You are an eligible [Employee] under this Plan if you meet **all** the following requirements:

- You are [An Employee] of the Policyholder.
- You are engaged in [full; part]-time work.
- You are included in the class of [Employees] that are eligible for coverage, as shown on the Application.

Effective Date

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

Your Certificate Effective Date is the date your insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if you are Actively at Work on that date.
- The date you return to an Actively-at-Work status if you are not Actively at Work on the date that is shown on the Certificate Schedule.

Plan Termination

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the [first] Policy year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number that was agreed upon by the Company and the Policyholder in the signed Master Application.

The Policyholder has the sole responsibility to notify you of the termination of the Plan. If the Plan terminates, it — as well as all Certificates and Riders issued under the Plan — will end on the stated termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

If the Plan ends, we will provide coverage for claims arising from Disabilities that were first Diagnosed while the Plan was in force.

Termination of [an Employee's] Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The [31]st day after the premium due date, if the premium has not been paid.
- The date you no longer meet the Plan's definition of [an Employee].
- The date you no longer belong to an eligible class.

If your coverage ends, we will provide coverage for claims that arise from short-term Disability that was first Diagnosed while your coverage was in force.

[Portability Privilege]

When you [end employment with the Employer] and your coverage would otherwise end, you may choose to continue your coverage under this Plan. You may continue the coverage that you had on the date your [employment] ended.

To keep your Certificate in force, you must meet the following three requirements:

- You must apply to the Company in writing within 31 days after the date your insurance would otherwise terminate.
- You must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- You must be engaged in [Full; Part]-time work.

Coverage will end:

- 31 days after the date you fail to pay any required premium, **or**
- The date this Group Plan is terminated, whichever occurs first.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate that are shown in your previously issued Certificate.]

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount that is payable on any premium due date. [The rates that are shown in this Schedule can be changed each year] [after the rate guarantee period has expired.] The Company will give the Policyholder written notice [31] days before any change in rates becomes effective.

Premium Payments

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

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

Grace Period

This Plan has a [31-day] Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next [31] days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

Section III – Definitions

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

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer's regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

Base Annual Pay is the annual income from your [Full-Time] Job with your employer. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which you can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a “month” is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions that require Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - Acute nephritis,
 - Nephrosis,
 - Cardiac decompensation,
 - Missed abortion,
 - Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - Ectopic pregnancy that is terminated, and
 - Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- Multiple gestation pregnancy.
- False labor.
- Occasional spotting.
- Morning sickness.

Other similar conditions that are associated with a difficult pregnancy are not considered Complications of Pregnancy.

Cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit that is shown on the Benefit Schedule.

Disability

- **Total Disability** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your [Full-Time] Job. To qualify as Total Disability, you may not be working at any job.
- **[Partial Disability]** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your [Full-Time] Job. To qualify as Partial Disability, you are able to work at any job earning less than [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent of the Annual Income of your [Full-Time] Job at the time you became disabled.]

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.
- A person who is licensed to treat the type of condition for which a claim is made.

A Doctor does **not** include you or your Family Member.

Elimination Period is the number of [continuous] days at the beginning of your Period of Disability for which there are no benefits payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

[Employee] is a person who meets the eligibility requirements that are under Section I – Eligibility, and who is covered under this Plan. The [Employee] under this Plan is you.

Family Member includes anyone related to you in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law; and spouses, as applicable.

Full-Time Job refers to a job at which you work, performing your job-related duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job [or On-the-Job] bodily injury that is not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of the cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders as well as adjustment disorders. It also includes any other condition that is usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the conditions stated above.

Off-the-Job Injury means an Injury that occurs while you are not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while you are working at any job for pay or benefits.

Period of Disability means the length of time that you are either Totally Disabled or [Partially Disabled] from one or more causes. It starts the first full day of Total Disability [Partial Disability] after you cease to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date you cease to be Totally Disabled, [Partially Disabled].
- The date you return to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition. Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- [It first manifested and was first treated after the Effective Date of coverage.]
- It occurs while coverage is in force.

Treatment or Medical Treatment is the consultation, care, or services that are provided by a Doctor. This includes receiving any diagnostic measures as well as taking prescribed drugs and medicines.

Section IV – Benefit Provisions

The benefit amounts payable that are under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Injury and if it occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you while a claim is pending, or to use an independent consultant and Doctor's statement to determine whether you are qualified to receive Disability benefits.**

You must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of your death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by [30, 60, 90, 120, 150, 180] days or more.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, you will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to the **same condition or a Related condition**, until [30, 60, 90, 120, 150, **180**] days after **all** the following conditions are met:

- You have been released by a Doctor from the prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within [90] days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability if they are not separated by your returning to work at a [Full-Time] Job for [1, 7, 14, 30] consecutive days, during which you are performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, you will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to an **unrelated cause**, until [1, 7, 14, 30] consecutive days after **all** the following conditions are met:

- You have been released by a Doctor from a prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within [90] days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* [or a new *Partial Disability Benefit Period* (a maximum of [3] months)], subject to a new Elimination Period.

[The Partial Disability Benefit has its own Benefit Period; it isn't subject to the Total Disability Benefit Period. You may be eligible for the Partial Disability Benefit even if you have not received the Total Disability Benefit.]

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a [Full-Time] Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within [30, 60, **90**] days of your last Treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period. It is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.

[PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a [Full-Time] Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Partial Disability within [30, 60, **90**] days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay [30, 35, 40, 45, **50**, 55, 60, 65, 70, 75, 80] percent of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months) and is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination Period appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after the Insured returns to work earning less than [80]% of the Base Annual Pay of his [Full-Time] job.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.]

[TOTAL DISABILITY BENEFIT: ON-THE-JOB INJURY

If you have a [Full-Time] Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within [30, 60, **90**] days of your last Treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit

Period. It is subject to the Elimination Period that is shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your Full-Time Job, or (2) working at any job.]

[PARTIAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If you have a [Full-Time] Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If the Insured's covered On-the-Job Injury causes his Partial Disability within [30, 60, **90**] days of his last Treatment for his covered On-the-Job Injury, we will pay [30, 35, 40, 45, **50**, 55, 60, 65, 70, 75, 80] percent of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months) and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.]

[MENTAL ILLNESS LIMITED BENEFIT]

If you are Totally Disabled due to a Mental Illness, (see **Section III – Definitions**) Disability benefits will be paid for the Period of Disability shown in the Benefit Schedule, so long as you are under the regular care and attendance of a Doctor.

The Mental Illness Limited Benefit is subject to the lifetime maximum that is shown in the Benefit Schedule.]

[ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT]

If you are Totally Disabled due to alcoholism or drug addiction, Disability benefits will be paid for the Period of Disability that is shown in the Benefit Schedule.

The Alcoholism and Drug Addiction Limited Benefit is subject to the lifetime maximum that is shown in the Benefit Schedule.]

[PRE-EXISTING CONDITIONS BENEFIT]

We will pay a [25; 50; 75]% benefit for any Disability that occurs after the effective date which is caused by, resulting from — or affected by — a Pre-existing Condition if the Disability occurs within the [3; 6; 12]-month period prior to your Effective Date.]

The Company will not reduce a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after your Effective Date.]

[WAIVER OF PREMIUM BENEFIT]

If your covered Sickness or covered Off-the-Job Injury [or covered On-the-Job Injury] causes your Total Disability [or Partial Disability] [for more than [90, 60, 30] consecutive days] while this coverage is in force, we will waive, from month to month, the premium for the Certificate and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Benefit Schedule.

For premiums to be waived, we will require both the statement of an employer and the statement of a Doctor certifying that you are unable to perform your customary duties or activities. We may each month thereafter require a Doctor's statement that your inability to perform those duties or activities continues.

We may ask for and use an independent consultant to determine your Disability when this benefit is in force.

All premiums must be paid to keep the Certificate and any applicable rider(s) in force until we approve your claim for this Waiver of Premium Benefit. Premium payments for your coverage must resume the earlier of your returning to work or within [90] days after you no longer qualify for Disability benefits.

[The Waiver of Premium Benefit is not available with a three-month Total Disability Benefit Period.]

Section V – Limitations & Exclusions Provisions

[Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, [pregnancy], or injury that existed within the [3; 6; 12]-month period before your Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated you[.], **or**
- symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.]

[We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability was diagnosed within the [3; 6; 12]-month period after your Effective Date.]

The Company will not reduce or deny a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after your Effective Date.]

[Pregnancy Limitation

Within the first [nine months] of the Effective Date of coverage, we will *not* pay benefits for a Disability that is caused by, or occurs as a result of, your Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for [nine months] from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery** and **eight weeks for cesarean delivery**, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.]

[Continuity of Coverage Upon Transfer of Insurance Carriers

When we replace another carrier's plan, we provide the following Continuity of Coverage protection. We provide this coverage for loss due to a Pre-existing Condition if you were insured under the prior plan at the time of transfer.

Benefits may be payable for a loss due to a pre-existing condition if all the following conditions are met:

- You were insured by the prior carrier at the time of transfer.
- You were actively employed and insured under this Plan on its Effective Date.
- The Benefit Period and Elimination Period under your prior coverage is the same as, or less than, your Benefit Period and Elimination Period under this Plan.

The benefits will be determined as follows:

- We will apply this Plan's Pre-existing Conditions Limitation. If you qualify for benefits, you will be paid according to your Certificate's Benefit Schedule.
- If you cannot satisfy this Plan's Pre-existing Conditions Limitation, the prior carrier's pre-existing condition limitation will be applied:

- If you satisfy the prior carrier's pre-existing condition limitation, giving consideration towards continuous time insured under both coverages, you will be paid according to the prior carrier's benefit schedule (including benefit period, elimination period, and maximum monthly benefit).
- If you cannot satisfy the Pre-existing Conditions Limitation of this Certificate, or that of the prior carrier, no benefit will be paid.]

Limitations and Exclusions

- A. We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- B. We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.
- C. We will not pay benefits for a Disability that is caused by or occurs as a result of:
1. [Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.]
 2. [Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.]
 3. [An intentionally self-inflicted Injury.]
 4. [A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.]
 5. [Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.]
 6. [Mental Illness as defined in **Section III – Definitions.**]
 7. [Alcoholism or drug addiction.]
 8. [An Injury that arises from any employment.]
 9. [Injury or Sickness that is covered by Worker's Compensation.]
 10. [Sickness or Injury for which the [Employee] is eligible to receive benefits under any sick leave (sick days) plan.]
 11. [The loss of a professional license, occupational license, or certification.]
 12. [Having cosmetic surgery or other elective procedures that are not Medically Necessary.]

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

You must give written notice of claim:

- Within 60 days after a diagnosis of Disability **or**
- As soon as is reasonably possible.

Notice must include your name and your Certificate number. Notice can be mailed to the Company at:
P.O. Box 427, Columbia, South Carolina, 29202.

Claim Forms

When the Company receives notice of a claim, we will send forms to you so that you can file Proof of Loss. (Details are included in the **Proof of Loss** section below.)

If the Company does not provide the forms within 15 working days, you can meet Proof of Loss

requirements by providing a written statement about the nature and extent of the loss. You will also need to provide a statement by the treating Doctor. You must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to all documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). You must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202.

You must provide Proof of Loss documentation within 90 days after the date of diagnosis of the Disability. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for you to provide this proof within the required time.

You must provide the proof as soon as is reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of your legal mental capacity.

Claims Payment Timeframe

Once we have received the required Proof of Loss, the Company will pay, deny, or settle each submitted claim within 30 calendar days.

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of your death, we will pay those benefits in the following order:

1. To any approved assignee.
2. To your beneficiary.
3. To your surviving spouse.
4. To your estate.

Changing of Beneficiary

You can ask us to change your beneficiary at any time. The request must be in writing, and the change must be approved by us. If approved, it will go into effect the day you sign the request. The change will not have any bearing on payments made before we approved the request.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Physical Examination and Autopsy

The Company may have you examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or for an autopsy.

Legal Action

You cannot take legal action against us for benefits under this Plan:

- Within 60 days after you have sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that you have specifically assigned the benefits of your Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If you are covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by you or your estate, as the case may be, will be effective.

We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or you have made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- the Policyholder, **or**
- you, **or**
- your beneficiary.

This will ensure that the Policyholder or you have an opportunity to review the information that is provided in the Application. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- will not be valid unless approved in writing by an executive officer of the Company.
- must be noted on or attached to the Contract.
- may not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by you to be valid.

Time Limit on Certain Defenses

After two years from the Effective Date of your coverage, no misstatements, except fraudulent misstatements, made by you in the Application shall be used to void your coverage or to deny a claim for Disability starting after the expiration of such two-year period.

[No claim for loss incurred or Disability starting after [12] months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after your coverage has been in force [12] months.]

Misstatement of Age

If your age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if your misstated age at the time of Application was outside the age limits for your coverage.

Misstatement of Occupation or Income

If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level. Any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. If a clerical error occurs, we will make a premium adjustment.

Individual Certificates

We will give the Policyholder a Certificate for each [Employee]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

Required Information

The Policyholder will furnish all information and proofs which we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII – Certificate Schedule

INSURED	GROUP POLICY NUMBER
EFFECTIVE DATE	CERTIFICATE NUMBER
INITIAL PREMIUM	FIRST RENEWAL DATE

BENEFIT PERIOD

Benefit	Benefit Period
Total Disability (Non-Occupational)	[3, 6, 12] Months
[Partial Disability	[3] Months]
[Total Disability (24-Hour)	[3, 6, 12] Months]
[Mental Illness Limited Benefit	[90] Days per [12-]month period], lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit	[90] Days per [12-]month period], lifetime maximum]

ELIMINATION PERIOD

Total and/or Partial Disability	Elimination Period
Injury	[0, 7, 14, 30, 60, 90] Days
Sickness	[7, 14, 30, 60, 90] Days

MONTHLY BENEFIT FOR DISABILITY CAUSED BY *INJURY*

BENEFIT	We will pay this amount per month:	Beginning on this date of disability:	After this Period of Elimination for <i>Injury</i> :	For a maximum Benefit Period of:
Total Disability (Non-Occupational)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days	[3, 6, 12] Months
[Partial Disability	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3] Months]
[Total Disability (24-Hour)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3, 6, 12] Months]
[Mental Illness Limited Benefit	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period], lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period], lifetime maximum]

MONTHLY BENEFIT FOR DISABILITY CAUSED BY SICKNESS

BENEFIT	We will pay this amount per month:	Beginning on this date of disability:	After this Period of Elimination for <i>Sickness</i>:	For a maximum Benefit Period of:
Total Disability (Non-Occupational)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days	[3, 6, 12] Months
[Partial Disability]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3] Months]
[Total Disability (24-Hour)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3, 6, 12] Months]
[Mental Illness Limited Benefit	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period], lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period], lifetime maximum]

Inquiries and Customer Service

CONTINENTAL AMERICAN INSURANCE COMPANY
 Customer Service Department
 2801 Devine Street, Columbia, South Carolina 29205
 Toll Free Customer Service Number - 800-433-3036

If we at Continental American Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
 1200 West Third Street
 Little Rock, AR 72201
 (501) 371-2640 or (800) 852-5494



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205
800.433.3036]

MASTER APPLICATION FOR GROUP SHORT-TERM DISABILITY INSURANCE

[Employer, Union] Name: _____
City and State of Issue: _____

... hereby applies to **CONTINENTAL AMERICAN INSURANCE COMPANY** for a **Group Short-Term Disability Insurance Plan**.

1. Class of [Employees] Eligible for Coverage:	
<input type="checkbox"/> Regular [full; part]-time [Employees] [under age [75]]	
<input type="checkbox"/> Regular [full; part]-time [Employees] [under age [75]], except _____	
[Class: <input type="checkbox"/> P] <input type="checkbox"/> A] <input type="checkbox"/> B] <input type="checkbox"/> C] <input type="checkbox"/> E]	
<input type="checkbox"/> Other: _____	
[Employee] Requirements:	
Number of benefit-eligible [Employees]: _____	
A [full; part]-time [Employee] must work the following number of hours per week: _____	
A [full; part]-time [Employee] must complete the following number of continuous month[s] of service to be eligible for coverage: _____	
A [full; part]-time [Employee] must be Actively at Work on the date he applies for coverage and on the date his Group Short-Term Disability Insurance becomes effective.	
2.	The minimum number of enrolled [Employees] necessary to keep the Group Policy in force: _____
3.	The requested Effective Date for the Group Policy: _____
4. Plan Options:	
<input type="checkbox"/> Non-Occupational] <input type="checkbox"/> 24-Hour Coverage] <input type="checkbox"/> Partial Disability] <input type="checkbox"/> Pre-Existing Condition Benefit]	
<input type="checkbox"/> Mental Illness Limited Benefit] <input type="checkbox"/> Alcoholism and Drug Addiction Limited Benefit]	
Elimination Period: _____	Benefit Period: _____
Percentage of Income Replacement: [60]%	
The percentage of income replacement may vary for state-sponsored disability programs for [Employees] who reside in: California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island	
5.	Will this Group Short-Term Disability Insurance Policy replace any existing Group Short-Term Disability Insurance Policy? <input type="checkbox"/> YES <input type="checkbox"/> NO
	[Will this Group Short-Term Disability Insurance Policy replace existing Aflac Short-Term Disability individual coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO]
If this coverage will replace any existing Aflac individual policy, please be aware that it may be in your [Employees'] best interest to maintain their individual guaranteed-renewable policy with Aflac via direct bill. [Employees] may contact Aflac for an explanation of their options for both continuation or cancellation of any existing coverage.	
6. General Agreement:	
[The policyholder agrees to transmit the total premiums under the Group Policy to Continental American Insurance Company at its Home Office when due.] No agent or other person except an officer can make or change any contract or agreement on behalf of Continental American Insurance Company.	
Signed on this date: _____	
By: _____	
Title: _____	
State of Signature: (State of Signature must be same as State of Issue)	

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



**CONTINENTAL AMERICAN
INSURANCE COMPANY**

[EMPLOYEE] APPLICATION

[<500L] [>500L]

Please Mail To: [Post Office Box 427
Columbia, South Carolina 29202
800.433.3036]

FOR HOME OFFICE USE ONLY			
PLAN	PLAN CODE	ID NUMBER	
<i>Group Short-Term Disability</i>			
Endorsement:			
EFFECTIVE DATE:			
FOR AGENT USE ONLY			
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Hire	<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> Newly Eligible
<input type="checkbox"/> New Coverage	<input type="checkbox"/> Change in Coverage	Deduction Start Date: _	
[Employee] Name/Certificateholder (First, MI, Last)		Social Security Number/ID Number	Date of Birth
Street Address		City	State
[Employer]		Job Class/Occupation	Hire Date/Change of Status Date
Daytime Phone Number ()	Beneficiary Name/Relationship (estate unless designated otherwise)		
If you answer "no" to the following questions, you will not be eligible for coverage:			
[Are you currently working [part-time;full-time] for at least [19] hours per week for the [Employer] listed above?]			<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you earn at least [\$9,000] base annual pay working for your [Employer], the Policyholder?			<input type="checkbox"/> YES <input type="checkbox"/> NO
DISABILITY			
[Class: <input type="checkbox"/> P] <input type="checkbox"/> A] <input type="checkbox"/> B] <input type="checkbox"/> C] <input type="checkbox"/> E]		Elimination Period:	Accident: _____ Sickness: _____
<input type="checkbox"/> 24-Hour] <input type="checkbox"/> Non-Occupational]		Benefit Period:	
[Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No]		Monthly Benefit Amount:	\$
Annual Salary: \$		Cost per pay period:	\$
[Are you currently covered by on-the-job disability income replacement under a collective bargaining agreement, workers' compensation, or a similar law in your job with the [Employer] listed on this application?]			<input type="checkbox"/> Yes <input type="checkbox"/> No
[<500L] [>500L]			
1	What is your current height and weight?		_____ft _____in _____lbs
2	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?		<input type="checkbox"/> YES <input type="checkbox"/> NO
3	In the last 2 years have you been diagnosed, received medical advice, sought treatment (including surgery), or taken medication for any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; e) High blood pressure, resulting in your now taking 3 or more medications for treatment; or f) Cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? (Cancer does not include basal cell or squamous cell carcinoma.)		<input type="checkbox"/> YES <input type="checkbox"/> NO
4	In the past [12] months, have you for any reason — other than colds, flu, routine childbirth, appendectomy, tonsillectomy, cholecystectomy (gall bladder removal), or hysterectomy — had a [20]% or more reduction in hours for 5 or more consecutive days due to a muscular injury or disorder of the neck, back, shoulder, knee, or other joint.		<input type="checkbox"/> YES <input type="checkbox"/> NO

This application is not complete unless signed and dated as indicated.

5	In the last 2 years have you been treated for — or counseled for — alcohol or drug abuse?	<input type="checkbox"/> YES <input type="checkbox"/> NO
[6	Have you, in the last 5 years: a) had your driver's license suspended or revoked, b) been charged with operating a motor vehicle while under the influence of drugs or alcohol, and/or c) been involved in 3 or more motor vehicle accidents?	<input type="checkbox"/> YES <input type="checkbox"/> NO]
[7	In the past 5 years have you been diagnosed, received medical advice, sought treatment including surgery, or taken medication for any of the following: a) Systemic lupus or other connective tissue disease, fibromyalgia, chronic fatigue syndrome, rheumatoid arthritis, disc disease, or joint replacements; b) Multiple sclerosis, muscular dystrophy or Parkinson's disease, amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), or Huntington's disease; c) Schizophrenia, psychosis, major depressive disorder, bipolar disorder, or post-traumatic stress disorder; or d) Alzheimer's disease, dementia, organic brain disease, or memory loss?	<input type="checkbox"/> YES <input type="checkbox"/> NO]
[8	In the past 2 years, have you had, or been treated for, or been told by a Doctor that you have: a) Neck, back, joint, bone, muscle, or tendon injury (excluding sprains or strains treated for less than 3 weeks or fractures not treated surgically); or b) Carpal Tunnel Syndrome?	<input type="checkbox"/> YES <input type="checkbox"/> NO]

Is this coverage intended to replace or change any other existing short-term disability coverage?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES , please provide coverage information below:		
Carrier:		
Policy Number:		
Effective Date of Existing Coverage:		
[Does this coverage replace any existing Aflac short-term disability coverage in force?		<input type="checkbox"/> YES <input type="checkbox"/> NO]
<p>[If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill. You should contact your insurance carrier for an explanation of your options for both continuation or cancellation of your existing coverage.]</p> <p>Coverage will not become effective unless you are actively at work [part-time; full-time] on the enrollment date and on the effective date.</p> <p>CERTIFICATION: I have read the completed Application and I realize any false statement or misrepresentation in the Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Application is approved and the necessary premium is paid.</p> <p>I understand and agree that the coverage that I am applying for may have a pre-existing condition limitation.</p> <p>[I authorize [my employer] to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.]</p> <p>[I certify that I currently work [part-time; full-time] at [19] hours per week for the [employer] listed on this application.]</p> <p>[I certify that I earn at least [\$9,000] per year.]</p> <p>Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p> <p>Signature of Applicant: _____ Date: _____</p> <p>Signature of Agent: _____ Date: _____</p> <p>Agent No.: _____ State of Enrollment: _____</p>		

This application is not complete unless signed and dated as indicated.

SERFF Tracking #:

CAIC-128834455

State Tracking #:

Company Tracking #:

9312

State:

Arkansas

Filing Company:

Continental American Insurance Company

TOI/Sub-TOI:

H11G Group Health - Disability Income/H11G.002 Short Term

Product Name:

Short Term Disability C50000

Project Name/Number:

Short Term Disability 50000/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/15/2013
Comments:			
Attachment(s):			
CAIC Readability Certification.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	01/15/2013
Bypass Reason:	Applications are uploaded under the Form Schedule tab.		

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved	01/15/2013
Comments:			
Attachment(s):			
Cover Letter.pdf			



READABILITY CERTIFICATION

I, James J. Hennessy, hereby certify that the following forms have the following readability score as calculated by the Flesch Reading Ease Test:

<u>Form</u>	<u>Readability Score</u>
C50100	40.0
C50101	40.7

Digitally signed by James J. Hennessy
DN: cn=James J. Hennessy, o=CAIC/
Aflac, ou=2nd VP, Compliance,
email=JHennessy@caicworksite.com,
c=US
Date: 2013.01.04 16:41:31 -05'00'

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance
Continental American Insurance Company

January 4, 2013

Date



January 4, 2013

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Continental American Insurance Company NAIC#71730 FEIN 57-0514130
TOI: H11G Group Health - Disability Income
Sub-TOI: H11G.002 Short Term
Proposed Effective Date: On Approval
Domicile State Approval: SC Pending
Forms:
C50100AR Master Policy
C50101AR Certificate
C50201AR Master Application
C50202AR Enrollment Form

Dear Sir or Madam:

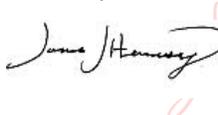
The above captioned forms are being submitted for approval. This is a new filing and will not replace any other forms on file with your department. These documents are in final form.

The forms contained in this filing represent our Group Disability Income product that will be solicited through voluntary, payroll deduction enrollments based on the company's underwriting requirements. We will be marketing this product to employer groups and union groups in accordance with your state guidelines. This product will be marketed on a voluntary, payroll-deduction basis.

Bracketed items in this filing indicate variable information and may be removed from some group plans. Any or all of the variables could be used in each plan, policy, or certificate, and the variable benefits will be selected according to the group's specifications.

Thank you for your consideration. If you have any questions, please contact Sara McCormick at 1.888.730.2244, ext. 4952 or at CompanyCompliance@aflac.com.

Sincerely,

 Digitally signed by James J. Hennessy
DN: cn=James J. Hennessy, o=CAIC/
Aflac, ou=2nd VP, Compliance,
email=JHennessy@caicworksite.com,
c=US
Date: 2013.01.04 16:42:48 -05'00'

James J. Hennessy, AIRC, ACP, CCP
Vice President, Compliance
/scm

State: Arkansas
TOI/Sub-TOI: H11G Group Health - Disability Income/H11G.002 Short Term
Product Name: Short Term Disability C50000
Project Name/Number: Short Term Disability 50000/
Filing Company: Continental American Insurance Company

Superseded Schedule Items

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

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/07/2013	Replaced 01/15/2013	Form	Certificate of Insurance	01/14/2013	C50101AR STD Certificate.pdf (Superseded)
01/03/2013	Replaced 01/15/2013	Form	Master Policy	01/07/2013	C50100AR STD Master Policy.pdf (Superseded)
01/03/2013	Replaced 01/15/2013	Form	Certificate of Insurance	01/07/2013	C50101AR STD Certificate.pdf (Superseded)



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205

800.433.3036]

GROUP SHORT-TERM DISABILITY INSURANCE CERTIFICATE

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Certificate. Benefits are paid for short-term Disability that is caused by Sickness or Off-the-Job Injury [or On-the-Job Injury]. This Certificate does not provide benefits for any other Sickness or condition.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

ANY CERTIFICATES ISSUED IN THE STATE OF ARKANSAS ARE GOVERNED BY THE STATE OF ARKANSAS

[ABC COMPANY, INC.] (“the Policyholder”) applied for coverage under this Group Short-Term Disability Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “we,” “us,” or “our”). For the purpose of this Plan, “you” (including “your” and “yours”) refers to you. Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. Your Application is maintained on file and made part of this Certificate. (Please note that male pronouns—such as *you*, *you*, and *your*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

Please read your Certificate carefully.

We certify that you are insured under the Group Short-Term Disability Insurance Policy (the “Plan”). The Plan was issued to your [Employer], the Policyholder. This coverage provides benefits for loss resulting from short-term disability. The Certificate is subject to the definitions, exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

Notice of Non-Insured Benefits

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or who become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services.
- Educational services.
- Benefit statement services.
- Payroll or plan administration services.

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, as well as related services.

In addition, CAIC may arrange for third-party service providers (such as pharmacies, optometrists, dentists, and accountants) to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

Table of Contents

Section I	-	Eligibility, Effective Date, Termination, and Portability
Section II	-	Premium Provisions
Section III	-	Definitions
Section IV	-	Benefit Provisions
Section V	-	Limitations & Exclusions Provisions
Section VI	-	Claim Provisions
Section VII	-	General Provisions
Section VIII	-	Certificate Schedule

Section I – Eligibility, Effective Date, Termination, and Portability

Eligibility

You are an eligible [Employee] under this Plan if you meet **all** the following requirements:

- You are [An Employee] of the Policyholder.
- You are engaged in [full; part]-time work.
- You are included in the class of [Employees] that are eligible for coverage, as shown on the Application.

Effective Date

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

Your Certificate Effective Date is the date your insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if you are Actively at Work on that date.
- The date you return to an Actively-at-Work status if you are not Actively at Work on the date that is shown on the Certificate Schedule.

Plan Termination

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the [first] Policy year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number that was agreed upon by the Company and the Policyholder in the signed Master Application.

The Policyholder has the sole responsibility to notify you of the termination of the Plan. If the Plan terminates, it — as well as all Certificates and Riders issued under the Plan — will end on the stated termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

If the Plan ends, we will provide coverage for claims arising from Disabilities that were first Diagnosed while the Plan was in force.

Termination of [an Employee's] Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The [31]st day after the premium due date, if the premium has not been paid.
- The date you no longer meet the Plan's definition of [an Employee].
- The date you no longer belong to an eligible class.

If your coverage ends, we will provide coverage for claims that arise from short-term Disability that was first Diagnosed while your coverage was in force.

Portability Privilege

When you [end employment with the Employer] and your coverage would otherwise end, you may choose to continue your coverage under this Plan. You may continue the coverage that you had on the date your [employment] ended.

To keep your Certificate in force, you must meet the following three requirements:

- You must apply to the Company in writing within 31 days after the date your insurance would otherwise terminate.
- You must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- You must be engaged in [Full; Part]-time work.

Coverage will end:

- 31 days after the date you fail to pay any required premium, **or**
- The date this Group Plan is terminated, whichever occurs first.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate that are shown in your previously issued Certificate.]

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount that is payable on any premium due date. [The rates that are shown in this Schedule can be changed each year] [after the rate guarantee period has expired.] The Company will give the Policyholder written notice [31] days before any change in rates becomes effective.

Premium Payments

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

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

Grace Period

This Plan has a [31-day] Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next [31] days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

Section III – Definitions

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

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer’s regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

Base Annual Pay is the annual income from your [Full-Time] Job with your employer. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which you can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a “month” is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions that require Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - Acute nephritis,
 - Nephrosis,
 - Cardiac decompensation,
 - Missed abortion,
 - Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - Ectopic pregnancy that is terminated, and
 - Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- Multiple gestation pregnancy.
- False labor.
- Occasional spotting.
- Morning sickness.

Other similar conditions that are associated with a difficult pregnancy are not considered Complications of Pregnancy.

Cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit that is shown on the Benefit Schedule.

Disability

- ***Total Disability*** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your [Full-Time] Job. To qualify as Total Disability, you may not be working at any job.
- ***[Partial Disability]*** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your [Full-Time] Job. To qualify as Partial Disability, you are able to work at any job earning less than [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent of the Annual Income of your [Full-Time] Job at the time you became disabled.]

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.
- A person who is licensed to treat the type of condition for which a claim is made.

A Doctor does **not** include you or your Family Member.

Elimination Period is the number of [continuous] days at the beginning of your Period of Disability for which there are no benefits payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

[Employee] is a person who meets the eligibility requirements that are under Section I – Eligibility, and who is covered under this Plan. The [Employee] under this Plan is you.

Family Member includes anyone related to you in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law; and spouses, as applicable.

Full-Time Job refers to a job at which you work, performing your job-related duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job [or On-the-Job] bodily injury that is not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of the cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders as well as adjustment disorders. It also includes any other condition that is usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the conditions stated above.

Off-the-Job Injury means an Injury that occurs while you are not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while you are working at any job for pay or benefits.

Period of Disability means the length of time that you are either Totally Disabled or [Partially Disabled] from one or more causes. It starts the first full day of Total Disability [Partial Disability] after you cease to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date you cease to be Totally Disabled, [Partially Disabled].
- The date you return to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition. Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- [It first manifested and was first treated after the Effective Date of coverage.]
- It occurs while coverage is in force.

Treatment or **Medical Treatment** is the consultation, care, or services that are provided by a Doctor. This includes receiving any diagnostic measures as well as taking prescribed drugs and medicines.

Section IV – Benefit Provisions

The benefit amounts payable that are under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Injury and if it occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you while a claim is pending, or to use an independent consultant and Doctor’s statement to determine whether you are qualified to receive Disability benefits.**

You must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of your death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by [30, 60, 90, 120, 150, 180] days or more.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, you will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to the **same condition or a Related condition**, until [30, 60, 90, 120, 150, **180**] days after **all** the following conditions are met:

- You have been released by a Doctor from the prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within [90] days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability if they are not separated by your returning to work at a [Full-Time] Job for [1, 7, 14, 30] consecutive days, during which you are performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, you will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to an **unrelated cause**, until [1, 7, 14, 30] consecutive days after **all** the following conditions are met:

- You have been released by a Doctor from a prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within [90] days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* [or a new *Partial Disability Benefit Period* (a maximum of [3] months)], subject to a new Elimination Period.

[The Partial Disability Benefit has its own Benefit Period; it isn't subject to the Total Disability Benefit Period. You may be eligible for the Partial Disability Benefit even if you have not received the Total Disability Benefit.]

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a [Full-Time] Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within [30, 60, **90**] days of your last Treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period. It is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.

[PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a [Full-Time] Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Partial Disability within [30, 60, **90**] days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay [30, 35, 40, 45, **50**, 55, 60, 65, 70, 75, 80] percent of the Daily Disability

Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months) and is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination Period appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after the Insured returns to work earning less than [80]% of the Base Annual Pay of his [Full-Time] job.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.]

[TOTAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If you have a [Full-Time] Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within [30, 60, **90**] days of your last Treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period. It is subject to the Elimination Period that is shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your Full-Time Job, or (2) working at any job.]

[PARTIAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If you have a [Full-Time] Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If the Insured's covered On-the-Job Injury causes his Partial Disability within [30, 60, **90**] days of his last Treatment for his covered On-the-Job Injury, we will pay [30, 35, 40, 45, **50**, 55, 60, 65, 70, 75, 80] percent of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months) and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.]

[MENTAL ILLNESS LIMITED BENEFIT]

If you are Totally Disabled due to a Mental Illness, (see **Section III – Definitions**) Disability benefits will be paid for the Period of Disability shown in the Benefit Schedule, so long as you are under the regular care and attendance of a Doctor.

The Mental Illness Limited Benefit is subject to the lifetime maximum that is shown in the Benefit Schedule.]

[ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT]

If you are Totally Disabled due to alcoholism or drug addiction, Disability benefits will be paid for the Period of Disability that is shown in the Benefit Schedule.

The Alcoholism and Drug Addiction Limited Benefit is subject to the lifetime maximum that is shown in the Benefit Schedule.]

[PRE-EXISTING CONDITIONS BENEFIT

We will pay a [25; 50; 75]% benefit for any Disability that occurs after the effective date which is caused by, resulting from — or affected by — a Pre-existing Condition if the Disability occurs within the [3; 6; 12]-month period prior to your Effective Date.]

The Company will not reduce a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after your Effective Date.]

[WAIVER OF PREMIUM BENEFIT

If your covered Sickness or covered Off-the-Job Injury [or covered On-the-Job Injury] causes your Total Disability [or Partial Disability] [for more than [90, 60, 30] consecutive days] while this coverage is in force, we will waive, from month to month, the premium for the Certificate and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Benefit Schedule.

For premiums to be waived, we will require both the statement of an employer and the statement of a Doctor certifying that you are unable to perform your customary duties or activities. We may each month thereafter require a Doctor's statement that your inability to perform those duties or activities continues. We may ask for and use an independent consultant to determine your Disability when this benefit is in force.

All premiums must be paid to keep the Certificate and any applicable rider(s) in force until we approve your claim for this Waiver of Premium Benefit. Premium payments for your coverage must resume the earlier of your returning to work or within [90] days after you no longer qualify for Disability benefits.

[The Waiver of Premium Benefit is not available with a three-month Total Disability Benefit Period.]

Section V – Limitations & Exclusions Provisions

[Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, [pregnancy], or injury that existed within the [3; 6; 12]-month period before your Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated you[.], **or**
- symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.]

[We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability was diagnosed within the [3; 6; 12]-month period after your Effective Date.]

The Company will not reduce or deny a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after your Effective Date.]

[Pregnancy Limitation

Within the first [nine months] of the Effective Date of coverage, we will *not* pay benefits for a Disability that is caused by, or occurs as a result of, your Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for [nine months] from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery and eight weeks for cesarean**

delivery, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.]

[Continuity of Coverage Upon Transfer of Insurance Carriers

When we replace another carrier's plan, we provide the following Continuity of Coverage protection. We provide this coverage for loss due to a Pre-existing Condition if you were insured under the prior plan at the time of transfer.

Benefits may be payable for a loss due to a pre-existing condition if all the following conditions are met:

- You were insured by the prior carrier at the time of transfer.
- You were actively employed and insured under this Plan on its Effective Date.
- The Benefit Period and Elimination Period under your prior coverage is the same as, or less than, your Benefit Period and Elimination Period under this Plan.

The benefits will be determined as follows:

- We will apply this Plan's Pre-existing Conditions Limitation. If you qualify for benefits, you will be paid according to your Certificate's Benefit Schedule.
- If you cannot satisfy this Plan's Pre-existing Conditions Limitation, the prior carrier's pre-existing condition limitation will be applied:
 - If you satisfy the prior carrier's pre-existing condition limitation, giving consideration towards continuous time insured under both coverages, you will be paid according to the prior carrier's benefit schedule (including benefit period, elimination period, and maximum monthly benefit).
 - If you cannot satisfy the Pre-existing Conditions Limitation of this Certificate, or that of the prior carrier, no benefit will be paid.]

Limitations and Exclusions

- A.** We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- B.** We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.
- C.** We will not pay benefits for a Disability that is caused by or occurs as a result of:
1. [Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.]
 2. [Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.]
 3. [An intentionally self-inflicted Injury.]
 4. [A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.]
 5. [Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.]
 6. [Mental Illness as defined in **Section III – Definitions.**]
 7. [Alcoholism or drug addiction.]
 8. [An Injury that arises from any employment.]
 9. [Injury or Sickness that is covered by Worker's Compensation.]
 10. [Sickness or Injury for which the [Employee] is eligible to receive benefits under any sick leave (sick days) plan.]
 11. [The loss of a professional license, occupational license, or certification.]
 12. [Having cosmetic surgery or other elective procedures that are not Medically Necessary.]

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

You must give written notice of claim:

- Within 60 days after a diagnosis of Disability or
- As soon as is reasonably possible.

Notice must include your name and your Certificate number. Notice can be mailed to the Company at:
P.O. Box 427, Columbia, South Carolina, 29202.

Claim Forms

When the Company receives notice of a claim, we will send forms to you so that you can file Proof of Loss. (Details are included in the **Proof of Loss** section below.)

If the Company does not provide the forms within 15 working days, you can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. You will also need to provide a statement by the treating Doctor. You must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to all documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). You must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202.

You must provide Proof of Loss documentation within 90 days after the date of diagnosis of the Disability. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for you to provide this proof within the required time.

You must provide the proof as soon as is reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of your legal mental capacity.

Claims Payment Timeframe

Once we have received the required Proof of Loss, the Company will pay, deny, or settle each submitted claim within 30 calendar days.

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of your death, we will pay those benefits in the following order:

1. To any approved assignee.
2. To your beneficiary.
3. To your surviving spouse.
4. To your estate.

Changing of Beneficiary

You can ask us to change your beneficiary at any time. The request must be in writing, and the change must be approved by us. If approved, it will go into effect the day you sign the request. The change will not have any bearing on payments made before we approved the request.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Physical Examination and Autopsy

The Company may have you examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or for an autopsy.

Legal Action

You cannot take legal action against us for benefits under this Plan:

- Within 60 days after you have sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that you have specifically assigned the benefits of your Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If you are covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by you or your estate, as the case may be, will be effective.

We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or you have made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- the Policyholder, **or**
- you, **or**
- your beneficiary.

This will ensure that the Policyholder or you have an opportunity to review the information that is provided in the Application. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- will not be valid unless approved in writing by an executive officer of the Company.
- must be noted on or attached to the Contract.
- may not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by you to be valid.

Time Limit on Certain Defenses

After two years from the Effective Date of your coverage, no misstatements, except fraudulent misstatements, made by you in the Application shall be used to void your coverage or to deny a claim for Disability starting after the expiration of such two-year period.

[No claim for loss incurred or Disability starting after [12] months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after your coverage has been in force [12] months.]

Misstatement of Age

If your age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if your misstated age at the time of Application was outside the age limits for your coverage.

Misstatement of Occupation or Income

If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level. Any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. If a clerical error occurs, we will make a premium adjustment.

Individual Certificates

We will give the Policyholder a Certificate for each [Employee]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

Required Information

The Policyholder will furnish all information and proofs which we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII – Certificate Schedule

INSURED	GROUP POLICY NUMBER
EFFECTIVE DATE	CERTIFICATE NUMBER
INITIAL PREMIUM	FIRST RENEWAL DATE

BENEFIT PERIOD

Benefit	Benefit Period
Total Disability (Non-Occupational)	[3, 6, 12] Months
[Partial Disability]	[3] Months]
[Total Disability (24-Hour)]	[3, 6, 12] Months]
[Mental Illness Limited Benefit]	[90] Days per [12-]month period], lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit]	[90] Days per [12-]month period], lifetime maximum]

ELIMINATION PERIOD

Total and/or Partial Disability	Elimination Period
Injury	[0, 7, 14, 30, 60, 90] Days
Sickness	[7, 14, 30, 60, 90] Days

MONTHLY BENEFIT FOR DISABILITY CAUSED BY *INJURY*

BENEFIT	We will pay this amount per month:	Beginning on this date of disability:	After this Period of Elimination for <i>Injury</i> :	For a maximum Benefit Period of:
Total Disability (Non-Occupational)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days	[3, 6, 12] Months
[Partial Disability]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3] Months]
[Total Disability (24-Hour)]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3, 6, 12] Months]
[Mental Illness Limited Benefit]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period], lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period], lifetime maximum]

MONTHLY BENEFIT FOR DISABILITY CAUSED BY SICKNESS

BENEFIT	We will pay this amount per month:	Beginning on this date of disability:	After this Period of Elimination for <i>Sickness</i>:	For a maximum Benefit Period of:
Total Disability (Non-Occupational)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days	[3, 6, 12] Months
[Partial Disability	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3] Months]
[Total Disability (24-Hour)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3, 6, 12] Months]
[Mental Illness Limited Benefit	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period, lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period, lifetime maximum]



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205

800.433.3036]

GROUP SHORT-TERM DISABILITY INSURANCE POLICY

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Policy. Benefits are paid for short-term Disability caused by Sickness or Off-the-Job Injury [or On-the-Job Injury]. This Policy does not provide benefits for any other Sickness or condition.

IF THE INSURED HAS ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

ANY POLICIES ISSUED IN THE STATE OF ARKANSAS ARE GOVERNED BY THE STATE OF ARKANSAS

[ABC COMPANY, INC.] (the "Policyholder") applied for coverage under this Group Short-Term Disability Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "we," "us," or "our"). Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as *he*, *him*, and *his*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

This is a limited Plan. Please read it carefully.

This Plan becomes effective on the Effective Date at 12:01 a.m., as determined by the Policyholder's address. Plan Termination is governed by Section I. The Plan continues to be effective while premiums are paid, as provided in Section II.

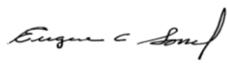
The Plan's first Anniversary Date appears below. Subsequent anniversaries will be the same date each following year.

The Policyholder may add new [Employees] from time to time, according to the Plan's terms.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown below.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

[]

[Eugene C. Sorrel, President]

Group Policy Number [1234]

Effective Date [January 1, 2012]

Jurisdiction [State Name]

Anniversary Date [January 1, 2013]

Non-Participating

Notice of Non-Insured Benefits

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services.
- Educational services.
- Benefit statement services.
- Payroll or plan administration services.

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers (such as pharmacies, optometrists, dentists, and accountants) to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

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[Section X	-	Incorporation of Rider Provisions]

Section I – Eligibility, Effective Date, Termination, and Portability

Eligibility

A person is an eligible [Employee] under this Plan if he meets **all** the following requirements:

- He is [An Employee] of the Policyholder.
- He is engaged in [full; part]-time work.
- He is included in the class of [Employees] eligible for coverage, as shown on the Application.

Effective Date

The Plan's Effective Date is shown on Page 1.

[An Employee's] Effective Date is the date his insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if the [Employee] is Actively at Work on that date.
- The date the [Employee] returns to an Actively-at-Work status if he is not Actively at Work on the date that is shown on the Certificate Schedule.

Plan Termination

The Plan may terminate for any of the following reasons.

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the [first] Policy year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application.

The Policyholder has the sole responsibility to notify [Employees] of the Plan's termination. If the Plan terminates, it—and all Certificates [and Riders] issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

If the Plan ends, we will provide coverage for claims arising from Disabilities that were first diagnosed while the Plan was in force.

Termination of [an Employee's] Insurance

[An Employee's] insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The [31]st day after the premium due date, if the premium has not been paid.
- The date he no longer meets the Plan's definition of [an Employee].
- The date he no longer belongs to an eligible class.

If an Insured's coverage ends, we will provide coverage for claims arising from short-term Disability that was first diagnosed while his coverage was in force.

Portability Privilege

When [an Employee] [ends employment with the employer] and his coverage would otherwise end, that [Employee] may choose to continue his coverage under this Plan. The [Employee] may continue the coverage that he had on the date his [employment] ended.

To keep his Certificate in force, the [Employee] must meet the following three requirements:

- He must apply to the Company in writing within 31 days after the date his insurance would otherwise terminate.
- He must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- He must be engaged in [full; part]-time work.

Coverage will end:

- 31 days after the date the [Employee] fails to pay any required premium, **or**
- The date this Group Plan is terminated, whichever occurs first.

If [an Employee] qualifies for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.]

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount payable on any premium due date. [The rates shown in this Schedule can be changed each year] [after the rate guarantee period has expired]. The Company will give the Policyholder written notice [31] days before any change in rates becomes effective.

Premium Payments

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

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

Grace Period

This Plan has a [31-day] Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next [31] days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

Section III – Definitions

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

Actively at Work refers to an Insured's ability to perform his regular employment duties for a full normal workday. The Insured may perform these activities either at his employer's regular place of business or at a location where the Insured may be required to travel to perform the regular duties of his employment.

Base Annual Pay is the [Employee's] annual income from his [Full-Time] Job with the Policyholder. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which the Insured can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a "month" is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions requiring Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - Acute nephritis,
 - Nephrosis,
 - Cardiac decompensation,
 - Missed abortion,
 - Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - Ectopic pregnancy that is terminated, and
 - Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- multiple gestation pregnancy.
- false labor.
- occasional spotting.
- morning sickness.

Other similar conditions associated with a difficult pregnancy are not considered Complications of Pregnancy.

Cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit shown on the Benefit Schedule.

Disability

- **Total Disability** refers to the Insured's being under the care and attendance of a Doctor due to a condition that causes his inability to perform the material and substantial duties of his [Full-Time] Job with the employer. To qualify as Total Disability, the Insured may not be working at any job.

- **[Partial Disability]** refers to the Insured's being under the care and attendance of a Doctor due to a condition that causes his inability to perform the material and substantial duties of his [Full-Time] Job. To qualify as Partial Disability, the Insured is able to work at any job earning less than [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80] percent of the Base Annual Pay of his [Full-Time] Job at the time he became disabled.]

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.
- A person who is licensed to treat the type of condition for which a claim is made.

A Doctor does **not** include the Insured or the Insured's Family Member.

Elimination Period is the number of [continuous] days at the beginning of the Insured's Period of Disability for which no benefits are payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

[Employee] is a person who meets eligibility requirements under **Section I – Eligibility**, and who is covered under this Plan. The [Employee] is the Insured under this Plan.

Family Member includes anyone related to the Insured in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law; and spouses, as applicable.

Full-Time Job refers to a job at which the Insured works, performing his occupational duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job [or On-the-Job] bodily injury not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective. The Insured is named on his Certificate Schedule. The Insured is always the covered eligible [Employee] under an employer group Policy.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders and adjustment disorders. It also includes any other condition usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

Off-the-Job Injury means an Injury that occurs while the Insured is not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while the Insured is working at any job for pay or benefits.

Period of Disability means the length of time the Insured is either Totally Disabled or [Partially Disabled] from one or more causes. It starts the first full day of Total Disability [Partial Disability] after the Insured ceases to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date the Insured ceases to be Totally Disabled [Partially Disabled].
- The date the Insured returns to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition. Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- [It first manifested and was first treated after the Effective Date of coverage.]
- It occurs while coverage is in force.

Treatment or Medical Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Section IV – Benefit Provisions

The benefit amounts payable under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if the Insured’s Disability is caused by a covered Sickness or covered Injury and occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with the Insured while a claim is pending, or to use an independent consultant and Doctor’s statement to determine whether the Insured is qualified to receive Disability benefits.**

The Insured must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of the Insured’s death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by [30, 60, 90, 120, 150, 180] days or more.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, the Insured will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to the **same condition or a related condition**, until [30, 60, 90, 120, 150, **180**] days after **all** the following conditions are met:

- He has been released by a Doctor from the prior Disability.
- He is no longer disabled.
- He is no longer qualified to receive any Disability benefits under this Policy.

After his Disability Benefit Period, the Insured may continue his coverage if **all** the following conditions are met:

- He returns to work within [90] days after his Benefit Period ends.
- Premium payments for his coverage resumes upon his return to work.
- The group Policy is still in force upon his return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability if they are not separated by the Insured's returning to work at a [Full-Time] Job for [1, 7, 14, 30] consecutive days, during which he is performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, the Insured will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to an **unrelated cause**, until [1, 7, 14, 30] consecutive days after **all** the following conditions are met:

- He has been released by a Doctor from a prior Disability.
- He is no longer disabled.
- He is no longer qualified to receive any Disability benefits under this Policy.

After his Disability Benefit Period, the Insured may continue his coverage if **all** the following conditions are met:

- He returns to work within [90] days after his Benefit Period ends.
- Premium payments for his coverage resumes upon his return to work.
- The group Policy is still in force upon his return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* [or a new *Partial Disability Benefit Period* (a maximum of [3] months)], subject to a new Elimination Period.

[The Partial Disability Benefit has its own Benefit Period; it is not subject to the Total Disability Benefit Period. An insured may be eligible for the Partial Disability Benefit even if he had not received the Total Disability Benefit.]

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If the Insured has a [Full-Time] Job at the time of his Sickness or Off-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Total Disability within [30, 60, **90**] days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay him the Daily Disability Benefit for each day of his Total Disability. This benefit is payable up to the Total Disability Benefit Period and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied. Also see the Uniform Provision titled "Term," and the definition of "Benefit Period."

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of his pre-Disability Base Annual Pay.

[PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If the Insured has a [Full-Time] Job at the time of his Sickness or Off-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered Sickness or covered Off-the-Job Injury causes his Partial Disability within [30, 60, **90**] days of his last Treatment for his covered Sickness or covered Off-the-Job Injury, we will pay one-half of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months) and is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination Period appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after the Insured returns to work earning less than [80]% of the Base Annual Pay of his [Full-Time] job.

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of his pre-Disability Annual Income.]

[TOTAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If the Insured has a [Full-Time] Job at the time of his On-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered On-the-Job Injury causes his Total Disability within [30, 60, **90**] days of his last Treatment for his covered On-the-Job Injury, we will pay him the Daily Disability Benefit for each day of his Total Disability. This benefit is payable up to the Total Disability Benefit Period and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his Full-Time Job, or (2) working at any job.]

[PARTIAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If the Insured has a [Full-Time] Job at the time of his On-the-Job Injury, we will insure him as follows while coverage is in force:

If the Insured's covered On-the-Job Injury causes his Partial Disability within [30, 60, **90**] days of his last Treatment for his covered On-the-Job Injury, we will pay one-half of the Daily Disability Benefit for each day of his Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months) and is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

The Insured will no longer be qualified to receive this benefit upon the earlier of his: (1) being released by his Doctor to perform the material and substantial duties of his [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of his pre-Disability Base Annual Pay.]

[MENTAL ILLNESS LIMITED BENEFIT]

If the Insured is Totally Disabled due to a Mental Illness, (see **Section III – Definitions**) Disability benefits will be paid for the Period of Disability shown in the Benefit Schedule, provided that the Insured is under the regular care and attendance of a Doctor.

The Mental Illness Limited Benefit is subject to the lifetime maximum shown in the Benefit Schedule.]

[ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT]

If the Insured is Totally Disabled due to alcoholism or drug addiction, Disability benefits will be paid for the Period of Disability shown in the Benefit Schedule.

The Alcoholism and Drug Addiction Limited Benefit is subject to the lifetime maximum shown in the Benefit Schedule.]

[PRE-EXISTING CONDITIONS BENEFIT]

We will pay a [25; 50; 75]% benefit for any Disability occurring after the effective date which is caused by, resulting from — or affected by — a Pre-existing Condition if the Disability occurs within the [3; 6; 12]-month period prior to the Insured's Effective Date.

The Company will not reduce a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after the Insured's Effective Date.]

[WAIVER OF PREMIUM BENEFIT

If the Insured's covered Sickness or covered Off-the-Job Injury [or covered On-the-Job Injury] causes his Total Disability [or Partial Disability] [for more than [90, 60, 30] consecutive days] while this coverage is in force, we will waive, from month to month, the premium for the Certificate and any applicable rider(s) for as long as he remains disabled, up to the applicable Benefit Period shown in the Benefit Schedule.

For premiums to be waived, we will require an employer's statement and a Doctor's statement certifying the Insured's inability to perform his customary duties or activities, and may each month thereafter require a Doctor's statement that his inability to perform those duties or activities continues. We may ask for and use an independent consultant to determine the Insured's Disability when this benefit is in force.

All premiums must be paid to keep an Insured's Certificate and any applicable rider(s) in force until we approve his claim for this Waiver of Premium Benefit. Premium payments for the Insured must resume the earlier of his returning to work or within [90] days after he no longer qualifies for Disability benefits.

[The Waiver of Premium Benefit is not available with a three-month Total Disability Benefit Period.]

Section V – Limitations & Exclusions Provisions

[Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, [pregnancy], or injury that existed within the [3; 6; 12]-month period before the Insured's Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated the Insured[.], **or**
- symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.]

[We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability was diagnosed within the [3; 6; 12]-month period after the Insured's Effective Date.]

The Company will not reduce or deny a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after the Insured's Effective Date.]

[Pregnancy Limitation

Within the first [nine months] of the Effective Date of coverage, we will *not* pay benefits for a Disability that is caused by, or occurs as a result of, the Insured's Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for [nine months] from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery** and **eight weeks for cesarean delivery**, less the Elimination Period, unless the Insured furnishes proof that her Disability continues beyond these time frames due to Complications of Pregnancy.]

[Continuity of Coverage Upon Transfer of Insurance Carriers

When we replace another carrier's plan, we provide the following Continuity of Coverage protection. We provide this coverage for loss due to a Pre-existing Condition for covered [Employees] who were insured under the prior plan at the time of transfer.

Benefits may be payable for a loss due to a pre-existing condition for [an Employee] if **all** of the following conditions are met:

- He was insured by the prior carrier at the time of transfer.
- He was actively employed and insured under this Plan on its Effective Date.
- His Benefit Period and Elimination Period under his prior coverage is the same as, or less than, his Benefit Period and Elimination Period under this Plan.

The benefits will be determined as follows:

- We will apply this Plan's Pre-existing Conditions Limitation. If the [Employee] qualifies for benefits, he will be paid according to his Certificate's Benefit Schedule.
- If the [Employee] cannot satisfy this Plan's Pre-existing Conditions Limitation, the prior carrier's pre-existing condition limitation will be applied:
 - If the [Employee] satisfies the prior carrier's pre-existing condition limitation, giving consideration towards continuous time insured under both policies, he will be paid according to the prior carrier's benefit schedule (including benefit period, elimination period, and maximum monthly benefit).
 - If he cannot satisfy the Pre-existing Conditions Limitation of this Policy, or that of the prior carrier, no benefit will be paid.]

Limitations and Exclusions

- A. We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- B. We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which the Insured received benefits that were not lawfully due and that fraudulently induced payment.
- C. We will not pay benefits for a Disability that is caused by or occurs as a result of:
1. [Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.]
 2. [Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.]
 3. [An intentionally self-inflicted Injury.]
 4. [A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.]
 5. [Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.]
 6. [Mental Illness as defined in **Section III – Definitions.**]
 7. [Alcoholism or drug addiction.]
 8. [An Injury arising from any employment.]
 9. [Injury or Sickness covered by Worker's Compensation.]
 10. [Sickness or Injury for which the [Employee] is eligible to receive benefits under any sick leave (sick days) plan.]
 11. [Loss of a professional license, occupational license, or certification.]
 12. [Having cosmetic surgery or other elective procedures that are not Medically Necessary.]

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

The Insured must give written notice of claim:

- Within 60 days after a diagnosis of Disability **or**
- As soon as reasonably possible.

Notice must include the Insured's name and the Certificate number. Notice can be mailed to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202.

Claim Forms

When the Company receives notice of a claim, we will send the Insured forms so that he can file Proof of Loss (details included in the **Proof of Loss** section below).

If the Company does not provide the forms within 15 working days, the Insured can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. The Insured will also need to provide a statement by the treating Doctor. The Insured must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to all documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). The Insured must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202.

The Insured must provide Proof of Loss documentation within 90 days after the date of diagnosis of the Disability. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for the Insured to provide this proof within the required time.

The Insured must provide the proof as soon as reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of the Insured's legal mental capacity.

Claims Payment Timeframe

Once we receive the required Proof of Loss, the Company will pay, deny, or settle each submitted claim within 30 calendar days.

Payment of Claims

We will pay all benefits to the Insured unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

1. To any approved assignee.
2. To the Insured's beneficiary.
3. To the Insured's surviving spouse.
4. To the Insured's estate.

Changing of Beneficiary

The Insured can ask us to change his beneficiary at any time. The request must be in writing, and the change must be approved by us. If approved, it will go into effect the day the Insured signs the request. The change will not have any bearing on payments made before we approved the request.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Physical Examination and Autopsy

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Legal Action

The Insured cannot take legal action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of the Insured's benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that the Insured has specifically assigned the benefits of his Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If the Insured is covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by the Insured or the Insured's estate, as the case may be, will be effective. We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or an Insured has made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- the Policyholder, **or**
- the Insured, **or**
- the Insured's beneficiary.

This will ensure that Policyholders or Insureds have an opportunity to review the information they have provided in their Applications. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- will not be valid unless approved in writing by an executive officer of the Company.
- must be noted on or attached to the Contract.
- may not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by the Insured to be valid.

Time Limit on Certain Defenses

After two years from the Effective Date of the Insured's coverage, no misstatements, except fraudulent misstatements, made by the Insured in the Application shall be used to void his coverage or to deny a claim for Disability commencing after the expiration of such two-year period.

[No claim for loss incurred or Disability commencing after [12] months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the Insured's coverage has been in force [12] months.]

Misstatement of Age

If the Insured's age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if the Insured's misstated age at the time of Application was outside the age limits for his coverage.

Misstatement of Occupation or Income

If the Insured's occupation has been misstated, the benefits will be those that the premiums paid would have purchased for his correct occupation. If his income has been misstated, the benefit payable will be that which would have been allowed for his true income level, and any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, we will make a premium adjustment.

Individual Certificates

We will give the Policyholder a Certificate for each [Employee]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

Required Information

The Policyholder will furnish all information and proofs which we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII – Benefit Schedule

ELIGIBILITY

[All [Full-Time] [Employees] working at least [19] hours or more weekly, who are Actively at Work[, and have completed at least [6] months of continuous employment with the Policyholder].]

BENEFIT PERIOD

Benefit	Benefit Period
Total Disability (Non-Occupational)	[3, 6, 12] Months
[Partial Disability	[3] Months]
[Total Disability (24-Hour)	[3, 6, 12] Months]
[Mental Illness Limited Benefit	[90] Days per [12-]month period, lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit	[90] Days per [12-]month period, lifetime maximum]

ELIMINATION PERIOD

Total and/or Partial Disability	Elimination Period
Injury	[0, 7, 14, 30, 60, 90] Days
Sickness	[7, 14, 30, 60, 90] Days

Section IX – Schedule of Premiums

The Monthly Benefit Amount for Total Disability issued is subject to [60%] of the eligible [Employee's] Base Annual Pay.*

BENEFIT AMOUNTS

Minimum	[5] units (\$500/Month)
Maximum	[60] units (\$6,000/Month)
The percentage of income replacement may vary for state-sponsored disability programs for [Employees] who reside in: California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island	

***Base Annual Pay** is the [Employee's] annual income from his [Full-Time] Job with his employer. This pay excludes overtime pay, bonuses, or any other special pay.

[The maximum benefit for which the [Employee] is eligible to apply will be reduced by any other group, individual, or franchise Disability Income coverage to be continued.]

Any increase in the Monthly Disability Benefit due to an increase in earnings is subject to written Application to and acceptance by Continental American Insurance Company. Evidence of insurability may be required.

PREMIUMS

The table below shows the premiums applicable to the Plan on the Effective Date. The rates shown are for each \$100.00 of monthly benefit amount [and include the rate for Partial Disability Benefits]. Rates can be changed [annually].

Ages	Units	Monthly Rate per \$100 of Monthly Benefit
[[18-49]	\$100	\$xx.xx]
[[50-59]	\$100	\$xx.xx]
[[60-74]	\$100	\$xx.xx]

[Section X – Incorporation of Rider Provisions

The attached listed Certificate Riders are made a part of this Plan.

Rider Name

[rider name

Form Number

form number]]



CONTINENTAL AMERICAN INSURANCE COMPANY

[2801 Devine Street, Columbia, South Carolina 29205

800.433.3036]

GROUP SHORT-TERM DISABILITY INSURANCE CERTIFICATE

This coverage only pays benefits for short-term Disability as listed in the Benefit Schedule of this Certificate. Benefits are paid for short-term Disability that is caused by Sickness or Off-the-Job Injury [or On-the-Job Injury]. This Certificate does not provide benefits for any other Sickness or condition.

IF YOU HAVE ANY OTHER DISABILITY BENEFIT IN FORCE WITH US, ONLY ONE DISABILITY BENEFIT IS PAYABLE.

ANY CERTIFICATES ISSUED IN THE STATE OF ARKANSAS ARE GOVERNED BY THE STATE OF ARKANSAS

[ABC COMPANY, INC.] (“the Policyholder”) applied for coverage under this Group Short-Term Disability Insurance Policy (the “Plan”). This Plan is issued by Continental American Insurance Company (the “Company,” “we,” “us,” or “our”). For the purpose of this Plan, “you” (including “your” and “yours”) refers to you. Based on the Application and based on the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. Your Application is maintained on file and made part of this Certificate. (Please note that male pronouns—such as *you*, *you*, and *your*—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. These refer to terms with very specific definitions as they apply to this insurance Plan.

Please read your Certificate carefully.

We certify that you are insured under the Group Short-Term Disability Insurance Policy (the “Plan”). The Plan was issued to your [Employer], the Policyholder. This coverage provides benefits for loss resulting from short-term disability. The Certificate is subject to the definitions, exclusions, and other provisions of the Plan.

Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Certificate Effective Date is shown in the Certificate Schedule. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

Notice of Non-Insured Benefits

From time to time, Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for CAIC coverage or who become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services.
- Educational services.
- Benefit statement services.
- Payroll or plan administration services.

The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, as well as related services.

In addition, CAIC may arrange for third-party service providers (such as pharmacies, optometrists, dentists, and accountants) to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

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Section I – Eligibility, Effective Date, Termination, and Portability

Eligibility

You are an eligible [Employee] under this Plan if you meet **all** the following requirements:

- You are [An Employee] of the Policyholder.
- You are engaged in [full; part]-time work.
- You are included in the class of [Employees] that are eligible for coverage, as shown on the Application.

Effective Date

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

Your Certificate Effective Date is the date your insurance takes effect. That date is **one of** the two following dates:

- The date that is shown on the Certificate Schedule if you are Actively at Work on that date.
- The date you return to an Actively-at-Work status if you are not Actively at Work on the date that is shown on the Certificate Schedule.

Plan Termination

The Plan may terminate for any of the following reasons:

- The premium is not paid before the end of the Grace Period.
- The Company cancels the Plan any time after the end of the [first] Policy year. To do this, the Company must give 31 days' written notice.
- The number of participating [Employees] is less than the number that was agreed upon by the Company and the Policyholder in the signed Master Application.

The Policyholder has the sole responsibility to notify you of the termination of the Plan. If the Plan terminates, it — as well as all Certificates and Riders issued under the Plan — will end on the stated termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

If the Plan ends, we will provide coverage for claims arising from Disabilities that were first Diagnosed while the Plan was in force.

Termination of [an Employee's] Insurance

Your insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The [31]st day after the premium due date, if the premium has not been paid.
- The date you no longer meet the Plan's definition of [an Employee].
- The date you no longer belong to an eligible class.

If your coverage ends, we will provide coverage for claims that arise from short-term Disability that was first Diagnosed while your coverage was in force.

Portability Privilege

When you [end employment with the Employer] and your coverage would otherwise end, you may choose to continue your coverage under this Plan. You may continue the coverage that you had on the date your [employment] ended.

To keep your Certificate in force, you must meet the following three requirements:

- You must apply to the Company in writing within 31 days after the date your insurance would otherwise terminate.
- You must pay the required premium — the premium in effect at the time of port — to the Company no later than 31 days after the date the Certificate would otherwise terminate and on each premium due date thereafter.
- You must be engaged in [Full; Part]-time work.

Coverage will end:

- 31 days after the date you fail to pay any required premium, **or**
- The date this Group Plan is terminated, whichever occurs first.

If you qualify for this Portability Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate that are shown in your previously issued Certificate.]

Section II – Premium Provisions

Premium Calculations

The Schedule of Premiums determines the premium amount that is payable on any premium due date. [The rates that are shown in this Schedule can be changed each year] [after the rate guarantee period has expired.] The Company will give the Policyholder written notice [31] days before any change in rates becomes effective.

Premium Payments

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

Aggregate premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

Grace Period

This Plan has a [31-day] Grace Period. If a renewal premium is not paid on or before its due date, the premium may be paid during the next [31] days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan.

Section III – Definitions

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

Actively at Work refers to your ability to perform your regular employment duties for a full normal workday. You may perform these activities either at your employer’s regular place of business or at a location where you may be required to travel to perform the regular duties of your employment.

Base Annual Pay is the annual income from your [Full-Time] Job with your employer. This pay excludes overtime pay, bonuses, or any other special pay.

Benefit Period is the maximum number of days *after* the Elimination Period, if any, for which you can be paid benefits for any Period of Disability. Each new Benefit Period is subject to a new Elimination Period. See the Benefit Schedule for the Benefit Period.

For the purposes of this calculation, a “month” is defined as 30 days for which benefits are paid.

Complications of Pregnancy refers to:

- Conditions that require Medical Treatment that comes before or comes after the termination of a pregnancy. The diagnoses for this Medical Treatment must be distinct from pregnancy but either adversely affected by pregnancy or caused by pregnancy. For a condition to be a Complication of Pregnancy, it must constitute a classifiably distinct pregnancy complication. Examples of such Complications of Pregnancy are:
 - Acute nephritis,
 - Nephrosis,
 - Cardiac decompensation,
 - Missed abortion,
 - Disease of the vascular, hemopoietic, nervous, or endocrine systems, and
 - Similar medical and surgical conditions of comparable severity.
- Further Complications of Pregnancy include:
 - Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement,
 - Ectopic pregnancy that is terminated, and
 - Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy *do not include* the following conditions:

- Multiple gestation pregnancy.
- False labor.
- Occasional spotting.
- Morning sickness.

Other similar conditions that are associated with a difficult pregnancy are not considered Complications of Pregnancy.

Cesarean deliveries are not considered Complications of Pregnancy.

Daily Disability Benefit is one-thirtieth of the applicable monthly Disability benefit that is shown on the Benefit Schedule.

Disability

- ***Total Disability*** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your [Full-Time] Job. To qualify as Total Disability, you may not be working at any job.
- ***[Partial Disability]*** refers to your being under the care and attendance of a Doctor due to a condition that causes your inability to perform the material and substantial duties of your [Full-Time] Job. To qualify as Partial Disability, you are able to work at any job earning less than [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent of the Annual Income of your [Full-Time] Job at the time you became disabled.]

Doctor is defined as a person who meets **all** the following criteria:

- A person who is legally qualified to practice medicine.
- A person who is licensed as a physician by the state where Treatment is received.
- A person who is licensed to treat the type of condition for which a claim is made.

A Doctor does **not** include you or your Family Member.

Elimination Period is the number of [continuous] days at the beginning of your Period of Disability for which there are no benefits payable. See the Benefit Schedule for the Elimination Period. Each new Benefit Period is subject to a new Elimination Period.

[Employee] is a person who meets the eligibility requirements that are under Section I – Eligibility, and who is covered under this Plan. The [Employee] under this Plan is you.

Family Member includes anyone related to you in the following manner: spouse, brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren, father- or mother-in-law; and spouses, as applicable.

Full-Time Job refers to a job at which you work, performing your job-related duties for pay or benefits, for the required number of hours per week. This requirement appears under the Eligibility section of the Benefit Schedule.

Injury refers to an Off-the-Job [or On-the-Job] bodily injury that is not otherwise excluded. An Injury meets **all** the following criteria:

- It is directly caused by a covered accident.
- It is not caused by Sickness, disease, bodily infirmity, or any other cause.
- It occurs on or after the Effective Date of coverage and while coverage is in force.

Insured means the eligible person whose coverage under the Certificate becomes effective.

Medically Necessary refers to Treatment, services, or supplies that are necessary and appropriate for the diagnosis or Treatment of a Sickness or an Injury based upon generally accepted medical practice.

Mental Illness is defined as a Total Disability resulting from psychiatric or psychological conditions, regardless of the cause. Mental Illness includes but is not limited to the following: bipolar affective disorder (manic-depressive syndrome), delusional (paranoid) disorders, psychotic disorders, somatoform disorders (psychosomatic illness), eating disorders, schizophrenia, anxiety disorders, depression, stress, post-partum depression, personality disorders as well as adjustment disorders. It also includes any other condition that is usually treated by a Doctor, mental health provider, or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the conditions stated above.

Off-the-Job Injury means an Injury that occurs while you are not working at any job for pay or benefits.

On-the-Job Injury means an Injury that occurs while you are working at any job for pay or benefits.

Period of Disability means the length of time that you are either Totally Disabled or [Partially Disabled] from one or more causes. It starts the first full day of Total Disability [Partial Disability] after you cease to be Actively at Work for the Policyholder. It ends on the **earlier** of the following two dates:

- The date you cease to be Totally Disabled, [Partially Disabled].
- The date you return to an Actively at Work status for any employer.

Sickness refers to a covered illness, disease, infection, or any other abnormal physical condition. Sickness must meet **all** the following criteria:

- It must not be caused by an Injury.
- [It first manifested and was first treated after the Effective Date of coverage.]
- It occurs while coverage is in force.

Treatment or **Medical Treatment** is the consultation, care, or services that are provided by a Doctor. This includes receiving any diagnostic measures as well as taking prescribed drugs and medicines.

Section IV – Benefit Provisions

The benefit amounts payable that are under this section are shown in the Benefit Schedule.

We will pay the following benefits, as applicable, if your Disability is caused by a covered Sickness or covered Injury and if it occurs while this coverage is in force. All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations, and other Policy terms.

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury. **We reserve the right to meet with you while a claim is pending, or to use an independent consultant and Doctor’s statement to determine whether you are qualified to receive Disability benefits.**

You must be under the care and attendance of a Doctor for these benefits to be payable. Benefits will cease on the date of your death.

Separate Periods of Disability

SAME OR RELATED CONDITION

Separate Periods of Disability resulting from the **same condition or a related condition** are considered a continuation of the prior Disability if they are not separated by [30, 60, 90, 120, 150, 180] days or more.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, you will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to the **same condition or a Related condition**, until [30, 60, 90, 120, 150, **180**] days after **all** the following conditions are met:

- You have been released by a Doctor from the prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within [90] days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

UNRELATED CAUSES

Separate Periods of Disability resulting from **unrelated causes** are considered a continuation of the prior Disability if they are not separated by your returning to work at a [Full-Time] Job for [1, 7, 14, 30] consecutive days, during which you are performing the material and substantial duties of that job.

Once the maximum *Total Disability Benefit Period* [or maximum *Partial Disability Benefit Period*] has been paid, you will not be eligible for a new *Total Disability Benefit Period* [or for a new *Partial Disability Benefit Period*] for Disability due to an **unrelated cause**, until [1, 7, 14, 30] consecutive days after **all** the following conditions are met:

- You have been released by a Doctor from a prior Disability.
- You are no longer disabled.
- You are no longer qualified to receive any Disability benefits under this Certificate.

After your Disability Benefit Period, you may continue your coverage if **all** the following conditions are met:

- You return to work within [90] days after your Benefit Period ends.
- Premium payments for your coverage resume upon your return to work.
- The group Policy is still in force upon your return to work.

Periods of Disability meeting either of these separation requirements will begin a new *Total Disability Benefit Period* [or a new *Partial Disability Benefit Period* (a maximum of [3] months)], subject to a new Elimination Period.

[The Partial Disability Benefit has its own Benefit Period; it isn't subject to the Total Disability Benefit Period. You may be eligible for the Partial Disability Benefit even if you have not received the Total Disability Benefit.]

TOTAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a [Full-Time] Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Total Disability within [30, 60, **90**] days of your last Treatment for your covered Sickness or covered Off-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period. It is subject to the Elimination Period shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.

[PARTIAL DISABILITY BENEFIT: SICKNESS or OFF-THE-JOB INJURY

If you have a [Full-Time] Job at the time of your Sickness or Off-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered Sickness or covered Off-the-Job Injury causes your Partial Disability within [30, 60, **90**] days of your last Treatment for your covered Sickness or covered Off-the-Job Injury, we will pay one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months). It is subject to the Elimination Period. The Partial Disability Benefit Period and the Elimination

Period both appear in the Benefit Schedule. The Partial Disability Benefit Period begins after the Elimination Period has been satisfied and after you return to work earning less than [80]% of the Base Annual Pay of your [Full-Time] job.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.]

[TOTAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If you have a [Full-Time] Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Total Disability within [30, 60, **90**] days of your last Treatment for your covered On-the-Job Injury, we will pay you the Daily Disability Benefit for each day of your Total Disability. This benefit is payable up to the Total Disability Benefit Period. It is subject to the Elimination Period that is shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied.

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your Full-Time Job, or (2) working at any job.]

[PARTIAL DISABILITY BENEFIT: ON-THE-JOB INJURY]

If you have a [Full-Time] Job at the time of your On-the-Job Injury, we will insure you as follows while coverage is in force:

If your covered On-the-Job Injury causes your Partial Disability within [30, 60, **90**] days of your last Treatment for your covered On-the-Job Injury, we will pay one-half of the Daily Disability Benefit for each day of your Partial Disability. This benefit is payable up to the Partial Disability Benefit Period (a maximum period of [3] months). It is subject to the Elimination Period that is shown in the Benefit Schedule. The Total Disability Benefit Period begins after the Elimination Period has been satisfied. Also see the Uniform Provision titled “Term” and the definition of “Benefit Period.”

You will no longer be qualified to receive this benefit upon the earlier of your: (1) being released by your Doctor to perform the material and substantial duties of your [Full-Time] Job, or (2) working at any job earning [30, 35, 40, 45, 50, 55, 60, 65, 70, 75, **80**] percent or more of your pre-Disability Annual Income.]

[MENTAL ILLNESS LIMITED BENEFIT]

If you are Totally Disabled due to a Mental Illness, (see **Section III – Definitions**) Disability benefits will be paid for the Period of Disability shown in the Benefit Schedule, so long as you are under the regular care and attendance of a Doctor.

The Mental Illness Limited Benefit is subject to the lifetime maximum that is shown in the Benefit Schedule.]

[ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT]

If you are Totally Disabled due to alcoholism or drug addiction, Disability benefits will be paid for the Period of Disability that is shown in the Benefit Schedule.

The Alcoholism and Drug Addiction Limited Benefit is subject to the lifetime maximum that is shown in the Benefit Schedule.]

[PRE-EXISTING CONDITIONS BENEFIT

We will pay a [25; 50; 75]% benefit for any Disability that occurs after the effective date which is caused by, resulting from — or affected by — a Pre-existing Condition if the Disability occurs within the [3; 6; 12]-month period prior to your Effective Date.]

The Company will not reduce a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after your Effective Date.]

[WAIVER OF PREMIUM BENEFIT

If your covered Sickness or covered Off-the-Job Injury [or covered On-the-Job Injury] causes your Total Disability [or Partial Disability] [for more than [90, 60, 30] consecutive days] while this coverage is in force, we will waive, from month to month, the premium for the Certificate and any applicable rider(s) for as long as you remain disabled, up to the applicable Benefit Period shown in the Benefit Schedule.

For premiums to be waived, we will require both the statement of an employer and the statement of a Doctor certifying that you are unable to perform your customary duties or activities. We may each month thereafter require a Doctor's statement that your inability to perform those duties or activities continues. We may ask for and use an independent consultant to determine your Disability when this benefit is in force.

All premiums must be paid to keep the Certificate and any applicable rider(s) in force until we approve your claim for this Waiver of Premium Benefit. Premium payments for your coverage must resume the earlier of your returning to work or within [90] days after you no longer qualify for Disability benefits.

[The Waiver of Premium Benefit is not available with a three-month Total Disability Benefit Period.]

Section V – Limitations & Exclusions Provisions

[Pre-Existing Conditions Limitation

Pre-existing Condition is an illness, disease, infection, disorder, [pregnancy], or injury that existed within the [3; 6; 12]-month period before your Effective Date. For a condition to have been Pre-existing:

- a Doctor must have advised, diagnosed, or treated you[.], **or**
- symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.]

[We will **not** pay benefits for any Disability resulting from or affected by a Pre-existing Condition if the Disability was diagnosed within the [3; 6; 12]-month period after your Effective Date.]

The Company will not reduce or deny a claim for benefits for any Disability that was diagnosed more than [3; 6; 12] months after your Effective Date.]

[Pregnancy Limitation

Within the first [nine months] of the Effective Date of coverage, we will *not* pay benefits for a Disability that is caused by, or occurs as a result of, your Pregnancy or childbirth. Disability due to Complications of Pregnancy will be covered to the same extent as a covered Sickness.

After this coverage has been in force for [nine months] from the Effective Date of coverage, Disability benefits for childbirth *will be* payable. The maximum Period of Disability allowed for Disability due to childbirth is **six weeks for noncesarean delivery** and **eight weeks for cesarean delivery**, less the Elimination Period, unless you furnish proof that your Disability continues beyond these time frames due to Complications of Pregnancy.]

[Continuity of Coverage Upon Transfer of Insurance Carriers

When we replace another carrier's plan, we provide the following Continuity of Coverage protection. We provide this coverage for loss due to a Pre-existing Condition if you were insured under the prior plan at the time of transfer.

Benefits may be payable for a loss due to a pre-existing condition if all the following conditions are met:

- You were insured by the prior carrier at the time of transfer.
- You were actively employed and insured under this Plan on its Effective Date.
- The Benefit Period and Elimination Period under your prior coverage is the same as, or less than, your Benefit Period and Elimination Period under this Plan.

The benefits will be determined as follows:

- We will apply this Plan's Pre-existing Conditions Limitation. If you qualify for benefits, you will be paid according to your Certificate's Benefit Schedule.
- If you cannot satisfy this Plan's Pre-existing Conditions Limitation, the prior carrier's pre-existing condition limitation will be applied:
 - If you satisfy the prior carrier's pre-existing condition limitation, giving consideration towards continuous time insured under both coverages, you will be paid according to the prior carrier's benefit schedule (including benefit period, elimination period, and maximum monthly benefit).
 - If you cannot satisfy the Pre-existing Conditions Limitation of this Certificate, or that of the prior carrier, no benefit will be paid.]

Limitations and Exclusions

- A. We will not pay benefits whenever coverage provided by this Policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.
- B. We will not pay benefits whenever fraud is committed in making a claim under this coverage or any prior claim under any other Aflac coverage for which you received benefits that were not lawfully due and that fraudulently induced payment.
- C. We will not pay benefits for a Disability that is caused by or occurs as a result of:
 1. [Any act of war, declared or undeclared; insurrection; rebellion; or act of participation in a riot.]
 2. [Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.]
 3. [An intentionally self-inflicted Injury.]
 4. [A commission of a crime for which the Insured has been convicted; we will not pay a benefit for any Period of Disability during which the Insured is incarcerated.]
 5. [Travel in, or jumping or descent from any aircraft, except when a fare-paying passenger in a licensed passenger aircraft.]
 6. [Mental Illness as defined in **Section III – Definitions.**]
 7. [Alcoholism or drug addiction.]
 8. [An Injury that arises from any employment.]
 9. [Injury or Sickness that is covered by Worker's Compensation.]
 10. [Sickness or Injury for which the [Employee] is eligible to receive benefits under any sick leave (sick days) plan.]
 11. [The loss of a professional license, occupational license, or certification.]
 12. [Having cosmetic surgery or other elective procedures that are not Medically Necessary.]

Benefits will be paid for only one Disability at a time, even if the Disability is caused by more than one Sickness, more than one Injury, or a Sickness and an Injury.

Section VI – Claim Provisions

Notice of Claim

You must give written notice of claim:

- Within 60 days after a diagnosis of Disability **or**
- As soon as is reasonably possible.

Notice must include your name and your Certificate number. Notice can be mailed to the Company at:
P.O. Box 427, Columbia, South Carolina, 29202.

Claim Forms

When the Company receives notice of a claim, we will send forms to you so that you can file Proof of Loss. (Details are included in the **Proof of Loss** section below.)

If the Company does not provide the forms within 15 working days, you can meet Proof of Loss requirements by providing a written statement about the nature and extent of the loss. You will also need to provide a statement by the treating Doctor. You must provide this information within the time limit stated in the **Proof of Loss** section.

Proof of Loss

Proof of Loss refers to all documentation that supports a claim (this information is often found in standardized medical documents, such as hospital bills and operative reports). You must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202.

You must provide Proof of Loss documentation within 90 days after the date of diagnosis of the Disability. However, the Company will not invalidate or reduce any claim if it was not reasonably possible for you to provide this proof within the required time.

You must provide the proof as soon as is reasonably possible. The Company will not accept proof any later than one year and three months after diagnosis of the Disability, except in the absence of your legal mental capacity.

Claims Payment Timeframe

Once we have received the required Proof of Loss, the Company will pay, deny, or settle each submitted claim within 30 calendar days.

Payment of Claims

We will pay all benefits to you unless otherwise assigned. For any benefits that remain unpaid at the time of your death, we will pay those benefits in the following order:

1. To any approved assignee.
2. To your beneficiary.
3. To your surviving spouse.
4. To your estate.

Changing of Beneficiary

You can ask us to change your beneficiary at any time. The request must be in writing, and the change must be approved by us. If approved, it will go into effect the day you sign the request. The change will not have any bearing on payments made before we approved the request.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Physical Examination and Autopsy

The Company may have you examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or for an autopsy.

Legal Action

You cannot take legal action against us for benefits under this Plan:

- Within 60 days after you have sent us written Proof of Loss; **or**
- More than 3 years from the time written proof is required to be given.

Section VII – General Provisions

Assignment

We will not assume responsibility for determining the validity of an assignment of your benefits to a provider of services. No such assignment of benefits will be recognized until we receive notice that you have specifically assigned the benefits of your Group Short-Term Disability Insurance Certificate.

Other Insurance With Continental American Insurance Company

If you are covered under more than one Continental American Insurance Certificate with Disability benefits, only one Disability benefit chosen by you or your estate, as the case may be, will be effective.

We will return all premiums paid for the canceled benefits from the date of duplication, less any benefits paid under these policies from such date.

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- this Policy
- the Master Application
- Certificates
- endorsements
- benefit agreements **and**
- riders (if any).

All statements (excluding fraudulent ones) that the Policyholder or you have made in the Application will be considered representations, **not** warranties.

If statements on the Application require additional review, the Company will send a copy of the Application to:

- the Policyholder, **or**
- you, **or**
- your beneficiary.

This will ensure that the Policyholder or you have an opportunity to review the information that is provided in the Application. The Company *will not* void insurance or reduce benefits (as a result of statements made on the Application) without sending Application copies as outlined above.

Changes to this Plan:

- will not be valid unless approved in writing by an executive officer of the Company.
- must be noted on or attached to the Contract.
- may not be made by any agent (nor can an agent waive any Plan provisions).

Any Rider, Endorsement, or Application that modifies, limits, or excludes coverage under this Plan must be signed by you to be valid.

Time Limit on Certain Defenses

After two years from the Effective Date of your coverage, no misstatements, except fraudulent misstatements, made by you in the Application shall be used to void your coverage or to deny a claim for Disability starting after the expiration of such two-year period.

[No claim for loss incurred or Disability starting after [12] months from the Effective Date of coverage shall be reduced on the grounds that a Sickness or physical condition, not excluded from coverage by name or specific description, had existed before the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after your coverage has been in force [12] months.]

Misstatement of Age

If your age has been misstated on the Application, the benefits will be those the premium paid would have purchased at the correct age. We will refund all unearned premiums paid, less any benefits paid, if your misstated age at the time of Application was outside the age limits for your coverage.

Misstatement of Occupation or Income

If your occupation has been misstated, the benefits will be those that the premiums paid would have purchased for your correct occupation. If your income has been misstated, the benefit payable will be that which would have been allowed for your true income level. Any overpayment of premium will be refunded.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. If a clerical error occurs, we will make a premium adjustment.

Individual Certificates

We will give the Policyholder a Certificate for each [Employee]. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

Required Information

The Policyholder will furnish all information and proofs which we may reasonably require with regard to the Plan.

Conformity With State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII – Certificate Schedule

INSURED	GROUP POLICY NUMBER
EFFECTIVE DATE	CERTIFICATE NUMBER
INITIAL PREMIUM	FIRST RENEWAL DATE

BENEFIT PERIOD

Benefit	Benefit Period
Total Disability (Non-Occupational)	[3, 6, 12] Months
[Partial Disability]	[3] Months]
[Total Disability (24-Hour)]	[3, 6, 12] Months]
[Mental Illness Limited Benefit]	[90] Days per [12-]month period], lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit]	[90] Days per [12-]month period], lifetime maximum]

ELIMINATION PERIOD

Total and/or Partial Disability	Elimination Period
Injury	[0, 7, 14, 30, 60, 90] Days
Sickness	[7, 14, 30, 60, 90] Days

MONTHLY BENEFIT FOR DISABILITY CAUSED BY *INJURY*

BENEFIT	We will pay this amount per month:	Beginning on this date of disability:	After this Period of Elimination for <i>Injury</i> :	For a maximum Benefit Period of:
Total Disability (Non-Occupational)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days	[3, 6, 12] Months
[Partial Disability]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3] Months]
[Total Disability (24-Hour)]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3, 6, 12] Months]
[Mental Illness Limited Benefit]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period], lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit]	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period], lifetime maximum]

MONTHLY BENEFIT FOR DISABILITY CAUSED BY SICKNESS

BENEFIT	We will pay this amount per month:	Beginning on this date of disability:	After this Period of Elimination for <i>Sickness</i>:	For a maximum Benefit Period of:
Total Disability (Non-Occupational)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days	[3, 6, 12] Months
[Partial Disability	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3] Months]
[Total Disability (24-Hour)	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[3, 6, 12] Months]
[Mental Illness Limited Benefit	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period, lifetime maximum]
[Alcoholism and Drug Addiction Limited Benefit	\$xx.xx		[0, 7, 14, 30, 60, 90] Days]	[90] Days per [12-]month period, lifetime maximum]