



## AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687  
(904) 992-1776

A Stock Company

### GROUP CRITICAL ILLNESS INSURANCE POLICY NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, or our) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy.

The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholders' signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

A handwritten signature in cursive script that reads "Gary Stewart".

Secretary

A handwritten signature in cursive script that reads "Gregory J. Seidos".

President

**THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**

## TABLE OF CONTENTS

POLICY SPECIFICATIONS.....	3
POLICYHOLDER PROVISIONS .....	4-5
GLOSSARY.....	6-7
CERTIFICATE PROVISIONS MADE PART OF GROUP POLICY .....	7

## POLICY SPECIFICATIONS

POLICYHOLDER: TORTOISE INVESTMENTS, LLC  
 POLICY NUMBER: 33179  
 POLICY EFFECTIVE DATE: JANUARY 1, 2018  
 POLICY ANNIVERSARY DATE: January 1, 2019 and the first day of January each calendar year thereafter.  
 GOVERNING JURISDICTION: the state of Kansas and subject to the laws of that jurisdiction.

**ELIGIBLE CLASS(ES):** All full-time active employees working at least 30 hours per week.

**ELIGIBILITY WAITING PERIOD:** First date of calendar month after date of hire

**PLAN I - BASIC BENEFIT AMOUNT:** \$10,000 for Insured Employee  
 \$5,000 for Insured Spouse  
 \$5,000 for Insured Child(ren)

**GUARANTEED ISSUE LIMIT:** \*\$50,000

**OPTIONAL BENEFITS:** Cancer Critical Illness Benefit – Same as Basic Benefit Amount  
 Wellness Benefit - \$50.00 per year per covered person

\* Employees who were covered for amounts of insurance under the prior Group Critical Illness policy sponsored by the policyholder in excess of \$5,000, up to a maximum of \$50,000, in increments of \$1,000. Such employees are eligible for equal amounts of coverage under this Critical Illness policy. The Guaranteed Issue Limit for employees insured under the prior group policy is their benefit amount at the time prior policy terminated.

**INITIAL RATE:** Monthly rate per employee for **PLAN I:**

Premium Rates	Age	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
<b>Non-Tobacco</b>	18-35	\$7.35	\$11.15	\$7.35	\$11.15
	36-50	\$16.35	\$24.65	\$16.35	\$24.65
	51-60	\$33.55	\$50.45	\$33.55	\$50.45
	61-63	\$51.95	\$78.05	\$51.95	\$78.05
	64+	\$75.85	\$113.90	\$75.85	\$113.90
<b>Tobacco</b>	18-35	\$11.45	\$17.30	\$11.45	\$17.30
	36-50	\$27.65	\$41.60	\$27.65	\$41.60
	51-60	\$57.05	\$85.70	\$57.05	\$85.70
	61-63	\$81.75	\$122.75	\$81.75	\$122.75
	64+	\$120.05	\$180.20	\$120.05	\$180.20

## POLICY SPECIFICATIONS (Continued)

**PLAN II - BASIC BENEFIT AMOUNT:**     \$30,000 for Insured Employee  
                                                    \$15,000 for Insured Spouse  
                                                    \$15,000 for Insured Child(ren)

**GUARANTEED ISSUE LIMIT:**             \*\$50,000

**OPTIONAL BENEFITS:**                    Cancer Critical Illness Benefit – Same as Basic Benefit Amount  
                                                    Wellness Benefit - \$50.00 per year per covered person

\* Employees who were covered for amounts of insurance under the prior Group Critical Illness policy sponsored by the policyholder in excess of \$5,000, up to a maximum of \$50,000, in increments of \$1,000. Such employees are eligible for equal amounts of coverage under this Critical Illness policy. The Guaranteed Issue Limit for employees insured under the prior group policy is their benefit amount at the time prior policy terminated.

**INITIAL RATE:**                             Monthly rate per employee for **PLAN II:**

<b>Premium Rates</b>	<b>Age</b>	<b>Employee Only</b>	<b>Employee &amp; Spouse</b>	<b>Employee &amp; Child(ren)</b>	<b>Family</b>
<b>Non-Tobacco</b>	18-35	\$17.56	\$26.46	\$17.56	\$26.46
	36-50	\$44.56	\$66.97	\$44.56	\$66.97
	51-60	\$96.15	\$144.36	\$96.15	\$144.36
	61-63	\$151.35	\$227.15	\$151.35	\$227.15
	64+	\$223.06	\$334.71	\$223.06	\$334.71
<b>Tobacco</b>	18-35	\$29.85	\$44.89	\$29.85	\$44.89
	36-50	\$78.45	\$117.79	\$78.45	\$117.79
	51-60	\$166.65	\$250.10	\$166.65	\$250.10
	61-63	\$240.77	\$361.28	\$240.77	\$361.28
	64+	\$355.65	\$533.60	\$355.65	\$533.60

**POLICY SPECIFICATIONS (Continued)**

**PLAN III - BASIC BENEFIT AMOUNT:** \$50,000 for Insured Employee  
 \$25,000 for Insured Spouse  
 \$25,000 for Insured Child(ren)

**GUARANTEED ISSUE LIMIT:** \*\$50,000

**OPTIONAL BENEFITS:** Cancer Critical Illness Benefit – Same as Basic Benefit Amount  
 Wellness Benefit - \$50.00 per year per covered person

\* Employees who were covered for amounts of insurance under the prior Group Critical Illness policy sponsored by the policyholder in excess of \$5,000, up to a maximum of \$50,000, in increments of \$1,000. Such employees are eligible for equal amounts of coverage under this Critical Illness policy. The Guaranteed Issue Limit for employees insured under the prior group policy is their benefit amount at the time prior policy terminated.

**INITIAL RATE:** Monthly rate per employee for **PLAN I:**

<b>Premium Rates</b>	<b>Age</b>	<b>Employee Only</b>	<b>Employee &amp; Spouse</b>	<b>Employee &amp; Child(ren)</b>	<b>Family</b>
<b>Non-Tobacco</b>	18-35	\$27.77	\$41.78	\$27.77	\$41.78
	36-50	\$72.77	\$109.28	\$72.77	\$109.28
	51-60	\$158.76	\$238.27	\$158.76	\$238.27
	61-63	\$250.75	\$376.25	\$250.75	\$376.25
	64+	\$370.26	\$555.52	\$370.26	\$555.52
<b>Tobacco</b>	18-35	\$48.24	\$72.49	\$48.24	\$72.49
	36-50	\$129.24	\$193.99	\$129.24	\$193.99
	51-60	\$276.26	\$414.52	\$276.26	\$414.52
	61-63	\$399.78	\$599.80	\$399.78	\$599.80
	64+	\$591.26	\$887.02	\$591.26	\$887.02

**RATE GUARANTEE DATE:** 01/01/2019

**PREMIUM DUE:** The initial date agreed to between American Heritage Life Insurance Company and the policyholder and each specified date thereafter.

The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

**COST OF COVERAGE:** The insured employee pays the cost of the coverage

**DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:**

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

**NAME**

NONE

**LOCATION (CITY AND STATE)**

## **POLICYHOLDER PROVISIONS**

### **RATE GUARANTEE**

A change in premium rate will not take effect before the Rate Guarantee Date except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insured employees or members changes by 25% or more; or
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than 25% of those eligible for coverage are participating.

We will notify the policyholder in writing at least 30 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

### **PREMIUM INCREASES OR DECREASES**

Premium increases or decreases may take effect any time subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

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

### **INFORMATION REQUIRED FROM THE POLICYHOLDER**

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
  - a. who are eligible to become insured; and
  - b. whose coverage changes; and
  - c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

### **WHEN EVIDENCE OF INSURABILITY IS REQUIRED**

Evidence of insurability is required if:

1. the employee or member:
  - a. voluntarily canceled coverage and is reapplying; or
  - b. is applying for an amount of coverage over the Guaranteed Issue Limit; or
  - c. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period.
2. an eligible dependent did not enroll within 31 days of eligibility.

## **POLICYHOLDER PROVISIONS (Continued)**

### **INCONTESTABILITY**

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void this policy.

### **CLERICAL ERROR**

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

### **CANCELING POLICY**

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 31 days written notice to the policyholder, if:

1. less than 25% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 5 employees or members are insured; or
6. the policyholder fails to pay any premium within the 31 day grace period.

If the premium is not paid during the grace period, this policy will terminate automatically at the end of the grace period. The policyholder is liable for the premium for coverage during the grace period. The policyholder must pay us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

### **ENTIRE CONTRACT**

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the insured employee or member.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

### **CERTIFICATES OF INSURANCE**

We will issue certificates of insurance for each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the benefits provided; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to coverage under this policy.

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

## GLOSSARY

**Active Employment.** Means the employee or member is working for the employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. For the purposes of this policy:

1. the employee or member must be working at least the minimum number of hours as described under Eligible Class(es); and
2. the employee or member will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee's or member's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires such employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

**Calendar Year.** Means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

**Eligibility Waiting Period.** Means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible for coverage.

**Employee.** Means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

**Employer.** Means the individual, company or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

**Evidence of Insurability.** Means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.

**Family Coverage.** Means coverage that includes the insured employee or member as defined, his or her eligible spouse and children as described in the certificate.

**Grace Period.** Means a period of 31 days following the premium due date during which premium payment may be made.

**Individual and Child(ren) Coverage.** Means coverage that includes only the insured employee or member, as defined and eligible children as described in the certificate.

**Individual and Spouse Coverage.** Means coverage that includes only the insured employee or member, as defined, and his or her eligible spouse as described in the certificate.

**Individual Coverage.** Means coverage that includes only the insured employee or member, as defined.

**Initial Enrollment Period.** Means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending 31 days after the date he or she is first eligible to apply for coverage.



## **GLOSSARY (Continued)**

**Insured Employee or Member.** Means the employee or member accepted for coverage by us who has completed and signed the enrollment form or evidence of insurability and whose name appears on the certificate specification page.

**Member.** Means a member in good standing in an labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States; and (b) is (1) engaged in, or (2) able to engage in and currently seeking, active employment.

**Policyholder.** Means the legal entity to whom this policy is issued.

**We, Us, and Our.** Means American Heritage Life Insurance Company.

## **CERTIFICATE PROVISIONS MADE PART OF THIS GROUP POLICY**

The remainder of this group policy consists of the provisions that will appear in the group certificate, including any optional riders or endorsements or amendments. The group certificate describes the insurance made available under this group policy to insured employees or members and their dependents, if applicable.

**(This space intentionally left blank.)**



**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687  
(904) 992-1776

A Stock Company

**THIS IS A CRITICAL ILLNESS POLICY WHICH PROVIDES STATED BENEFITS FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**



## AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:

1776 AMERICAN HERITAGE LIFE DRIVE

JACKSONVILLE, FLORIDA 32224-6687

(904) 992-1776

A Stock Company

### Endorsement

**This Endorsement is made a part of the Group Policy to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this Endorsement.**

The CERTIFICATES OF INSURANCE provision in the GENERAL PROVISIONS section is deleted in its entirety and replaced with the following:

#### **CERTIFICATES OF INSURANCE**

We will furnish to the policyholder a certificate of insurance for delivery to each insured employee or member. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

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

All other requirements of the policy not specifically stated within this endorsement still apply.

Secretary



## AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687  
(904) 992-1776

A Stock Company

### CERTIFICATE OF INSURANCE

This certificate of insurance ("certificate") describes your insurance coverage under the policy.

In this certificate, the words:

"You" and "your" mean the named insured employee or member shown on the Certificate Specifications page who is a member of an eligible class as described in the policy and for whom premiums are remitted.

"We", "us" and "our" mean American Heritage Life Insurance Company.

"This policy" and "the policy" mean the policy of insurance issued by us to the policyholder.

The policy alone makes up the agreement under which insurance coverage is provided and benefits are determined. If the terms of your certificate and the policy differ, the policy will govern. The policy may be inspected at the office of the policyholder during normal business hours.

Coverage under the policy is issued in consideration of your enrollment or other form of application and the payment of the first premium.

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due.

The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

The policy and this certificate may be changed in whole or in part or cancelled by agreement between us and the policyholder. Such an action may be taken without the consent or notice to you or anyone covered under the policy. Only an authorized officer at our home office can approve a change. The approval must be in writing and endorsed on or attached to the policy. No other person, including an agent, may change the policy or certificate or waive any of its provisions. Premiums are subject to periodic changes.

This certificate supersedes and replaces any certificate previously issued to you under the policy.

A handwritten signature in black ink that reads "Cary Stewart".

Secretary

A handwritten signature in black ink that reads "Gregory J. Seides".

President

**THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS  
ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED.  
THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**

**TABLE OF CONTENTS**

**CERTIFICATE SPECIFICATIONS .....3**

**GENERAL PROVISIONS ..... 4 – 8**

**CONTINUATION OF INSURANCE (COBRA) ..... 9 – 10**

**PORTABILITY ..... 11**

**LIMITATIONS AND EXCLUSIONS ..... 12**

**BENEFITS..... 13-15**

**CLAIM INFORMATION ..... 16-17**

**GLOSSARY ..... 18 – 20**

**AMERICAN HERITAGE LIFE INSURANCE COMPANY**  
 1776 American Heritage Life Drive, Jacksonville, Florida 32224

**CERTIFICATE SPECIFICATIONS**

FORM NO.	DESCRIPTION OF BENEFITS		ANNUAL PREMIUM AMOUNT
GVCIC2KS	INITIAL CRITICAL ILLNESS	BASIC BENEFIT AMOUNT	\$00.00
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
		INSURED CHILD(REN)	\$25,000
	SECOND EVENT INITIAL CRITICAL ILLNESS	SAME AMOUNT AS INITIAL CRITICAL ILLNESS	\$00.00
	CANCER CRITICAL ILLNESS	BASIC BENEFIT AMOUNT	\$00.00
	INSURED EMPLOYEE	\$50,000	
	INSURED SPOUSE	\$25,000	
		INSURED CHILD(REN)	\$25,000
	SECOND EVENT CANCER CRITICAL ILLNESS	SAME AMOUNT AS CANCER CRITICAL ILLNESS	\$00.00
	SUPPLEMENTAL CRITICAL ILLNESS I	BASIC BENEFIT AMOUNT	\$00.00
INSURED EMPLOYEE	\$50,000		
INSURED SPOUSE	\$25,000		
	INSURED CHILD(REN)	\$25,000	
INCREASING CRITICAL ILLNESS BENEFIT			\$00.00
INSURED EMPLOYEE	\$250.00/PER COVERAGE YEAR*		
INSURED SPOUSE	\$125.00/PER COVERAGE YEAR*		
	INSURED CHILD(REN)	\$125.00/PER COVERAGE YEAR*	
		*FOR COVERAGE YEARS 2-5	
WELLNESS BENEFIT		\$25/TEST	\$00.00
FAMILY COVERAGE			

The effective date of each benefit is the Effective Date unless otherwise specified.

**TOTAL PREMIUMS**

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
\$000.00	\$000.00	\$00.00	\$00.00	\$00.00

Premium Payment Method	PAYROLL – MONTHLY	Premium Class	TOBACCO/NON-TOBACCO
------------------------	-------------------	---------------	---------------------

INSURED:	JOHN DOE	ISSUE AGE:	35
EFFECTIVE DATE:	MAY 01, 2010	CERTIFICATE NUMBER:	123456
POLICY NUMBER:	GROUP106		
BENEFICIARY:	AS NAMED AT ENROLLMENT OR LATER CHANGED		

GROUP CRITICAL ILLNESS COVERAGE

GVCIC2KS

## GENERAL PROVISIONS

### EFFECTIVE DATE OF COVERAGE

Your coverage will be effective at 12:01 a.m. on the effective date shown on the Certificate Specifications page provided you are actively employed on that date.

If you are not actively employed on that date due to disability, injury, sickness, temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date you return to active employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

For any change in coverage that is subject to evidence of insurability, the change in coverage is effective on the date we approve such change.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.

### WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE COVERAGE

1. You may apply for coverage during:
  - a. the initial enrollment period; or
  - b. at any other time, subject to evidence of insurability.
2. You may increase coverage at any time, subject to evidence of insurability.
3. You may discontinue coverage at any time.

### WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. you:
  - a. voluntarily canceled coverage and are reapplying; or
  - b. are applying for an amount of coverage over the guaranteed issue limit; or
  - c. are applying for the coverage, or an increase in the amount of coverage, at any time after your initial enrollment period; or
2. an eligible dependent did not enroll within 31 days of eligibility.

**(This space intentionally left blank.)**

## GENERAL PROVISIONS (Continued)

### ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. your legal spouse or domestic partner; and
2. your unmarried children including adopted children from the moment of placement in the residence, stepchildren, children of a domestic partner or legal ward who are under 22 years old, or under 26 years old and full-time students at an educational institution of higher learning beyond high school. Your children must be dependent on you for support or reside with you over 50% of the time in a regular parent-child relationship and be named on the enrollment or evidence of insurability form.

After the effective date, any person (except newborns, who are covered from the moment of birth) who becomes an eligible dependent can be added to the certificate if we are notified within 31 days after they become eligible.

If you have Individual Coverage or Individual and Child(ren) Coverage, then marry and desire coverage for your spouse, we must be notified within 31 days of the marriage. We will change the coverage to Individual and Spouse Coverage or Family Coverage and provide notification of the additional premium due. If we are not notified within 31 days of the marriage, then evidence of insurability will be required for the spouse.

If you have Individual Coverage or Individual and Child(ren) Coverage, then establish a domestic partnership and desire coverage for your domestic partner, we must be notified within 31 days of the date the domestic partnership was formed. We will change the coverage to Individual and Spouse Coverage or Family Coverage and provide notification of the additional premium due. If we are not notified within 31 days of the date a domestic partnership was formed, then evidence of insurability will be required.

A child born to you or your spouse or domestic partner, while Individual and Child(ren) Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under the certificate. No additional premium will be required for newborns added if Individual and Child(ren) Coverage or Family Coverage is in force at the time the newborn is added.

If you have Individual Coverage or Individual and Spouse Coverage, newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for a newborn child, you must notify us within 31 days of that child's birth. Upon notification, we will convert your Individual Coverage to Individual and Child(ren) Coverage or Individual and Spouse Coverage to Family Coverage and provide notification of the additional premium due. If you do not notify us within 31 days of the birth of the child, the temporary automatic coverage ends.

An adopted child or child pending adoption will be covered as follows, as long as Individual and Child(ren) Coverage or Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by you within 31 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, coverage will begin from the date of the petition or adoption from the moment of placement, in no case shall the time from the date of placement to the date the petition for adoption exceed 280 days.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.



## GENERAL PROVISIONS (Continued)

### TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day you are actively employed with your employer or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE provision; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible; or
6. the date you have received the maximum total percentage of the basic benefit amount for each critical illness; or
7. upon our discovery of fraud or material misrepresentation in the presentation of a claim under this certificate.

We will provide coverage for a payable claim that occurs while a covered person is covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death.

Coverage for a dependent child ends on your death or the certificate anniversary next following the date the child is no longer eligible. This is the earlier of when the child: (a) marries; or (b) reaches age 22 (26 if a full-time student attending an educational institution of higher learning beyond high school); or (c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

The child's coverage continues as long as the certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if you have Individual and Children Coverage or Family Coverage and there are other eligible dependents insured under the policy.

Coverage may be eligible for continuation as outlined in the CONTINUATION OF INSURANCE (COBRA) provision or the PORTABILITY PRIVILEGE provision.

### TEMPORARY LAYOFF, LEAVE OF ABSENCE OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If you cease active employment or membership in the union or association because of a temporary layoff or leave of absence while coverage is in force, we will continue your coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved your leave in writing. Coverage will be continued for 3 months following the date you ceased active employment or membership in the union or association.

If your coverage ends while on a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active status.

We will not:

1. apply a new pre-existing condition exclusion; or
2. require evidence of insurability.

## **GENERAL PROVISIONS (Continued)**

### **WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR GROUP INSURANCE**

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior group policy if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. you:
  - a. were in active employment on the policy date of this policy; and
  - b. had been continuously insured under this policy since the policy date; and
  - c. were insured under the prior group policy when it terminated; and
3. the covered person making the claim:
  - a. has been continuously insured under this policy since the policy date; and
  - b. was insured under the prior group policy when it terminated; and
4. the prior group policy:
  - a. had the same policyholder as this policy; and
  - b. provided coverage substantially similar to this policy; and
  - c. was issued before the policy date of this policy; and
  - d. terminated within 60 days of the policy date of this policy.

### **WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR INDIVIDUAL INSURANCE**

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior individual policy if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. you:
  - a. were in active employment on the policy date of this policy; and
  - b. had been continuously insured under this policy since the policy date; and
  - c. were insured under the prior individual policy when it terminated; and
3. the covered person making the claim:
  - a. has been continuously insured under this policy since the policy date; and
  - b. was insured under the prior individual policy when it terminated; and
4. the prior individual policy:
  - a. provided coverage substantially similar to this policy; and
  - b. was issued before the policy date of this policy; and
  - c. terminated within 60 days of the policy date of this policy.

### **LEGAL ACTION**

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 5 years from the time written proof of loss is required to have been furnished.

## **GENERAL PROVISIONS (Continued)**

### **INCONTESTABILITY**

After 2 years from the effective date of coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim.

### **CLERICAL ERROR**

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by us or the policyholder documenting any clerical errors.

### **AGENCY**

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

**(This space intentionally left blank.)**

## **CONTINUATION OF INSURANCE (COBRA)**

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if your insurance would otherwise end due to one of the following events, called a qualifying event:

1. Termination of employment (other than by reason of gross misconduct), or of your eligibility due to reduction in your hours. Insurance may be continued for you and any dependents, except for domestic partners and their covered dependents.
2. Your death. Insurance may be continued for any covered person, except for domestic partners and their covered dependents.
3. Divorce or legal separation. Insurance may be continued for any dependent whose insurance would otherwise end. However, COBRA does not extend continuation of coverage to domestic partners and their dependents.
4. Your becoming eligible for Medicare. Insurance may be continued for any insured's dependents who are not entitled to Medicare, except for domestic partners and their covered dependents.
5. A child ceasing to be an eligible dependent as defined in the policy. Insurance may be continued for that child.
6. Your employer files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of critical illness insurance, you must be insured under the policy on the day before the qualifying event. In the case of bankruptcy, you must also be: (a) an employee who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

You will not be denied continuation solely because you are covered under another group critical illness plan or eligible for Medicare on the date the qualifying event occurs.

### **COVERAGE CONTINUED**

The insurance being continued by this section is subject to all terms and provisions of the policy that do not conflict with this section. The insurance will be the same as if the qualifying event had not occurred. The continued insurance will be subject to any changes to the policy affecting the benefits of your class following the qualifying event.

### **NOTIFICATION AND PAYMENT REQUIREMENTS**

You have the responsibility to inform your employer of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

Your employer has the responsibility of notifying the plan administrator of: (a) your death, termination of employment, or reduction in hours; or (b) your employer's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify you of the right to continue within 14 days of the notice described above. You will then have 60 days to elect to continue your insurance. Failure to elect to continue insurance within 60 days after you are notified by the plan administrator will result in loss of the right to continue such insurance.

You will be required to pay a premium for the continued insurance to the policyholder. You will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

## CONTINUATION OF INSURANCE (COBRA) – (Continued)

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

### TERMINATION

Insurance being continued by this section will terminate on the first of the following dates that apply:

1. The date the policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverages have been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date you become covered under any other group critical illness policy, whether as an insured employee or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date you become entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees of employers under Chapter 11 Bankruptcy and their dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
  - a. If you are totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, you must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
    1. within 60 days of the Social Security determination of total disability; and
    2. within the initial 18 months of continuation coverage.
  - b. If you have a qualifying event (termination or reduction in hours worked) and you had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
    1. 36 months from the date you first became entitled to Medicare; or
    2. 18 months from your termination or reduction in hours.
  - c. For a qualifying event involving retired employees of employers under Chapter 11 Bankruptcy and their dependents, the maximum period of continuation coverage is:
    1. the lifetime of the retiree; or
    2. the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
    3. 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.

## **PORTABILITY PRIVILEGE**

We will provide portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

1. coverage under the policy terminates under the TERMINATION OF COVERAGE provision; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made for that purpose.

No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

### **PORTABILITY COVERAGE**

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

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

### **PORTABILITY PREMIUMS**

Premiums for portability coverage are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The portability premium rate may differ from the premium rate in effect for insured employees or members and may change on any premium due date. If you are on portability coverage, we will give you written notice at least 31 days before a change is to take effect.

### **GRACE PERIOD**

The grace period, as defined in the policy, will apply to each certificate holder of portability coverage as if such covered person is the policyholder.

### **TERMINATION OF INSURANCE**

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

1. the date you again become eligible for insurance under the policy; or
2. the last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period; or
3. with respect to insurance for dependents:
  - a. the date your insurance terminates; or
  - b. the date the dependent ceases to be an eligible dependent, as defined.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

### **TERMINATION OF THE POLICY**

If the policy terminates, you and your covered dependents will be eligible to exercise the portability privilege on the termination date of the policy. Portability coverage may continue beyond the termination date of the policy, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

### **PRE-EXISTING CONDITION LIMITATION**

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from, a pre-existing condition when the date of diagnosis for the critical illness is within 12 months after the effective date of coverage.

A pre-existing condition is a sickness, injury or other condition, whether diagnosed or not, for which, during the 12 months just prior to the effective date of coverage, either:

1. symptoms existed; or
2. medical advice or treatment was recommended by or received from a physician or other member of the medical profession, acting within the scope of their license.

### **EXCLUSIONS**

We will not pay benefits for a critical illness that is, or is caused by, contributed to by or results from:

1. War, declared or undeclared, participation in a riot, insurrection or rebellion.
2. Intentionally self-inflicted injury or action.
3. Illegal activities or participation in an illegal occupation.
4. Suicide while sane, or self-destruction while insane, or any attempt at either.
5. Substance abuse, to include abuse of alcohol, alcoholism, drug addiction or dependence upon any controlled substance.

**(This space intentionally left blank.)**

## CRITICAL ILLNESS BENEFIT

### GENERAL

Subject to the conditions, limitations and exclusions of this coverage, we will pay a benefit when a covered person is diagnosed with a critical illness described in this coverage if:

1. the date of diagnosis for the critical illness is while the covered person is insured under the policy; and
2. the critical illness is not excluded by name or specific description.

A covered person can receive a benefit for each critical illness only once, unless the Second Event Critical Illness Benefit for that critical illness is included in the coverage.

A covered person can receive benefits for different critical illnesses described in the policy if the dates of diagnosis for each critical illness are separated by at least 90 days.

Coverage for a covered person terminates when the covered person is not eligible for any further benefits.

Each critical illness must be diagnosed by a physician in the United States. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant. Emergency situations that occur while the covered person is outside the United States may be reviewed and considered for approval by a United States physician on foreign soil or when the covered person returns to the United States.

We do not pay any benefit for any condition or loss not described below.

### INITIAL CRITICAL ILLNESS BENEFIT

**A. BENEFIT AMOUNT.** The benefit amount for each initial critical illness is the percentage shown below for that initial critical illness multiplied by the basic benefit amount shown on the Certificate Specifications page applicable to the covered person.

Initial Critical Illness	Percentage of Basic Benefit Amount
Heart Attack	100%
Stroke	100%
Coronary Artery By-Pass Surgery	25%
Major Organ Transplant	100%
End Stage Renal Failure	100%

**B. BENEFIT DESCRIPTION.** The initial critical illnesses are:

1. **Heart Attack.** The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area.

The diagnosis must be based on both:

- a. new electrocardiographic changes; and
- b. elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

Heart attack does not include an established (old) myocardial infarction.

The date of diagnosis for Heart Attack is the date of death (infarction) of a portion of the heart muscle.

2. **Stroke.** The death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

Stroke does not include: transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits.

The date of diagnosis for Stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.



## CRITICAL ILLNESS BENEFIT (Continued)

### B. BENEFITS DESCRIPTION. (Continued)

3. **Coronary Artery By-Pass Surgery.** The surgical operation to correct narrowing or blockage of one or more coronary arteries with by-pass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required.

Coronary artery by-pass surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

The date of diagnosis for Coronary Artery By-Pass Surgery is the date the actual coronary artery by-pass surgery occurs.

4. **Major Organ Transplant.** The surgical transplantation of a heart, lung, liver, pancreas, or kidney. The transplanted organ must come from a human donor.

The date of diagnosis for Major Organ Transplant is the date the actual surgery occurs for the covered transplant.

5. **End Stage Renal Failure.** The irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis.

End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas.

The date of diagnosis for End Stage Renal Failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.

(This space intentionally left blank.)

**OPTIONAL BENEFITS**

**CANCER CRITICAL ILLNESS BENEFIT**

**A. BENEFIT AMOUNT.** The benefit amount for each cancer critical illness is the percentage shown below for that cancer critical illness multiplied by the basic benefit amount shown on the Certificate Specifications page applicable to the covered person.

<b>Cancer Critical Illness</b>	<b>Percentage of Basic Benefit Amount</b>
Carcinoma in situ	25%
Invasive Cancer	100%

**B. BENEFIT DESCRIPTION.** The cancer critical illnesses are:

1. **Carcinoma In Situ.** A cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

Carcinoma in situ includes:

- a. early prostate cancer diagnosed as stages A, I or II or equivalent staging; and
- b. melanoma not invading the dermis.

Carcinoma in situ does not include:

- a. other skin malignancies; or
- b. pre-malignant lesions (such as intraepithelial neoplasia); or
- c. benign tumors or polyps.

2. **Invasive Cancer.** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Invasive Cancer includes Leukemia and Lymphoma.

Invasive cancer does not include:

- a. carcinoma in situ; or
- b. tumors in the presence of any human immuno-deficiency virus; or
- c. skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or
- d. early prostate (stages A, I or II) cancer.

**C. DIAGNOSIS REQUIREMENTS.** A cancer critical illness must be diagnosed in one of two ways:

1. **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set by the American Board of Pathology.

2. **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis only if:

- a. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- b. there is medical evidence to support the diagnosis.

The date of diagnosis for cancer critical illness is the day the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based.

The “first diagnosis of cancer” includes a diagnosis of a recurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the recurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter.

For purposes of this benefit, “treatment” does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

“Maintenance drug therapy” means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer recurrence rather than the palliation or suppression of a cancer that is still present.

## OPTIONAL BENEFITS

### WELLNESS BENEFIT

We pay the amount shown on the Certificate Specifications page per calendar year per covered person for any one of the below. Each covered person is covered for no more than the amount shown on the Certificate Specifications page per calendar year. The eligible Wellness Benefits are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

**(This space intentionally left blank.)**

## WAIVER OF PREMIUM BENEFIT

We will waive your premiums for this coverage if, while covered under the policy, you:

1. become disabled due to a critical illness for which a benefit is paid; and
2. remain disabled for at least 90 consecutive days.

After the 90<sup>th</sup> day, we will waive the premiums due for the first 90 days and each consecutive day thereafter you are disabled, until the earliest of:

1. the date you are no longer disabled; or
2. 2 years from the first day of disability; or
3. the date coverage ends according to the TERMINATION OF COVERAGE provision.

"Disabled" means you are:

1. unable to work; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

"Unable to work" means:

1. During the first 365 days of disability, you are unable to work at the occupation you were performing when your disability began.
2. During the second 365 days of disability, you are unable to work at any gainful occupation for which you are suited by education, training or experience.

This benefit is payable only for the disability of the insured employee or member. It does not apply to any other covered person. You must provide sufficient proof of disability at least once every 6 months.

**(This space intentionally left blank.)**

## **CLAIM INFORMATION**

### **NOTICE OF CLAIM**

We encourage you to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any benefit covered by the policy, or as soon as is reasonably possible. Notice given to us by, or on behalf of, you or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with your name and certificate number, is notice to us.

The claim form can be requested from us. If the form is not received from us within 15 days of the request, written proof of claim may be sent to us without waiting for the form.

### **FILING A CLAIM**

You must complete all applicable sections of the claim form and then give it to your attending physician. The physician should complete his or her section statement of the form and send it directly to us.

### **PROOF OF CLAIM**

Written proof must be furnished to us within 90 days of each critical illness or payable loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

### **PHYSICAL EXAMINATION AND AUTOPSY**

We have the right, at our own expense, to have you examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

### **PAYMENT OF CLAIMS**

After receiving written proof of claim, we will immediately pay all benefits then due under this certificate and we will make payment to you. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate.

If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to \$1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

### **OVERPAID CLAIM**

We have the right to correct benefit payments that are made in error. You have the responsibility to return any overpayment to us. We have the responsibility to make additional payments if any underpayments have been made.

### **UNPAID PREMIUM**

Upon the payment of a claim under the policy, any unpaid premium may be deducted.

## **CLAIM INFORMATION (Continued)**

### **CLAIM REVIEW**

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

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. your right to submit any additional information that might allow us to change our decision.

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

### **APPEALS PROCEDURE**

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

**(This space intentionally left blank.)**

## GLOSSARY

**Active Employment** or **Actively Employed** means that the covered person is working for his/her employer for earnings that are paid regularly and that the covered person is performing the material and substantial duties of his/her regular occupation. When used in connection with you:

1. you must be working at least the minimum number of hours as described under Eligible Class(es); and
2. you will be deemed to be in active employment on a day which is not one of your employer's scheduled work days only if you were actively employed on the preceding scheduled work day.

The covered person's work site must be:

1. the employer's usual place of business; or
2. an alternative work site at the direction of the employer; or
3. a location to which the covered person's job requires travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

**Calendar Year** means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

**Covered Person** means any of the following:

1. any eligible family member (including you) named on the enrollment or evidence of insurability and acceptable for coverage by us; or
2. any eligible family member added by endorsement after the effective date; or
3. a newborn child.

**Critical Illness** means one of the critical illnesses described in the CRITICAL ILLNESS BENEFIT provision for which a benefit may be paid.

**Domestic Partner** means your same-sex or opposite-sex partner who is eligible for coverage provided that:

1. Both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. If your state of residence has no domestic partnership laws, but the policyholder seeks to provide insurance benefits to domestic partners, you must satisfy the definition of domestic partner as defined by the policyholder; or
3. If your state of residence has no domestic partnership law and the policyholder has no domestic partnership definition, but the policyholder seeks to provide insurance benefits to domestic partners, then both you and your same-sex or opposite-sex partner must:
  - a. have resided together in the same permanent residence; and
  - b. be at least 18 years of age; and
  - c. intend to remain each other's sole domestic partner indefinitely; and
  - d. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of one another; or the domestic partner must be chiefly dependent upon you for care and financial assistance; and
  - e. not be legally married to or the legal domestic partner of anyone else; and
  - f. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.

**Employer** means the individual, company or corporation where the covered person is in active employment, and includes any division, subsidiary, or affiliated company of the employer.

## GLOSSARY (Continued)

**Evidence of Insurability** means a statement of your or your dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.

**Family Coverage** means coverage that includes you, your spouse or domestic partner and eligible children.

**Grace Period** means a period of 31 days following the premium due date during which premium payment may be made.

**Individual Coverage** means coverage that includes only you, as defined.

**Individual and Children Coverage** means coverage that includes only you, as defined, and eligible children.

**Individual and Spouse Coverage** means coverage that includes only you, as defined, and your eligible spouse or domestic partner.

**Initial Enrollment Period** means one of the following periods during which you may first apply, in writing, for coverage under the policy:

1. a period before the policy effective date as set by us and the policyholder if you are eligible for coverage on the policy effective date; or
2. the period ending 31 days after the date you are first eligible to apply for coverage if you become eligible for coverage after the policy effective date.

**Injury** means accidental bodily injury.

**Material and Substantial Duties** means duties that:

1. are normally required for the performance of the covered person's regular occupation; and
2. cannot be reasonably omitted or modified, except that if the covered person is required to work on average in excess of 40 hours per week. We will consider the covered person able to perform that requirement if he/she is working or has the capacity to work 40 hours per week.

**Payable Claim** means a claim for which we are liable under the terms of the policy.

**Physician** means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize you, or your domestic partner, spouse, children, parents, or siblings as a physician for a claim.

**Policy** means the policy of insurance issued by us to the policyholder.

**Policy Date** means the effective date of the policy.

**Policyholder** means the legal entity to whom the policy is issued.

**Re-enrollment Period** means a period of time as set by the policyholder and us during which you may apply, in writing, for coverage under the policy, or change coverage under the policy if you are currently enrolled.

**Sickness** means an illness or disease.



## GLOSSARY (Continued)

**Symptoms** mean the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

**Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence** means you are absent from active employment for a period of time that has been agreed to in advance in writing by your employer.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

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

**We, Us** and **Our** mean American Heritage Life Insurance Company.

**You** and **Your** mean the named insured employee or member shown on the Certificate Specifications page who is a member of an eligible class as described in the policy and for whom premiums are remitted.

(This space intentionally left blank.)



**AMERICAN HERITAGE LIFE INSURANCE COMPANY**

**HOME OFFICE:**

**1776 AMERICAN HERITAGE LIFE DRIVE**

**JACKSONVILLE, FLORIDA 32224-6687**

**(904) 992-1776**

**A Stock Company**

**THIS IS A CRITICAL ILLNESS CERTIFICATE WHICH PROVIDES STATED BENEFITS  
ONLY FOR SPECIFIED SICKNESSES AND INJURIES OR OTHER BENEFITS THAT MAY BE ADDED.  
THIS CERTIFICATE DOES NOT PROVIDE BENEFITS FOR ANY OTHER CONDITIONS.**



## AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:  
1776 AMERICAN HERITAGE LIFE DRIVE  
JACKSONVILLE, FLORIDA 32224-6687  
(904) 992-1776

A Stock Company

### Endorsement

**This Endorsement is made part of the Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Policy, not inconsistent with this Endorsement.**

All references to the eligibility and termination of dependents are revised to the following:

Eligible dependents are:

1. your legal spouse or domestic partner; and
2. your children and your domestic partner's children.

A child is a person under age 26 who is:

1. your or your domestic partner's natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with you or your domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

If your domestic partner is a covered person, your domestic partner's coverage ends upon termination of the domestic partnership or your death.

Coverage for your child will end on the issue day of the month that follows when the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the 2 year period following the child's attainment of the limiting age for eligibility.

Domestic Partner means your same-sex or opposite-sex partner who is eligible for coverage provided that:

1. both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. if your state of residence has no domestic partnership laws, you must satisfy the definition of domestic partner as defined by the policyholder.

Issue day means the same day of the month as the effective date of coverage.

All other requirements of the certificate not specifically stated within this endorsement still apply.

Secretary



## ***Important Privacy Policy Notice***

At Allstate Benefits (“AB”), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information (“customer information”) that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we’ve asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

### **What do we do with your information?**

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

**What kind of customer information do we have, and where did we get it?**

Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

**How do we protect your customer information?**

We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

**How can you find out what information we have about you?**

You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB  
Policyholder Services (Privacy Section)  
1776 American Heritage Life Drive  
Jacksonville, FL 32224-6687

**If you are an Internet user ...**

Our website, [www.allstateatwork.com](http://www.allstateatwork.com), provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing [www.allstateatwork.com](http://www.allstateatwork.com), please be sure to read the Privacy Statement that appears there. To learn more, the [www.allstateatwork.com](http://www.allstateatwork.com) Privacy Statement provides information relating to your use of the website. This includes, for example:

- 1) our use of online collecting devices known as “cookies”;
- 2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
- 3) who should use our website;
- 4) the security of information over the Internet;
- 5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don't hesitate to contact your agent or write us at:

AB  
Policyholder Services (Privacy Section)  
1776 American Heritage Life Drive  
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

- |                                          |                                |
|------------------------------------------|--------------------------------|
| American Heritage Life Insurance Company | Holiday Life Insurance Company |
| Bluegrass Life Insurance Company         | Kentucky Home Mutual           |
| Acme United Insurance Company            | Keystone State Life            |
| SMA Life Assurance Company               | National Guardian Life         |



Benefits

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**EFFECTIVE APRIL 14, 2003**

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

- 1) the past, present or future physical or mental health condition of the individual; or
- 2) the provision of health care to the individual; or
- 3) the past, present or future payment for the provision of health care to the individual.

### **Uses and Disclosures of Protected Health Information With Your Written Authorization**

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any

time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

### **Uses and Disclosures of Protected Health Information Without Your Written Authorization**

**For Payment.** We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

**For Plan Administrative Operations.** We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

**To Individuals Involved In Your Care.** We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**To Our Business Associates.** Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

**To Plan Sponsors.** If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

**For Other Products and Services.** We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

**For Disclosure With Authorization.** Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

**For Other Uses and Disclosures.** We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.
- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.
- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.
- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.
- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.
- to law enforcement officials as required by law to report wounds, injuries or crimes.
- to coroners, medical examiners and/or funeral directors consistent with law.
- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.
- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

### **Your Rights**

**Right to Inspect and Copy Your Protected Health Information.** You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

**Right to Amend Your Protected Health Information.** You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

**Right to an Accounting of the Disclosures of Your Protected Health Information.** Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

**Right to Request Confidential Communications.** We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.



**Right to Request Restrictions on Use and Disclosure of Your Protected Health Information.** You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the “Contact Information” provided at the end of this Notice.

**Personal Representatives.** You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

**Right to Receive Paper Copy of this Notice.** You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

### **Complaints**

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the “Contact Information” at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

### **Contact Information**

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits  
Attn: HIPAA Privacy Officer  
1776 American Heritage Life Drive  
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

**GENERAL PURPOSES AND LIMITATIONS OF THE  
KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION  
K.S.A. 40-3001 et. seq.**

**DISCLAIMER**

THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR ALL OR A PORTION OF THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS AND EXCLUSIONS, AND IS CONDITIONED UPON RESIDENCY IN THIS STATE. THEREFORE, YOU SHOULD NOT RELY UPON COVERAGE BY THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY. INSURANCE COMPANIES AND THEIR AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELLING YOU ANY FORM OF AN INSURANCE POLICY, OR TO INDUCE YOU TO PURCHASE ANY FORM OF AN INSURANCE POLICY. EITHER THE KANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE KANSAS INSURANCE DEPARTMENT WILL RESPOND TO ANY QUESTIONS YOU MAY HAVE REGARDING THIS DOCUMENT.

Kansas Life and Health Insurance Guaranty Association  
2909 SW Maupin Lane  
Topeka, KS 66614

Kansas Insurance Department  
420 SW 9<sup>th</sup> Street  
Topeka, KS 66612

This is a brief summary of the Kansas Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. If there is any inconsistency between this notice and Kansas law, then Kansas law will control.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Kansas law, with funding from assessments paid by other insurance companies. This safety net was created under Kansas law, which determines who and what is covered and the amounts of coverage. The basic protections provided by the Association are:

- Life Insurance  
\$300,000 in death benefits  
\$100,000 in cash surrender or withdrawal values
- Health Insurance  
\$500,000 in hospital, medical and surgical insurance benefits  
\$300,000 in disability insurance benefits  
\$300,000 in long-term care insurance benefits  
\$100,000 in other types of health insurance benefits
- Annuities  
\$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits, as well as certain aggregate limits.