
Central States Health & Life Co. of Omaha

Cancer Supplemental Insurance

**In this packet:
Application
Outline of Coverage**

Georgia

**Additional forms may be required,
but not included in this packet**

**For use with
Brochure Form 406B
Monthly Maximum Options**

 **CSO** Central States Health & Life Co. of Omaha
P.O. Box 34350 • Omaha, NE 68134-0350

Section A: General Information

Applicant's Name (Print First, Middle, Last)			Sex	Birth Date	Social Security Number	
Street Address				Telephone		
City, State, Zip Code						
Spouse's Name (If to be insured)			Sex	Birth Date		
Children (Print First, Middle, Last)	Sex	Birth Date	Children (Print First, Middle, Last)	Sex	Birth Date	
1.			4.			
2.			5.			
3.			6.			

I hereby apply for the following coverage: Individual Single Parent Family Family

Cancer Policy Form C18 GA
Hospital Confinement Benefit (Check one): \$150 per day \$250 per day \$350 per day

Benefit Riders: Radiation Treatment, Chemotherapy, Hormone Therapy, Immunotherapy and Related Services Benefit Rider (Must check one): <input type="checkbox"/> Form 8302 <input type="checkbox"/> Form 8303 <input type="checkbox"/> Form 8304	Optional Benefit Riders: Internal Cancer First Occurrence Benefit Rider Form 8288 (Check one): <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 Hospital Intensive Care Confinement Benefit Rider Form 8290 with a Daily Benefit of (Check one): <input type="checkbox"/> \$300 <input type="checkbox"/> \$600 <input type="checkbox"/> Specified Disease Benefit Rider Form 8311
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Billing Type: Worksite Association _____ (name)
 List Bill Pre-Authorized Check Direct Bill

Total premium \$ _____ Monthly* Quarterly Semi-Annually Annually Other _____
*Monthly Direct Bill Not Available Make all checks payable to Central States Health & Life Co. of Omaha.

Section B: Employment Information

Applicant's Occupation	Employment Date (mo/yr)	Do you work 20 hours or more a week at this occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Section C: Medical Information

1a. **Skin Cancer** - Have you or any person to be insured been treated for or diagnosed with non-melanoma skin cancer in the last 2 years? Yes No
If "Yes", identify name(s) of person(s) _____

1b. **Cancer** - Have you or any person to be insured during the past 10 years ever been treated for, diagnosed with or advised they may have internal cancer, carcinoma in situ, melanoma or any malignancy? Yes No
If "Yes", identify name(s) of person(s), list the name of condition and date of last treatment: _____

The person(s) named in questions 1a and 1b may be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy issuance.

2. Have you or any person to be insured during the past 10 years ever been advised by a member of the medical profession to have any diagnostic tests related to cancer which have not been completed or for which results have not been received? Yes No
If "Yes", identify name(s) of person(s): _____

The person(s) named in question 2 will be excluded from coverage but may reapply once diagnostic tests have been completed and for which results have been received.

3. Have any persons to be insured within the past 10 years ever been treated for or diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Antibodies to Human T-lymphotrophic Virus Type III (HTLV-III) prior to this date? Yes No
If "Yes", identify name(s) of person(s): _____

Section C: Medical Information (cont'd)

Specified Disease Rider Form 8311 (complete questions 4 and 5 only if applying for Form 8311) —

- 4. Have you or any person to be insured during the past 10 years ever been treated for, diagnosed with or advised they may have any of the following diseases: Addison’s Disease, Budd-Chiari Syndrome, Cerebral Palsy, Cystic Fibrosis, Encephalitis, Huntington’s Disease, Legionnaire’s Disease, Lou Gehrig’s Disease, Lupus Erythematosus, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Osteomyelitis, Polio, Rabies, Reye’s Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Tuberculosis, Whooping Cough? Yes No
If “Yes”, identify name(s) of person(s), list the name of condition and date of last treatment: _____

The person(s) named in question 4 may be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy issuance.

- 5. Have you or any person to be insured during the past 10 years ever been advised by a member of the medical profession to have any diagnostic tests related to one of the specified diseases listed above which have not been completed or for which results have not been received? Yes No
If “Yes”, identify name(s) of person(s): _____

The person(s) named in question 5 will be excluded from coverage but may reapply once diagnostic tests have been completed and for which results have been received.

Hospital Intensive Care Rider Form 8290 (complete questions 6a & 6b only if applying for Form 8290) —

- 6a. Are you or any family member (applying or not applying for coverage) currently pregnant? Yes No
If “Yes” to question 6a, Hospital Intensive Care Rider Form 8290 cannot be issued.
- 6b. Have you or any person to be insured during the past 10 years ever been treated for or diagnosed with a heart attack, heart condition, heart trouble, or any abnormality of the heart prior to this date? Yes No
If “Yes”, identify name(s) of person(s): _____

The person(s) named in question 6b will be excluded from coverage for any hospital or intensive care confinement resulting from any disease or disorder of the heart, and shall be limited to three days coverage in connection with any other hospital intensive care confinement and will be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant prior to policy/rider issuance.

Section D: Other Information

- 1. Is this insurance to replace any other cancer insurance you currently have? Yes No
If “Yes,” provide name of insurance company: _____
- 2. Have you received the Outline of Coverage? Yes No

QUESTIONS 3 AND 4 APPLY IF ANY PERSON TO BE INSURED IS AGE 65 OR OLDER:

- 3. Have you received a copy of the “Guide to Health Insurance for People with Medicare”? Yes No
- 4. Have you received a copy of the “Medicare Duplication Acknowledgment Form”? Yes No

Section E: Declarations

I certify that I have read, or had read to me, the completed application and realize that any false statement or misrepresentation thereon which materially affects the insurance company’s acceptance of any person for coverage under a policy or rider may result in loss of coverage for that person during the first two policy years. I also understand the benefits provided are payable for loss resulting from a positive diagnosis of cancer or specified disease (if applied for) that begins more than 30 days after the effective date of coverage for each insured person. There is no interim coverage provided. The “Policy Effective Date” will be the date recorded on the Policy Schedule by the Home Office. It is not the date the application is signed.

I understand that the policy I am applying for has a pre-existing conditions limitation. A pre-existing condition means a cancer or specified disease (if applied for) which is first diagnosed (clinical or pathological) prior to the effective date of coverage for each insured person. I also understand that any premiums deducted prior to the effective date of the policy are pre-paid premiums and will be applied to coverage beginning on the effective date.

Dated at _____ City _____ State _____ Date _____ Month _____ Day _____ Year _____

Signature of Applicant _____

Signature of Agent _____ Agent # _____

CENTRAL STATES HEALTH & LIFE CO. OF OMAHA

P.O. Box 34350 • 96th & Western • Omaha, Nebraska 68134-0350

EMPLOYEE PAYROLL AUTHORIZATION

I hereby authorize my employer and Central States Health & Life Co. of Omaha and its business associates (CSO) to share and exchange my confidential information as well as the confidential information of any of my family members applying for CSO coverage for the purpose of facilitating payroll deduction of my premiums for CSO coverage. I understand confidential information to be the information on my application for coverage including: name, social security number, date of birth, premium amounts, type of coverage, health information and whether I (or any family member) is or is not issued coverage for medical or any other reason. My employer and CSO may not share any other medical information unless I provide specific additional authorization.

Employer: _____

Date: _____

Print Employee Name: _____

Employee Signature: _____

433B

3-03

Submit with Application

CENTRAL STATES HEALTH & LIFE CO. OF OMAHA

P.O. Box 34350 • 96th & Western • Omaha, Nebraska 68134-0350

Request for Pre-Authorized Check (PAC) Payment Plan

Note: This form allows your financial institution to pay the premiums for you automatically. Send this form and voided check to the Home Office.

Authorization to withdraw funds by Central States Health & Life Co. of Omaha. As a convenience to me, I authorize you to make payments to Central States Health & Life Co. of Omaha by withdrawing funds from my account by check, draft or automatic debit entry. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. This authorization is to remain in effect until you receive notice from me to revoke it.

DATE NAME OF INSURED (Please Print)

Financial Institution _____

Routing No. _____

Account No _____

AUTHORIZED SIGNATURE AS SHOWN ON ACCOUNT

Policy Number _____

Withdraw on the due date of my policy.

Withdraw on the following date:

Withdraw from my:

Checking Account Savings Account Other

Withdraw from my account:

Monthly Quarterly Semi-annually Annually

Central States Health & Life Co. of Omaha

Home Office: Located at 96th & Western, P.O. Box 34350, Omaha, Nebraska 68134-0350
A MUTUAL LEGAL RESERVE COMPANY

ELIMINATION RIDER

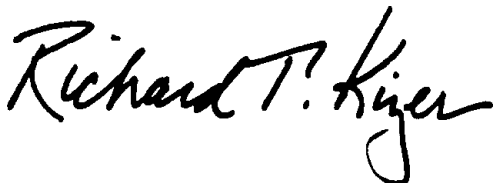
RIDER EFFECTIVE DATE: (same as Policy Effective Date if no date shown): _____

In consideration of the issuance or reinstatement of the Policy to which this Rider is attached, it is hereby understood and agreed that the person named in the application as having a condition listed below prior to the date the application was signed, is excluded from coverage as indicated below:

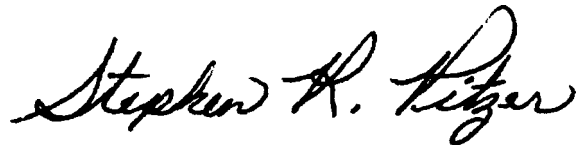
- A. Skin Cancer We will not be liable for any loss resulting from skin cancer affecting _____ for a period of two (2) years from the Rider Effective Date. Coverage for anyone excluded under this section is limited to loss resulting from any cancer other than skin cancer.
- B. All Cancers Including Malignant Melanomas We will not be liable for any loss resulting from cancer (including skin cancer) affecting _____, who is completely excluded from cancer coverage and coverage for cancer screening tests under the Policy and any attached riders.
- C. Specified Diseases (If Rider Form 8311 is applied for) We will not be liable for any loss resulting from _____ (named Specified Disease) affecting _____, who is excluded from coverage for the named Specified Disease.
- D. Hospital Intensive Care (If Rider Form 8290 is applied for) We will not be liable for any benefits under the Hospital Intensive Care Confinement Benefit Rider for _____ for loss resulting from any disease or disorder of the heart. Furthermore, the hospital intensive care benefits for such person will be limited to three days in connection with any one period of confinement for any other injuries or sickness, not the 30 days as stated in the Policy/Rider.

Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy other than as stated above.

CENTRAL STATES HEALTH & LIFE CO. OF OMAHA



Chairman & Chief Executive Officer



Senior Vice President

Accepted by: _____
Signature of Applicant

CENTRAL STATES HEALTH & LIFE CO. OF OMAHA

P.O. Box 34350 • 96th & Western • Omaha, Nebraska 68134-0350

(herein called "We", "Our" or "Us")

CANCER COVERAGE POLICY FORM C18 GA

—OUTLINE OF COVERAGE—

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

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

- I. **READ YOUR POLICY CAREFULLY** - This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore important that you **READ YOUR POLICY CAREFULLY!**
- II. Cancer coverage is designed to provide you with coverage paying benefits only when certain losses occur as a result of cancer. Coverage is provided for the benefits outlined in Paragraph III. The benefits described in Paragraph III may be limited by Paragraph IV.
- III. The benefits of the policy are payable for loss that results from a positive diagnosis of a cancer under the terms of the policy.

Benefits for experimental treatment are payable on the same basis as any other benefit under the policy.

We will pay the following benefits for the treatment of cancer.

- (1) **Hospital Confinement** – pays the daily hospital confinement benefit selected by you for each day of covered hospital confinement.
- (2) **Government or Charity Hospital** – pays the daily hospital confinement benefit for each day of covered confinement in a government or charity hospital. The benefits received under this benefit provision are in lieu of all other benefits provided in the policy and riders, except First Occurrence or Hospital Intensive Care Benefit (if selected), Transportation and Lodging Benefit, and Adult Companion Lodging and Transportation Benefit.
- (3) **Outpatient Surgery Facility Benefit** – pays a benefit two times the daily hospital confinement benefit for covered outpatient surgery in a hospital or in a free-standing surgical facility. This benefit is not payable for surgery in a physician's office or clinic. This benefit is also not payable for skin cancer as defined in the policy.
- (4) **Surgical Benefit** – pays up to \$10,000 per calendar year for each insured person for charges made by a surgeon for surgery in or out of a hospital as outlined in the Surgical Benefits Schedule in the policy. The maximum amount payable for surgical procedures related to skin cancer is \$500 per calendar year for each insured person.
- (5) **Second Surgical Option** – pays the charges incurred up to \$250 for a second, if necessary, surgical opinion.
- (6) **Anesthesia** – pays 25% of the amount payable under the Surgical Benefit for the administration of an anesthetic. Not payable for skin cancer.
- (7) **Blood and Blood Plasma** – pays the charges incurred up to \$100 per day for blood, blood plasma, platelets, therapeutic pheresis, transfusion, administration, cross-matching, typing and processing of blood, blood plasma and platelets when given on a day when Hospital Confinement or Outpatient Surgical Facility Benefit is payable. Does not pay for blood which is donated or replaced. This benefit is limited to \$5,000 per calendar year for each insured person. Does not pay for immunoglobulins, immunotherapy or colony-stimulating factors.
- (8) **Breast Reconstruction/Breast Prostheses** – pays: (a) the charges incurred up to \$5,000 for surgically implanted breast prostheses, breast tissue expanders and natural breast reconstruction that is performed as a direct result of surgery for cancer treatment. Limited to a lifetime maximum of \$5,000 per insured person; and (b) the charges incurred up to \$250 for external breast prostheses prescribed as a direct result of surgery for cancer treatment. Limited to a lifetime maximum of \$250 per insured person.

- (9) Cancer Screening Test(s) – pays the scheduled amount up to \$100 per calendar year for each insured person for cancer screening tests performed by a physician. A positive diagnosis of cancer is not required for this benefit to be payable.
- (10) Ambulance Benefit – pays the charges incurred per trip to transfer an insured person to the hospital for confinement as an inpatient. Also pays the charges for the trip home from the hospital upon discharge. The ambulance service must be performed by a licensed or professional ambulance service. This benefit is limited to \$5,000 per calendar year for each insured person.
- (11) Transportation and Lodging – pays up to \$10,000 per calendar year for each insured person for any combination of the following for non-local treatment prescribed by the attending physician as necessary:
- (a) for treatment which requires hospital confinement: (i) up to \$1,500 of the charges incurred for the round trip coach fare on a common carrier to the hospital that provides the prescribed covered treatment; or (ii) 50¢ per mile for personal automobile expense for non-local trips, not to exceed 700 miles round trip. This benefit is payable once for each period of continuous confinement.
 - (b) for treatment which does not require hospital confinement: (i) up to \$1,500 of the charges incurred for the round trip coach fare on a common carrier to the facility that provides the prescribed covered treatment, or 50¢ per mile for personal automobile expense for non-local trips, not to exceed 700 miles round trip; and (ii) the charges incurred for a single room in a motel, hotel or other accommodations acceptable to us, up to a maximum of \$50 per day. This benefit is limited to the number of days non-local covered treatment is received.
- The Transportation and Lodging benefit will not be paid for periodic checkups, for visits to see the person requiring treatment or when an insured person is receiving non-covered treatment.
- (12) Adult Companion Lodging and Transportation – pays the following expenses up to \$7,500 per calendar year for one adult companion to be near you or any insured person when you or such person has been confined in a non-local hospital for covered treatment: (a) the charges incurred for a single room in a motel, hotel, or other accommodations acceptable to us, up to a maximum of \$50 per day. This benefit is limited to the number of days of the confined person's hospitalization; and (b) up to \$1,500 of the charges incurred for the round trip coach fare on a common carrier or a personal automobile allowance of 50¢ per mile for non-local trips from the visiting adult companion's residence to the hospital in which the hospitalized person is confined. Does not pay the personal automobile allowance in excess of 700 miles round trip. This benefit will be payable for an adult companion residing in the continental United States. In the event that the insured person receiving treatment is a dependent child, pays up to another \$7,500 per calendar year for the benefits listed above for a second adult companion. This benefit will not be paid for visits when the insured person receives non-covered treatments or periodic checkups.
- (13) Bone Marrow or Peripheral Stem Cell Donors – pays up to \$5,000 per calendar year for the following expenses of a bone marrow or peripheral stem cell donor when the donor is someone other than the insured person (when the insured person is the recipient of the bone marrow or peripheral stem cell transplant): (a) the charges incurred up to \$2,000 for medical expenses, including hospital charges directly relating to the transplant; (b) the charges incurred up to \$1,500 for the round trip coach fare on a common carrier to the city where the transplant is performed; and (c) the charges incurred up to \$50 per day for lodging and meal expenses when the donor is asked to remain near the hospital for possible donation of additional blood components.
- (14) Extended Care Facility – pays the charges incurred up to \$60 per day for confinement in an extended care facility. Such confinement must: (a) be at the recommendation of the attending physician; and (b) begin within 30 days of a covered hospital confinement. Extended Care Facility benefits will be limited to the number of covered days of the prior hospital confinement, up to a lifetime maximum of 365 days for each insured person. For each day this benefit is payable, hospital confinement benefits are NOT payable.
- (15) Hospice Care – pays the charges incurred up to \$100 per day for care provided by a hospice if the insured person has been diagnosed as terminally ill. This benefit is payable for a lifetime maximum of 120 days and for confinement in a hospice care center, including centers that are in designated areas of a hospital, or in the insured person's home.
- (16) Home Health Care Services – pays the charges incurred up to \$100 per day for services provided at home, not to exceed a maximum of 60 days per calendar year when an insured person is provided services by a licensed home health care agency. Such care must be prescribed by a physician and cannot be provided by a relative. This benefit will not be payable on the same day that hospice care is payable.
- (17) Artificial Limb – pays the charges incurred up to \$2,500 when an amputation is performed for an artificial limb and the procedure to affix or implant it. This benefit is limited to a lifetime maximum of \$2,500 for each insured person.
- (18) Hairpiece Benefit – pays the charges incurred up to a lifetime maximum of \$200 per insured person for a hairpiece when hair loss is the result of cancer treatment.

- (19) Durable Medical Equipment – pays the charges incurred, not to exceed \$1,000 per calendar year, for the rental or purchase of the following pieces of durable medical equipment: (a) a respirator or similar mechanical device; (b) brace; (c) crutches; (d) hospital bed; or (e) wheel chair.
- (20) Physical or Speech Therapy – pays the charges incurred up to \$25 per day for physical or speech therapy received as a result of cancer not to exceed a lifetime maximum of \$1,000 for each insured person.
- (21) Waiver of Premium – premiums will be waived starting with the first policy renewal date following a 90-day period of disability by you if the disability begins before you turn age 65 due to cancer . Premiums are waived for as long as you remain disabled and are receiving treatment for cancer for which benefits are payable.

OPTIONAL BENEFIT RIDERS (check if applied for and additional premium, if any paid):

- INTERNAL CANCER FIRST OCCURRENCE BENEFIT RIDER FORM 8288 –

Benefit (check one): \$2,500 \$5,000

Pays the first time an insured person is diagnosed as having internal cancer. This benefit is payable one time only for each insured person.

- HOSPITAL INTENSIVE CARE CONFINEMENT BENEFIT RIDER FORM 8290 –

Daily Benefit (Check one): \$300 \$600

Pays the daily benefit selected for each day of confinement in a hospital intensive care unit as the result of a covered injury or sickness. Benefits begin on the first day of confinement for a covered injury or a covered sickness.

Pays \$150 for each day of confinement in a sub-acute intensive care unit, if the sub-acute intensive care unit confinement immediately follows an intensive care unit confinement. We will pay \$150 per day for confinement in a regular hospital room if the regular room confinement was immediately preceded by an intensive care unit confinement, or by sub-acute intensive care confinement which was immediately preceded by an intensive care unit confinement. The number of days paid for confinement in a sub-acute intensive care unit, a regular hospital room, or any combination thereof will not exceed the number of covered days of hospital intensive care confinement.

Pays ambulance charges incurred per trip to transfer an insured person to the hospital for confinement as an inpatient in a hospital intensive care unit. This benefit is limited to \$5,000 per calendar year for each insured person.

Total benefits for any one period of confinement are limited to 30 days, and all benefits reduce 50% after an insured person is age 70 or older.

Benefits are not payable for any disease or disorder of the heart if the insured person has been treated for, or diagnosed as having a heart attack, heart condition, heart trouble, or any abnormality of the heart prior to the Rider Effective Date. This exclusion applies whether or not such person is aware of the actual diagnosis. The benefits for such insured person will be limited to three days coverage in connection with any other hospital intensive care confinement.

Also, the rider does not cover confinement resulting from intentionally self-inflicted injuries or suicide attempts.

- RADIATION TREATMENT, CHEMOTHERAPY, HORMONE THERAPY, IMMUNOTHERAPY AND RELATED SERVICES BENEFIT RIDERS (**must check only one**):

- Form 8302 –

The benefits payable under this portion of the rider are limited to 50% of the charges incurred up to a maximum of \$1,250 per calendar month for each insured person for any combination of the following when used for the treatment of cancer.

- (a) Radiation treatment.
 (b) Chemotherapy, hormone therapy and immunotherapy drugs that are administered intravenously or directly by a physician.
 (c) Chemotherapy, hormone therapy and immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider.

In addition, pays the charges incurred for services related to the above benefit up to \$500 per calendar year for any combination of the following: (a) professional fees for administering the covered drugs; (b) medical supplies, equipment and solutions; (c) laboratory tests; (d) X-rays, port films, MRIs, scans and ultrasounds; (e) clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services; (f) treatment consultation, planning and office visits; or (g) supportive and protective care drugs.

Form 8303 –

The benefits payable under this portion of the rider are limited to 50% of the charges incurred up to a maximum of \$2,500 per calendar month for each insured person for any combination of the following when used for the treatment of cancer. After the insured person has received \$125,000 in benefits under this portion of the rider, benefits for any combination of the following are limited to 50% of the charges incurred up to a maximum of \$1,200 per calendar month.

- (a) Radiation treatment.
- (b) Chemotherapy, hormone therapy and immunotherapy drugs that are administered intravenously or directly by a physician.
- (c) Chemotherapy, hormone therapy and immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider. Always subject to a maximum of \$1,200 per calendar month.

In addition, pays the charges incurred for services related to the above benefit up to \$500 per calendar year for any combination of the following: (a) professional fees for administering the covered drugs; (b) medical supplies, equipment and solutions; (c) laboratory tests; (d) X-rays, port films, MRIs, scans and ultrasounds; (e) clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services; (f) treatment consultation, planning and office visits; or (g) supportive and protective care drugs.

Form 8304 –

The benefits payable under this portion of the rider are limited to 50% of the charges incurred up to a maximum of \$5,000 per calendar month for each insured person for any combination of the following when used for the treatment of cancer. After the insured person has received \$125,000 in benefits under this portion of the rider, benefits for any combination of the following are limited to 50% of the charges incurred up to a maximum of \$1,200 per calendar month.

- (a) Radiation treatment.
- (b) Chemotherapy, hormone therapy and immunotherapy drugs that are administered intravenously or directly by a physician.
- (c) Chemotherapy, hormone therapy and immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider. Always subject to a maximum of \$1,200 per calendar month.

In addition, pays the charges incurred for services related to the above benefit up to \$500 per calendar year for any combination of the following: (a) professional fees for administering the covered drugs; (b) medical supplies, equipment and solutions; (c) laboratory tests; (d) X-rays, port films, MRIs, scans and ultrasounds; (e) clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services; (f) treatment consultation, planning and office visits; or (g) supportive and protective care drugs.

SPECIFIED DISEASE BENEFIT RIDER FORM 8311 -

The benefits of the rider are payable for loss that results from a positive diagnosis of a specified disease under the terms of the rider.

Benefits for treatment of the listed specified diseases are subject to a lifetime maximum of \$50,000 for each insured person.

Pays \$250 per day for each day of covered hospital confinement.

Pays 50% of the charges incurred up to a maximum of \$1,200 per calendar month for each insured person for any combination of the following when used for the treatment of a specified disease.

- (a) Radiation treatment.
- (b) Chemotherapy, hormone therapy and immunotherapy drugs that are administered intravenously or directed by a physician.
- (c) Chemotherapy, hormone therapy and immunotherapy drugs that are self-administered or taken orally, up to a maximum of \$300 for each filled prescription or supply of drugs received from a medical provider.

Pays the charges incurred for services related to the above benefit up to \$500 per calendar year for any combination of the following: (a) professional fees for administering the covered drugs; (b) medical supplies, equipment and solutions; (c) laboratory tests; (d) X-rays, port films, MRIs, scans and ultrasounds; (e) clinical treatment planning, clinical treatment management, medical radiation physics, dosimetry, treatment devices and special services; (f) treatment consultation, planning and office visits; or (g) supportive and protective care drugs.

The following are the specified diseases covered by the rider:

Addison's Disease	Lupus Erythematosus	Rheumatic Fever
Budd-Chiari Syndrome	Multiple Sclerosis	Rocky Mountain Spotted Fever
Cerebral Palsy	Meningitis	Sickle Cell Anemia
Cystic-Fibrosis	Muscular Dystrophy	Tay-Sachs Disease
Encephalitis	Osteomyelitis	Tetanus
Huntington's Disease	Polio	Toxic Shock Syndrome
Legionnaire's Disease	Rabies	Tuberculosis
Lou Gehrig's Disease	Reye's Syndrome	Whooping Cough

IV. EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS-LIMITATIONS FOR CERTAIN CONDITIONS

Benefits will not be payable for loss caused by pre-existing conditions during the first two years the policy is in force. After this two-year period, however, loss due to such conditions will be payable unless specifically excluded from coverage. This two-year period is measured from the effective date of coverage for each insured person. A pre-existing condition means a cancer or specified disease (if applied for) which is first diagnosed (clinical or pathological) prior to the effective date of coverage for each insured person. Conditions that are fully disclosed to us on the application and not excluded or limited by us, are not considered pre-existing conditions.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR

The policy pays only for loss resulting from cancer or specified diseases (if applied for), as defined in the policy where there was a positive diagnosis more than 30 days after the effective date of coverage for each insured person and while this policy is in force. It DOES NOT cover:

- (1) Any other disease or sickness.
- (2) Injuries.
- (3) Evaluation or treatment of any condition, disease, illness or incapacity that has been caused, complicated, worsened, or affected by cancer or a specified disease (if applied for), or which results from cancer or specified disease (if applied for) treatment.
- (4) Care and treatment received outside the United States or its territories.
- (5) Hospital confinement or expenses that are incurred in a government or charity hospital, except as specifically provided in the government or charity hospital benefit.
- (6) Hospital confinement or expenses that are incurred prior to the effective date of coverage, regardless of the date of positive diagnosis.
- (7) Hospital confinement or expenses that are incurred while the policy is not in force or has lapsed. or
- (8) Hospital confinement or expenses that are incurred for breast reconstruction or breast prostheses, except as specifically provided in the Breast Reconstruction/Breast Prostheses benefit.

WAITING PERIOD

Benefits will only be payable for loss resulting from a positive diagnosis of cancer or specified disease (if applied for) that begins more than 30 days after the policy effective date for each insured person, including insured dependents. If the insured person has a positive diagnosis within the first 30 days, benefits will not be paid for any condition or charges incurred related to that positive diagnosis during the first two years after the policy effective date for each insured person. If you have a loss resulting from a positive diagnosis of cancer or a specified disease (if applied for) that begins within the first 30 days after the policy effective date, you also have the option to request termination of this policy from its inception and receive a full refund of premium.

INTOXICANTS AND NARCOTICS

We will not be liable for any loss sustained or contracted as the result of an insured person being physically or mentally impaired due to being under the influence of alcohol or any narcotic unless administered on the advice of a physician. "Being under the influence of alcohol", for purposes of the policy, means a blood alcohol level of 0.08 or more. The insured person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or sickness, irrespective of whether those injuries occurred while the insured person was driving a motor vehicle or engaged in any other activity.

V. RENEWABILITY

The policy is guaranteed renewable for life. We will renew the policy each time you send us the premium. It must be paid on or before the date it is due or during the 31 days that follow.

VI. PREMIUM CHANGE

We may change the premium rates for the policy. The change will be based on a new table of rates. We can only change the premium if we change it for all policies like yours in your class.

VII. The Annual Premium is \$ _____; if other than annual \$ _____, mode _____.

Premiums are payable in advance or during the grace period (you have a 31-day grace period to pay your premium).

I hereby acknowledge that this Outline of Coverage was delivered to me on _____ by _____
(Date)

(Signature of Agent)

(Signature of Applicant)

This Outline of Coverage is not a contract. It is intended only as a general description of the policy provisions in the planning of your insurance program. The benefits are determined by the terms and conditions of the policy alone. IN ALL CASES, CONSULT YOUR POLICY FOR FULL DETAILS.

RETAIN THIS OUTLINE FOR YOUR RECORDS