New Employee Packets
Provided by American Fidelity Assurance Company

Jefferson County
Public Schools
Shaping the Future

American Fidelity
Assurance Company
Our Family, Dedicated to Yours™

Cyndi Godsey,
Executive Account Specialist
Kentucky Branch Office
2525 Harrodsburg Rd., Ste. 115
Lexington, KY 40504
800-934-8030
Dear Jefferson County Public Schools (JCPS) New Employee:

Congratulations on your decision to join the JCPS family. As your local American Fidelity Assurance Company representative for this area, I would like to introduce myself. My name is Cyndi Godsey and I am available to assist you with your benefit needs.

American Fidelity Assurance Company provides insurance products to public schools and has been providing quality service to employees of Jefferson County for over twenty-five years. I look forward to being able to continue to foster that long-standing relationship and provide services and products to you and JCPS in the future.

I have included brochures for you to learn more about the important benefits available to you such as:

**Disability Income Insurance***
_Are you protecting your paycheck?_ Consider insurance to protect your ability to pay for the rent/mortgage, utilities, car payment, etc. Disability benefits are payable when you are unable to work due to a covered Accident or Illness.

**Limited Benefit Cancer Insurance***++
The overall cost of cancer is estimated at $263.8 billion in 2010; $102.8 billion for direct costs (medical expense) and $161.0 billion for indirect costs. (American Cancer Society: Cancer Facts and Figures 2010, pg. 3). American Fidelity has a Cancer policy available with an optional Hospital Intensive Care Unit Rider that may be purchased or paid for with pre-tax dollars.

**Limited Benefit Accident Only Insurance***++

I encourage you to take some time to look over these important benefit options and begin to determine which pieces of your benefits puzzle we can help you put into place.

In each benefit section, you can find all of the forms needed to enroll in that benefit. Return your completed paperwork or feel free to contact me at (502)742-2756 to apply for coverage or discuss your benefit needs.

Sincerely,

Cyndi M. Godsey,
Account Manager
American Fidelity Educational Services

*Benefits may vary by state.
*These products may contain limitations, exclusions and waiting periods.
*These products are inappropriate for people who are eligible for Medicare coverage.
Disability Income Insurance

American Fidelity Assurance Company
Ask yourself...

- How long could you go without a paycheck?
- Do you rely on your income?
- What’s your most valuable asset?
- If you’re like most of us, would you agree that your income is important in maintaining your lifestyle?
- Is your paycheck committed to monthly obligations?
- Do you have auto, homeowners, boat insurance, etc.? Have you insured the income you use to pay those and all your other bills?

Why do you need disability insurance?

What would happen if your income stopped today? Are you prepared to provide for yourself and those you love in the event of a serious accident or illness? Unless you’ve planned for such a loss, losing your income can produce tragic results. If you’re like most of us, your income is truly your most valuable asset! Without it, all of our other assets go away. Payments for rent, mortgage, utilities, insurance, groceries, clothing, and cars continue regardless of your ability to work. Plan today! Protect yourself before it’s too late with an American Fidelity Salary Protection Plan.

How does your plan work?

Find your monthly salary in the schedule inside to determine your eligible Monthly Disability Benefit. Your monthly salary is determined by dividing your annual salary, exclusive of overtime pay, weekend, or summer work compensation, bus or other allowances, bonuses or district-funded fringe benefits, by 12. If there is a reduction or misstatement of salary that results in your being ineligible for this Monthly Disability Benefit, your Monthly Disability Benefit will be reduced.
### Benefit Schedule

Several benefit options are available to you. You may participate in the Plan under any one of the benefit levels outlined below, provided the Monthly Disability Benefit level selected does not exceed 66⅔% of your regular monthly salary. Your monthly salary is defined as your annual compensation divided by 12.

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ELIGIBILITY
All active full-time employees working 20 hours or more per week. Proof of good health may be required by us in order to be eligible for disability coverage. We will rely on answers given on your application to determine if coverage can be issued. Regardless of your health at the time of application, if coverage is approved and issued, claims incurred while coverage is in force will be subject to all terms of the Policy including any Pre-Existing Condition limitation.

EFFECTIVE DATE OF COVERAGE
Your coverage will take effect on the requested Effective Date following the date we approve your written application, provided you are on Active Employment and premium has been paid.

Important Policy Provisions

MINIMUM DISABILITY BENEFIT
The Disability Payment payable will be no less than $100.00 or 10% of the Monthly Disability Benefit, whichever is greater.

IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND NOT WORKING
Your Disability Payment will be the lesser of:
(a) The Disability Benefit (as indicated on your application for coverage, as approved by us); or
(b) 66 2/3% of your Monthly Compensation less any Deductible Sources of Income you receive or are entitled to receive.

DEDUCTIBLE SOURCES OF INCOME WILL INCLUDE
(a) Other group disability income;
(b) Governmental or other retirement system as a result of your Regular Occupation, whether due to disability, normal retirement or voluntary election of retirement benefits;
(c) United States Social Security Act or similar plan or act, including any amounts due your dependent(s) on account of your Disability;
(d) Sick leave or other salary or wage continuance plans provided by the Employer which extend beyond 30 calendar days from the date of Disability;
(e) State Disability;
(f) Unemployment compensation; and
(g) Workers’ Compensation law, occupational disease law or any similar act or law.

If we determine that you may qualify for benefits under items (b), (c), or (g) listed above, we may estimate the amount of benefits you may be entitled to receive.

COST OF LIVING ADJUSTMENT
The Disability Payment will not be reduced due to a cost of living increase if the increase from a Deductible Source of Income takes effect after the onset of Disability and while benefits are payable under the Policy.

DIRECT DEPOSIT DISABILITY BENEFITS
In the event you choose the direct deposit option on an approved claim, we will deposit your benefits directly into your bank account at no additional cost. This can accelerate access to your benefits by several days. We also have a toll-free fax that allows you instant transmission of your claim forms to our benefits department.

IF YOU ARE DISABLED DUE TO A COVERED DISABILITY AND WORKING
We will provide a Disability Payment if you are Disabled and your monthly Disability Earnings, if any, are less than 20% of your Monthly Compensation due to the same Sickness or Accidental Injury.

If you are Disabled and your Disability Earnings are greater than 20% of your Monthly Compensation due to the same Sickness or Accidental Injury, we will figure your payment as follows:
You will receive payments based on the percentage of Monthly Compensation you are losing due to your Disability computed as follows:
(a) subtract your Disability Earnings from your Monthly Compensation;
(b) divide the answer in item (a) by your Monthly Compensation. This is your percentage of lost earnings; and
(c) multiply your Disability Payment by the answer in item (b).

We will stop payments and your claim will end, if at any time you are no longer Disabled or if your Disability Earnings exceed 80% of your Monthly Compensation or at the end of 1 year, whichever comes first.

The Elimination Period cannot be satisfied with days you are Disabled and working.

ALCOHOLISM AND DRUG ADDICTION LIMITED BENEFIT
If you are Disabled due to alcoholism or drug addiction, a limited benefit of up to 15 days for each Disability will be paid. In no event will benefits be paid for more than 15 days of Disability in any 12-month period. If drug addiction is sustained at the hands of, or while under the Regular and Appropriate Care of a Physician in the course of treatment for Accidental Injury or Sickness, it will be covered the same as any other illness.

DIRECT DEPOSIT DISABILITY BENEFITS
In the event you choose the direct deposit option on an approved claim, we will deposit your benefits directly into your bank account at no additional cost. This can accelerate access to your benefits by several days. We also have a toll-free fax that allows you instant transmission of your claim forms to our benefits department.

DONOR BENEFIT
If you are disabled as a result of being an organ or tissue donor, we will pay your benefit as any other Illness under the terms of your plan.
EXCLUSIONS

The Policy does not cover any loss, fatal or non-fatal, which results from:

(a) intentionally self-inflicted injury while sane or insane;
(b) an act of war, declared or undeclared;
(c) Accidental Injury sustained or Sickness contracted while in the service of the armed forces of any country;
(d) committing a felony; or
(e) penal incarceration.

We will not pay benefits for Disability or any other loss for any period for which you are incarcerated in a penal or correctional institution for a period of 30 consecutive days or longer.

PRE-EXISTING CONDITION LIMITATION

If Disability is due to a Pre-Existing Condition and begins before you have been continuously covered under the Policy for 12 months, no Disability Benefit will be payable. Thereafter, a benefit of up to 1 month in every 12-month period will be provided. This provision will not apply if you have:

(a) gone treatment-free;
(b) incurred no expense;
(c) taken no medication; and
(d) received no diagnosis or advice from a Physician for 12 consecutive months for such condition(s).

Benefits will not be excluded for Disability due to a Pre-Existing Condition, which begins after you have been continuously covered under the Policy for 24 months.

Any increase in benefits will be subject to this Pre-Existing Condition Limitation. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by us.

LEAVE OF ABSENCE

Your coverage may be continued for up to 1 year during a Leave of Absence approved in writing by your Employer.

TERMINATION OF INSURANCE

Your insurance coverage will end on the earliest of these dates:

(a) the date you do not meet the Eligibility requirements as defined in the Eligibility paragraph in this brochure;
(b) the date you retire;
(c) the date you cease to be on Active Employment, except as provided for under the Leave of Absence provision;
(d) the end of the last period for which premium has been paid; or
(e) the date the Policy is discontinued.

If:

(a) your coverage ends as a result of your termination of Active Employment;
(b) such termination is caused by an Accidental Injury or Sickness for which Disability Benefits would be payable; and
(c) Disability is established prior to the termination of Active Employment, then:

Disability Benefits will be paid as if such termination had not occurred.

Termination of the Policy will have no affect on Disability Payments, which began before termination. We may end your coverage if you submit a fraudulent claim.

DEFINITIONS

ACTIVE EMPLOYMENT: Means you are doing in the usual manner all of the regular duties of your employment on a full-time basis on a scheduled work day and these duties are being done at one of the places of business where you normally do such duties or at some location to which your employment sends you. You will be said to be on Active Employment on a day which is not a scheduled work day only if you are not Disabled and would be able to perform in the usual manner all the regular duties of your employment if it were a scheduled work day.

DISABILITY PAYMENT: Means your Disability Benefit minus Deductible Sources of Income.

DISABILITY EARNINGS: Means the gross monthly earnings you receive while Disabled and working.

DISABILITY: Means that you are unable to perform the material and substantial duties of your Regular Occupation.

HOSPITAL: The term “Hospital” shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatrics ward; or as an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

PRE-EXISTING CONDITION: Means a disease, Accidental Injury, Sickness, physical condition or mental illness for which you:

(a) had treatment;
(b) incurred expense;
(c) took medicine;
(d) received care or services including diagnostic testing or related measures;
(e) or received a diagnosis or advice from a Physician, during the 12-month period immediately before your Effective Date of coverage.

The term Pre-Existing Condition will also include conditions which are related to such disease, Accidental Injury, Sickness, physical condition, or mental illness.
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Residence Address: Number & Street (Not a P.O. Box)

City ___________________ State ___ Zip ____________

Mailing Address (if different than Residence)

City ___________________ State ___ Zip ____________

Employer Name ____________________________ Employer/MCP # ________

Salary: $ ________ Occupation ____________________________

Are you currently able to perform the duties of your occupation? Yes ☐ No ☐

Applicant’s E-mail Address:

2. BENEFITS APPLIED FOR:

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1z=Individual; y=Individual & Spouse; x=Individual, Spouse & Child(ren); v=Individual & Children; s=Spouse TOTAL

3. BENEFICIARY:

First Name ____________________________ Middle Name ____________________________ Last Name ____________________________ Relationship to Insured ____________________________ Country of Citizenship ____________________________

4. ELECTION: I hereby enroll, add or change, as checked above, group insurance coverage(s) for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay.

5. ACKNOWLEDGMENT: I understand and agree that:

- The information in this application will be used to determine my eligibility for insurance; the statements and answers shown in this application (first page and, if applicable, the second page) are true and complete; the Company may rely upon such answers as the basis of my contract; and no coverage will take effect until the application is approved by the Company, the first premium is received, and a Certificate is issued.
- Any Change requires written notice and acceptance in writing by the applicant.
- If applying for disability income coverage, OTHER INCOME I AM ENTITLED TO RECEIVE WILL, IF APPLICABLE, REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.
- “Pre-Existing Conditions” may not be covered; and I should read my Certificate for a more detailed explanation of the Pre-Existing Condition exclusion, if any.
- BROCHURE(S) # ____________________________ HAS/HAVE BEEN EXPLAINED TO ME, AND I HAVE RECEIVED A COPY/COPIES; OR, I HAVE HAD ACCESS TO AND THE OPPORTUNITY TO PRINT THE BROCHURE(S). (Please initial): ____________

6. FRAUD NOTICE: Any person, who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

AGENT SIGNATURE (where required by law) ____________________________ Date ____________________________

Agent # ____________________________ SIGNATURE (Applicant) ____________________________
PROPOSED INSURED’S NAME: ________________________________

HEALTH HISTORY:

7. Within the past 5 years, have you received a diagnosis, taken medication and/or had treatment by a member of the medical profession for any of the following:

Cancer (other than basal or squamous cell skin cancer), heart and/or circulatory disorder, peripheral vascular disease (PVD), stroke or transient ischemic attack, liver or kidney disorder/disease (excluding stones), pulmonary disease, diabetes requiring insulin, rheumatoid arthritis, epilepsy, ulcerative colitis, Crohn’s disease, organ transplant, systemic lupus erythematosus, disorder of blood cells or blood clotting disorder, seizures, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or Human Immunodeficiency Virus (HIV), Chronic Fatigue Syndrome (CFS), fibromyalgia, alcohol or drug addiction or abuse, or neurological disorder (excluding headaches or migraines).

Yes ☐ No ☐

8. Within the past 12 months, have you:

Received advice from a medical provider, taken medication, incurred an expense, undergone tests, or received any treatment or counseling for a condition related to: (a) your back, neck or spine; (b) a mental or nervous condition; or (c) had surgery recommended that has not yet been performed or received a referral for surgery consultation?

Yes ☐ No ☐

9. Are you currently pregnant?

Yes ☐ No ☐

10. I hereby represent that I have read the above statements and all of the medical conditions or they have been read to me. I also understand that additional investigation could occur at time of claim and any misrepresentation contained herein relied on by the Company may be used to reduce or deny a claim and/or void the coverage if such misrepresentation materially affects the acceptance of the risk.

(Please initial): _______________
Accident Only Insurance

American Fidelity Assurance Company
A Covered Person under American Fidelity Assurance Company’s Limited Benefit Accident Only Insurance Policy can expect the following benefits when a Covered Accident happens:

**ACCIDENT EMERGENCY TREATMENT BENEFIT**

**Hospital Emergency Room**
- Enhanced Plus Plan - $200  
  *Total with Enhancement Rider*
- Enhanced Plus Plan - $250

**Doctor’s Office**
- Enhanced Plus Plan - $125  
  *Total with Enhancement Rider*
- Enhanced Plus Plan - $250

These benefits are provided for a Covered Person who receives emergency treatment in a Physician's office or Hospital emergency room within 72 hours of the Covered Accident, including physician fees, x-rays and emergency services. Benefits for x-rays are not payable under this benefit if payable under the X-ray Benefit under the optional Benefit Enhancement Rider. This benefit is payable once per Covered Person per Covered Accident.

**ACCIDENT FOLLOW-UP TREATMENT BENEFIT**
- $50 per treatment for Enhanced Plus Plan

This benefit provides for necessary follow-up treatment of injuries in addition to the emergency treatment administered within 72 hours of a Covered Accident for up to four treatments per Covered Person per Covered Accident. This benefit is not payable for the same visit in which a Physical Therapy Benefit is paid. This benefit is also not payable if the Non-Emergency Accident Follow-up benefit is paid under the optional Benefit Enhancement Rider.

**MEDICAL IMAGING BENEFIT**
- $150 for Enhanced Plus Plan  
  *Total with Enhancement Rider*
- $200 for Enhanced Plus Plan

You receive this benefit for a Covered Person who has either a Magnetic Resonance Imaging (MRI), a Computed Tomography (CT) scan, a Computed Axial Tomography (CAT) scan, a Positron Emission Tomography (PET) scan or an ultrasound.

**HOSPITAL CONFINEMENT BENEFITS**

**Hospital Admission**
- Enhanced Plus Plan - $1,500

**Intensive Care Confinement**
- Enhanced Plus Plan - $900

**Hospital Confinement**
- Enhanced Plus Plan - $300

You will receive a one-time Hospital Admission Benefit per Covered Accident if a Covered Person is Hospital Confined due to accidental Injuries (does not include emergency room and outpatient treatment). You will also receive a daily benefit for a Hospital Confinement that is longer than 18 hours for up to 365 days and an additional daily benefit for Confinement in an Intensive Care Unit up to 15 days.

**WELLNESS BENEFIT**
- Enhanced Plus Plan - $75

After coverage is in force 12 months, you or any other Covered Person can receive a benefit for an annual routine physical exam, including immunizations and preventive testing. Services must be supervised by a Physician and a charge must be incurred for the service. The benefit does not apply to dental or eye exams and is payable once per policy per calendar year.
ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

Accidental Death Benefit
- Enhanced Plus Plan – $20,000 - $200,000
  Total With Rider = $30,000 - $200,000

Accidental Dismemberment Benefit
- Enhanced Plus Plan – $400 - $60,000
  Total With Rider = $1,000 - $60,000

The amount of benefits payable are dependent upon the Covered Person involved and the type of Covered Accident. Benefits apply when a Covered Person's Accidental Death or Dismemberment occurs within 90 days of a Covered Accident. In the event that Accidental Death and Dismemberment result from the same Covered Accident, only the Accidental Death benefit will be paid. Only the highest single benefit will be paid. Accidental Death or Dismemberment must be independent of any disease or bodily infirmity or any other cause. Loss of use does not constitute dismemberment except as stated for eye injuries in the policy.

Additional Medical Expense Benefits

AMBULANCE BENEFIT
- $150 for Ground Ambulance Transport
- $500 for Air Ambulance Transport
  Total with Enhancement Rider
  - $300 for Ground Ambulance Transport
  - $1,500 for Air Ambulance Transport

This benefit is provided when accidental injuries due to a Covered Accident requires a Covered Person to be transported by a licensed ambulance to a Hospital or emergency center. If air and ground ambulance transportation is required for the same Covered Accident, only the highest benefit amount will be paid.

TRANSPORTATION BENEFIT
- $300 per round trip
You will receive this benefit for transportation of a Covered Person requiring specialized treatment and Hospital Confinement in a non-local Hospital due to injuries sustained in a Covered Accident. The non-local Hospital must be at least 100 miles away, one way (50 miles if Benefit Enhancement Rider is elected), using the most direct route, from the closer of the Covered Person’s residence or site of the Covered Accident. Travel must be by scheduled bus, plane, train or car and excludes Ambulance service. The treatment must be prescribed by a Physician and not be available locally. Benefits are provided for up to three round trips per Calendar Year per Covered Person. Transportation benefits will only be provided for the Injured Covered Person.

FAMILY MEMBER LODGING AND MEALS BENEFIT
- $100 per day of Confinement
You will receive this benefit for lodging and meals for a family member to be near a Covered Person who is Hospital Confined in a non-local Hospital. The non-local Hospital must be at least 100 miles away, one way (50 miles if Benefit Enhancement Rider is elected), using the most direct route, from the closer of the Covered Person’s residence or site of the Covered Accident. This benefit is payable only during the period the Injured Covered Person is Hospital confined. This benefit is paid for up to 30 days of Hospital Confinement per Covered Accident.

APPLIANCES
- $100
This benefit provides for one of the following: crutches, leg braces, back braces, walkers, or wheel chairs. This benefit is not payable for Prosthetic Devices.

BLOOD, PLASMA AND PLATELETS
- $250
This benefit does not include payment for immunoglobulins.

BURNS
- $100 - $10,000
This benefit is provided for second and third degree burns received in a Covered Accident when treated by a Physician within 72 hours.

SKIN GRAFT
- 25% of the covered Burn Benefit
This benefit is paid when a Covered Person receives a skin graft for a burn which benefits were paid under the Burn Benefit.

DISLOCATIONS
- $25 - $3,000
Benefit amount varies by the joint involved, type of treatment, and type of anesthesia. If a Covered Person receives more than one Dislocation in a Covered Accident, we will pay for all Dislocations up to two times the amount shown in the Schedule of Benefits for the Dislocation involved that has the highest benefit amount. No other amount will be paid under this benefit. Benefits are payable only for the first Dislocation of a joint which occurs while this policy is in force and requires open or closed Reduction.

EXPLORATORY SURGERY WITHOUT SURGICAL REPAIR
- $250
This benefit is payable for only one exploratory surgery without surgical repair per Covered Accident per Covered Person.

EYE INJURY
- $250 for surgical repair; $50 for removal of foreign body
These benefits will be paid for one or both eyes requiring treatment by a Physician due to a Covered Accident. If permanent loss of use of one or both eyes occurs, benefits will be paid under the Accidental Dismemberment Benefit.

FRACTURES
- $25 - $3,000
Benefit varies based on the bone involved, type of fracture and type of treatment. If the Covered Person fractures more than one bone in a Covered Accident, payment is made for all Fractures up to two times the amount for the bone involved that has the highest benefit amount. All fractures must be treated by a Physician.

INTERNAL INJURIES
- $1,000
This benefit is provided for open abdominal or thoracic surgery performed within 72 hours of a Covered Accident.

LACERATIONS
- $25 - $400
This benefit varies based on the severity of the laceration. The lacerations must be repaired or treated by a Physician.

“Total With Rider” equals the base policy benefit amount plus the additional amount of increase with Accident Benefit Enhancement Rider added.
CONCUSSION BENEFIT

- $200
This benefit is provided for a Covered Person who sustains a concussion and is diagnosed by a Physician within 72 hours of the Covered Accident using any type of medical imaging.

PHYSICAL THERAPY

- $25 per treatment
This benefit is provided for up to one treatment per day for up to eight treatments per Covered Person per Covered Accident. The benefit is not payable for the same visit that the Accident Follow-up Treatment Benefit is paid. This benefit is also not payable if the Non-Emergency Accident Follow-up benefit is paid under the optional Benefit Enhancement Rider.

PROSTHESIS

- $500
This benefit is not payable for hearing aids; dental aids; false teeth; eye glasses; cosmetic aids such as hair wigs; joint replacements such as artificial hips or knees.

RUPTURED DISC OR TORN KNEE CARTILAGE

- $500
This benefit is provided for surgical repair performed by a Physician.

TENDONS, LIGAMENTS AND ROTATOR CUFF

- $500 for single surgical repair;
- $750 for multiple surgical repair
The tendons, ligaments or rotator cuff must be treated by a Physician and must be repaired through surgery.

EMERGENCY DENTAL WORK

- $150 for broken teeth repaired with crown;
- $50 for extraction of broken teeth regardless of number of teeth
This benefit provides for repair to natural teeth when treated by a Physician or dentist. Initial dental treatment must be received within 72 hours of the Covered Accident. Benefits paid only once per Covered Person per Covered Accident.

PARALYSIS

- Quadriplegia $10,000; Paraplegia $5,000
The duration of the Paralysis must be a minimum of 3 consecutive months. This benefit is paid once per lifetime per Covered Person.

### Family Coverage

Several options are available to extend coverage to your family:

- **Individual & Spouse Plan** – Covers you and your Spouse.
- **Individual & Children Plan** – Covers you and each Eligible Child, as defined in the policy.
- **Family Plan** – Covers you, your Spouse and each Eligible Child, as defined in the policy.

Guaranteed Renewable

You are guaranteed the right to renew your base policy during your lifetime as long as you pay premiums when due or within the premium grace period. You cannot be singled out for a rate increase for any reason. The Insurer has the right to increase premium rates only if rates for all policies in this class change.

---

**Accident Benefit Enhancement Rider**

*Enhance your benefit amount and options by adding the Accident Benefit Enhancement Rider to your policy.*

**NON-Emergency Accident Initial Treatment Benefit**

- $125
We will pay the amount shown in the Schedule of Benefits for a Covered Person who receives initial medical treatment for Injuries sustained in a Covered Accident when such treatment is received more than 72 hours after the Covered Accident. Initial medical treatment must: (1) be received in a Physician’s office or emergency room for Injuries sustained in a Covered Accident; and (2) be the first treatment received by the Covered Person for such Injuries; and (3) occur within 30 days following the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

**Non-Emergency Accident Follow-up Treatment Benefit**

- $50 per treatment
This benefit provides for necessary follow-up treatment of Injuries in addition to the initial medical treatment administered when such initial treatment was received more than 72 hours after a Covered Accident for up to two treatments per Covered Person per Covered Accident. Medical treatment must be provided by a Physician. This benefit is not payable for a visit in which a Physical Therapy Benefit or the Accident Follow-up Treatment Benefit is paid.

**X-Ray Benefit**

- $150
We will pay the amount shown in the Schedule of Benefits for a Covered Person who has an x-ray performed due to Injuries sustained in a Covered Accident. The x-ray must be done at the request of a Physician. This benefit is payable one time per Covered Person per Covered Accident. This benefit does not cover any tests payable under the Medical Imaging Benefit or any other screening or medical imaging tests.

**Outpatient Hospital or Ambulatory Surgical Center Benefit**

- $350
When a surgical procedure is performed on an outpatient basis in a Hospital or at an Ambulatory Surgical Center on a Covered Person for Injuries sustained in a Covered Accident, we will pay the indemnity amount shown in the Schedule of Benefits for the facility fee charged by such Hospital or Ambulatory Surgical Center. We will only pay one Outpatient Hospital or Ambulatory Surgical Center Benefit per Covered Person in a 24-hour period even if more than one surgical procedure is performed. This benefit will not be paid for surgery performed in a Hospital emergency room or in a Physician’s office.

**Anesthesia Benefit**

- $250
We will pay the amount shown in the Schedule of Benefits for the services of an anesthesiologist received as a result of a surgery performed due to Injuries sustained in a Covered Accident. Hospital Confinement is not required to receive this benefit. We will only pay one Anesthesia Benefit per Covered Person in a 24-hour period even if more than one surgical procedure is performed. This benefit is not payable for local anesthesia.

By adding the Accident Benefit Enhancement rider to your policy, you will also receive additional benefit amounts to the following benefits: Accident Emergency Treatment Benefit; Hospital Emergency Room and Doctor’s Office; Medical Imaging Benefit; Ambulance Benefit; and Accidental Death or Dismemberment Benefit.
LIMITATIONS AND EXCLUSIONS
All benefits are only paid as a result of injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified.

An Accident is defined as a sudden, unexpected and unintended event, which results in bodily injury, which is independent of disease or bodily infirmity or any other cause. The policy will not pay benefits for injuries received prior to the Effective Date of coverage that are aggravated or re-injured by any event that occurs after the Effective Date.

A hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

No benefits will be provided for an Accident that is caused by or occurs as a result of: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; participation in any form of flight aviation other than as a fare-paying passenger in a fully licensed/passenger-carrying aircraft; any act that was caused by war, declared or undeclared, or service in any of the armed forces; participation in any activity or event while under the influence of any narcotic unless administered by a Physician or taken according to the Physician’s instructions; participation in, or attempting to participate in, a felony, riot or insurrection. (A felony is as defined by the law of the jurisdiction in which the activity takes place.); participation in parachuting, bungee jumping, rappelling, mountain climbing or hang gliding.

Benefits will not be provided for medical treatment for an Accident that occurred outside the United States or its territories. Benefits will not be paid for services rendered by a member of the immediate family of a Covered Person.

This is a brief description of the coverage. For actual benefits, limitations, exclusions and other provisions, please refer to the policy, AO-03, and optional rider, Accident Only Benefit Enhancement Rider, AMDI-258 Series. Availability of riders may vary by state and employer. Additional riders are subject to our general underwriting guidelines and coverage is not guaranteed. This coverage does NOT replace Workers’ Compensation Insurance. This product is inappropriate for people who are eligible for Medicaid coverage.

ACCIDENT ONLY MONTHLY PREMIUMS

<table>
<thead>
<tr>
<th>ENHANCED PLUS PLAN</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Individual</td>
<td>Individual &amp; Spouse</td>
</tr>
<tr>
<td>Plan</td>
<td>$26.60</td>
<td>$33.80</td>
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<tr>
<td>Rider</td>
<td>6.80</td>
<td>8.10</td>
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</table>

The premium and amount of benefits may vary dependent upon the plan selected.

American Fidelity Assurance Company
Our Family, Dedicated to Yours™
2000 N. Classen Boulevard • Oklahoma City, Oklahoma 73106 • (800) 654-8489
www.afadvantage.com

AO-03 Series
ACCIDENT ONLY
APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N Classen Blvd Oklahoma City, Oklahoma 73106

PROPOSED INSURED INFORMATION

Last Name (maiden name)    First Name    Full Middle Name    Suffix

Age    Date of Birth    Gender    Soc Sec Number    Requested Eff Date    Date of Employment
Mo/Day/Yr    M    F

Residence Address (Number and Street)    Work Phone #    Home Phone #    Country of Citizenship

City    State    Zip    E-mail Address

Mailing Address (if different than Residence)
Number and Street
City    State    Zip

Employer
MCP #    Salary $

Annual    Monthly

SIC Code    Rating Class

Do you now have or have you ever had any other coverage with us?
Yes    No

Is the insurance applied for intended to replace or change any coverage you now have with us or another company?
Yes    No

If YES, give company name(s) and policy

Is the insurance applied for to be in addition to any other Accident Only coverage with us or any other company?
Yes    No

A person may be covered by only one Accident Only policy.

PLANS:

Accident Benefits

Individual
Individual & Spouse
24 Hour
Non Occupational

Individual
Individual and Spouse
24 Hour
Non Occupational

Base Policy
Basic
Enhanced
Enhanced Plus

Upgrade - Benefit
Enhancement Rider

RIDER

BASE PREMIUM: $

PREMIUM: $

RIDER PREMIUM: $

Total Modal Premium $

MCH #

Distribution ID Code

Payor

Premium Frequency:

Monthly    Semi-Annual
Quarterly    Annual

Billing Method:

Direct Bill    Bank

List Bill

SPOUSE INFORMATION, If To Be Covered

Spouse’s First Name    Full Middle Name    Last Name    Country of Citizenship

Soc Sec Number

Date of Birth (Mo/Day/Yr)

BENEFICIARY INFORMATION

Is the Beneficiary the same as the spouse listed above?
Yes    No    If “No”, please list Beneficiary’s name.

First Name    Full Middle Name    Last Name    Relationship to Insured    Country of Citizenship

Contingent Beneficiary:

First Name    Full Middle Name    Last Name    Relationship to Insured    Country of Citizenship
WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I have received and reviewed a copy of consumer brochure # SB

WAIVER: I understand that no benefits will be paid for any loss that occurs while participating in: any sport for pay or profit; any contest of speed in a power driven vehicle for pay or profit; parachuting; bungee jumping; rappelling; mountain climbing or hang gliding. The statements and answers in this application are true and complete, to the best of my knowledge. The statements and answers in this application shall be deemed representations and not warranties. The policy will be issued when the application is approved and we receive payment of the first premium. I understand that the policy becomes effective on the Effective Date shown in the Policy Schedule. It is not necessarily the date the application is signed. I understand that benefits will only be paid for a Covered Accident that occurs on or after the Effective Date.

Agent # ______________ Date Signed ______________ Signed At ________________

LICENSED AGENT’S SIGNATURE (where required by law)  APRICANT’S SIGNATURE
Acknowledgment

Thank you for considering American Fidelity in planning for your financial security. We appreciate the opportunity you have given us to present our products to you.

In order for you to make an informed decision regarding application for coverage(s), we have developed a detailed brochure(s) that outline(s) the provisions of the insurance plan(s). Please read the brochure(s) carefully and ask a Company representative any questions you may have regarding information contained in the brochure(s).

Our Company will rely on answers given on your application(s) for coverage(s) in order to determine if coverage(s) can be issued. Moreover, we have the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. If you are applying for any coverage(s) that is(are) subject to insurability it may result in additional investigations while the application(s) is(are) being underwritten and at time of any claim. Any underwriting decision will rely upon the cooperation of medical providers and pro-active assistance from you, the applicant, in obtaining medical information needed to determine eligibility for coverage(s).

Please remember some group coverage(s) may require you to be on Active Service on that date in order for your coverage(s) to begin. Any health coverage(s) for which you are applying may have wording that may limit benefits for a preexisting medical condition for which you had treatment, took medication, received a diagnosis, or incurred expense. Any health coverage(s) for which you are applying may also have wording that could limit or reduce your benefits.

PLEASE ACKNOWLEDGE THAT BROCHURE(S) # ____________________________

HAS(HAVE) BEEN EXPLAINED TO YOU AND THAT YOU HAVE RECEIVED A COPY OF THE BROCHURE(S) BY SIGNING BELOW. A COPY OF THIS FORM WILL BE ENCLOSED WITH YOUR CERTIFICATE AND/OR POLICY.

Signed                                    Dated

Social Security Number

M-2195(204)
Cancer Insurance

American Fidelity Assurance Company
AMERICAN FIDELITY ASSURANCE COMPANY’S

Cancer Insurance
Basic and Enhanced C-12D Plans

A Limited Benefit Cancer Indemnity Insurance Policy
Cancer Can Be A Costly Disease.

Anyone can develop Cancer. Most Cancers are not inherited, but rather are the result of damage to genes that occurs during one’s lifetime.* If you think it can’t happen to you, think again.

CONSIDER THESE FACTS

- Men have a 1 in 2 lifetime risk of developing Cancer. Women have a 1 in 3 chance of developing some form of Cancer.*

With statistics like this, it would help to prepare for Cancer early. Ask yourself, “If I were to be diagnosed, how would I pay for this costly disease?”

Non-medical expenses, such as travel, lodging, and meals, are usually not covered by most medical policies. Only 41% of the overall medical cost of Cancer is for direct expenses, while 59% of Cancer treatment costs are not direct medical costs.* It is essential to have a plan set in place that would help if you were diagnosed.

Cancer screenings can help detect Cancer earlier which could increase your survival rate if you were to be diagnosed with Cancer. The 5-year relative survival rate for all Cancers diagnosed is 66%.* Yet, sadly, many Americans cannot afford the expense of these all-important screenings.

The good news is that American Fidelity provides a product that can help with these expenses. Our Limited Benefit Cancer Insurance plan can help cover the cost of these screenings, giving you the early detection that can be so important when fighting the illness.

American Fidelity Can Help.

American Fidelity’s Limited Benefit Cancer Policy may help with the indirect costs of Cancer such as:

- Loss of your income
- Spouse’s loss of income
- Babysitters
- Travel expenses (auto & air)
- Long distance phone calls
- Meals away from home
- Motel rooms

Our policy provides wellness benefits to help with the costs of screenings for the early detection of some Cancers as well as the financial aid you may need if diagnosed with Cancer. Limited Benefit Cancer Indemnity Protection benefits are paid directly to you, so they can be used however you need.

*American Cancer Society: Cancer Facts and Figures 2009
# Summary of Benefits

## Screening & Follow-Up

<table>
<thead>
<tr>
<th>Description</th>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic and Prevention</strong></td>
<td>$60 per test; 1 per Calendar Year</td>
<td>$75 per test; 1 per Calendar Year</td>
</tr>
<tr>
<td>Pays the indemnity amount for receipt of one generally medically recognized internal Cancer screening test per Covered Person per Calendar Year including, but not limited to: mammogram; breast ultrasound; breast thermography; breast Cancer blood test (CA 15-3); colon Cancer blood test (CEA); prostate-specific antigen blood test (PSA); flexible sigmoidoscopy; colonoscopy; virtual colonoscopy; ovarian Cancer blood test (CA-125); pap smear (lab test required); chest x-ray; hemocult stool specimen; serum protein electrophoresis (blood test for myeloma); or ThinPrep Pap test. Screening tests payable under this benefit will ONLY be paid under this benefit and does not include any test payable under the Medical Imaging Benefit. Benefits will only be paid for tests performed after the 30-day period following the Covered Person’s effective date of coverage.</td>
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## Treatment & Procedures

<table>
<thead>
<tr>
<th>Description</th>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Radiation Therapy/Chemotherapy/Immunotherapy</strong> Administered by Medical Personnel at a Medical Facility</td>
<td>$300 per day</td>
<td>$400 per day</td>
</tr>
<tr>
<td><strong>Self Injected/Oral/Pump/Implant</strong></td>
<td>$300 per day; Maximum 4 days per calendar month</td>
<td>$400 per day; Maximum 4 days per calendar month</td>
</tr>
<tr>
<td>Pays the indemnity amount when a Covered Person receives Radiation Therapy, Chemotherapy, or Immunotherapy as defined in the policy. We will pay this benefit only once per day regardless of the number of treatments received on that day. Benefits for oral and topical Chemotherapy are only paid on the day the prescription is filled or if dispensed by pump on the day the pump is filled or refilled. Benefits for implants are only paid on the day of implantation. Anti-nausea drugs are not covered under this benefit. This benefit does not include any drugs/medicines covered under the Drugs and Medicine Benefit or the Hormone Therapy Benefit.</td>
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</tbody>
</table>

## Surgical Benefit

<table>
<thead>
<tr>
<th>Description</th>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unit Dollar Amount</strong></td>
<td>$30 per Surgical Unit</td>
<td>$40 per Surgical Unit</td>
</tr>
<tr>
<td><strong>Maximum Per Operation</strong></td>
<td>$3,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Pays an indemnity benefit up to the Maximum Per Operation amount shown in the Schedule of Benefits in the policy when a surgical operation is performed on a Covered Person for covered diagnosed Cancer, Skin Cancer, or reconstructive surgery due to Cancer. Benefits will be calculated by multiplying the surgical unit value assigned to the procedure, as shown in the most current Physician’s Relative Value Table, by the Unit Dollar Amount shown in the Schedule of Benefits. Two or more surgical procedures performed through the same incision will be considered one operation and benefits will be limited to the most expensive procedure. Diagnostic surgeries that result in a negative diagnosis of Cancer are not covered under this benefit. Any diagnostic surgery covered under the Diagnostic and Prevention Benefit will not be covered under this benefit. Bone marrow surgeries are paid under the Bone Marrow Transplant Benefit. Surgeries required to implant a permanent prosthetic device are covered under the Prosthetic Benefit.</td>
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</tbody>
</table>

## Medical Imaging

<table>
<thead>
<tr>
<th>Description</th>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unit Dollar Amount</strong></td>
<td>$200 per Image; Maximum of 2 per Calendar Year</td>
<td>$300 per Image; Maximum of 2 per Calendar Year</td>
</tr>
<tr>
<td>Pays the indemnity amount for a Covered Person who has been diagnosed with Cancer who receives either an MRI; CT scan; CAT scan; or PET scan when done at the request of a Physician due to Cancer or the treatment of Cancer.</td>
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</tbody>
</table>

## Anesthesia

<table>
<thead>
<tr>
<th>Description</th>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>25% of Amount Paid for Covered Surgery</strong></td>
<td>25% of Amount Paid for Covered Surgery</td>
<td></td>
</tr>
<tr>
<td>Pays 25% of the amount paid for a covered surgery for the services of an anesthesiologist. Services of an anesthesiologist for bone marrow transplants, Skin Cancer, or surgical prosthesis implantation are not covered under this benefit.</td>
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## Blood, Plasma and Platelets

<table>
<thead>
<tr>
<th>Description</th>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unit Dollar Amount</strong></td>
<td>$150 per day; Maximum $7,500 per Calendar Year</td>
<td>$200 per day; Maximum $10,000 per Calendar Year</td>
</tr>
<tr>
<td>Pays the indemnity amount for blood, plasma and platelets. This does not include any laboratory processes. Colony stimulating factors are not covered under this benefit. Benefits for Blood, Plasma and Platelets are ONLY provided under this benefit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TREATMENT & PROCEDURES (CON’T)

<table>
<thead>
<tr>
<th>Drugs and Medicine</th>
<th>BASIC PLAN</th>
<th>ENHANCED PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Confinement</td>
<td>$200 per Confinement</td>
<td>$300 per Confinement</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$100 per calendar month</td>
<td>$150 per calendar month</td>
</tr>
</tbody>
</table>

Pays the indemnity amount for anti-nausea and pain medication prescribed by a Physician for a Covered Person for treatment of Cancer, who is also receiving Radiation Therapy/Chemotherapy/Immunotherapy, a covered surgery, or a Bone Marrow/Stem Cell Transplant. This benefit does not cover associated administrative procedures. This benefit does not include drugs/medicines covered under the Radiation/Chemotherapy/Immunotherapy Benefit or the Hormone Therapy Benefit.

### Bone Marrow/Stem Cell Transplant

| Autologous                                              | $1,000 per Calendar Year  | $1,500 per Calendar Year  |
| Non-autologous                                          | $3,000 per Calendar Year  | $4,500 per Calendar Year  |

Pays the indemnity amount when a bone marrow transplant or peripheral blood stem cell transplant is performed on a Covered Person as treatment for a diagnosed Cancer. This benefit will not be paid for the harvest of bone marrow or stem cells from a donor.

### Experimental Treatment

<table>
<thead>
<tr>
<th>Paid as any non-experimental benefit</th>
<th>Paid as any non-experimental benefit</th>
</tr>
</thead>
</table>

Pays benefits for Experimental Treatment prescribed by a Physician, as defined in the policy, the same as any other benefit covered under this policy. This benefit does not provide coverage for treatments received outside of the United States or its territories.

### Donor Expenses

| $1,000 per donation                                     | $1,000 per donation                |

Pays the indemnity amount shown for a donor’s expenses incurred on behalf of a Covered Person for a covered surgery due to organ transplant or a Bone Marrow/Stem Cell Transplant. Blood donor expenses are not covered under this benefit.

### Physical or Speech Therapy

| $25 per visit; up to 4 visits per Calendar Month       | $25 per visit; up to 4 visits per Calendar Month |

Pays the indemnity amount if a Physician advises a Covered Person to seek physical therapy or speech therapy. Physical or speech therapy must be performed by a caregiver licensed in physical or speech therapy and be needed as a result of Cancer or the treatment of Cancer. We will pay for one treatment per day up to four treatments per calendar month per Covered Person for any combination of physical or speech therapy treatments up to a lifetime maximum of $1,000.

### Facilities & Equipment

<table>
<thead>
<tr>
<th>Hospital Confinement</th>
<th>$400 per day first 30 days</th>
<th>$600 per day thereafter</th>
</tr>
</thead>
</table>

Pays the indemnity amount for a Covered Person while confined to a Hospital for at least 18 continuous hours for the treatment of Cancer. A Hospital is not an institution, or part thereof, used as: a hospice unit, including any bed designated as a hospice or swing bed; a convalescent home; a rest or nursing facility; a rehabilitative facility; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction. This benefit will not be paid for outpatient treatment or a stay of less than 18 hours in an observation unit or emergency room.

### Outpatient Hospital or Ambulatory Surgical Center

| $400 per day of Surgery                                 | $600 per day of Surgery           |

Pays the indemnity amount shown towards the facility fee charges of an Ambulatory Surgical Center or Hospital for an outpatient surgical procedure of a diagnosed Cancer. Surgical procedures for Skin Cancer are not covered under this benefit.

### U.S. Government/Charity Hospital or HMO

| $200 per day in lieu of most benefits                  | $300 per day in lieu of most benefits |

If an itemized list of services is not available because a Covered Person is: confined in a charity Hospital or U.S. Government owned Hospital; or covered under a Health Maintenance Organization (H.M.O.) or Diagnostic Related Group (D.R.G.) where no charges are made to the Covered Person for treatment of Cancer or Dread Disease, the Primary Insured may convert benefits under the policy to pay the indemnity amount shown. This benefit will be paid in lieu of most benefits under the policy.

### Extended Care Facility

| $75 per day                                            | $100 per day                      |

Pays the indemnity amount for each day room and board charges are incurred while a Covered Person is confined in an Extended Care Facility due to Cancer at the direction of a Physician that begins within 14 days after a covered Hospital Confinement. Paid for up to the same number of days benefits were paid for the Covered Person’s preceding Hospital Confinement.

### Hospice

| $75 per day;                                          | $100 per day;                     | $18,000 Lifetime Maximum    |
| $13,500 Lifetime Maximum                              |                                    |                             |

Pays the indemnity amount for Hospice Care directed by a licensed Hospice organization, as defined in the policy, of a Covered Person expected to live six months or less due to Cancer. This benefit does not include: well baby care; volunteer services; meals; housekeeping services; or family support after the death of the Covered Person.

### Prosthesis

| Surgically Implanted                                   | $1,500 per Device; 1 per Site     | $2,000 per Device; 1 per Site |
| Non-surgically Implanted                                | $150 per Device; 1 per Site       | $200 per Device; 1 per Site   |

Pays the indemnity amount for a prosthetic device received due to Cancer that manifested after the 30th day following the Effective Date, and its surgical implantation if required as a direct result of surgery for Cancer. This benefit does not cover prosthetic related supplies. Temporary prosthetic devices used as tissue expanders are covered under the Surgical Benefit. Lifetime maximum of two surgically implanted prosthetics per Covered Person. Lifetime maximum of three non-surgically implanted prosthetics per Covered Person.

### Hair Prosthesis

| $150 Lifetime Maximum                                  | $200 Lifetime Maximum             |

Pays the indemnity amount for a Covered Person’s hair prosthesis needed as a direct result of Cancer or the treatment of Cancer. This benefit is payable once per Covered Person per lifetime and is only payable under this benefit.
### CARE & CONSULTATION

<table>
<thead>
<tr>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending Physician</td>
<td>$40 per day while Hospital Confined</td>
</tr>
</tbody>
</table>

Pays the indemnity amount for one Physician’s visit per day when a Covered Person requires the services of a Physician, other than a surgeon while Hospital Confined for the treatment of Cancer.

<table>
<thead>
<tr>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Special Nursing</td>
<td>$150 per day while Hospital Confined</td>
</tr>
</tbody>
</table>

Pays the indemnity amount shown for Full-time special nursing care (other than that regularly furnished by a Hospital) while a Covered Person is Hospital Confined for treatment of Cancer. “Full-time” means at least eight consecutive hours during a 24 hour period. Care must be provided by a Nurse, as defined by the Policy, be prescribed by a Physician and be Medically Necessary for the treatment of Cancer.

<table>
<thead>
<tr>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>$75 per day; up to same number of days of paid Hospital Confinement</td>
</tr>
</tbody>
</table>

Pays the indemnity amount for a Covered Person’s Home Health Care, as described in the policy, required due to Cancer when prescribed by a Physician in lieu of Hospital Confinement beginning within 14 days after a Hospital Confinement. This benefit does not include physical or speech therapy. This benefit will be paid for up to the same number of days benefits were paid for the Covered Person’s preceding Hospital Confinement. If the Covered Person qualifies for coverage under the Hospice Care Benefit, the Hospice Care Benefit will be paid in lieu of this benefit. This benefit does not include: nutrition counseling; medical social services; medical supplies; prosthesis or orthopedic appliances; rental or purchase of durable medical equipment; drugs or medicines; child care; meals or housekeeping services. The caregiver may not be a family member.

<table>
<thead>
<tr>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd and 3rd Surgical Opinion</td>
<td>$300 per diagnosis; Additional $300 for 3rd</td>
</tr>
</tbody>
</table>

Pays the indemnity amount once per diagnosis for a Covered Person’s second surgical opinion and if the second disagrees with the first, a third opinion, when the attending Physician recommends surgery for the treatment of Cancer. Surgical opinions for reconstructive, Skin Cancer, or prosthesis surgeries are not covered under this benefit.

### TRANSPORTATION & LODGING

<table>
<thead>
<tr>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>$200 per trip; $2,000 per trip</td>
</tr>
</tbody>
</table>

Pays the indemnity amount shown for either licensed air or ground ambulance transportation of a Covered Person to a Hospital or from one medical facility to another where the Covered Person is admitted as an Inpatient and Hospital Confined for at least 18 consecutive hours for treatment of Cancer. Paid for up to two trips per Hospital Confinement for any combination of air or ground ambulance.

<table>
<thead>
<tr>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient &amp; Family Member Transportation</td>
<td>Round Trip Coach Fare or $0.50 per mile up to a Maximum $1,500 per round trip</td>
</tr>
<tr>
<td>Outpatient &amp; Family Member Lodging</td>
<td>$60 per day up to 90 days per Calendar Year</td>
</tr>
</tbody>
</table>

These benefits pay for the transportation of a Covered Person and/or one adult family member when the Covered Person has been diagnosed with Cancer and receives covered Radiation Therapy, Chemotherapy, Immunotherapy, Bone Marrow/Stem Cell Transplant, or surgery due to Cancer in the nearest Physician prescribed Hospital providing such treatment that is at least 50 miles away from the Covered Person’s residence, using the most direct route. Travel must be by scheduled bus, plane or train, or by car and be within the United States or its Territories. Benefits will be provided for only one mode of transportation per round trip and will be paid for up to 12 round trips per Calendar Year. Benefits for travel of the Covered Person and/or family member will be paid: once per Covered Person’s Hospital Confinement; or only on days of Covered Person’s outpatient specialized treatment. Benefits for lodging of the Covered Person and/or family member will be paid: once per Covered Person’s Hospital Confinement; or only on days of Covered Person’s outpatient specialized treatment. If the family member and the Covered Person travel in the same car or lodge in the same room, benefits for travel and lodging will only be paid under the Transportation and Lodging Benefit for the patient.

### ADDITIONAL BENEFITS

<table>
<thead>
<tr>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dread Disease</td>
<td>$200 per day first 30 days per Hospital Confinement; $400 per day thereafter</td>
</tr>
</tbody>
</table>

Pays an indemnity amount for each period of Hospital Confinement for treatment of a Dread Disease as defined in the policy, including: Addison’s Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Diphtheria, Encephalitis, Grand Mal Epilepsy, Legionnaire’s Disease, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Reye’s Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Systemic Lupus Erythematosus, Tay-Sachs Disease, Tetanus, Toxic Epidermal Neerosis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever, and Whipple’s Disease. Benefits for Dread Disease are ONLY provided under this benefit.

**Waiver of Premium**

If the Primary Insured becomes disabled due to Cancer and remains so for more than 90 continuous days, we will pay all premiums due after the 90th day so long as the Primary Insured remains disabled. “Disabled” means the Primary Insured’s inability because of Cancer: to work at any job for which (s)he is qualified by education, training or experience; not working at any job for pay or benefits; and under the care of a Physician for the treatment of Cancer. This policy must be in force at the time disability begins and the Primary Insured must be under age 65.
FAMILY COVERAGE
You can take advantage of several options to extend coverage to your family:

- **Individual** – You.
- **Single Parent Family** – You and each Eligible Child, as defined in the policy.
- **Family Plan** – You and your spouse and Eligible Children, as defined in the policy.

GUARANTEED RENEWABLE
You are guaranteed the right to renew your base policy during your lifetime as long as you pay premiums when due or within the premium grace period. We have the right to increase premiums by class.

### C-12D MONTHLY PREMIUMS†

<table>
<thead>
<tr>
<th></th>
<th>Basic Plan</th>
<th>Enhanced Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual</td>
<td>One Parent Family</td>
</tr>
<tr>
<td>18-40</td>
<td>15.70</td>
<td>23.30</td>
</tr>
<tr>
<td>41-50</td>
<td>22.90</td>
<td>34.00</td>
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<tr>
<td>51-60</td>
<td>31.60</td>
<td>47.10</td>
</tr>
<tr>
<td>61+</td>
<td>43.30</td>
<td>64.50</td>
</tr>
</tbody>
</table>

†The premium and amount of benefits provided vary dependent upon the plan selected.

Hospital Intensive Care Unit Rider

Intensive Care Unit $600 per day; up to 30 days per confinement

Ambulance Benefit $100 per Admission

Pays each day a Covered Person is confined in an ICU, as defined in the rider, due to accident or sickness. A day is defined as a 24-hour period. If confined to an ICU for a portion of a day, a pro rata share of the daily benefit will be paid. Benefits will not be paid for an ICU confinement that begins prior to the Effective Date of the rider. Pays the amount shown for ambulance charges for transportation to a Hospital where the Covered Person is admitted to an Intensive Care Unit within 24 hours of arrival. Benefits reduce by 50% at age 70.

### HOSPITAL INTENSIVE CARE UNIT RIDER MONTHLY PREMIUMS

<table>
<thead>
<tr>
<th></th>
<th>ICU Rider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual</td>
</tr>
<tr>
<td>18-40</td>
<td>3.40</td>
</tr>
<tr>
<td>41-50</td>
<td>4.20</td>
</tr>
<tr>
<td>51-60</td>
<td>5.50</td>
</tr>
<tr>
<td>61+</td>
<td>7.10</td>
</tr>
</tbody>
</table>
Critical Illness Rider

Pays the specified Maximum Benefit Amount, depending upon the amount chosen at time of application, upon first diagnosis of a Covered Critical Illness, as defined in the rider and as shown on the Policy Schedule, and the Date of Diagnosis occurs after the 30th day following the Covered Person’s Effective Date of coverage under the rider. Once each Benefit is paid for a Covered Person, the Benefit is no longer available for such Covered Person. All benefit amounts reduce by 50% at age 70.

CRITICAL ILLNESS RIDER MONTHLY PREMIUMS†

$2,500 Unit / Maximum $10,000 Per Rider

<table>
<thead>
<tr>
<th></th>
<th>$2,500</th>
<th>$5,000</th>
<th>$7,500</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ind</td>
<td>1.50</td>
<td>3.00</td>
<td>4.50</td>
<td>6.00</td>
</tr>
<tr>
<td>1 Parent Family</td>
<td>2.20</td>
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</tr>
<tr>
<td>2 Parent Family</td>
<td>2.90</td>
<td>5.80</td>
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<td>11.60</td>
</tr>
<tr>
<td>41-50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ind</td>
<td>3.00</td>
<td>6.00</td>
<td>9.00</td>
<td>12.00</td>
</tr>
<tr>
<td>1 Parent Family</td>
<td>4.50</td>
<td>9.00</td>
<td>13.50</td>
<td>18.00</td>
</tr>
<tr>
<td>2 Parent Family</td>
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<td>23.20</td>
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<tr>
<td>51-60</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ind</td>
<td>4.90</td>
<td>9.80</td>
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<tr>
<td>1 Parent Family</td>
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<td>14.60</td>
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<tr>
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<td>37.60</td>
</tr>
<tr>
<td>61+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ind</td>
<td>7.10</td>
<td>14.20</td>
<td>21.30</td>
<td>28.40</td>
</tr>
<tr>
<td>1 Parent Family</td>
<td>10.60</td>
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<tr>
<td>2 Parent Family</td>
<td>13.80</td>
<td>27.60</td>
<td>41.40</td>
<td>55.20</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>$2,500</th>
<th>$5,000</th>
<th>$7,500</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack/Stroke Only</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ind</td>
<td>0.80</td>
<td>1.60</td>
<td>2.40</td>
<td>3.20</td>
</tr>
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<td>1 Parent Family</td>
<td>1.20</td>
<td>2.40</td>
<td>3.60</td>
<td>4.80</td>
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<td>2 Parent Family</td>
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<td>3.00</td>
<td>4.50</td>
<td>6.00</td>
</tr>
<tr>
<td>41-50</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Ind</td>
<td>2.10</td>
<td>4.20</td>
<td>6.30</td>
<td>8.40</td>
</tr>
<tr>
<td>1 Parent Family</td>
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<td>16.40</td>
</tr>
<tr>
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</tr>
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<td>Ind</td>
<td>3.10</td>
<td>6.20</td>
<td>9.30</td>
<td>12.40</td>
</tr>
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<td>Ind</td>
<td>4.60</td>
<td>9.20</td>
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<tr>
<td>2 Parent Family</td>
<td>8.90</td>
<td>17.80</td>
<td>26.70</td>
<td>35.60</td>
</tr>
</tbody>
</table>

†The premium and amount of benefits provided vary dependent upon the plan selected.
Limitations and Exclusions

ELIGIBILITY
This policy will be issued only to those persons who meet American Fidelity Assurance Company’s insurability requirements. This product is inappropriate for those people who are eligible for Medicaid Coverage. The policy and the Internal Cancer coverage under the Critical Illness Rider will not be issued to anyone who has been diagnosed or treated for Cancer in the previous ten years. The Heart Attack or Stroke coverage under the Critical Illness Rider will not be issued to anyone who has been diagnosed or treated for any heart or stroke related conditions. The Hospital Intensive Care Unit Rider will not cover heart conditions for a period of two years following the Effective Date of coverage for anyone who has been diagnosed or treated for any heart related condition prior to the 30th day following the Covered Person’s Effective Date of coverage.

Cancer means a disease which is manifested by autonomous growth (malignancy) in which there is uncontrolled growth, function, or spread (local or distant) of cells in any part of the body. This includes Cancer in situ and malignant melanoma. It does not include other conditions which may be considered precancerous or having malignant potential such as: leukoplakia; hyperplasia; acquired immune deficiency syndrome (AIDS); polycythemia; actinic keratoses; myelodysplastic and non-malignant myeloproliferative disorders; aplastic anemia; atypia; non-malignant monoclonal gamopathy; carcinoma; or pre-malignant lesions, benign tumors or polyps.

BASE POLICY
All diagnosis of Cancer must be positively diagnosed by a legally licensed doctor of medicine certified by the American Board of Pathology or American Board of Osteopathic Pathology. This policy pays only for loss resulting from definitive Cancer treatment including direct extension, metastatic spread or recurrence. Proof must be submitted to support each claim. This policy also covers other conditions or diseases directly caused by Cancer or the treatment of Cancer. This policy does not cover any other disease, sickness or incapacity even though after contracting Cancer it may have been aggravated or affected by Cancer or the treatment of Cancer except for conditions specifically stated in the Dread Disease Benefit. No benefits are payable for any Covered Person for any loss incurred during the first year of this policy as a result of a Pre-Existing Condition. A Pre-Existing Condition is a Cancer or Specified Disease for which, within 12 months prior to the Effective Date of coverage, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession, or for which symptoms manifested in such a manner as would cause an ordinarily prudent person to seek diagnosis, medical advice or treatment. Pre-Existing Conditions specifically named or described as excluded in any part of this contract are never covered. This policy contains a 30-day waiting period during which no benefits will be paid under this policy. If any Covered Person has a Cancer or Specified Disease diagnosed before the end of the 30-day period immediately following the Covered Person’s Effective Date, coverage for that person will apply only to loss that is incurred after one year from the Effective Date of such person’s coverage. If any Covered Person is diagnosed as having a Cancer or Specified Disease during the 30-day period immediately following the Effective Date, you may elect to void the policy from the beginning and receive a full refund of premium. All benefits payable only to the maximum amount listed in the Schedule of Benefits in the policy.

HOSPITAL INTENSIVE CARE UNIT RIDER
No benefits will be provided during the first two years of this rider for Hospital Intensive Care Unit confinement caused by any heart condition when any heart condition was diagnosed or treated prior to the 30th day following the Covered Person’s Effective Date of this rider. (The heart condition causing the confinement need not be the same condition diagnosed or treated prior to the Effective Date). No benefits will be provided if the loss results from: attempted suicide whether sane or insane; intentional self-injury; being intoxicated or under the influence of any narcotic or hallucinogenic unless administered on the advice of a Physician; or any act of war, declared or undeclared, or any act related to war; or military service for any country at war. No benefits will be paid for confinements in units such as: Surgical Recovery Rooms, Progressive Care, Burn Units, Intermediate Care, Private Monitored Rooms, Observation Units, Telemetry Units or Psychiatric Units not involving intensive medical care; or other facilities which do not meet the standards for Hospital Intensive Care Unit as defined in the Rider. For a newborn child born within the ten-month period following the effective date of this rider, no benefits will be provided for Hospital Intensive Care Unit Confinement that begins within the first 30 days following the birth of such child.

CRITICAL ILLNESS RIDER
Benefits will only be paid for a Covered Critical Illness as shown on the Policy Schedule page in the policy. No benefits will be provided for any loss caused by or resulting from: intentionally self-inflicted bodily injury, suicide or attempted suicide, whether sane or insane; intentional self-injury; being intoxicated or under the influence of any narcotic or hallucinogenic unless administered on the advice of a Physician; or any act of war, declared or undeclared, or any act related to war; or military service for any country at war; or a Pre-Existing Condition (Pre-Existing Condition, as used in this rider means any sickness or condition for which, prior to the Effective Date of coverage, medical advice, consultation or treatment, including prescribed medications, was recommended by or received from a member of the medical profession, or for which symptoms manifested in such a manner as would cause an ordinarily prudent person to seek diagnosis, medical advice or treatment.); or a Covered Critical Illness when the Date of Diagnosis occurs during the Waiting Period; or participation in any activity or event while intoxicated or under the influence of any narcotic unless administered by a Physician or taken according to the Physician’s instructions; or participation in, or attempting to participate in, a felony, riot or insurrection (A felony is as defined by the law of the jurisdiction in which the activity takes place.). Internal Cancer does not include: other conditions that may be considered pre-cancerous or having malignant potential such as: Acquired immune deficiency syndrome (AIDS); Actinic keratoses; or Myelodysplastic and non-malignant myeloproliferative disorders; or Aplastic anemia; or Atypia; or Non-malignant monoclonal gamopathy; or Pre-malignant lesions, benign tumors or polyps; or Leukoplakia; or Hyperplasia; or Carcinoid; or Polycythemia; or Cancer in situ or any skin Cancer other than invasive malignant melanoma into the dermis or deeper.

This is a brief description of the coverage. For actual benefits and other provisions, please refer to the policy. This coverage does not replace Workers’ Compensation Insurance.
## Proposed Insured Information

<table>
<thead>
<tr>
<th>1. Last Name</th>
<th>First Name</th>
<th>Full Middle Name</th>
<th>Suffix</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Age</td>
<td>Date of Birth</td>
<td>Sex</td>
<td>SSN</td>
</tr>
<tr>
<td>Mo Day Yr</td>
<td>M ☐ F ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Residence Address</td>
<td>Work Phone #</td>
<td>Home Phone #</td>
<td>Country of Citizenship</td>
</tr>
<tr>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. City</td>
<td>State</td>
<td>Zip</td>
<td>E-Mail Address</td>
</tr>
<tr>
<td>5. Mailing Address (if different than Residence)</td>
<td>Number and Street</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>6. Employer</td>
<td>MCP #</td>
<td>Salary $</td>
<td>Occupation</td>
</tr>
<tr>
<td>7. Is the insurance applied for intended to replace or change any coverage you now have with us?</td>
<td>Yes ☐ No ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES, give policy number(s).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> A person may be covered by only one American Fidelity Assurance Company individual cancer policy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Is the insurance applied for intended to replace or change any coverage you now have with another carrier?</td>
<td>Yes ☐ No ☐ If YES, list all health insurance currently in force in your name. List name of insurer and amount of insurance, if known.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Benefits Requested:

<table>
<thead>
<tr>
<th>Composite Rate</th>
<th>AGE BAND: 0 - 40</th>
<th>41 - 50</th>
<th>51 - 60</th>
<th>61 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ _______ ☐ C1106</td>
<td>☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4</td>
<td>Monthly</td>
<td>$C1106</td>
<td></td>
</tr>
<tr>
<td>$ _______ ☐ First Occurrence Rider (conversions only)</td>
<td>Critical Illness Rider</td>
<td>☐ Quarterly ☐ Bank Draft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$ _______ ☐ Cancer</td>
<td>☐ Heart/Stroke</td>
<td>☐ Semi-Annual ☐ List Bill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$ _______ ☐ ICU Rider</td>
<td>☐ Other</td>
<td>☐ Annual ☐ Skip Month or Other (Describe below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$ _______ ☐ Other</td>
<td>☐ Skip Month or Other (Describe below)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Modal Premium $ ____________ Distribution ID Code ____________
MCH # ____________ Payor # ____________

## Additional Proposed Insureds

<table>
<thead>
<tr>
<th>10. Spouse’s First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>SSN</th>
<th>Date of Birth</th>
<th>Country of Citizenship</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Are Eligible Children to be covered?</td>
<td>Yes ☐ No ☐</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Beneficiary Information

| 12. Is the Beneficiary the same as the spouse listed above? | Yes ☐ No ☐ |
| If not, please list Beneficiary’s name below. |
| 13. First Name | Middle Name | Last Name | Relationship to Insured | Country of Citizenship |
| 14. Contingent Beneficiary: | First Name | Middle Name | Last Name | Relationship to Insured | Country of Citizenship |

Remarks:
HEALTH QUESTIONS (Please answer for ALL Covered Persons)

15. I represent that no person to be covered has been treated or diagnosed by a member of the medical profession for Cancer, Carcinoma, Sarcoma, Hodgkin’s Disease, Leukemia, Lymphoma, melanoma or malignant tumor in any form within the last 10 years except (if none, check here ☐) ____________________ (Name and Relationship to Proposed Insured)

who is to be excluded from coverage under this policy, the First Occurrence Rider, and cancer coverage under the Critical Illness Rider. (If the person has had only skin cancer, a copy of the pathology report must be submitted with the application. If the skin cancer was diagnosed or treated within the last three years, the person will be excluded from skin cancer coverage under this policy.)

16. I represent that no person or persons to be covered is now, or ever has been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or had any positive test results indicating Human Immunodeficiency Virus (HIV) except (if none check here ☐) ____________________ (Name and Relationship to Proposed Insured)

who is to be excluded from coverage under this policy and any rider(s) attached to the policy.

17. I also represent that no person or persons to be covered has ever been advised by a member of the medical profession to have any diagnostic tests, examinations, or consultations to determine the existence of cancer: that have not been completed; or that results have not been received; or results were abnormal and no follow-up or resolution has occurred, except (if none check here ☐) ____________________ (Name and Relationship to Proposed Insured)

who is to be excluded from coverage under this policy and any rider(s) attached to the policy.

COMPLETE WHEN REQUESTING C1106, C12D06 OR C12M06

18. I represent that no person to be covered has now or has ever had: Addison’s Disease, Amyotrophic Lateral Sclerosis, Grand Mal Epilepsy, Systemic Lupus Erythematosus, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Reye’s Syndrome, Sickle Cell Anemia, Tay-Sachs Disease, Toxic Epidermal Necrolysis, Tuberculosis or Whipple’s Disease in any form except (list person’s name and disease if any) ____________________ (Name, Disease and Relationship to Proposed Insured)

who is to be excluded from coverage under the Dread Disease Benefit for the Disease listed.

COMPLETE WHEN REQUESTING CRITICAL ILLNESS RIDER (Available only with C1106, C12D06 OR C12M06)

19. I also represent that no person to be covered has now or has ever been treated or diagnosed by a member of the medical profession for heart attack, coronary angioplasty, coronary artery bypass, coronary artery disease, disease of the heart or circulatory system, any abnormality of the heart, transient ischemic attack (TIA) or stroke except (if none check here ☐) ____________________ (Name and Relationship to Proposed Insured)

who is to be excluded from Heart Attack/Stroke coverage under the Critical Illness Rider.

SIGNATURES

The statements and answers in this application are true and complete, to the best of my knowledge. The policy will be issued when the application and payment of the first premium is received and approved by us. I understand that the policy becomes effective on the Effective Date shown in the Policy Schedule. It is not necessarily the date the application is signed. I understand that in no event, except in the absence of legal capacity, may proof of loss be given later than 12 months after the date proof of loss is otherwise required. This application shall be altered solely by the applicant or by his written consent. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Agent # ____________________ Signed At ____________________

Date Signed ____________________

LICENSED AGENT’S SIGNATURE

APPLICANT’S SIGNATURE

(where required by law)
Acknowledgment

Thank you for considering American Fidelity in planning for your financial security. We appreciate the opportunity you have given us to present our products to you.

In order for you to make an informed decision regarding application for coverage(s), we have developed a detailed brochure(s) that outline(s) the provisions of the insurance plan(s). Please read the brochure(s) carefully and ask a Company representative any questions you may have regarding information contained in the brochure(s).

Our Company will rely on answers given on your application(s) for coverage(s) in order to determine if coverage(s) can be issued. Moreover, we have the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. If you are applying for any coverage(s) that is(are) subject to insurability it may result in additional investigations while the application(s) is(are) being underwritten and at time of any claim. Any underwriting decision will rely upon the cooperation of medical providers and pro-active assistance from you, the applicant, in obtaining medical information needed to determine eligibility for coverage(s).

Please remember some group coverage(s) may require you to be on Active Service on that date in order for your coverage(s) to begin. Any health coverage(s) for which you are applying may have wording that may limit benefits for a preexisting medical condition for which you had treatment, took medication, received a diagnosis, or incurred expense. Any health coverage(s) for which you are applying may also have wording that could limit or reduce your benefits.

PLEASE ACKNOWLEDGE THAT BROCHURE(S) # _____________________________
HAS(HAVE) BEEN EXPLAINED TO YOU AND THAT YOU HAVE RECEIVED A COPY OF THE BROCHURE(S) BY SIGNING BELOW. A COPY OF THIS FORM WILL BE ENCLOSED WITH YOUR CERTIFICATE AND/OR POLICY.

Signed

Dated

Social Security Number

M-2195(204)
Acknowledgment

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Dated

Social Security Number

M-2195(204)