United American Cancer Policy

Limited Benefit . . . means this policy covers cancer only.

Guaranteed Renewable* Cancer Coverage for Individuals and Families:

● First Occurrence Benefit of $1,500
● Surgical Benefits up to $3,750
● In-Hospital Benefits —
  Daily Hospital Confinement Benefit . . . you select
  the benefit that’s right for you — $150 or $300
  Radiation and Chemotherapy
  Blood and Plasma
  Private-Duty Nurse
  Ambulance Benefit

Good Risk Benefit . . . each 5th anniversary date
the policy is in force, each covered adult will receive $250 less any other benefits paid
as a result of expenses incurred during the preceding five-year period. (See details inside.)

United American Stands For . . .

● Strength Of Tradition . . . Meeting customers’ life and health insurance needs since 1947.
● Assurance Of Service . . . Agent serviced for the life of the policy, plus complete Home Office customer support.

* Guaranteed Renewable for Life . . .
COMPANY CANNOT CANCEL POLICY AS LONG AS PREMIUMS ARE PAID ON TIME. COMPANY MAY CHANGE PREMIUM RATES BY CLASS AS PROVIDED IN THE GUARANTEED RENEWAL PROVISION.

Presented By:

United American Insurance Company
Since 1947
POST OFFICE BOX 8080 • McKinney, Texas  75070

Licensed in 49 states, District of Columbia, and Canada
First Occurrence Benefit . . . $1,500 payable when first diagnosed with internal cancer. This benefit is payable only once to each covered person and is not payable for skin cancer.

Up to $3,750 in Surgical Benefits . . .

Surgeon's Fee up to $3,000 . . .
Incur charges are reimbursed according to surgery performed for a diagnosed cancer as outlined in this plan's Schedule of Operations; maximum benefit is $3,000.

Anesthetic Fee up to $750 . . .
Pays incurred charges up to 25 percent of the Surgeon's Fee outlined in the Schedule of Operations.

In-Hospital Benefits . . . These benefits are payable when you are confined to the hospital.

Daily Confinement Benefit . . .
Daily confinement benefit is paid during required hospital stays with no limit on the number of days! Select $150 or $300 a day.

Radiation and Chemotherapy . . .
Pays $100 per day for radiation or chemotherapy received while confined in the hospital. This benefit does not cover laboratory tests, diagnostic X-Ray, or preplanning procedures related to these treatments.

Blood and Plasma . . .
Pays incurred charges for blood or plasma received during your hospital stay up to $50, times the number of days you are confined to the hospital.

Private-Duty Nursing . . .
Payable when you require the full-time, private-duty services of a Registered Nurse (RN), Licensed Practical Nurse (LPN), or a Licensed Vocational Nurse (LVN); pays in-hospital charges incurred up to $100 per day.

Ambulance Benefit . . .
Pays $100 per trip for transfer to the hospital for confinement as an inpatient and pays $100 per trip from the hospital upon discharge. The ambulance service must be performed by a licensed or professional ambulance company.

Note: BENEFITS REDUCE AT AGE 65. On the first policy anniversary date after a covered adult's 65th birthday, some benefits terminate. Benefits are no longer payable for any otherwise eligible service that is received after such anniversary date. This termination of benefits does not apply to the First Occurrence Benefit, Hospital Confinement Benefit, or Good Risk Benefit.

Good Risk Benefit . . . If premiums have been paid to and this policy is in force on the 5th anniversary date, and on each successive 5th policy anniversary date, a $250 Good Risk Benefit is paid to each covered adult* less any other benefits paid for expenses incurred by such covered adult* during the preceding five-year period.

* A 'covered adult' is only the primary insured and the spouse of the primary insured, and only if both are listed in the Policy Schedule.

Waiting Period
This policy contains a 30-day 'waiting period' which means the FIRST OCCURRENCE BENEFIT is not payable to anyone who has cancer diagnosed before the policy has been in force 30 days from the 'Effective Date'. If a covered person has cancer first diagnosed during the 'waiting period', all other benefits apply only to loss commencing after two years from 'Effective Date' of the policy, or at the option of the covered person. The covered person may elect to void the policy from the beginning and receive a full refund of premium.

Limitations and Exclusions
This policy pays only for loss resulting from definitive Cancer treatment including the direct extension, metastatic spread, or reoccurrence. Pathological proof thereof must be submitted. Clinical diagnosis of Cancer is accepted under the conditions specified in our definition of cancer. This policy does not provide benefits for any other disease, sickness, or incapacity.

This policy will not be issued to anyone over the age of 63. This policy does not cover loss due to:
1. Any hospital stay or other service for which a covered person does not incur a charge; or
2. Any loss incurred outside the United States; or
3. Any service furnished by you, members of your immediate family, or household; or
4. Any expenses incurred for services or materials not medically necessary; or
5. Any losses incurred prior to the Policy Effective Date.

MAKE CHECK PAYABLE TO UNITED AMERICAN, NOT TO AN INDIVIDUAL.

Received of ___________________________ for _____________ months premium, other policy fees and noninsurance charges with application for Policy Form CAGR. If for any reason policy is not issued, payment is to be refunded in full. Insurance is not effective until policy applied for has been issued.

Date ___________________ Authorized Signature ___________________

UNITED AMERICAN INSURANCE COMPANY
Post Office Box 8080 • McKinney, Texas 75070 • (972) 529-5085
www.unitedamerican.com

Keep this page
It highlights the benefits of your policy. It is not a contract. Your actual policy provisions will govern your benefits.
**APPLICATION FOR INSURANCE**

- **UNITED AMERICAN INSURANCE COMPANY** • A LEGAL RESERVE STOCK COMPANY • ADMINISTRATIVE OFFICES: McKinney, Texas

### 1. Full Name(s) of Family Member(s) to be Insured

- **(a) (Applicant / Primary Insured)**
- **(b) (Spouse / Covered Adult)**
- **(c) (Child / Covered Person)**
- **(d) (Child / Covered Person)**
- **(e) (Child / Covered Person)**
- **(f) (Child / Covered Person)**

### 2. PRINT – Where should premium notices be sent?

- **Name:** ____________________________
- **No. & St. or Rt. No.:** ______________________
- **City:** _____________________________
- **State:** _____________________________
- **ZIP:** _____________________________

### 3. Do any of you have any existing (or pending applications for) hospital, medical, or surgical insurance?

- **Yes**  □  **No** □

- **Company:** ____________________________  **Policy No.:** ____________________________

- **Describe Coverage:** ____________________________

- **Daily Room Benefit:** ____________________________

### 4. Will this policy replace any existing coverage?

- **Yes**  □  **No** □

### 5. Within the past 10 years, has the Applicant or any family member to be insured been diagnosed or treated for any type of internal cancer, melanoma, malignant growth, leukemia, or Hodgkin’s disease?

- **Yes**  □  **No** □

### 6. Within the past 10 years, has the Applicant or any family member to be insured been diagnosed or treated for any type of skin cancer, melanoma, malignant skin growth, or premalignant lesions?

- **Yes**  □  **No** □

### 7. I hereby apply to United American Insurance Company for a policy to be issued in reliance on my written answers to the foregoing questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an Outline of Coverage for the policy applied for.

The undersigned Agent certifies that the Applicant has read, or had read to him, the completed application and that the Applicant realizes any false statement or misrepresentation in the application may result in loss of coverage under the policy.

I authorize any insurance company, hospital, physician, or other practitioner having any information available as to my diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that any information obtained will not be released to any person or organization except to reinsuring companies or other persons or organizations performing business or legal services in connection with this application, with a claim or as may be otherwise lawfully required. I agree that a photostat of this authorization is acceptable. This authorization remains in effect for a period of 30 months from the date signed. I understand I may request a copy of this authorization.

I certify: (1) I have accurately recorded the information supplied by the Applicant; and (2) I have given an Outline of Coverage for the policy applied for to the Applicant.

**Agent’s Signature:** ____________________________  **Agent No.:** ____________________________

**Agent’s Address:** ____________________________

**Mail Policy to:**  □  Applicant  □  Agent

**Amount paid to Agent $ ___________ for first ____ months premiums.**

**Company:** ____________________________  **Policy No.:** ____________________________

**Describe Coverage:** ____________________________

**Daily Room Benefit:** ____________________________

If the answer to question 5 or 6 is "YES" the person to whom the "YES" answer applies is not eligible for such coverage:

**Applicant’s Initials:** ____________________________

**Dated at:** ____________________________

**I understand this policy contains a 30-day waiting period, and that no benefits are payable if cancer is diagnosed before the policy has been in force 30 days from the Effective Date on the Policy Schedule.**

**Applicant’s Signature:** ____________________________

**CAGR CA2**

1012
Form CAGR — Rates Male or Female — Cancer Policy

If only children are being insured: one child, use individual rates; two or more children, use one-parent family rates.

IMPORTANT — For one-parent or two-parent family rates use issue age of oldest covered person:

<table>
<thead>
<tr>
<th>Issue Age Last Birthday</th>
<th>Individual Rates</th>
<th>One-Parent Family Rates</th>
<th>Two-Parent Family Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Insured</td>
<td>Primary Insured (Parent), Child(ren)</td>
<td>Primary Insured (Parent), Spouse (Parent), Child(ren)</td>
</tr>
<tr>
<td></td>
<td>A    S    Q    M</td>
<td>A    S    Q    M</td>
<td>A    S    Q    M</td>
</tr>
<tr>
<td>0-35</td>
<td>132   69   35   12</td>
<td>176   92   47   16</td>
<td>264   137  70   24</td>
</tr>
<tr>
<td>36-45</td>
<td>187   97   50   17</td>
<td>231   120  61   21</td>
<td>374   194  99   34</td>
</tr>
<tr>
<td>46-63</td>
<td>242   126  64   22</td>
<td>286   149  76   26</td>
<td>484   252 128   44</td>
</tr>
</tbody>
</table>

REGISTRATION FEE: $6 to be paid with each policy in addition to the initial premium.

Total initial premium $________________ for ______ months.

AUTOMATIC PAYMENT PLAN AUTHORIZATION

All premiums are automatically withdrawn from your account on MONTHLY mode unless a different mode is checked in the box below.

☐ QUARTERLY  ☐ SEMIANNUAL  ☐ ANNUAL

Date ____________________

Signature (as it appears on bank records) ____________________

PLEASE READ BEFORE SIGNING AUTHORIZATION ABOVE:

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks, or electronic debits drawn on my account by and payable to the order of the United American Insurance Company, McKinney, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

ATTACH APPLICANTS VOIDED PERSONALIZED CHECK HERE

UAI0169 1012