

State: Arkansas **Filing Company:** United National Life Insurance Company of America
TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity
Product Name: RU12DV
Project Name/Number: RU12DV/RU12DV

Filing at a Glance

Company: United National Life Insurance Company of America
Product Name: RU12DV
State: Arkansas
TOI: H14I Individual Health - Hospital Indemnity
Sub-TOI: H14I.000 Health - Hospital Indemnity
Filing Type: Form/Rate
Date Submitted: 01/02/2013
SERFF Tr Num: GRTT-128832178
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: RU12DV
Implementation: On Approval
Date Requested:
Author(s): Ann Ryan, Jane Cooper, Frances Markiewicz
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 01/03/2013
Disposition Status: Approved-Closed
Implementation Date:
State Filing Description:

State: Arkansas **Filing Company:** United National Life Insurance Company of America
TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity
Product Name: RU12DV
Project Name/Number: RU12DV/RU12DV

General Information

Project Name: RU12DV Status of Filing in Domicile: Pending
Project Number: RU12DV Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 01/03/2013
State Status Changed: 01/03/2013
Deemer Date: Created By: Jane Cooper
Submitted By: Jane Cooper Corresponding Filing Tracking Number:

Filing Description:

Dental and Vision Rider RU12DV
Outline of Coverage OCU9910-AR(R12)
Outline of Coverage OCU0950(CR)-AR(R12)
Outline of Coverage OCU0430-1A-AR
Application UAPPH1-10A-AR(Rev 12-12)
Actuarial Memorandum and Rates

We are submitting the attached Dental and Vision Benefit Rider, an application and rates for review and approval. These are new forms that are not intended to replace any forms previously submitted or approved.

The attached Dental and Vision Benefit Rider, form RU12DV, is intended to be offered on a general-use basis with several previously-approved individual supplemental indemnity products. The Dental and Vision Benefit Rider is intended to provide a limited and supplemental indemnity for certain dental services. The previously approved forms are:

U9910-AR, an individual Hospital Confinement Indemnity policy approved by your state on August 12, 1999.

U0950-AR, an individual Hospital & Home Care Indemnity policy, approved in your state on March 1, 2010 under SERFF tracking # GRTT-126512874.

U0430-AR, an individual specified disease policy, providing scheduled benefits, was originally approved in your state on December 16, 2004.

Also attached is a new individual application for the Dental and Vision Benefit Rider, form UAPPH1-10A-AR(Rev 12-12) that we intend to use in offering the coverages above.

Updated Outlines of Coverage for the above policies are attached as well. The Outline form numbers for each of the above policies are submitted as Supporting Documentation:

For Policy Form U9910-AR: OCU9910-AR(R12).
For Policy Form U0950-AR: OCU0950(CR)-AR(R12).
For Policy Form U0430-AR: OCU0430-1A-AR.

We use multiple computer systems to generate documents. Therefore, actual issued forms may have a different font style than these submitted forms. As a result, provisions may appear on different pages and lines may not match up exactly. The

State: Arkansas **Filing Company:** United National Life Insurance Company of America
TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity
Product Name: RU12DV
Project Name/Number: RU12DV/RU12DV

wording and its order, however, will remain identical. We do not anticipate re-filing for a font style variation.

Bracketed material in the forms represents variability. The text listed as variable will either be included or excluded based on client & policyholder selection, elections of optional benefits and changes in coverage offerings. The maximum benefit levels for this product will be either \$400, \$800 or \$1200 per calendar year; otherwise the benefit levels will not change unless we file such changes with your Department.

We appreciate your assistance in this filing.

Thank you for your time and attention to this filing. If you have any questions, please contact me toll free at 800-338-7452, Ext. 5655 or e-mail me at jcoop@gtlic.com.

Company and Contact

Filing Contact Information

Ann Ryan, aryan@gtlic.com
 1275 Milwaukee Ave. 847-904-5587 [Phone] 5587 [Ext]
 Glenview, IL 60025 847-699-0093 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: 2 forms & 1 rate @ \$50 each.
 Per Company: No

Company	Amount	Date Processed	Transaction #
United National Life Insurance Company of America	\$150.00	01/02/2013	66189414

SERFF Tracking #:

GRTT-128832178

State Tracking #:

Company Tracking #:

RU12DV

State:

Arkansas

Filing Company:

United National Life Insurance Company of America

TOI/Sub-TOI:

H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name:

RU12DV

Project Name/Number:

RU12DV/RU12DV

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/03/2013	01/03/2013

State: Arkansas

Filing Company:

United National Life Insurance Company of America

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: RU12DV

Project Name/Number: RU12DV/RU12DV

Disposition

Disposition Date: 01/03/2013

Implementation Date:

Status: Approved-Closed

Comment:

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

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Rider	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

State: Arkansas

Filing Company:

United National Life Insurance Company of America

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: RU12DV

Project Name/Number: RU12DV/RU12DV

Form Schedule

Lead Form Number: RU12DV

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/03/2013	Application	UAPPH1-10A(Rev 12-12)	AEF	Initial		50.000	UAPPH1-10A-AR (Rev 12-12).pdf
2	Approved-Closed 01/03/2013	Rider	RU12DV	POLA	Initial		50.000	RU12DV.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

Section A: Applicant Information

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

Primary Applicant

1. Last Name _____ First Name _____ MI _____
 Social Sec # _____ - _____ - _____ Age _____ Gender: M F Birth date ____/____/____

Spouse

2. Last Name _____ First Name _____ MI _____
 Social Sec # _____ - _____ - _____ Age _____ Gender: M F Birth date ____/____/____

Dependents

3. Last Name _____ First _____ MI ____ Age ____ Birth date ____/____/____ Social Sec # _____ - ____ - _____
 4. Last Name _____ First _____ MI ____ Age ____ Birth date ____/____/____ Social Sec # _____ - ____ - _____
 5. Last Name _____ First _____ MI ____ Age ____ Birth date ____/____/____ Social Sec # _____ - ____ - _____
 6. Last Name _____ First _____ MI ____ Age ____ Birth date ____/____/____ Social Sec # _____ - ____ - _____

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

7. Street Address _____ City _____ ST ____ Zip Code _____
 8. Telephone (Day) _____ Applicant's E-mail Address _____

Section B: Coverage Selection and Premiums

<input type="checkbox"/> Hospital Confinement Indemnity (U9910)	<input type="checkbox"/> Hospital Confinement & Home Care Indemnity (U0950) Secure Advantage	<input type="checkbox"/> First Diagnosis Cancer (U0430) Cancer Plus
<p>Coverage: (check applicable)</p> <input type="checkbox"/> Primary Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children <p>Plan Daily Benefit: (check one)</p> <input type="checkbox"/> Plan A: \$37.50 <input type="checkbox"/> Plan D: \$225 <input type="checkbox"/> Plan B: \$100 <input type="checkbox"/> Plan E: \$300 <input type="checkbox"/> Plan C: \$150 <input type="checkbox"/> Plan F: \$400 <p>Rider</p> <input type="checkbox"/> Dental and Vision (RU12DV) <input type="checkbox"/> Primary: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Spouse: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Dependents 18+: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200	<p>Coverage: (check applicable)</p> <input type="checkbox"/> Primary Applicant <input type="checkbox"/> Spouse <p>Plan: (check one)</p> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan C <input type="checkbox"/> Plan B <input type="checkbox"/> Plan D <p>Riders</p> <input type="checkbox"/> Dependent Children – Plan A Only <p><input type="checkbox"/> Dental and Vision (RU12DV) <input type="checkbox"/> Primary: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Spouse: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Dependents 18+: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200</p>	<p>Coverage: (check applicable)</p> <input type="checkbox"/> Primary Applicant <input type="checkbox"/> Family <p>Scheduled Base Plan (check one)</p> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan C <input type="checkbox"/> Plan B <input type="checkbox"/> Plan D <p>Riders</p> <input type="checkbox"/> Heart Attack and Stroke <input type="checkbox"/> Return of Premium <input type="checkbox"/> Lump Sum \$ _____ <div style="text-align: right;">\$1,000 - \$10,000</div> <p><input type="checkbox"/> Dental and Vision (RU12DV) <input type="checkbox"/> Primary: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Spouse: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Dependents 18+: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200</p>
<p>Check boxes below for dependents covered under the Dental and Vision Rider: (All dependents must apply for same level.)</p> <input type="checkbox"/> Dependent Line 3 <input type="checkbox"/> Dependent Line 4 <input type="checkbox"/> Dependent Line 5 <input type="checkbox"/> Dependent Line 6		

Modal Premium: \$ _____ = Premium Due: \$ _____	Modal Premium: \$ _____ = Premium Due: \$ _____	Modal Premium: \$ _____ = Premium Due: \$ _____
Premium Payment Modes: <input type="checkbox"/> Monthly Bank Draft (.084) <input type="checkbox"/> Quarterly (.265) <input type="checkbox"/> Semi-Annual (.52) <input type="checkbox"/> Annual		
Total Premium Collected: \$ _____]		

Section C: Medical / Underwriting Questions

Replacement question must be answered for ALL plans.

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

[Hospital Confinement Indemnity (U9910)]

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

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

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

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

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

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

[Cancer Plus - First Diagnosis Cancer (U0430)]

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

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

[Dental and Vision (RU12DV)]

Answer the following question if applying for the Dental and Vision (RU12DV):

- 1e. Does any person to be insured currently wear prescription eyewear, glasses or contacts? Yes No
If yes, name of person this applies to _____]

Section D: Authorization / Agreement

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

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

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

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

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

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

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

Signed at _____
Date _____ City and State _____

Signature of Applicant _____ Spouse/Domestic Partner Signature (if applicable) _____

AGENT'S STATEMENT

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

Agent's Name (Printed) _____ Agent Code _____ Date Signed _____

Agent's signature _____ Agent's E-mail Address _____

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

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

P. O. Box 1154, Glenview, Illinois, 60025-1154

**THIS RIDER PROVIDES A LIMITED BENEFIT DURING THE FIRST 12 MONTHS
AFTER THE EFFECTIVE DATE.**

DENTAL AND VISION BENEFIT RIDER

EFFECTIVE DATE: [_____]

In consideration of the application and payment of the required Premium, this Rider is made a part of the Policy to which it is attached. This Rider takes effect on the Effective Date shown above. If no date is shown above, it begins on the Policy's Effective Date.

YOUR THIRTY (30) DAY RIGHT TO RETURN THIS RIDER

If You are not satisfied with this Rider, You may return it to Us within thirty (30) days of its receipt. You may return it to Us by mail or to the agent who sold it. We'll then refund all premiums paid for this Rider and it will be void.

RIDER DEFINITIONS

Dentist: Means a person who is licensed to practice dentistry in the state where services are rendered and is acting within the scope of that license. A Dentist shall also mean a licensed doctor performing dental services within the scope of that license. It does not include You, or a Family Member.

Doctor: Means any licensed Dentist, Ophthalmologist and Optometrist. It does not include You, or a Family Member.

Insured Percent: Means the percentage of covered expenses We pay for covered expenses during each Calendar Year after the Deductible is satisfied. The Insured Percent is shown in the Rider Schedule.

Necessary Dental Treatment: Dental services or supplies which are consistent with currently accepted dental practice. Any operation, treatment, service or supply not a valid course of treatment recognized by the American Dental Association is not considered Necessary Dental Treatment.

Ophthalmologist: Means a physician who specializes in ophthalmology in the state where services are rendered and is acting within the scope of that license. It does not include You, or a Family Member.

Optometrist: Means a specialist licensed to practice optometry in the state where services are rendered and is acting within the scope of that license. It does not include You, or a Family Member.

Rider Deductible Amount: Means a dollar amount of covered expenses You must pay each Calendar Year before We pay any benefits. The Rider Deductible Amount is shown in the Rider Schedule.

A new Rider Deductible Amount will apply each Calendar Year.

Rider Maximum Amount: Means the maximum benefit amounts for services provided by a Dentist, Ophthalmologist, Optometrist or Doctor, which are payable during the first Calendar Year and thereafter as shown in the Rider Schedule.

Usual and Customary Expense: Means the usual fee charged by your Doctor for a given service and which is within the range of fees charged by other doctors in the same area for similar services.

DENTAL AND VISION PROVISION

We will pay the Dental and Vision benefits subject to the:

1. Rider Deductible Amount;
2. Insured Percent of covered expenses up to the Rider Maximum Amount per Calendar Year;
3. Definitions, limitations and exclusions and other provisions of the Policy and this Rider.

DENTAL AND VISION BENEFIT

We will pay the Usual and Customary Expenses You incur for necessary dental and vision treatment for the services and supplies shown below. After You satisfy the Rider Deductible Amount, We will pay the Insured Percent of covered expenses up to the Rider Maximum Amount per Calendar Year. The Rider Deductible, Insured Percent and the Rider Maximum Amounts are shown in the Rider Schedule.

1. Dental

We will pay up to the Rider Maximum Amount for services of a licensed Dentist including one annual examination and cleaning, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as necessary by a Dentist, according to the timeframes below.

After this Rider has been in force three (3) months, we will pay the cost of one (1) dental cleaning, occurring after such three (3) month period, up to the Dental Cleaning Maximum each Calendar Year as shown in the Rider Schedule. This benefit is not subject to the Rider Deductible Amount; however, it is subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force six (6) months, we will pay benefits for fillings or root canal treatment occurring after such six (6) month period, subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force twelve (12) months, we will pay benefits for the following:

Bridges, crowns, full dentures or partials, any services or treatment relating to the replacement of natural teeth which were missing on this rider's Effective Date, out-patient dental surgery, "full mouth" extractions or fluoride treatments occurring after such twelve (12) month period and subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force twelve (12) months, we will pay benefits for the following:

Any replacement or repair of existing bridges or dentures occurring after such twelve (12) month period, not to exceed the Rider Maximum Amount per Calendar Year as listed in the Rider Schedule. If replacement or repair of existing bridges or dentures is needed as the result of Injury, the 12 month period is not applicable.

2. Vision

We will pay up to the Rider Maximum Amount for visits to a licensed ophthalmologist or optometrist for the purpose of eye refractions and examinations, including the cost of eyeglasses or contact lenses as prescribed by such doctor, according to the timeframes below.

After this Rider has been in force three (3) months, we will pay the cost of one (1) eye exam or one (1) eye refraction, occurring after such three (3) month period, up to the Eye Exam Maximum each Calendar Year as shown in the Rider Schedule. This benefit is not subject to the Rider Deductible Amount; however, it is subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force six (6) months, we will pay benefits for the following:

Eyeglasses or contact lenses purchased after such six (6) month period, not to exceed the Prescription Eyewear maximum of \$200 per Calendar year as listed in the Rider Schedule. If eyeglasses or contact lenses are needed as the result of Injury, the six (6) month period is not applicable.

EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
 - That performed by a Dental Hygienist under the supervision of a Dentist; and
 - X-rays ordered by a Dentist.
- Treatment, services or supplies which:
 - Are not Necessary Dental Treatment, except as provided herein;
 - Are Experimental/Investigational in nature;
 - Conditions covered by Workers Compensation Services.
- Treatment by a Family Member;
- Services or supplies for which there would be no charge in the absence of insurance;
- A service furnished to You for:

- Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic; or
- Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule).
- Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments; denture duplication; or sealants.
- Oral hygiene instructions; plaque control; acid etch; or prescription for take-home fluoride.
- Overdentures and associated procedures.
- Services not completed by the end of the month in which insurance terminates.
- Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:

- Treatment, services or supplies which:
 - Are Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay; or
 - Treatment by any Family Member.
- Conditions covered by Worker's Compensation Services;
- Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids;
- Non-prescription (plano) eyewear;
- Medical or surgical treatments of the eyes, unless to correct refraction of the eyes; or
- Eye examinations required by an employer as a condition of employment.

RENEWAL CONDITIONS

This Rider is renewed when the Policy to which it is attached is renewed.

TERMINATION

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

PREMIUM

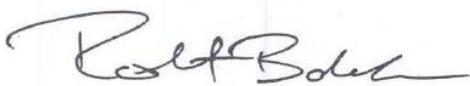
This Rider requires the payment of premium in addition to the premium due for the Policy. The premium for this Benefit Rider is shown in the Rider Schedule.

We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium in the time required by Your state.

CONDITIONS

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

Signed for United National Life Insurance Company of America at Glenview, Illinois, by



Secretary



President

UNITED NATIONAL LIFE INSURANCE COMPANY
P.O. BOX 1154, GLENVIEW, IL 60025

DENTAL AND VISION BENEFIT RIDER

RIDER SCHEDULE

This is a summary of Rider benefits. Please read the entire contract for a full explanation of Policy and Rider benefits and limitations. All benefits are per Covered Person.

POLICY NUMBER: [UNL 123456]
EFFECTIVE DATE: [MONTH XX, XXXX]
NAME OF INSURED: [JOHN DOE]

	<u>BENEFIT AMOUNT</u>	<u>PREMIUM</u>
[[DENTAL AND VISION BENEFIT RIDER:]
RIDER DEDUCTIBLE AMOUNT:	\$[100.00] PER CALENDAR YEAR	
RIDER MAXIMUM AMOUNT: 1 ST CALENDAR YEAR:	[80%] UP TO \$[200/400/600] PER CALENDAR YEAR	
2 ND CALENDAR YEAR AND THEREAFTER:	[80%] UP TO \$[400/800/1200] PER CALENDAR YEAR	
DENTAL CLEANING MAXIMUM: (NOT SUBJECT TO RIDER DEDUCTIBLE AMOUNT)	UP TO \$[75] PER CALENDAR YEAR	
EYE EXAM/REFRACTION MAXIMUM: (NOT SUBJECT TO RIDER DEDUCTIBLE AMOUNT)	UP TO \$[50] PER CALENDAR YEAR	
PRESCRIPTION EYEWEAR (EYEGLASSES OR CONTACTS)	UP TO \$[200] PER CALENDAR YEAR	
	TOTAL PREMIUM	\$[XXX.XX]

SERFF Tracking #:

GRTT-128832178

State Tracking #:

Company Tracking #:

RU12DV

State: Arkansas

Filing Company:

United National Life Insurance Company of America

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: RU12DV

Project Name/Number: RU12DV/RU12DV

Rate Information

Rate data applies to filing.

Filing Method: serff

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: 0.000%

Effective Date of Last Rate Revision: 12/27/2012

Filing Method of Last Filing: None

Company Rate Information

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

SERFF Tracking #:

GRTT-128832178

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

RU12DV

State:

Arkansas

Filing Company:

United National Life Insurance Company of America

TOI/Sub-TOI:

H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name:

RU12DV

Project Name/Number:

RU12DV/RU12DV

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1	Approved-Closed 01/03/2013	Rates	U9910-AR, U0950-AR, U0430-AR	New		Exh 1_DV_rider.pdf
2	Approved-Closed 01/03/2013	Rates	U9910-AR, U0950-AR, U0430-AR	New		Exh 2_DV_rider.pdf

United National Life Insurance Company

Dental and Vision Benefit Rider RU12DV

Exhibit 1 Annual Premium Rates

Issue Age	Benefit Level		
	\$400	\$800	\$1,200
18-39	245.00	290.00	330.00
40-49	270.00	325.00	375.00
50-55	290.00	353.00	411.00
56-60	303.00	368.00	428.00
61-65	319.00	384.00	443.00
66-70	339.00	403.00	458.00
71-75	359.00	418.00	473.00
76-80	379.00	433.00	488.00
81-85	399.00	449.00	505.00

Premium Modal Factors:

Semi-Annual	0.520 x Annual
Quarterly	0.265 x Annual
Monthly PAC	0.084 x Annual

United National Life Insurance Company

Dental and Vision Benefit Rider RU12DV

Exhibit 2 Anticipated Durational Loss Ratio Pattern

Policy Year	Earned Premium	Incurred Claims	Loss Ratio
1	300	111	37%
2	227	162	71%
3	190	108	56%
4	165	91	55%
5	146	77	53%
6	129	69	53%
7	114	62	54%
8	100	55	54%
9	88	49	55%
10	78	44	56%
11	68	39	56%
12	60	34	57%
13	53	31	58%
14	46	27	58%
15	40	24	59%
16	35	21	59%
17	31	19	60%
18	27	16	61%
19	23	14	62%
20	20	13	62%
21	17	11	63%
22	15	10	63%
23	13	8	64%
24	11	7	65%
25	10	6	65%
26	8	5	66%
27	7	5	66%
28	6	4	67%
29	5	4	68%
30	4	3	68%

Anticipated LR @

3.5% \$1,618 \$887 55%

SERFF Tracking #:

GRTT-128832178

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

RU12DV

State:

Arkansas

Filing Company:

United National Life Insurance Company of America

TOI/Sub-TOI:

H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name:

RU12DV

Project Name/Number:

RU12DV/RU12DV

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/03/2013
Comments:	Flesch Certification attached.		
Attachment(s):	READ CERTIFICATION.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/03/2013
Comments:	Application is attached.		
Attachment(s):	UAPPH1-10A-AR (Rev 12-12).pdf		

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	01/03/2013
Comments:			
Attachment(s):	OCU0430-1A-AR(R12).pdf OCU0950(CR)-AR(R12).pdf OCU9910-AR(R12).pdf		

CERTIFICATE OF READABILITY

Form Number(s): RU12DV, UAPPH1-10A (Rev 11-12), OCU0430-1A-AR(R12),
OCU0950(CR)-AR(R12), OCU9910-AR(R12)

Flesch Test Score(s): 50, 45, 50, 50, 50,

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

GUARANTEE TRUST LIFE INSURANCE COMPANY



Robert Baluk, General Counsel

Date: December 27, 2012

Section A: Applicant Information

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

Primary Applicant

1. Last Name _____ First Name _____ MI _____

Social Sec # _____ - _____ - _____ Age _____ Gender: M F Birth date ____/____/____

Spouse

2. Last Name _____ First Name _____ MI _____

Social Sec # _____ - _____ - _____ Age _____ Gender: M F Birth date ____/____/____

Dependents

3. Last Name _____ First _____ MI ____ Age ____ Birth date ____/____/____ Social Sec # _____ - ____ - _____

4. Last Name _____ First _____ MI ____ Age ____ Birth date ____/____/____ Social Sec # _____ - ____ - _____

5. Last Name _____ First _____ MI ____ Age ____ Birth date ____/____/____ Social Sec # _____ - ____ - _____

6. Last Name _____ First _____ MI ____ Age ____ Birth date ____/____/____ Social Sec # _____ - ____ - _____

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

7. Street Address _____ City _____ ST ____ Zip Code _____

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

Section B: Coverage Selection and Premiums

<input type="checkbox"/> Hospital Confinement Indemnity (U9910)	<input type="checkbox"/> Hospital Confinement & Home Care Indemnity (U0950) Secure Advantage	<input type="checkbox"/> First Diagnosis Cancer (U0430) Cancer Plus
<p>Coverage: (check applicable)</p> <p><input type="checkbox"/> Primary Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Children</p> <p>Plan Daily Benefit: (check one)</p> <p><input type="checkbox"/> Plan A: \$37.50 <input type="checkbox"/> Plan D: \$225 <input type="checkbox"/> Plan B: \$100 <input type="checkbox"/> Plan E: \$300 <input type="checkbox"/> Plan C: \$150 <input type="checkbox"/> Plan F: \$400</p> <p>Rider</p> <p><input type="checkbox"/> Dental and Vision (RU12DV) <input type="checkbox"/> Primary: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Spouse: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Dependents 18+: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200</p>	<p>Coverage: (check applicable)</p> <p><input type="checkbox"/> Primary Applicant <input type="checkbox"/> Spouse</p> <p>Plan: (check one)</p> <p><input type="checkbox"/> Plan A <input type="checkbox"/> Plan C <input type="checkbox"/> Plan B <input type="checkbox"/> Plan D</p> <p>Riders</p> <p><input type="checkbox"/> Dependent Children – Plan A Only</p> <p><input type="checkbox"/> Dental and Vision (RU12DV) <input type="checkbox"/> Primary: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Spouse: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Dependents 18+: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200</p>	<p>Coverage: (check applicable)</p> <p><input type="checkbox"/> Primary Applicant <input type="checkbox"/> Family</p> <p>Scheduled Base Plan (check one)</p> <p><input type="checkbox"/> Plan A <input type="checkbox"/> Plan C <input type="checkbox"/> Plan B <input type="checkbox"/> Plan D</p> <p>Riders</p> <p><input type="checkbox"/> Heart Attack and Stroke <input type="checkbox"/> Return of Premium <input type="checkbox"/> Lump Sum \$ _____ <div style="text-align: right;">\$1,000 - \$10,000</div></p> <p><input type="checkbox"/> Dental and Vision (RU12DV) <input type="checkbox"/> Primary: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Spouse: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 <input type="checkbox"/> Dependents 18+: <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200</p>
<p>Check boxes below for dependents covered under the Dental and Vision Rider: (All dependents must apply for same level.)</p> <p><input type="checkbox"/> Dependent Line 3 <input type="checkbox"/> Dependent Line 4 <input type="checkbox"/> Dependent Line 5 <input type="checkbox"/> Dependent Line 6</p>		

Modal Premium: \$ _____ = Premium Due: \$ _____	Modal Premium: \$ _____ = Premium Due: \$ _____	Modal Premium: \$ _____ = Premium Due: \$ _____
Premium Payment Modes: <input type="checkbox"/> Monthly Bank Draft (.084) <input type="checkbox"/> Quarterly (.265) <input type="checkbox"/> Semi-Annual (.52) <input type="checkbox"/> Annual		
Total Premium Collected: \$ _____]		

Section C: Medical / Underwriting Questions

Replacement question must be answered for ALL plans.

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

[Hospital Confinement Indemnity (U9910)]

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

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

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

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

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

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

[Cancer Plus - First Diagnosis Cancer (U0430)]

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

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

[Dental and Vision (RU12DV)]

Answer the following question if applying for the Dental and Vision (RU12DV):

- 1e. Does any person to be insured currently wear prescription eyewear, glasses or contacts? Yes No
If yes, name of person this applies to _____]

Section D: Authorization / Agreement

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

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

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

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

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

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

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

Signed at _____
Date City and State

Signature of Applicant Spouse/Domestic Partner Signature (if applicable)

AGENT'S STATEMENT

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

Agent's Name (Printed) Agent Code Date Signed

Agent's signature Agent's E-mail Address

Mail Policy to Agent Insured

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

SPECIFIED DISEASE POLICY

OUTLINE OF COVERAGE
FIRST DIAGNOSIS CANCER BENEFIT POLICY

Policy Form U0430-AR
With Optional Rider Forms RU04HAS, RU04LS, RU11ROP [and RU12DV]

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECT OF WAIVER OF PREMIUM ON RETURN OF PREMIUM

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

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

EXCLUSIONS – The policy does not pay benefits for:

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

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

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

[OPTIONAL DENTAL AND VISION BENEFIT RIDER

THIS RIDER PROVIDES LIMITED BENEFITS DURING THE FIRST 12 MONTHS AFTER THE RIDER EFFECTIVE DATE. PLEASE READ YOUR RIDER CAREFULLY.

We will pay Dental and Vision benefits subject to the:

- Rider Deductible Amount;
- Insured Percent of covered expenses up to the Rider Maximum Amount per Calendar Year;
- Definitions, limitations and exclusions and other provisions of the Policy and this Rider.

DENTAL AND VISION BENEFIT - After You satisfy the Rider Deductible Amount, We will pay the Insured Percent of covered expenses up to the Rider Maximum Amount per Calendar Year, subject to the timeframes below.. The Rider Deductible, Insured Percent and the Rider Maximum Amounts are shown in the Rider Schedule.

1. Dental

We will pay up to the Rider Maximum Amount for services of a licensed Dentist including one annual examination and cleaning, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as necessary by a Dentist, according to the timeframes below.

After this Rider has been in force three (3) months, we will pay the cost of one (1) dental cleaning, occurring after such three (3) month period, up to the Dental Cleaning Maximum each Calendar Year as shown in the Rider Schedule. This benefit is not subject to the Rider Deductible Amount; however, it is subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force six (6) months, we will pay benefits for fillings or root canal treatment occurring after such six (6) month period, subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force twelve (12) months, we will pay benefits for bridges, crowns, full dentures or partials, any services or treatment relating to the replacement of natural teeth which were missing on this rider's Effective Date, outpatient dental surgery, "full mouth" extractions or fluoride treatments occurring after such twelve (12) month period and subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force twelve (12) months, we will pay benefits for replacement or repair of existing bridges or dentures occurring after such twelve (12) month period, not to exceed the Rider Maximum Amount per Calendar Year as listed in the Rider Schedule. If replacement or repair of existing bridges or dentures is needed as the result of Injury, the 12 month period is not applicable.

2. Vision

We will pay up to the Rider Maximum Amount for visits to a licensed ophthalmologist or optometrist for the purpose of eye refractions and examinations, including the cost of eyeglasses or contact lenses as prescribed by such doctor, according to the timeframes below.

After this Rider has been in force three (3) months, we will pay the cost of one (1) eye exam or one (1) eye refraction, occurring after such three (3) month period, up to the Eye Exam Maximum each Calendar Year as shown in the Rider Schedule. This benefit is not subject to the Rider Deductible Amount; however, it is subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force six (6) months, we will pay benefits for eyeglasses or contact lenses purchased after such six (6) month period, not to exceed the Prescription Eyewear maximum of \$200 per Calendar year as listed in the Rider Schedule. If eyeglasses or contact lenses are needed as the result of Injury, the six (6) month period is not applicable.

DENTAL AND VISION RIDER EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
 - That performed by a Dental Hygienist under the supervision of a Dentist; and
 - X-rays ordered by a Dentist.
- Treatment, services or supplies which:
 - Are not Necessary Dental Treatment, except as provided herein;
 - Are Experimental/Investigational in nature;
 - Conditions covered by Workers Compensation Services.
- Treatment by a Family Member;

- Services or supplies for which there would be no charge in the absence of insurance;
- A service furnished to You for:
 - Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic; or
 - Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule).
- Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments; denture duplication; or sealants.
- Oral hygiene instructions; plaque control; acid etch; or prescription for take-home fluoride.
- Overdentures and associated procedures.
- Services not completed by the end of the month in which insurance terminates.
- Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:

- Treatment, services or supplies which:
 - Are Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay; or
 - Treatment by any Family Member.
- Conditions covered by Worker’s Compensation Services;
- Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids;
- Non-prescription (plano) eyewear;
- Medical or surgical treatments of the eyes, unless to correct refraction of the eyes; or
- Eye examinations required by an employer as a condition of employment.

RENEWAL CONDITIONS

This Rider is renewed when the Policy to which it is attached is renewed.

TERMINATION

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We’ll provide You with written notice of any change in the premium in the time required by Your state.]

INITIAL PREMIUM

FIRST DIAGNOSIS CANCER BENEFIT PLAN _____ \$ _____

HEART ATTACK OR STROKE BENEFIT RIDER \$ _____

EXPRESS PAY RIDER Benefit Amount \$ _____ \$ _____

RETURN OF PREMIUM RIDER \$ _____

[**DENTAL AND VISION BENEFIT RIDER** \$ _____]

TOTAL PREMIUM \$ _____

Agent’s Name: _____

Agent’s Address: _____

Telephone Number: _____

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

A Stock Company

P.O. Box 1154, Glenview, Illinois 60025-1154

(847) 803-5252

HOSPITAL CONFINEMENT HOME CARE INDEMNITY POLICY

Guaranteed Renewable for Life
Premiums May be Changed By Class

OUTLINE OF COVERAGE

For Policy Form U0950-AR [and Rider RU12DV]

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS IS A LIMITED POLICY

READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. Your policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

HOSPITAL CONFINEMENT INDEMNITY COVERAGE – Policies of this category are designed to provide to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Additional benefits, described in Parts I, II, and III below, are also provided on a fixed indemnity basis.

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

BENEFIT PROVISIONS

We will pay benefits, as shown in Parts I and II below, for Medically Necessary care, received by a Covered Person due to Injury or Sickness.

Benefits for Home Health Care or Homemaker/Companion Services are payable provided such care is needed because of the Covered Person's inability to perform 1 of the Activities of Daily Living, or because of a Cognitive Impairment. Homemaker/Companion Services and Daily Home Recovery must follow a covered Hospital Confinement.

We will pay benefits as shown in Part III, for Wellness Care and Accidental Death.

The benefits, as shown in Parts I, II, and III below, are subject to the benefit amounts shown in the Policy Schedule, the definitions, limitations, exclusions, and other provisions of the Policy.

Part I

A – Lump Sum Hospital Benefit

We will pay the Lump Sum Hospital Benefit Amount when a Covered Person is Hospital Confined as defined in the Policy. Lump Sum Hospital Benefits are payable only once during any One Period of Confinement, and are not subject to any Elimination Period.

B - Daily Hospital Confinement Indemnity Benefit

We will pay the Daily Benefit Amount for each day a Covered Person is confined in a Hospital when such confinement is Medically Necessary because of an Injury or Sickness. Benefits will begin on the first day of Hospital Confinement following the Elimination Period, and are subject to the Daily Benefit Amount. The Daily Benefit Amount and Elimination Period are shown in the Policy Schedule.

We will not pay more than a total of 180 days for Hospital Confinement during a Covered Person's lifetime.

C - Doctor's Office Visit Benefit

We will pay the Doctor's Office Weekly Benefit Amount as shown in the Policy Schedule, when a Covered Person receives the medical services of a Doctor. Limited to one Doctor's Office Weekly Benefit Amount regardless of the number of Doctor visits during the Week for which benefits are paid. If you select the optional

Child Benefit Rider, we won't pay more than a total of 5 weeks for visits to the doctors office per calendar year, for all Dependent Children.

We will not pay more than the Doctor's Office Calendar Year Maximum shown in the Policy Schedule.

D – Outpatient Surgery Benefit

We will pay the Outpatient Surgery Benefit Amount for a surgical procedure performed by a Doctor when such procedure is performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital. Surgical procedures and the services and supplies related to the surgical procedures are limited to two occurrences per calendar year not to exceed the Maximum Surgery Benefit Amount. The Outpatient Surgery Benefit Amount and the Maximum Surgery Benefit Amount are shown in the Policy Schedule.

We won't pay for multiple surgical procedures when such procedures are performed through the same incision or in immediate succession. We also won't pay for surgeries performed in a Doctor's office or when Hospital Confined.

E - Emergency Room Benefit

We will pay the Emergency Room Weekly Benefit Amount, as shown in the Policy Schedule, when a Covered Person receives Emergency Care, including emergency room services, due to an Injury.

We will not pay more than the Emergency Room Calendar Year Maximum shown in the Policy Schedule.

Part II

A - Home Health Care Benefits

We will pay the Home Health Care Benefit Amount for each Week a Covered Person receives 3 or more Home Health Care Practitioner visits on separate days. We will not pay more than the Home Health Benefit Maximum during any one Benefit Period for Home Health Care.

The Home Health Care Benefit Amount and Home Health Care Benefit Maximum are shown in the Policy Schedule.

B - Homemaker/Companion Benefit

We will pay the Homemaker/Companion Benefit Amount for each Week a Covered Person receives 2 or more Homemaker/Companion Services on separate days. Such services must follow a covered Hospital Confinement.

We will not pay more than the Homemaker/Companion Benefit Maximum during any one Benefit Period for Homemaker/Companion Services.

The Homemaker/Companion Benefit Amount and Homemaker/Companion Benefit Maximum are shown in the Policy Schedule.

C – Daily Home Recovery Benefit

We will pay the Daily Home Recovery Benefit Amount following a covered Hospital Confinement, not to exceed the number of days of such Hospital Confinement, and subject to the Home Recovery Benefit Maximum per covered Hospital Confinement. The Daily Home Recovery Benefit and the Home Recovery Benefit Maximum can be found in the Policy Schedule.

Part III

D – Wellness Care Benefit

We will pay the Wellness Care Benefit Amount for Wellness Care as defined in the Policy. Wellness Care must be prescribed (with the exception of an annual physical exam) and provided under the supervision of a Doctor. The Wellness Care Benefit Amount can be found in the Policy Schedule.

E – Accidental Death Benefit

We will pay the Accidental Death Benefit, shown on the Policy Schedule, to the Beneficiary named in the application (or as later changed) if You die solely as a result of Injuries. Accidental death must occur while this Policy is in force and within ninety (90) days after the Accident causing the Injuries. Our payment will be subject to all of the provisions of the Policy. The Accidental Death Benefit does not apply to any spouse or child that may be covered under this Policy or any rider attached to this Policy.

PRE-EXISTING CONDITION LIMITATION

A Pre-Existing Condition is: a Sickness or Injury, disclosed or not disclosed on the application, for which medical care, treatment, diagnosis or advice was received or recommended within the 6 month period immediately prior to the Covered Person's Effective Date of coverage under this Policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months prior to the Covered Person's Effective Date of coverage under this Policy. Treatment includes the taking of Prescription Drugs or medicines.

Pre-existing conditions are not covered unless the loss begins more than 6 months after the Covered Person's Effective Date of coverage.

EXCLUSIONS

This policy does not cover loss:

1. For treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Sickness or Injury;
 - Are determined to be Experimental/Investigational in nature by Us;
 - Are received without charge or legal obligation to pay;
 - Would not routinely be paid in the absence of insurance;
 - Are received from any Immediate Family Member.
2. For treatment of an Injury or Sickness due to war or an act of war, declared or undeclared; service in the armed forces of any country.
3. For treatment of intentionally self-inflicted injuries or attempted suicide while sane or insane.
4. For treatment of an Injury or Sickness for which a Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law (self-employed Covered Persons are covered for occupational Injury).
5. For normal pregnancy and childbirth if conception was before the Effective Date. Complications of pregnancy are covered as a Sickness.
6. For Mental or Nervous Disorders.
7. For treatment of an Injury that results from the Covered Person's commission of, or attempt to commit a felony, or from the Covered Person's being engaged in an illegal activity.
8. For cosmetic surgery. However "cosmetic surgery" does not include reconstructive surgery which is incidental because of previous surgery due to trauma, infection, or other disease of the involved part; or reconstructive surgery because of a congenital disease or anomaly.
9. For Injury due to being legally intoxicated, as defined by the jurisdiction in which an Accident occurs.
10. For loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.
11. For confinement or treatment received outside the United States or its possessions, unless loss is incurred while the Covered Person is on a trip of not more than 30 days' duration.

12. For services provided by a Home Health Care Agency which has any financial relationship with a Covered Person, with any member of the Covered Person's Immediate Family, or with a Covered Person's Doctor.
13. For the following surgeries under the Outpatient Surgery Benefit;
- Surgery performed in a Doctor's office or when Hospital Confined.
 - Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to Injury occurring while coverage is in force for the Covered Person;
 - Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the Medically Necessary treatment of a covered Sickness or Injury, unless the implants were implanted solely for cosmetic purposes and not for surgery performed as reconstruction resulting from an Sickness or Injury;
 - Surgery for non-malignant warts, moles (boils), and lesions unless Medically Necessary;
 - Surgery for sex transformation or reversal thereof;
 - Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to Sound Natural Teeth made necessary by Injury;
 - Surgery for refractive anomalies;
14. Under the Accidental Death Benefit due to;
- Bodily or mental infirmity.
 - Bacterial infections except:
Infections which occur simultaneously with or through a cut or wound sustained as the direct result of an Injury, independent of any other cause; and
The accidental ingestion of a contaminated substance.
 - Any kind of disease or hernia.
 - Medical or surgical treatment, except losses that result directly from surgical operations made necessary solely by Injury which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause, and performed within 90 days of the Accident.
 - Travel, or flight in or descent from any kind of aircraft unless:
As a fare paying passenger on a regularly scheduled flight; or
As a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.
 - Any Accident or occurrence arising out of or in the course of employment.
 - Sickness or its medical or surgical treatment, including diagnosis.
 - Voluntary gas inhalation or poison voluntarily taken, administered or inhaled.
 - Riding or driving as a professional in any kind of race for prize money or profit.

GUARANTEED RENEWABLE FOR LIFE You may keep this Policy, and Riders if attached, in force during Your entire lifetime, unless otherwise stated in the Rider, by paying the renewal premium at the intervals available to You at time of renewal. You must pay the renewal premium by its due date or during the 31 days that follow. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your premiums on time.

PREMIUMS SUBJECT TO CHANGE We may change the premium rates for this Policy/Riders by giving You at least 31 days prior written notice of any change in the renewal premium. We can only change the premium if We change it for all Policies/Riders like Yours in Your state on a class basis.

[OPTIONAL DENTAL AND VISION RIDER

THIS RIDER PROVIDES LIMITED BENEFITS DURING THE FIRST 12 MONTHS AFTER THE RIDER EFFECTIVE DATE. PLEASE READ YOUR RIDER CAREFULLY.

We will pay Dental and Vision benefits subject to the:

- Rider Deductible Amount;
- Insured Percent of covered expenses up to the Rider Maximum Amount per Calendar Year;
- Definitions, limitations and exclusions and other provisions of the Policy and this Rider.

DENTAL AND VISION BENEFIT - After You satisfy the Rider Deductible Amount, We will pay the Insured Percent of covered expenses up to the Rider Maximum Amount per Calendar Year, subject to the timeframes below.. The Rider Deductible, Insured Percent and the Rider Maximum Amounts are shown in the Rider Schedule.

1. Dental

We will pay up to the Rider Maximum Amount for services of a licensed Dentist including one annual examination and cleaning, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as necessary by a Dentist, according to the timeframes below.

After this Rider has been in force three (3) months, we will pay the cost of one (1) dental cleaning, occurring after such three (3) month period, up to the Dental Cleaning Maximum each Calendar Year as shown in the Rider Schedule. This benefit is not subject to the Rider Deductible Amount; however, it is subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force six (6) months, we will pay benefits for fillings or root canal treatment occurring after such six (6) month period, subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force twelve (12) months, we will pay benefits for bridges, crowns, full dentures or partials, any services or treatment relating to the replacement of natural teeth which were missing on this rider's Effective Date, out-patient dental surgery, "full mouth" extractions or fluoride treatments occurring after such twelve (12) month period and subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force twelve (12) months, we will pay benefits for replacement or repair of existing bridges or dentures occurring after such twelve (12) month period, not to exceed the Rider Maximum Amount per Calendar Year as listed in the Rider Schedule. If replacement or repair of existing bridges or dentures is needed as the result of Injury, the 12 month period is not applicable.

2. Vision

We will pay up to the Rider Maximum Amount for visits to a licensed ophthalmologist or optometrist for the purpose of eye refractions and examinations, including the cost of eyeglasses or contact lenses as prescribed by such doctor, according to the timeframes below.

After this Rider has been in force three (3) months, we will pay the cost of one (1) eye exam or one (1) eye refraction, occurring after such three (3) month period, up to the Eye Exam Maximum each Calendar Year as shown in the Rider Schedule. This benefit is not subject to the Rider Deductible Amount; however, it is subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force six (6) months, we will pay benefits for eyeglasses or contact lenses purchased after such six (6) month period, not to exceed the Prescription Eyewear maximum of \$200 per

Calendar year as listed in the Rider Schedule. If eyeglasses or contact lenses are needed as the result of Injury, the six (6) month period is not applicable.

DENTAL AND VISION RIDER EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
 - That performed by a Dental Hygienist under the supervision of a Dentist; and
 - X-rays ordered by a Dentist.
- Treatment, services or supplies which:
 - Are not Necessary Dental Treatment, except as provided herein;
 - Are Experimental/Investigational in nature;
 - Conditions covered by Workers Compensation Services.
- Treatment by a Family Member;
- Services or supplies for which there would be no charge in the absence of insurance;
- A service furnished to You for:
 - Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic; or
 - Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule).
- Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments; denture duplication; or sealants.
- Oral hygiene instructions; plaque control; acid etch; or prescription for take-home fluoride.
- Overdentures and associated procedures.
- Services not completed by the end of the month in which insurance terminates.
- Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:

- Treatment, services or supplies which:
 - Are Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay; or
 - Treatment by any Family Member.
- Conditions covered by Worker's Compensation Services;
- Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids;
- Non-prescription (plano) eyewear;
- Medical or surgical treatments of the eyes, unless to correct refraction of the eyes; or
- Eye examinations required by an employer as a condition of employment.

RENEWAL CONDITIONS

This Rider is renewed when the Policy to which it is attached is renewed.

TERMINATION

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium in the time required by Your state.]

INITIAL PREMIUM:

<input type="checkbox"/> Hospital Confinement Home Care Indemnity Policy	Premium: \$_____
<input type="checkbox"/> Child Benefit Rider	Premium: \$_____
<input type="checkbox"/> Dental and Vision Benefit Rider.....	Premium: \$_____]
	Total: \$_____

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

A Stock Company
P.O. Box 1154, Glenview, Illinois 60025-1154
(847) 803-5252

HOSPITAL CONFINEMENT INDEMNITY POLICY

Guaranteed Renewable for Life
Premiums May Be Changed By Class

OUTLINE OF COVERAGE

For Policy Form U9910-IL [and Optional Rider RU12DV]

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS IS A LIMITED POLICY

READ YOUR POLICY CAREFULLY - This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. Your policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

PART 1: HOSPITAL CONFINEMENT BENEFIT (INJURY OR SICKNESS)

We will pay the Daily Benefit Amounts shown on the Policy Schedule for each day a Covered Person is Confined as an inpatient in a Hospital due to Injury, Sickness, Mental or Nervous disorder. The Confinement must be Medically Necessary and must begin while the policy is in force. Benefits are subject to the daily benefit amount or a percentage of such amount as shown below:

1. for hospital confinement due to an injury or sickness, we will pay the Daily Benefit Amount;
2. for hospital confinement due to Cancer or a Heart Attack, we will **increase** the Daily Benefit Amount by 50%;
3. for hospital confinement due to an injury, we will **increase** the Daily Benefit Amount by 100% for each day both you and your spouse, who is a Covered Person, are confined;
4. for hospital confinement due to a mental or nervous disorder, we will **decrease** the Daily Benefit Amount, by 50%. We won't pay more than 30 days for any one period of confinement.

PART 2: ACCIDENTAL DEATH BENEFITS

1. We will pay the Accidental Death Benefit Amount if a Covered Person is injured due to an accident, which results in accidental death within 90 days of the accident. The Accidental Death Benefit amount is shown in the policy schedule.

We will not pay accidental death benefits for: (1) injury or loss that is caused or contributed to by sickness or disease; (2) injury or loss that is contributed to by an accident that occurs while the policy is not in force; or (3) injury due to being intoxicated or under the influence of any drug unless prescribed by a doctor.

2. **Return of Premiums - Insured Only** - For a covered Accidental Death of the Insured, the return of premium paid for the Insured's portion of the coverage will be equal to:

- a. the sum of the premiums the Insured paid for his or her portion of the coverage not to exceed \$10,000; LESS
- b. the sum of any benefits paid under the policy as the result of loss sustained by the Insured, exclusive of the Accidental Death Benefit Amount payable under this Part 2 for the Insured's accidental death.

PART 3: HOSPITAL OUTPATIENT BENEFITS

We will pay the Outpatient Daily Benefit Amount for each day a Covered Person is not hospital confined. The Outpatient Daily Benefit Amount is shown in the policy schedule. We will pay for the following treatment or services:

1. **FOR ACCIDENT AND SICKNESS**
 - a. Outpatient services including pre-admission testing provided within 72 hours before or after a surgical operation performed in a hospital or ambulatory surgical center. Pre-admission testing is not payable if a Covered Person voluntarily cancels or postpones surgery, except for events beyond such person's control; or
 - b. Outpatient services, including medical advice, tests or treatment in a hospital when the hospital bills a Covered Person for use of an outpatient or treatment room. We won't pay for such services if the hospital bills a Covered Person for either an inpatient or emergency room.

We won't pay benefits under both 3-1.a. and 3-1.b. above for the same day of outpatient care or surgery.

2. **FOR ACCIDENT ONLY**

- a. Emergency care and services provided by an outpatient department of a hospital if a Covered Person is injured in an accident and such care is provided within 7 days of the accident. Services for injuries include, but are not limited to the following:
1. a doctor's treatment;
 2. medical supplies; or
 3. x-rays or laboratory tests.

This benefit is payable for a Covered Person only once in any consecutive 7 day period.

- b. Local licensed professional ambulance services for each trip from the scene of an accident to a hospital. The Ambulance Benefit Amount is shown in the schedule.

We will pay benefits under both parts 3B(1) and 3B(2) above for the same loss.

We will pay benefits under either Part 3A or Part 3B for the same loss, but not both.

LIMITATIONS AND EXCLUSIONS:

PRE-EXISTING CONDITION LIMITATION

PRE-EXISTING CONDITION: A pre-existing condition is a medical condition: (a) for which medical advice, treatment, or medication was recommended by or received from a doctor, within the 24 month period before the Covered Person's Effective Date of Coverage; or (b) for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 month period before the Covered Person's Effective Date of Coverage, or would have allowed a person trained in Medicare to make a diagnosis of the condition producing the symptoms.

Pre-existing conditions are not covered unless the loss occurs more than 24 months after the Covered Person's Effective Date of Coverage.

EXCEPTIONS

The policy does not cover loss:

1. for treatment of an injury or sickness due to war or an act of war, declared or undeclared;
2. for treatment of intentionally self-inflicted injuries or attempted suicide while sane or insane;
3. for treatment of an injury or sickness for which a Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law (self-employed Covered Persons are covered for occupational injury);
4. for treatment in a hospital operated by the federal government unless you, by law, must pay;
5. for normal pregnancy and childbirth if conception was before the effective date. Complications of pregnancy are covered as a sickness;
6. for routine well-baby care;
7. for mental or nervous disorders except as provided for in the Hospital Confinement Benefit Section;
8. for treatment of an injury that results from the Covered Person's commission of, or attempt to commit a felony, or from the Covered Person's being engaged in an illegal occupation;
9. for cosmetic surgery, but "cosmetic surgery" does not include reconstructive surgery needed because of:
 - a. Injury; or
 - b. Birth defect of a covered child to a Covered Person while this policy is in force, or of a covered child adopted by a Covered person while the policy is in force.
10. for treatment of substance abuse, including alcoholism, drug addiction, narcotics, or hallucinogens; or
11. for confinement or treatment received outside the United States or its possessions, unless loss is incurred while the covered person is on a trip of not more than 60 days' duration.

GUARANTEED RENEWABLE FOR LIFE You may keep the policy in force during your entire lifetime by paying the renewal premium at the intervals available to you at time of renewal, or within the grace period. We cannot cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

PREMIUMS SUBJECT TO CHANGE We may change your premiums by giving you at least 31 days prior written notice. We can only do this when we change the premiums for all policies of this class in the state where you live.

[OPTIONAL DENTAL AND VISION BENEFIT RIDER

THIS RIDER PROVIDES LIMITED BENEFITS DURING THE FIRST 12 MONTHS AFTER THE RIDER EFFECTIVE DATE. PLEASE READ YOUR RIDER CAREFULLY.

We will pay Dental and Vision benefits subject to the:

- Rider Deductible Amount;
- Insured Percent of covered expenses up to the Rider Maximum Amount per Calendar Year;
- Definitions, limitations and exclusions and other provisions of the Policy and this Rider.

DENTAL AND VISION BENEFIT - After You satisfy the Rider Deductible Amount, We will pay the Insured Percent of covered expenses up to the Rider Maximum Amount per Calendar Year, subject to the timeframes below.. The Rider Deductible, Insured Percent and the Rider Maximum Amounts are shown in the Rider Schedule.

1. **Dental**

We will pay up to the Rider Maximum Amount for services of a licensed Dentist including one annual examination and cleaning, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as necessary by a Dentist, according to the timeframes below.

After this Rider has been in force three (3) months, we will pay the cost of one (1) dental cleaning, occurring after such three (3) month period, up to the Dental Cleaning Maximum each Calendar Year as shown in the Rider Schedule. This benefit is not subject to the Rider Deductible Amount; however, it is subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force six (6) months, we will pay benefits for fillings or root canal treatment occurring after such six (6) month period, subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force twelve (12) months, we will pay benefits for bridges, crowns, full dentures or partials, any services or treatment relating to the replacement of natural teeth which were missing on this rider's Effective Date, out-patient dental surgery, "full mouth" extractions or fluoride treatments occurring after such twelve (12) month period and subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force twelve (12) months, we will pay benefits for replacement or repair of existing bridges or dentures occurring after such twelve (12) month period, not to exceed the Rider Maximum Amount per Calendar Year as listed in the Rider Schedule. If replacement or repair of existing bridges or dentures is needed as the result of Injury, the 12 month period is not applicable.

2. **Vision**

We will pay up to the Rider Maximum Amount for visits to a licensed ophthalmologist or optometrist for the purpose of eye refractions and examinations, including the cost of eyeglasses or contact lenses as prescribed by such doctor, according to the timeframes below.

After this Rider has been in force three (3) months, we will pay the cost of one (1) eye exam or one (1) eye refraction, occurring after such three (3) month period, up to the Eye Exam Maximum each Calendar Year as shown in the Rider Schedule. This benefit is not subject to the Rider Deductible Amount; however, it is subject to the Rider Maximum Amount per Calendar Year.

After this Rider has been in force six (6) months, we will pay benefits for eyeglasses or contact lenses purchased after such six (6) month period, not to exceed the Prescription Eyewear maximum of \$200 per Calendar year as listed in the Rider Schedule. If eyeglasses or contact lenses are needed as the result of Injury, the six (6) month period is not applicable.

DENTAL AND VISION RIDER EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
 - That performed by a Dental Hygienist under the supervision of a Dentist; and
 - X-rays ordered by a Dentist.
- Treatment, services or supplies which:
 - Are not Necessary Dental Treatment, except as provided herein;

- Are Experimental/Investigational in nature;
- Conditions covered by Workers Compensation Services.
- Treatment by a Family Member;
- Services or supplies for which there would be no charge in the absence of insurance;
- A service furnished to You for:
 - Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic; or
 - Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule).
- Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments; denture duplication; or sealants.
- Oral hygiene instructions; plaque control; acid etch; or prescription for take-home fluoride.
- Overdentures and associated procedures.
- Services not completed by the end of the month in which insurance terminates.
- Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:

- Treatment, services or supplies which:
 - Are Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay; or
 - Treatment by any Family Member.
- Conditions covered by Worker's Compensation Services;
- Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids;
- Non-prescription (plano) eyewear;
- Medical or surgical treatments of the eyes, unless to correct refraction of the eyes; or
- Eye examinations required by an employer as a condition of employment.

RENEWAL CONDITIONS

This Rider is renewed when the Policy to which it is attached is renewed.

TERMINATION

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date You ask Us, in writing, to cancel this Rider; or
3. The date the Policy lapses for non-payment of premium.

PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium in the time required by Your state.]