USAble

CriticalCare Elite Product Manual

Includes:

Brochure
Field Reference Manual
Specimen Policy
Forms

GIS
GROUP INSURANCE SERVICES

CriticalCare Elite

In life there are unexpected events, be prepared with CriticalCare Elite.

In the next 4 minutes,
5 Americans will have a stroke.

In the next 4 minutes,
10 people in the US will be diagnosed with cancer.

**www.medicare.org*

USAble Life

You'll Choose Us For Life

CIP2-OC-TN (7-07)

LIMITED BENEFIT — FORM CIP2-WC (7-07) and CIP2 (7-07) — OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY This outline of coverage provides a brief description of some of the important features of your policy. **THIS IS NOT THE INSURANCE CONTRACT, AND ONLY THE ACTUAL POLICY PROVISIONS WILL CONTROL.** The policy sets forth, in detail, the rights and obligations of any covered person and USAble Life. It is, therefore, important that you READ YOUR POLICY CAREFULLY. This is a limited benefit policy and is designed to provide coverage ONLY when certain losses occur as a result of the specified critical illnesses as defined below and more fully in the policy. This policy does not provide for basic hospital, basic medical-surgical or major medical expenses. This policy provides benefits only if the date of diagnosis of specified critical illness is while the policy is in force for the covered person so diagnosed **AND** after the waiting period has been satisfied by that covered person. Important: Benefits received under this policy may be taxable. You should consult your personal tax advisor to determine whether or not payments received are subject to taxation.

covered illnesses

	with cancer	without cancer
Cancer	100%	n/a
Heart Attack	100%	100%
Stroke	100%	100%
End Stage Renal Disease	100%	100%
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	100%	100%
Quadriplegia	100%	100%
Major Organ Transplant Surgery	100%	100%
Coronary Artery Bypass Surgery*	25%	25%
Balloon Angioplasty, Stent, or Laser Relief Procedure*	10%	10%
Carcinoma in Situ*	10%	n/a

Lump sum payments *paid directly to you* upon first diagnosis of one of the covered critical illnesses shown above.

Choice of 2 plans and face amounts from $5,000 - $100,000, in $5,000 increments.

Waiting Period — No benefits will be paid for a specified critical illness diagnosed during the first 30 days following any covered person's effective date of coverage.

If the date of diagnosis of any covered person's specified critical illness occurs during the waiting period, the policy or any increase in coverage will be cancelled and all premiums returned.

**These benefits are each payable only once per covered person. If one or more of these benefits are paid, the remaining amount payable will be the original face amount reduced by all prior benefit payments. The waiting period will not apply to any specified critical illness caused by an accident.*

On the policy anniversary following attainment of age 75, the face amount of all benefits will be restated as 50% of the remaining amount payable.

The covered person's coverage terminates when 100% of the face amount has been paid, unless the Recurrent Benefit Rider is attached.

Wellness Benefit

We will pay a total of **$75** per calendar year for a covered person to undergo one of the covered tests or exams listed below.

- Mammography
- Flexible Sigmoidoscopy
- Chest X-Ray
- EKG
- Pap Smear
- Cholesterol & Diabetes Screening
- Colonoscopy
- PSA (Blood Test for Prostate Cancer)
- Breast Ultrasound
- CA 15-3 for Breast Cancer
- CA 125 for Ovarian Cancer
- CEA Blood Test for Colon Cancer
- Thermography
- Bone Marrow Testing
- Serum Protein Electrophoresis
- Fasting Blood Glucose Test
- Hemocult Stool Analysis
- Blood Test for Triglycerides

This benefit is payable once per covered person per calendar year and two times per family per calendar year.

Recurrent Benefit Rider (optional)

GROUP 1

- Cancer (if covered under your policy)
- Major Organ Transplant
- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- End Stage Renal Disease
- Quadriplegia

GROUP 2

- Heart Attack
- Stroke

We will pay an additional benefit if a covered person is diagnosed with a different Group 1 critical illness (a recurrence) than one for which payment was previously received under your policy.

We will pay an additional benefit if a covered person is diagnosed with a different Group 2 critical illness (a recurrence) than one for which payment was previously received under your policy.

We will pay an additional benefit if a covered person is diagnosed a second time with a Group 2 illness (a reoccurrence) for which payment was previously received, provided that treatment for such illness was not received during the 180-day period prior to the second illness.

If this rider is included, the covered person's coverage terminates when 200% of the face amount of the base policy has been paid.

definitions

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) is a progressive wasting of motor neuron of the brain and spinal column.

Balloon Angioplasty, Stent, or Laser Relief Obstruction Procedures are therapeutic procedures used to correct narrowing or blockage of one or more coronary arteries.

Cancer is a disease characterized by the spread of malignant cells and must be positively diagnosed with histopathological confirmation by a medical practitioner. (See Exceptions and Limitations)

Carcinoma in Situ is a disease characterized by malignant neoplasm of epithelial origin that is confined to the area in which it was discovered. (See Exceptions and Limitations)

Coronary Artery Bypass Surgery is a major surgical procedure requiring median sternotomy to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

End Stage Renal Disease (ESRD) is chronic irreversible failure of both kidneys to function which requires at least weekly hemodialysis or peritoneal dialysis or kidney transplantation.

Heart Attack is characterized by diagnosis of the death of a portion of the heart muscle resulting from inadequate blood supply.

Major Organ Transplant is human to human organ transplant of the liver, heart, lung, pancreas or bone marrow from a donor to the covered person.

Quadriplegia means the complete, irreversible paralysis and loss of use of both upper and lower limbs without severance.

Stroke is a cerebrovascular event resulting in permanent neurological deficit.

These definitions provide a brief description of the specified critical illness covered by your policy. Only the actual policy definitions will control.

why criticalcare elite?

- *The probability of surviving a critical illness before age 65 is almost twice as great as dying.**
- *Approximately, 1.5 million Americans suffer a heart attack each year. Of these, 1.1 million will survive at least 3 years.***
- *About 1.4 million new cancer cases are expected to be diagnosed in 2007.****

**National Center for Health Statistics*
***American Heart Association*
****American Cancer Society, Cancer Facts & Figures 2007*

You have applied for:

- ○ CRITICALCARE ELITE WITH CANCER
- ○ CRITICALCARE ELITE WITHOUT CANCER
  - ○ INDIVIDUAL
  - ○ INDIVIDUAL/SPOUSE
  - ○ 1 PARENT & FAMILY
  - ○ FULL FAMILY

APPLICANT FACE AMOUNT $ _____

SPOUSE FACE AMOUNT $ _____

CHILDREN FACE AMOUNT $ _____

RECURRENT BENEFIT RIDER ○ YES ○ NO

EXCEPTIONS AND LIMITATIONS

EXCEPTIONS — WHAT WE WILL NOT PAY FOR:

This policy pays only for loss resulting from specified critical illnesses or surgeries defined in the policy. We will not pay benefits for a specified critical illness or surgery that occurs as a result of the following:

1. Conditions other than the specified critical illnesses or surgeries defined in the policy.
2. The covered person being diagnosed with a specified critical illness during the waiting period, unless the specified critical illness is caused by an accident.
3. The covered person voluntarily participating or attempting to participate in an illegal activity.
4. The covered person intentionally causing a self-inflicted injury.
5. The covered person committing or attempting to commit suicide, whether sane or insane.
6. The covered person's voluntary involvement in any period of armed conflict, even if it is not declared.
7. Surgeries performed outside of the United States or its Territories.
8. Other Exclusions: We will not pay the Specified Critical Illness Benefit for the following:
   a) Cerebral symptoms due to transient ischemic attack (TIA), migraine, cerebral injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions.
   b) Leukemia, other than chronic lymphocytic leukemia, if there is no generalized dissemination of leukemia cells in the blood-forming bone marrow.
   c) All skin cancers, unless there is evidence of metastasis or the tumor is a malignant melanoma of greater than 1.5-mm maximum thickness as determined by histological examination using the Breslow method.
   d) All tumors which are histologically described as pre-malignant or non-invasive (including cervical dysplasia CIN-1, CIN-2, CIN-3), except carcinoma in situ.
   e) Non life-threatening cancers, such as prostate cancers which are histologically described as TNM Classification T1(a) or T1(b), or are of another equivalent or lesser classification.
   f) Papillary micro-carcinoma of the thyroid.
   g) Non-invasive papillary cancer of the bladder histologically described as TaNOMO or of a lesser classification.
   h) Chronic lymphocytic leukemia less than RAI Stage I or Binet Stage A-I.

PRE-EXISTING CONDITIONS LIMITATIONS FOR CERTAIN CONDITIONS

The benefits of the policy will not be payable for any loss caused by a pre-existing condition during the first 24 months the policy is in force. After this 24-month period, however, loss due to such conditions will be payable unless specifically excluded from coverage. This 24-month period is measured from the effective date of coverage for each covered person. A pre-existing condition means a specified critical illness which is diagnosed or treated within 24 months prior to the effective date of coverage for each covered person. Conditions which are: (a) fully disclosed to us on the application; and (b) not excluded or limited by us are not considered pre-existing conditions.

RENEWABILITY AND CONTINUATION

This policy and riders are guaranteed renewable during the covered person's lifetime. USAble Life may change the premium rate, but only if the rate is changed for all policies and purchased riders in the covered person's state.

This policy will not be issued to anyone 65 years of age or over on the initial effective date. If the covered person purchases the policy and/or riders prior to their 65th birthday, they may continue coverage after age 65 as long as they continue to timely pay the premium by the due date or during the 31 days that follow.

Covered dependents who no longer meet eligibility requirements may convert to an individual policy without evidence of insurability. A covered person spouse's coverage will terminate at the time of divorce. However, a covered person spouse's coverage can be converted upon divorce or the covered person's death.

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USAble Life is rated "A" (Excellent) by the A.M. Best Company.

A Rating and Analysis from the A.M. Best Company represents an independent opinion from the leading provider of insurer ratings of a company's financial strength and ability to meet its obligations to policyholders. Upon completion of evaluations, A. M. Best assigns the following Best's Ratings: A++ and A+ (Superior); A and A- (Excellent); B++ and B+ (Very Good); B and B- (Fair); C++ and C+ (Marginal); C and C- (Weak); D (Poor); E (Under Regulatory Supervision); F (In Liquidation); S (Rating Suspended).

USAble Life is rated "A" (Strong) by the Standard & Poor's Rating Company.

Standard & Poor's Insurer Financial Strength Ratings provide powerful decision-making tools for anyone interested in buying insurance. Standard & Poor's ratings are prospective evaluations of an insurer's financial security to its policyholders. Standard & Poor's Insurer Financial Strength Ratings range from "AAA" to "CC". An insurer rated "BBB" and higher ("A", "AA", "AAA") is regarded as having financial security characteristics that outweigh any vulnerabilities and is highly likely to have the ability to meet financial commitments. An insurer rated "BB" or lower is in the "vulnerable" range and is regarded as having vulnerable characteristics that may outweigh its strengths. "BB" indicates the least degree of vulnerability within the range. "CC" the highest degree of vulnerability.

FIELD REFERENCE MANUAL

CRITICALCARE ELITE

CIP2-FRM (7-07)

USAble Life

You'll Choose Us For Life

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CriticalCare Elite

GENERAL INFORMATION

The purpose of this booklet is to provide you with an easy to understand set of guidelines for writing and submitting CriticalCare Elite (Critical Illness) applications. Please do not consider these guidelines as hard and fast rules. They are intended to give you a general idea of how the underwriting process works.

There are many questions that will come up which can only be answered by calling the HOME OFFICE at 1-800-648-0271 (Hours 8:00 a.m. - 4:30 p.m. Central Time).

All of us at USAble Life want our experience working together to be pleasant, smooth and beneficial. You and your client are important to us. A few minutes invested in making sure you provide clear and complete information to USAble Life when submitting an application or calling the Home Office will help us best serve each other and our clients.

Confidential information, which will be used to make an underwriting decision, is frequently obtained from health care providers or other sources. USAble Life will not release this information; however, you should know that our staff will always try to approve coverage, and when we must deny an applicant we will not always be able to tell you why.

Licensing/Appointment/Contracting

Prior to soliciting new business for CriticalCare Elite policies, all sales representatives must be licensed to sell life and health insurance in each state in which they are selling, and must be appointed to write insurance with USAble Life in those states. Regardless of where the application is solicited, each sales representative must be licensed in the state where the applicant's resides.

Each sales representative must also be currently contracted with the company and must have received training from USAble Life on the CriticalCare Elite policy. Please do not solicit or submit business until the above mentioned steps are taken.

Promotional Materials

All promotional materials and advertising must be approved in **advance** by USAble Life. The USAble Life Marketing Department is authorized to approve any promotional or advertising material presented in any medium. Please check with our Marketing Department for a supply of approved promotional brochures.

IMPORTANT NOTICE REGARDING
STATE SPECIFIC REQUIREMENTS

The purpose of this document is to give you general information about CriticalCare Elite. There are a number of State mandated benefit changes that may be specific to your State. Please also refer to the brochure approved for your state, which outlines coverage available in your state.

GENERAL OUTLINE OF COVERAGE:

Description:

The CriticalCare Elite policy provides for a lump sum payment upon first positive diagnosis of a covered critical illness. Refer to page 6 for additional information.

An optional Recurrent Benefit Rider is available which provides for additional payments upon recurrent and reoccurrence of certain covered critical illnesses. Refer to page 4 for additional information.

A Wellness Benefit is included in the policy at no additional premium. Refer to page 4 for additional information.

With or Without Cancer:

A CriticalCare Elite policy is available with or without Cancer coverage. Your client may wish to keep their current Cancer policy and apply for a CriticalCare Elite policy without Cancer coverage. They may also apply for CriticalCare Elite coverage with Cancer and keep their present Cancer policy. CriticalCare Elite is not intended to replace any existing Cancer coverage since the lump sum payment of benefits is different from many Cancer policies which pay based upon the medical services received. See State Specific Benefits for exceptions.

Spouse & Dependent Coverage:

The policy is available as follows:

- Applicant Only
- Applicant & Spouse
- Applicant & Children
- Applicant, Spouse & Children

Issue Ages:

CriticalCare Elite is issue age rated. This means premiums are always based upon the insured's age on the policy's effective date, regardless of any future rate adjustments.

Proposed Insured/Applicant – 18 to 64
Eligible Spouse – Up to age 64
Children – 0 to 23 (if unmarried and dependent for 50% support) (May vary by state)

GENERAL OUTLINE OF COVERAGE (Continued)

Beneficiaries: Section 4 of the application will be used to name, and change, a beneficiary. Some of the covered critical illnesses can result in immediate death of the insured and the named beneficiary will receive the claim payment in that event.

Amounts of Coverage:

Employee Applicant – Face Amount of $5,000 to $100,000 in increments of $5,000.

Spouse – Face Amount of $5,000 to $100,000 in increments of $5,000 not to exceed the amount issued to Employee.

Children – Face Amount of $5,000 to $10,000 up to amount issued to Employee.

Spouse's signature on the application is required for spouse coverage amounts over $25,000.

Coverage amounts issued may vary by applicant, spouse and children. However, the coverage amount for a spouse and/or children may not exceed the amount issued on the applicant. Example: You may apply for $40,000 on the applicant, $40,000 on the Spouse and $10,000 on Children. In this example if the amount requested for the applicant was $20,000 then the amount available for the spouse could not be greater than $20,000. We will not issue amounts greater than the maximums listed above.

Waiting Period: Benefits are subject to a 30-day waiting period following the effective date of the policy.

Survival Period: There is no survival requirement following a covered critical illness to receive benefits.

Pre-Existing Limitation (24/24): Benefits are not payable for any loss caused by a pre-existing condition during the first 24 months the policy is in-force. A pre-existing condition means any specified critical illness which is diagnosed or treated during the 24 months prior to the effective date of coverage for each covered person (see policy pages 7 and 8). See State Specific Benefits for exceptions.

Reduction in Coverage at Age 75: Benefits reduce by 50% at age 75.

GENERAL OUTLINE OF COVERAGE (Continued)

Termination of Coverage: For individual policies, this policy terminates when 100% of the Face Amount has been paid (see next paragraph). For family policies, coverage for an individual terminates when 100% of the Face Amount for that individual has been paid (see next paragraph). However, the remaining family members' coverage remains in force and the premium will be adjusted accordingly.

If the Recurrent Benefit Rider is included, an insured person's coverage terminates when 200% of the face amount of the base policy has been paid.

Wellness Benefit: CriticalCare Elite includes a Wellness Benefit of $75 per calendar year per for a covered person to undergo one of the exams or tests listed below. $75 is paid as a "flat" benefit, regardless of the actual cost of the exam or test.

The Wellness Benefit is payable once per covered person, two times per family, per calendar year. The following tests or exams are covered:

- Mammography
- Flexible Sigmoidoscopy
- Chest X-Ray
- EKG
- Pap Smear
- Cholesterol & Diabetes Screening
- Colonoscopy
- Breast Ultrasound
- Thermography
- PSA Blood Test for Prostate Cancer
- CA 15-3 for Breast Cancer
- CA 125 for Ovarian Cancer
- CEA Blood Test for Colon Cancer
- Bone Marrow Testing
- Serum Protein Electrophoresis
- Fasting Blood Glucose Test
- Hemocult Stool Analysis
- Blood Test for Triglycerides

Optional Recurrent Benefit Rider:

The optional Recurrent Benefit Rider provides for more than one payment for certain covered critical illnesses. The policy benefits must be paid in full before benefits are available under the Recurrent Benefit Rider.

To understand how benefits are paid under the Recurrent Benefit Rider, it is important to know the definitions in the rider of "Recurrence" and "Reoccurrence."

"Recurrence" means the insured person is diagnosed with a *different* critical illness from a critical illness that was previously paid under the policy.

"Reoccurrence" means the insured person is diagnosed a second time with the *same* critical illness for which a critical illness was previously paid under the policy.

Optional Recurrent Benefit Rider (Continued)

Critical Illnesses Covered Under Recurrent Benefit Rider

Group 1 • Cancer, if covered under the policy • Major organ Transplant • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • End Stage Renal Disease • Quadriplegia **Group 2** • Heart Attack • Stroke	The Recurrent Benefit Rider pays an additional benefit if a covered person is diagnosed with a different Group 1 critical illness (recurrence) than one for which a payment was previously paid. The Recurrent Benefit Rider pays an additional benefit if a covered person is diagnosed with a different Group 2 critical illness (recurrence) than one for which a payment was previously paid. The Recurrent Benefit Rider pays an additional benefit if a covered person is diagnosed a second time with a Group 2 critical illness (reoccurrence) for which a payment was previously paid, provided that treatment for such illness was not received during the 180-day period prior to the second illness. "Treatment" means consultation, care, or services provided by a physician including diagnostic measures but does not include preventive medications or routine scheduled follow-up visits to a physician after the diagnosis of the initial critical illness.
If the Recurrent benefit Rider is included, a covered person's coverage terminates when 200% of the face amount of the policy has been paid.	

Examples of Recurrent Benefit
$100,000 Face Amount

Insured is diagnosed with Cancer	Policy pays $100,000
Insured is diagnosed with End Stage Renal Disease	Recurrent Benefit Rider pays $100,000
	Total Paid: $200,000
Insured is diagnosed with Lou Gehrig's Disease	Policy pays $100,000
Insured is diagnosed with a Stroke	Recurrent Benefit Rider pays $100,000
	Total Paid: $200,000
Insured is diagnosed with a Heart Attack	Policy pays $100,000
More than 180 days later insured is diagnosed a second time with a Heart Attack	Recurrent Benefit Rider pays $100,000
	Total Paid: $200,000

GENERAL OUTLINE OF COVERAGE (Continued)

The following is a list of the Covered Critical Illnesses:

	Percent of Face Amount	
Covered Critical Illness Benefits	**Option A**	**Option B**
1. Cancer	100%	N/A
2. Heart Attack	100%	100%
3. Stroke	100%	100%
4. End Stage Renal Failure	100%	100%
5. Major Organ Transplant Surgery	100%	100%
6. Quadriplegia	100%	100%
7. Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)	100%	100%
8. Coronary Artery Bypass Surgery*	25%	25%
9. Balloon Angioplasty, Stent, or Laser Relief Obstruction Surgery*	10%	10%
10. Carcinoma In Situ*	10%	N/A

* Each of the Coronary Artery Bypass Surgery Benefit (No 8 above), Balloon Angioplasty, Stent, or Laser Relief Obstruction Surgery Benefit (No. 9 above), or Carcinoma In Situ Benefit (No. 10. Above) are payable only once per insured. **Example:** If a claim for a Stent was paid on an insured and he had a Balloon Angioplasty later we would not pay the Balloon Angioplasty claim. However, if he had a Coronary Artery Bypass later we would pay 25% of the remaining balance of coverage. If one or more of these **benefits** are paid the Remaining Amount Payable will be the Original Face Amount reduced by all prior benefit payments.

Note: On the policy anniversary following attainment of age 75, the Face Amount will be restated as 50% of the Remaining Amount Payable.

DEFINITIONS OF CRITICAL ILLNESSES

1. **Cancer** – Means the presence of a malignant tumor that is characterized by progressive, uncontrolled growth, spread of malignant cells, and invasion and destruction of normal and surrounding tissue.

The following are **NOT** to be construed as cancer for purposes of this benefit:

a. Leukemia, other than chronic lymphocytic leukemia, if there is no generalized dissemination of leukemia cells in the blood-forming bone marrow.
b. All tumors which are histologically described as pre-malignant, non-invasive, or carcinoma in situ (including cervical dysplasia CIN-1, CIN-2, and CIN-3).
c. All skin cancers, unless there is evidence of metastasis or the tumor is a malignant melanoma of greater than 1.5 mm maximum thickness as determined by histological examination using the Breslow method.
d. Non life-threatening cancers, such as prostate cancers which are histologically described as TNM Classification T1(a) or T1(b), or are of another equivalent or lesser classification.
e. Papillary micro-carcinoma of the thyroid.
f. Non-invasive papillary cancer of the bladder histologically described as TaNOMO or of a lesser classification.
g. Chronic lymphocytic leukemia less than RAI Stage I or Binet Stage A-I.

2. **Heart Attack** – Means unequivocal diagnosis of the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area as evidenced by all of the following criteria:

a. Typical central chest pain suggestive of heart attack.
b. Diagnostic increase of specific cardiac markers typical for heart attack.
c. New ECG changes of infarction.
d. Reduction in left ventricular function demonstrated by left ventricular ejection fraction of less than 40% on echocardiogram.

3. **Stroke** – Means the suffering of a stroke as a result of a cerebrovascular event. Stroke must result in permanent neurological deficit measured three months or more after the event and result in a score of 3 or higher on the Modified Rankin Scale for stroke outcome. There must also be clear evidence on a CT, MRI, or similar appropriate imaging technique that a stroke has occurred, and either: (a) infarction of brain tissue; or (b) intracranial or subarachnoid hemorrhage.

Cerebral symptoms due to transient ischemic attacks (TIA), migraine, cerebral injury resulting from trauma, or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions are excluded.

4. **End Stage Renal Disease (ESRD)** – Means chronic irreversible failure of both kidneys to function such that the insured must undergo regular (at least weekly) hemodialysis or peritoneal dialysis or kidney transplantation.

DEFINITIONS OF CRITICAL ILLNESSES (Continued

5. **Major Organ Transplant** – means the human to human organ transplant from a donor to the insured person of one or more of the following organs: liver, heart, lung, pancreas, or the transplantation of bone marrow.
6. **Quadriplegia** – means the complete and irreversible paralysis of both upper and lower limbs. It means loss of use, without severance of a limb, which has lasted 30 days and is expected to last for a continuous period of 12 months or more from the date of the accident or sickness causing paralysis.
7. **Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)** – means a progressive degeneration of anterior horn cells of the spinal cord and the cranial nerves with involvement of both upper and lower motor neurons.
8. **Coronary Artery Bypass Surgery** – means major surgery requiring medial sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are not covered, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.
8. **Balloon Angioplasty, Stent or Laser Relief Obstruction Surgery** – means therapeutic procedures used to correct narrowing or blockage of one or more coronary arteries.
10. **Carcinoma In Situ** – means a malignant neoplasm of epithelial origin that is confined to the basement membrane. Carcinoma in situ must be diagnosed with histopathological confirmation. Pre-malignant lesions and carcinoma in situ of the skin, including melanoma in situ, are excluded.

BILLING AND PREMIUM PAYMENT

CriticalCare Elite is priced to be sold to employer/employee groups and have premiums paid by payroll deduction from the employee's salary. Direct sales to individuals cannot be accepted. CriticalCare Elite policies may be billed along with other USAble Life policies (example: Elite Life, CancerCare Elite, Accident Elite, etc.). Please observe the minimum billing and premium rules listed below when selling CriticalCare Elite.

NEW GROUPS: To keep billing expenses reasonable, the minimum size group that will be accepted is three (3) applications for at least $50 in monthly premium. This requirement can be met with any combination of USAble Life policies on the same premium statement.

EXISTING GROUPS: You may sell one or more CriticalCare Elite policies to groups that already meet the minimum billing requirements outlined above.

APPLICATIONS AND BROCHURE

Application: The approved application is form CIP2-APP (7-07). **Note:** if a special application is required by a state the same procedure outlined under Brochure listed below will be used for the form number.

Brochure: The approved brochure is form CIP2-OC (7-07). It has been approved in Arkansas. Please check with the Home Office for approval in your state or other states where you are licensed to write business and where the policy is approved. If a special brochure or application is required in another state the same form number will be used with a state specific notation following the form number. For example, CIP2-OC-XX (date) where XX equals the state designation. A new date will be assigned.

REPLACEMENT

Replacement Coverage – Other Companies:

Please Note: Not all States require the completion of a Replacement Form, but we recommend it.

A 24/24 pre-existing limitation applies to CriticalCare Elite and it may not be in the best interest of the prospective insured to replace another company's policy.

There is no "prior credit" provision in the CriticalCare Elite policy and it is not anticipated that exceptions will be made to allow this administratively.

If question #2 of Section 3 of the application is answered "yes" and the applicant is replacing coverage of another company, please complete "Notice to Applicant Regarding Replacement of Insurance," form, IND-REP.

NOTE: Please advise your applicant that he/she should not cancel existing coverage until the USAble Life coverage has been approved. USAble Life does not want you to be placed in the position of having an applicant's existing coverage terminated if he is uninsurable with us.

Replacement Of USAble Life Critical Illness:

Existing Critical Illness policyholders are allowed to retain their policies and apply to purchase a new CriticalCare Elite policy.

There may be requests from existing Critical Illness policyholders to exchange their policy for the new CriticalCare Elite policy.

Both Critical Illness and CriticalCare Elite are issue age rated. This means premiums are always based upon the insured's age on the policy's effective date, regardless of any future rate adjustments. Also, CriticalCare Elite has a 24/24 pre-existing limitation.

Therefore, we do not recommend that you solicit replacement of Critical Illness policies.

REPLACEMENT (Continued)

If there are special circumstances, you may request an approved exception from the Home Office.

Increases to Existing Coverage – Since Critical Illness and Care Elite are issue age rated, the existing policy must be terminated and a new policy issued at new issue age rates. The new policy will contain a 24/24/ pre-existing limitation and the application will be subject to medical underwriting approval in accordance with the underwriting rules outlined below.

Therefore, it is not recommended that Critical Illness be replaced by CriticalCare Elite.

Alternatively, those policyholders wanting additional coverage may keep their current policy and increase their overall critical illness protection by applying for an additional CriticalCare Elite policy.

Guaranteed Issue is not available to policyholders increasing coverage.

MEDICAL UNDERWRITING

Guaranteed Issue:

For New Groups With 50 or More Eligible Employees

Participation	Without Recurrent Benefit	With Recurrent Benefit
Greater of 50 Participants or 20% Participation	$5,000	None
Greater of 75 Participants or 30% Participation	$10,000	$5,000
Greater of 100 Participants or 40% Participation	$15,000	$10,000

Note:

1. Spouses and Children are not eligible and do not "count" toward participation.

Examples of CriticalCare Elite Guaranteed Issue
Without Recurrent Benefit*

Eligible Employees	Number of Participants	Guaranteed Issue	Eligible Employees	Number of Participants	Guaranteed Issue
3 – 99	Less than 50 50 – 74 75 - 99	None $5,000 $10,000	500 – 599	Less than 110 110 - 164 165 - 219 220 – 599	None $5,000 $10,000 $15,000
100 – 199	Less than 50 50 - 74 75 - 99 100 – 199	None $5,000 $10,000 $15,000	600 – 699	Less than 130 130 - 194 195 - 259 260 – 699	None $5,000 $10,000 $15,000
200 – 299	Less than 50 50 - 74 75 - 99 100 – 299	None $5,000 $10,000 $15,000	700 – 799	Less than 150 150 - 224 225 - 299 300 – 799	None $5,000 $10,000 $15,000
300 – 399	Less than 70 70 - 104 105 - 139 140 – 399	None $5,000 $10,000 $15,000	800 – 899	Less than 170 170 - 254 255 - 339 340 – 899	None $5,000 $10,000 $15,000
400 – 499	Less than 90 90 - 134 135 - 179 180 – 499	None $5,000 $10,000 $15,000	900 – 999	Less than 190 190 - 284 285 - 379 380 – 999	None $5,000 $10,000 $15,000
1,000 & over Consult Home Office					

*** Subtract $5,000 for Guaranteed Issue with Recurrent Benefit.**

Guaranteed Issue (Continued)

New Hires - May have Guaranteed Issue, up to the amount for which their group qualified, ONLY IF they apply during their group's regular scheduled annual enrollment for USAble Life benefits AND IF their date of hire is less than 12 months from the date of their application. Generally, the regular annual enrollment period will be defined as the enrollment for the employer group's IRC Sec. 125 Cafeteria Plan. The enrollment of Guaranteed Issue and enrollment dates will be closely monitored.

Any exceptions to this enrollment period must be approved by USAble Life.

Increases and Changes to Existing Coverage – Guaranteed Issue is not available.

Completing Medical Information on the Application:

It is very important that each insureds' height and weight be accurately recorded in Sections 1 and 2 of the application and each (see "Tiered" Underwriting below) question in SECTION 5 – MEDICAL INFORMATION of the application <u>is read, as printed, exactly to the applicant</u>. You should advise the applicant prior to asking the questions to please remember and be as accurate as possible in their answers since incorrect answers could lead to denial of a claim. In your own way express the importance of accurate answers to the questions being asked.

Applications will be underwritten based upon answers in the application. We will also secure a Medical Information Bureau (MIB) report on each applicant.

Tiered Underwriting:

The purposes of tiered underwriting are:

1. To allow you and the applicant to easily and quickly complete the Medical Information with Yes/No responses and minimal, if any, details.
2. It is only necessary for an applicant to answer the Medical Information required for the amount applied for. See **Tier Amounts of CriticalCare Elite and Required Underwriting** on the next page.
3. To allow applicants to be "guaranteed to be issued" a "tier" amount of CriticalCare Elite coverage if they are within height and weight limits and able to answer, "No" to specific questions in Section 5 of the application.
4. A minimum of further requirements; i.e., APS' and, therefore, fast processing by medical underwriting.

Tier Amounts and Required Underwriting (Continued)

Important Note: These limits are inclusive of any Guaranteed Issue. In other words, the amounts below that require underwriting **include** any Guaranteed issue and are **not in addition to Guaranteed Issue**. For example, an applicant who is eligible for $5,000 Guaranteed Issue may be offered Tier 1 underwriting up to $20,000 or total coverage of $25,000 rather than a total of $30,000.

Tier Amounts of CriticalCare Elite and Required Underwriting:

Tier I Amounts - $5,000 to $25,000

Only question 1. of Section 5, parts (a) through (g), need to be answered.

These are simple Yes/No questions and are designed to obtain any medical history of covered critical illnesses.

If all parts of question 1. are answered, “No” then the application will be approved.

Any "Yes" response will result in the application being declined for amounts over any Guaranteed issue.

Tier II Amounts - $25,001 - $50,000

In addition to question 1., only all parts of question 2. and question 3. need to be answered.

As with Tier I, these are simple Yes/No questions and are designed to obtain medical information regarding any current abnormal medical tests, specific symptoms not medically evaluated, history of diseases related to specific covered critical illnesses and family history.

If all parts of questions 1. and 2. and question 3 are answered, “No” then the application will be approved.

Any "Yes" response to questions 2. or 3. will result in the application being declined for amounts over $25,000.

However, if the answer to all parts of question 1. are “No” then the application will be approved for $25,000. If the answer to any parts of question 1. is also “Yes” the application will be declined for the amount over any Guaranteed Issue.

Tier Amounts and Required Underwriting (Continued)

Tier III Amounts - $50,001 - $100,000

All questions of Section 5 must be answered.

Tier III questions are "qualitative" questions that may require additional detail from the applicant.

Details of “Yes” answers to questions #4 through #8 should be included and the application will be subject to simplified medical underwriting. This means we may request an “APS” but will not require medical examinations or laboratory tests.

As with Tier I and II an applicant qualifying for the amounts of either Tier I or II will be issued for an amount for which they qualify regardless of whether they are declined for Tier III.

IMPORTANT ROLE OF SALES REPRESENTATIVE

Critical Illness coverage is a very new coverage in the United States. It has been sold in South Africa, England and Canada for a few years. Our new CriticalCare Elite policy is one of the best and most competitive new products being sold today. The policy (sample attached) is as simple and straightforward as we could make it and it has been written according to Insurance Department Readability Guidelines. However, it is a complicated policy due to the nature of the coverage and the medical terms that are used to describe payable medical conditions. For all of these reasons the sale of CriticalCare Elite will only be approved for Sales Representatives who have attended our training course and who have a thorough understanding of the coverage.

ELIMINATION RIDER

A Dependent Spouse or child that does not qualify for coverage will be eliminated by using elimination rider, form CIP-ELIM (sample attached). The premium will be adjusted accordingly. If the Applicant is uninsurable the application will be denied. We will not eliminate coverage by Benefit. For example, if a person has had a Stroke the Benefit for Stroke will not be eliminated. Coverage for the person who has had a stroke will be denied.

DEATH OF APPLICANT

See the CONTINUATION OF COVERAGE section of the policy. If the primary insured/applicant (employee) dies his/her spouse will become the Primary Insured under the policy. USABLE LIFE will change the policy, adjust premiums and bill the new Primary Insured direct.

EXCEPTIONS/EXCLUSIONS

The policy pays only for loss resulting from the listed specified critical illnesses or surgeries as outlined in the policy. For other exclusions (Exceptions) see the Brochure or page 6 of the policy.

ATTACHMENTS:

- Application form CIP2-APP (7-07)
- Elimination Rider form CIP-ELIM

STATE SPECIFIC REQUIREMENTS

Georgia:
1. CriticalCare Elite policy is not available without Cancer as a covered critical illness.
2. Pre-Existing Limitation is not included.
3. Guaranteed Issue is not available.

USAble Life

320 W. Capitol • P.O. Box 1650 • Little Rock, AR 72203-1650
(501) 375-7200 • (800) 648-0271

This is a Limited Policy – Read It Carefully!

No benefits will be paid for a covered specified critical illness which is diagnosed during the 30 day waiting period.

Policy Number: [000001234]
Primary Insured: [JOHN A DOE]
Effective Date: [July 1, 2007]

We agree, subject to all policy provisions, to pay the benefits of this policy and to provide the owner with all other rights of this policy.

The premium you paid and the application you completed place this policy in force as of the effective date. The effective date is shown in the Policy Schedule. A copy of your application is attached.

PART A IMPORTANT PLEASE READ

Your application is a part of this policy. PLEASE READ the copy of your application that is attached to this policy. Your policy was issued on the basis that all information in the application is correct and complete. If not, your policy may not be valid. If anything in your application is not correct, you should write to us within 30 days of the date you received this policy and let us know. Incorrect information could result in the denial of a claim or termination of this policy.

PART B 30-DAY RIGHT TO EXAMINE AND CANCEL POLICY

It is important to us that you are satisfied with this policy and that it meets your insurance needs. If you are not satisfied, you may return this policy to us within 30 days of the date you received it. The premium you paid will be promptly refunded. Then, the policy was never in force.

PART C RENEWAL AGREEMENT – GUARANTEED RENEWABLE FOR LIFE

We will renew your policy when you timely pay the premium. It must be paid on or before the date it is due or during the 31 days that follow. Your policy stays in force during this time.

You may cancel this policy at any time. The cancellation will be effective on the first day of the policy month following the date we receive your written cancellation notice, or on a later date if you so specify. Upon cancellation, we shall promptly return any unearned premium.

The face amount shown on the schedule page will reduce by 50% on the policy anniversary date after your 75th birthday.

This policy is a legal contract between you and us. PLEASE READ THIS POLICY CAREFULLY.

Signed for us at our Home Office on the effective date.

Mark Langston
Assistant Secretary

Jason Mann
President

GUARANTEED RENEWABLE FOR LIFE
CRITICAL ILLNESS POLICY WITH CANCER

TABLE OF CONTENTS

ADDITIONAL BENEFITS

Any additional benefits provided by rider(s) listed on Page 3 are fully described in the rider(s) that immediately precede the copy of your application.

POLICY SCHEDULE

This page shows specific information about this policy and is referred to throughout this policy.

Type of Coverage: [Full Family]

Insured(s)	Name	Face Amount on Issue Date*	Age	Tobacco Use
Primary	JOHN A DOE	$50,000		No
Spouse	JANE B DOE	$50,000		No
Children	Yes	$50,000		

** The face amount reduces by 50% on the first Policy Anniversary after age 75.*

Policy or Rider	Monthly Premium
[Critical Illness with Cancer Policy	0.00]
[Recurrent Benefit Rider]	9.40

Premium Schedule	Annual	Semiannual	Quarterly	Monthly
Total Premiums	[$XXX.XX	$XXX.XX	$XXX.XX	$XX.XX]

Premium Frequency Selected By You: [MONTHLY]

The [MONTHLY] Premium is available only through a salary deduction plan of the company or by bank draft.

Waiting Period: [30 Days]

Specified Critical Illness	Percentage of Face Amount
Cancer	100%
Heart Attack	100%
Stroke	100%
End Stage Renal Disease	100%
Amytrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)	100%
Quadriplegia	100%
Major Organ Transplant Surgery	100%
Coronary Artery Bypass Surgery ** *(This benefit is payable only once per insured)*	25%
Balloon Angioplasty, Stent, or Laser Relief Procedure ** *(This benefit is payable only once per insured)*	10%
Carcinoma in Situ ** *(This benefit is payable only once per insured)*	10%

** *If one or more of these benefits are paid, the remaining amount payable will be the original face amount reduced by all prior benefit payments. On the policy anniversary following attainment of age 75, the face amount will be restated as 50% of the remaining amount payable.*

Policy Number: [000001234]

Primary Insured: [JOHN A DOE]

Effective Date: [July 1, 2007]

PART D PREMIUM CHANGE

We may change the premium rates for this policy. We can only change the premium if we change it for all policies of this form number and premium classification in your state of issue that are then in force. We will not change the premium more than once in a 12-month period.

We will notify you in writing of any change in premium 31 days or more before the change is effective. Notice will be mailed to you at the address shown on our records. Please notify us of any change in address.

PART E DEFINITIONS

When we use the following words, this is what we mean:

"Accident" means only accidental bodily injury which:

(1) is sustained after the effective date of coverage; and
(2) is the direct cause of the loss independent of disease, bodily infirmity, or any other cause; and
(3) occurs while the policy is in force.

"Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)," for the purposes of this policy, means a progressive degeneration of anterior horn cells of the spinal cord and the cranial nerves with involvement of both upper and lower motor neurons.

"Balloon Angioplasty, Stent, or Laser Relief Obstruction Procedure," for the purposes of this policy, means therapeutic procedures used to correct narrowing or blockage of one or more coronary arteries.

"Cancer," for the purposes of this policy, means the presence of a malignant tumor that is characterized by progressive, uncontrolled growth, spread of malignant cells, and invasion and destruction of normal and surrounding tissue. Major interventionist treatment or major surgery must be considered necessary, or palliative care must have been initiated. Cancer must be positively diagnosed with histopathological confirmation by a medical practitioner who is a consultant oncologist. The following tumors are excluded:

(1) Leukemia, other than chronic lymphocytic leukemia, if there is no generalized dissemination of leukemia cells in the blood-forming bone marrow.
(2) All tumors which are histologically described as pre-malignant, non-invasive, or carcinoma in situ (including cervical dysplasia CIN-1, CIN-2, and CIN-3).
(3) All skin cancers, unless there is evidence of metastasis or the tumor is a malignant melanoma of greater than 1.5 mm maximum thickness as determined by histological examination using the Breslow method.
(4) Non life-threatening cancers, such as prostate cancers which are histologically described as TNM Classification T1(a) or T1(b), or are of another equivalent or lesser classification.
(5) Papillary micro-carcinoma of the thyroid;
(6) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification.
(7) Chronic lymphocytic leukemia less than RAI Stage I or Binet Stage A-I.

"Carcinoma in situ," for the purposes of this policy, means a malignant neoplasm of epithelial origin that is confined to the basement membrane. Carcinoma in situ must be diagnosed with histopathological confirmation. Pre-malignant lesions and carcinoma in situ of the skin, including melanoma in situ, are excluded.

Cancer and/or carcinoma in situ must be diagnosed in one of two ways:

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

Clinical Diagnosis
A clinical diagnosis of cancer or carcinoma in situ is based on the study of symptoms. We will pay benefits for a clinical diagnosis only if:

(1) a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and,
(2) there is medical evidence to support the diagnosis; and
(3) a physician is treating you for cancer and/or carcinoma in situ.

"Covered Person(s)" means persons, in addition to you, insured under this policy.

"Coronary Artery Bypass Surgery," for the purposes of this policy, means major surgery requiring median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Procedures that do not require median sternotomy are not covered, including but not limited to, minimally invasive, endoscopic, and "keyhole" heart surgery; balloon and laser angioplasty; stent procedures; and atherectomy.

"Date of Diagnosis" means the following:

For amyotrophic lateral sclerosis:
The date a neurologist determines that at least a 25% permanent whole person impairment exists based on an impairment evaluation performed in accordance with the then-current edition of the American Medical Association's Guide to the Evaluation of Permanent Impairment.

For cancer and/or carcinoma in situ:
The day the tissue specimen, blood samples and/or titer(s) are taken on which the diagnosis of cancer or carcinoma in situ is based.

For heart attack:
The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

For stroke:
The date a stroke occurred based on documented neurological deficits and neuroimaging studies. The diagnosis must be made by a licensed neurologist.

For end stage renal disease:

The date that your physician recommends that you begin renal dialysis or undergo a kidney transplant.

For quadriplegia:
The date of occurrence of the permanent loss of use of all four limbs and includes documented evidence of the illness or injury that caused the quadriplegia.

Major organ transplant surgery, coronary artery bypass surgery, or balloon angioplasty, stent, or laser relief obstruction procedure:
The date the surgery occurs for covered transplants, covered coronary artery bypass surgery, or balloon angioplasty, stent, or laser relief obstruction procedure.

"Effective Date" means the date shown on the Policy Schedule for all insured persons accepted for coverage at the time of issue provided the application has been accepted and approved by us, the policy has been issued and the full first premium has been paid; or the date shown by endorsement for all insured persons added to coverage after the policy has been issued. The effective date is assigned by us in accordance with our policy dating rules in effect at the time this policy is issued. The coverage provided by this policy will not be effective unless there has been no change since the date of the application and the effective date of the policy in the health of any proposed insured person listed on the application.

"End Stage Renal Disease (ESRD)," for the purposes of this policy, means chronic irreversible failure of both kidneys to function such that you must undergo regular (at least weekly) hemodialysis or peritoneal dialysis or kidney transplantation.

"He" or "His" The use of the male pronoun also includes the female.

"Heart Attack" or "Myocardial Infarction," for the purposes of this policy, means unequivocal diagnosis of the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area as evidenced by all of the following criteria:

(1) Typical central chest pain suggestive of heart attack;
(2) Diagnostic increase of specific cardiac markers typical for heart attack;
(3) New ECG changes of infarction; and
(4) Reduction in left ventricular function demonstrated by left ventricular ejection fraction of less than 40% on echocardiogram. Echocardiogram must be done at an accredited cardiac unit and be available for review.

After this policy has been issued, we may decide to accept other newly developed studies approved by the American College of Cardiology that are deemed to be at least as accurate in the positive diagnosis of heart attack as those previously listed.

"Home Office" means the principal office of USAble Life in Little Rock, Arkansas.

"Immediate Family" means anyone related to an insured person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or spouses of any of these.

"Insured Person" means you or any other person insured under this policy.
There are four types of coverage under this policy:

(1) "Individual" coverage;

(2) "Individual and Spouse" coverage;
(3) "One-Parent Family" coverage; or
(4) "Full Family" coverage.

If this policy is issued as an "Individual" policy, the word "Applicant" as shown on the application shall mean that we insure only you.

If this policy is issued as an "Individual and Spouse" policy, the words "Applicant and Spouse" as shown on the application shall mean that we insure you and your spouse.

If this policy is issued as a "One-Parent Family" policy, the words "Applicant and Children" as shown on the application shall mean that we insure you and all your dependent children who are eligible for coverage as stated in the Dependent provisions of this policy.

If this policy is issued as a "Full Family" policy, the words "Applicant, Spouse and Children" as shown on the application shall mean that we insure you, your spouse and all dependent children (of yours or your spouse) who are eligible for coverage as stated in the Dependent provisions of this policy.

"Major Organ Transplant," for the purposes of this policy, means the human to human organ transplant from a donor to the insured person of one or more of the following organs: liver, heart, lung, pancreas, or the transplantation of bone marrow. The transplantation of any other organs, parts of organs, tissues or cells is excluded.

"Pathologist" means a physician, other than yourself or an immediate family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.

"Physician" means a person who is providing services within the scope of his license, and is either: (a) licensed to practice medicine and prescribe and administer drugs or to perform surgery; or is (b) legally qualified and licensed as a medical practitioner and is required to be recognized, according to the insurance statutes or the insurance regulations of the governing jurisdiction. Such person must not be an immediate family member of any insured person. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible physicians under this policy.

"Policy" means this document, any riders, endorsements, or amendments to it, and the application.

"Policy Anniversary Date" means the annual anniversary of the policy effective date.

"Pre-existing Condition" means a specified critical illness that is diagnosed or for which treatment is received within 24 months prior to the effective date of coverage for each insured person. "Treatment" means consultation, care, or services provided by a physician including diagnostic measures and taking prescription drugs and medicines. If the issuance of an insured person's coverage was based on the medical history disclosed on the application, such condtions which were fully disclosed and not excluded or limited by us are not considered pre-existing conditions.

"Primary Insured" means the person named on page 1.

"Quadriplegia," for the purposes of this policy, means the complete and irreversible paralysis of both upper and lower limbs. It means loss of use, without severance of a limb, which has lasted 30 days and is expected to last for a continuous period of 12 months or more from the date of the accident causing paralysis or the date of diagnosis of the sickness causing paralysis.

"Renewal Date" means the date your next premium payment is due.

"Stroke," for the purposes of this policy, means the suffering of a stroke as a result of a cerebrovascular event. Stroke must result in permanent neurologic deficit measured three months or more after the event and result in a score of 3 or higher on the Modified Rankin Scale for stroke outcome. There must also be clear evidence on a CT, MRI, or similar appropriate imaging technique that a stroke has occurred, and either: (a) infarction of brain tissue; or (b) intracranial or subarachnoid hemorrhage.

Cerebral symptoms due to transient ischemic attack (TIA), migraine, cerebral injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions are excluded.

"Waiting Period" means the first thirty days following the insured person's effective date under this policy. No benefits will be paid for a covered specified critical illness that is diagnosed during the waiting period. If the date of diagnosis of any insured's specified critical illness occurs during the waiting period, this policy or any increase in coverage will be cancelled and all premiums returned. The waiting period will not apply to any specified critical illness caused by an accident.

"We," "Our," or "Us" means USAble Life.

"You" or "Your" means the person named as the primary insured on the Policy Schedule on page 3. You are insured for the benefits of the policy as of the effective date.

PART F EXCEPTIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS--LIMITATIONS FOR CERTAIN CONDITIONS:

The benefits of this policy will not be payable for loss caused by pre-existing conditions during the first 24 months this policy is in force. After this 24-month period, however, loss due to such pre-existing conditions will be payable unless specifically excluded from coverage. This 24 month period is measured from the effective date of coverage for each insured person.

EXCEPTIONS--WHAT WE WILL NOT PAY FOR:

This policy pays only for loss resulting from specified critical illnesses or surgeries, as defined in this policy. We will not pay benefits for a specified critical illness or surgery that occurs as a result of the following:

(1) Conditions other than the specified critical illnesses or surgeries defined in the policy.
(2) The insured person being diagnosed with a specified critical illness during the waiting period, unless the specified critical illness is caused by an accident.
(3) The insured person voluntarily participating or attempting to participate in an illegal activity.
(4) The insured person intentionally causing a self-inflicted injury.
(5) The insured person committing or attempting to commit suicide, whether sane or insane.

(6) The insured person's voluntary involvement in any period of armed conflict, even if it is not declared.
(7) Surgeries performed outside of the United States or its Territories.
(8) Other Exclusions: We will not pay the Specified Critical Illness Benefit for the following:
  (a) Cerebral symptoms due to transient ischemic attack (TIA), migraine, cerebral injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions.
  (b) Leukemia, other than chronic lymphocytic leukemia, if there is no generalized dissemination of leukemia cells in the blood-forming bone marrow.
  (c) All skin cancers, unless there is evidence of metastasis or the tumor is a malignant melanoma of greater than 1.5 mm maximum thickness as determined by histological examination using the Breslow method.
  (d) All tumors which are histologically described as pre-malignant or non-invasive (including cervical dysplasia CIN-1, CIN-2, and CIN-3), except carcinoma in situ.
  (e) Non life-threatening cancers, such as prostate cancers which are histologically described as TNM Classification T1(a) or T1(b), or are of another equivalent or lesser classification.
  (f) Papillary micro-carcinoma of the thyroid.
  (g) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification.
  (h) Chronic lymphocytic leukemia less than RAI Stage I or Binet Stage A-I.

PART G BENEFITS

According to the provisions of this policy, we insure you and, if named on the Policy Schedule, family members against the specified critical illnesses and surgeries mentioned in this section and defined in this policy.

SPECIFIED CRITICAL ILLNESS BENEFIT PRIOR TO AGE 75

We will pay a benefit if an insured person is diagnosed with one of the covered specified critical illnesses if:
(1) the Date of Diagnosis is after the Waiting Period:
(2) the Date of Diagnosis is during the life of the insured and while this policy is in force; and
(3) it is not excluded by name or specific description in this policy.

If the date of diagnosis of any insured's specified critical illness occurs during the waiting period, this policy or any increase in coverage will be cancelled and all premiums returned. The waiting period will not apply to any specified critical illness caused by an accident.

We will pay 25% of the face amount if an insured person has the following surgery performed:
- Coronary Artery Bypass Surgery (Payable only once per insured person.)

We will pay 10% of the face amount if an insured person has the following procedure performed:
- Balloon Angioplasty, Stent, Or Laser Relief Obstruction Procedure *(Payable only once per insured person.)*

We will pay 10% of the face amount if an insured person is diagnosed with:

- Carcinoma in situ (Payable only once per insured person.)

We will pay 100% of the face amount (less any amounts previously paid for diagnosis of carcinoma in situ, coronary artery bypass surgery, or balloon angioplasty, stent, or laser relief obstruction procedure) if an insured person is diagnosed with one of the following:

- Cancer
- Heart Attack
- Stroke
- End Stage Renal Disease
- Quadriplegia
- Major Organ Transplant
- Amyotrophic Lateral Sclerosis

The Coronary Artery Bypass Surgery Benefit, the Balloon Angioplasty, Stent, or Laser Relief Obstruction Procedure Benefit, and the Carcinoma in Situ Benefit are each payable only once per insured person. If one or more of these benefits are paid, the remaining amount payable will be the original face amount of this policy reduced by all prior benefit payments.

No benefits are payable for conditions other than the specified critical illnesses defined in the policy.

SPECIFIED CRITICAL ILLNESS BENEFIT AT AGE 75 AND AFTER

The face amount shown on the schedule page will reduce by 50% on the policy anniversary date after the insured person's 75th birthday. This will be the insured person's new face amount. However, if one or more benefits have been paid prior to age 75, the new face amount will be 50% of the remaining amount payable.

We will pay this benefit if an insured person is diagnosed with one of the covered specified critical illnesses if:

(1) the Date of Diagnosis is during the life of the insured and while this policy is in force; and
(2) it is not excluded by name or specific description in this policy.

We will pay 25% of the new face amount if an insured person has the following surgery performed:

- Coronary Artery Bypass Surgery (Payable only once per insured person.)

We will pay 10% of the new face amount if an insured person has the following procedure performed:

- Balloon Angioplasty, Stent, or Laser Relief Obstruction Procedure *(Payable only once per insured person.)*

We will pay 10% of the new face amount if an insured person is diagnosed with the following:

- Carcinoma in situ (Payable only once per insured person.)

We will pay 100% of the new face amount (less any amounts paid after the insured person reached age 75) if an insured person is diagnosed with one of the following:

- Cancer
- Heart Attack
- Stroke
- End Stage Renal Disease

- Quadriplegia
- Major Organ Transplant
- Amyotrophic Lateral Sclerosis

WELLNESS BENEFIT

We will pay a total of **$75 per calendar year** for an insured person to undergo a routine examination or other preventive testing. This benefit is payable once per insured person per calendar year and two times per family per calendar year.

Covered tests and exams are:

Mammography	Colonoscopy
Flexible Sigmoidoscopy	PSA (Blood Test for Prostate Cancer)
Chest X-Ray	Breast Ultrasound
EKG	CA 15-3 for Breast Cancer
Pap Smear	CA 125 for Ovarian Cancer
Cholesterol and Diabetes Screening	CEA Blood Test for Colon Cancer
Blood Test for Triglycerides	Hemocult Stool Analysis
Fasting Blood Glucose Test	Serum Protein Electrophoresis
Bone Marrow Testing	Thermography

PART H DEPENDENT PROVISIONS

ELIGIBLE DEPENDENTS:

IF THIS IS AN "INDIVIDUAL" PLAN THE FOLLOWING APPLIES: If this is an individual plan, it means that we insure only you. However, your dependents may become eligible for coverage. Dependents eligible for coverage include: (1) your spouse, if not legally separated from you; (2) your unmarried natural or step children under the age of 24 who are primarily dependent upon you for support and maintenance; and (3) newborn children, adopted children and children placed for adoption.

Eligible dependents not insured on the effective date may become insured persons, subject to acceptance by us of your written application and the payment of any required premium.

IF THIS IS AN "INDIVIDUAL AND SPOUSE" PLAN THE FOLLOWING APPLIES: If this is an "Individual and Spouse" policy, it means that we insure you and your spouse if not legally separated from you. However, your dependent children may become eligible for coverage. Dependent children eligible for coverage include: (1) your unmarried natural or step children under the age of 24 who are primarily dependent upon you for support and maintenance; and (2) newborn children, adopted children and children placed for adoption.

Eligible dependents not insured on the effective date may become insured persons, subject to acceptance by us of your written application and the payment of any required premium.

Newborn Children including adopted children and children placed for adoption ("Individual" and "Individual and Spouse" Plans): Any child of yours born while this policy is in force as an "Individual" or an "Individual and Spouse" plan will be covered immediately as an insured person from the moment of birth, and any newly adopted child or child placed for adoption will be covered

from the moment of placement, for as long as the later of these dates: (1) 90 days from the moment of birth or placement; or (2) the next renewal date following birth or placement.

In order for coverage to continue beyond such date, we must receive: (1) written notice of the birth of the newborn child, adoption, or the placement for adoption; and (2) the required premium within 31 days of our notifying you of the amount.

Please include the child's name and date of birth, date of adoption, or date placed for adoption with your notice. This notice must be received by us before the later of these dates: (1) 90 days from the date of birth, adoption, or placement for adoption; or (2) the next renewal date following birth, adoption or adoption placement.

If the required notice is not received by us during this period, a newborn child, newly adopted child or child placed for adoption may be covered after this date only if the following conditions are met: (1) your written application for coverage is approved by us; and (2) the payment of any required premium is made. Additional premium, if any, will begin on the first renewal date following the date of birth, adoption, or adoption placement.

Coverage for such newborn child will be the same as we provide for you.

IF THIS IS A "FAMILY" PLAN THE FOLLOWING APPLIES: If this is a "Full Family" policy, it means that we insure you, your spouse if not legally separated from you, and all dependent children (of yours or your spouse) listed on the application. If this is a "One-Parent Family" policy it means that we insure you and all your dependent children listed on the application. The term "Dependent children" includes your unmarried natural or step children, adopted children, children placed for adoption, and legal wards under age 24 who are primarily dependent upon you for support and maintenance.

Any family member specifically excluded from coverage by endorsement to this policy is not included in the family definition. Any person who becomes a family member after the effective date of this policy must be added by endorsement (except newborn children who are automatically covered from the moment of birth, and newly adopted children including children placed for adoption who are automatically covered from the moment of placement). Persons added as family members by endorsement will be subject to the pre-existing conditions provision. It is not necessary to notify us of a child's birth, adoption, or placement for adoption and no additional premium will be required for coverage of newborn children, adopted children, children placed for adoption, or children added as family members by endorsement. Additional premium is required when a spouse is added to a "one-parent" family policy.

PART I TERMINATION PROVISIONS

TERMINATION PRIOR TO AGE 75: An insured person's coverage will terminate when 100% of his face amount has been paid (200% if the Recurrent Benefit Rider is attached). An insured person's coverage cannot be continued or converted once his policy benefits have been paid in full.

POLICY ANNIVERSARY FOLLOWING 75TH BIRTHDAY: An insured person's coverage will terminate when 100% of his new, reduced face amount has been paid (200% if the Recurrent Benefit Rider is attached). An insured person's coverage cannot be continued or converted once his policy benefits have been paid in full.

TERMINATION OF DEPENDENT COVERAGE: Coverage for each dependent child will terminate on the renewal date following the earlier of: (a) his or her 24th birthday; (b) marriage; or (c) his or her termination of dependency upon you for support and maintenance.

If we accept a premium applicable to any such dependent after his or her 24th birthday, or termination of dependency, or after receiving notice of his or her marriage, coverage for such dependent will continue until the end of the period for which premium has been accepted.

If a child reaches the termination date stated above and continues to be both: (a) incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and (b) primarily dependent upon you for his support and maintenance, and you notify us about this, coverage for such child will continue while the policy is in force and so long as such disability continues and the applicable premium is paid. We will continue to charge any appropriate premium for that child as long as he/she qualifies as a handicapped dependent.

Coverage for a spouse, if an insured person, will terminate on the first renewal date following the date a court enters a final decree of dissolution of marriage (divorce).

CONVERSION PRIVILEGE: In the event an insured person applies not more than 60 days after the date coverage terminates under the Termination of Dependent Coverage provision and pays the required premium, we will issue a policy without proof of insurability. Premiums for a covered child who converts will be based upon our then current rate table for adults. The new policy will be one with benefits not exceeding those provided for such insured person under this policy and excluding any conditions not covered by this policy. The pre-existing conditions limitation in the new policy will continue from the insured person's original effective date. This provision also applies to dependent children in the event of your death. If such insured person fails to convert, all benefits shall cease as of the last day for which premiums have been collected.

CONTINUATION OF COVERAGE: If your coverage under this policy terminates, either due to your death or the payment of 100% of your face amount (200% if the Recurrent Benefit Rider is attached), and your spouse is an insured person; we agree thereafter to renew this policy each term with your spouse as the new primary insured, as long as: (a) such spouse lives, (b) he remains eligible for coverage, and (c) he pays the required premium before the end of the grace period. Premiums will be adjusted accordingly.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) CONTINUATION OF COVERAGE: If Section 1001 of COBRA applies to this policy, the coverage of a covered person whose coverage ends due to a Qualifying Event may be continued while the policy remains in force subject to the terms of this provision and all terms and provisions of the policy not inconsistent with this provision.

This provision shall not be interpreted to grant to any covered person any continuation rights under the policy in excess of those required by COBRA. If the employer fails to comply with the provisions of the policy concerning COBRA or the notice requirements or other standards under COBRA, we shall not assume the employer's obligation to provide notice of COBRA or continued coverage under the policy.

Qualifying Events: If any of the following events result in termination of a covered person's coverage under this policy, the covered person would be eligible for continuation under COBRA:

(1) a covered person divorcing or becoming legally separated from his spouse; or
(2) a dependent child ceasing to be eligible as defined by the policy.

Requirements for COBRA Continuation of Coverage: Continuation under this provision is subject to a covered person requesting it and paying any required premium to the employer or us within the election period.

This policy and in particular this provision, constitutes initial notice of your possible COBRA rights under the policy; and your employer, as the Plan Administrator, must notify you, if qualified to elect continuation of coverage under COBRA, of your right to elect coverage within 14 days of the happening of any of the qualifying events listed above. You must notify the Plan Administrator within 60 days of the happening of the qualifying event (1) or (2) above.

The qualified covered person must elect to continue coverage under the policy within 60 days of the later of:

(1) the date the notification of election rights is sent, or
(2) the date coverage under the policy terminates.

Otherwise, the option to elect COBRA shall end on the date 60 days following the date his coverage under the policy terminated.

Coverage Continued: The coverage continued for a covered person under this provision shall be the same as provided under the policy for other covered persons in the same benefit class in which such covered person would have been covered had his coverage not been terminated.

Termination of COBRA Continuation Coverage: Once in effect, COBRA continuation coverage for a covered person under this section shall terminate at the end of the last period for which premium contributions for such coverage have been made, if you or other responsible person does not make, when due, the required premium contribution to the employer or us.

PART J HOW TO FILE A CLAIM

NOTICE OF CLAIM: Written notice of claim must be given to us within 30 days after loss covered by this policy occurs or starts. If notice is not given within that time, it must be given as soon as it is reasonably possible. Notice must be given to us at our Home Office in Little Rock, Arkansas. It should include your name, the name of the insured person, and the policy number as shown in the Policy Schedule.

CLAIM FORMS: We will send a claim form for filing proof of loss after we receive the notice of claim. If these forms are not sent to the claimant within 15 days after giving such notice, the claimant will meet the proof of loss requirement by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS: Written proof of loss must be given to us within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

PART K CLAIMS INFORMATION

TIME OF PAYMENT OF CLAIMS: Benefits for any loss covered by this policy will be paid as soon as we receive written proof.

PAYMENT OF CLAIMS: All benefits will be paid to you. Any benefits unpaid at your death will be paid to the designated beneficiary. If the beneficiary dies on the same day the primary insured dies, benefits will be paid as if that beneficiary had died before the primary insured. If there is no named beneficiary living at your death, we may pay, at our discretion, any amount due to one of the following classes of survivors: (1) your spouse; (2) your surviving children in equal shares; (3) your mother and/or father; (4) your brother and/or sister; or (5) your estate. At our option, an amount up to the maximum allowable by the state laws of the insured person's state of residence may be paid to any person who incurred funeral or other expenses related to the last illness or death of the insured person.

BENEFICIARY: The beneficiary is the person(s) you name in writing on your application to receive any amount of insurance that is left unpaid at your death. The beneficiary's name is on record in our Home Office. If you name more than one beneficiary, those who survive will share equally unless you specify otherwise.

CHANGE OF BENEFICIARY: You may change a beneficiary by giving us written notice at our Home Office on a form acceptable to us. When we receive the notice, it will be effective on the date made, subject to any payment we may have made before we receive it. The consent of the beneficiary or beneficiaries is not required to surrender, assign, or change beneficiaries, or to make any other changes in this policy.

TERMINATION OF BENEFITS: No benefits are payable after the termination of this policy except for covered losses which begin prior to such termination. Provided, if the insured person is totally disabled from a condition covered by this policy at the time of termination, benefits shall continue during the term of such total disability but are limited to the payment of the maximum benefit. See "Extension of Benefits" below.

EXTENSION OF BENEFITS: Termination of insurance for an insured person will not affect a claim for continuous loss that began while coverage was in force on that person, as long as such person is totally disabled. For the purposes of this provision, total disability means the complete incapacity of the insured person as the result of the covered sickness or injury:

(1) to engage in any occupation for pay or profit for which he is or may become reasonably qualified by training, education, experience, age, and physical and mental capacity; or
(2) if not employed, to engage in the normal activities of a person of the same age and sex who is free of any physical or mental disease or disorder; and
(3) which requires the regular care of a physician.

PHYSICAL EXAMINATION AND AUTOPSY: We, at our own expense, have the right to have an insured person examined by a physician of our choice when and as often as is reasonable during the handling of a claim and to do an autopsy where it is not forbidden by law.

LEGAL ACTIONS: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

UNPAID PREMIUM: We may deduct any unpaid premium then due from the payment of a claim under this policy.

REFUND OF PREMIUM: On the death of the insured person, proceeds payable hereunder shall include the amount of unearned premium paid beyond the end of the policy month in which death occurred. Payment shall be made in one lump sum no later than 30 days after proof of the insured person's death has been furnished us.

DEATH DURING WAITING PERIOD: If the Primary Insured or Spouse dies during the first 30 days of coverage, we will refund any paid premium as outlined under "Payment of Claims." If a dependent child dies during the first 30 days his coverage was in force, we will refund his premium only if the deceased child was the only child covered under this policy.

INSURANCE FRAUD: Warning — Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud and prosecuted. USAble Life may terminate this policy if the insured person has filed a fraudulent claim or statement with us.

PART L GENERAL INFORMATION

ENTIRE CONTRACT AND CHANGES: This policy is a legal contract between you and us. The entire contract consists of the policy, which includes the application, and any attached papers. No change in this policy will be effective until approved by one of our officers. This approval can only be in writing and must be noted on or attached to this policy. No agent has authority to change this policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: In the absence of fraud, we will not use your statements which relate to insurability to contest this insurance for any claim that is incurred after this policy has been in force for two years during the life of the insured person, except for fraudulent misrepresentation. Nor will we use any of your statements on a reinstatement application to contest this insurance for any claim that is incurred after two years from the reinstatement effective date.

No claim for loss incurred after two years from the date an insured person becomes covered under this policy shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description existed prior to the effective date of such insured person's coverage.

The above provision also applies to any riders, endorsements, or amendments attached to this policy. In applying them, the words "rider," "endorsement," or "amendment" will be used for the word "policy."

GRACE PERIOD: A grace period will apply to payment of premiums (except the initial premium). During the grace period, your policy will stay in force. This grace period means that if you pay your

premiums within 31 days after they are due, your policy remains continuously in force. If you do not, your policy is terminated at the end of the 31-day grace period.

MISSTATEMENT OF AGE: This policy is only available for issue at ages 64 and below. If the age of an insured person has been misstated one of the following will apply:

(1) the benefits will be those the premium paid would have purchased at the correct age; or

(2) if the insured was age 65 or over when this policy was issued, we will refund premium and no benefits will be payable.

MISSTATEMENT OF USE OF TOBACCO: If the use of tobacco by any insured person has been misstated, any amount payable under this policy will be such as the premium paid would have purchased had the use of tobacco been correctly stated.

REINSTATEMENT: If any renewal premium is not paid within the time allowed for payment and we, or our authorized agent, accept a premium without requiring an application for reinstatement, that payment shall reinstate this policy. If we require an application, this policy will be reinstated when we approve it. If we do not approve the application, this policy will be reinstated on the 45th day after the date of the application unless we notify you in writing of its disapproval. The reinstated policy only covers loss due to sickness that is diagnosed or treated more than 10 days after the date of reinstatement, and loss due to injury that takes place after the date of reinstatement.

In all other respects you and we have the same rights under this policy as we both had before it lapsed, unless special conditions are added to this policy in connection with the reinstatement. Any premium accepted in connection with this provision will be used for a period for which payment has not been made, but not to any period more than 60 days before the date of reinstatement.

OTHER INSURANCE WITH US: If you are covered under more than one policy of this form or like form with us, only one policy, chosen by you or your estate, will be effective (this includes coverage for any insured person). We will refund all premiums paid for all other policies from the date of duplication less any benefits paid under these policies from such date.

NON-PARTICIPATING: This policy is non-participating. Its premiums do not include a charge for participation in surplus.

TERM OF COVERAGE: Coverage starts on the effective date at 12:01 a.m., standard time where you live. It ends at 12:01 a.m. on the same standard time on the renewal date, subject to the grace period. This policy may be renewed only as stated in the Renewal Agreement. Each time this policy is renewed, the new term begins when the old term ends.

CHARTER AND BY-LAWS: No provisions of our charter or by-laws not included in this policy shall void this policy or be used in defense of any legal proceedings with regard to it.

CONFORMITY WITH STATE STATUTES: The provisions of this policy conform with the law of the state in which you reside on the policy effective date. If any do not, they are hereby amended so that they do conform.

POLICY SCHEDULE: The Policy Schedule and information it contains is a part of the policy.

IMPORTANT NOTICE

To comply with Tennessee Insurance Rule 0780-1-57, the following information is provided to assist you in answering any questions you might have. Our Policyholder Service Office is:

USAble Life
320 W. Capitol, Suite 700
P. O. Box 1650
Little Rock, AR 72203-1650
Phone (501) 375-7200 or (800) 648-0271

We appreciate the opportunity to serve your insurance needs.

SPECIMEN

320 W. Capitol • P.O. Box 1650 • Little Rock, AR 72203-1650
(501) 375-7200 • (800) 648-0271

THIS IS A LIMITED POLICY – READ IT CAREFULLY

GUARANTEED RENEWABLE FOR LIFE
CRITICAL ILLNESS POLICY WITH CANCER

Please Print Using Dark Ink

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

CRITICAL ILLNESS APPLICATION

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc	

☐ New Application ☐ Change Form ☐ Replaces Policy No. _____

SECTION 1 - APPLICANT INFORMATION

Name (First, MI, Last)				Social Security No.	
Home Address	City	State	Zip	County	
Occupation (Be Exact)	Date of Birth	Age	Birth State or Country	Sex ☐ Male ☐ Female	Height (ft-in.) / Weight (lbs.)
Employer	Date Employed Full-time	Work Phone	Home Phone	Have you used any tobacco products within the past 36 months? ☐ Yes ☐ No	

SECTION 2 – SPOUSE & CHILDREN INFORMATION

Full Name	Occupation	Sex	Date of birth mo.	day	yr.	Birth State or Country	Ht. Ft. Ins.	Wt. lbs.
(spouse)								
(child)								
(child)								
(child)								

Has your spouse used any tobacco products within the past 36 months? ☐ Yes ☐ No

SECTION 3 – PLAN SELECTION

■ **New Applicant** ■ **Application for Change**

Select Type of Policy/Optional Rider:

☐ CRITICAL ILLNESS WITH CANCER
☐ CRITICAL ILLNESS WITHOUT CANCER
☐ OPTIONAL RECURRENT BENEFIT RIDER

I hereby apply for the following coverage:

☐ Applicant Only
☐ Applicant & Spouse
☐ Applicant & Children
☐ Applicant, Spouse & Children

	Face Amount Applying For (Increments of $5,000)	Number of Units ($5,000 per Unit)	Rate	Monthly Premium
Applicant			X	= $ 0.00
Spouse*			X	= $ 0.00
Children** ☐ $5,000 ☐ $10,000			X	= $ 0.00
		TOTAL PREMIUM AMOUNT		$ 0.00

*** Spouse's signature required if amount exceeds $25,000.**
**** The maximum amount of Children's coverage is $10,000.**

1. Does any person applying for coverage currently have a Critical Illness or Cancer Policy with us or any other insurance company? ☐ Yes ☐ No If yes, give name of company, list type of policy and amount of coverage. _____
2. REPLACEMENT: Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____
3. OUTLINE: Have you received the Outline of Coverage (in those states where required by law)? ☐ Yes ☐ No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" on page 2 of this application; (c) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (d) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (e) agree that this authorization shall be valid for two (2) years from the application date; (f) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (g) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand no person to be insured is also covered by any Title XIX program – Medicaid or any similar name (Not applicable to residents of AZ, MO, NC, OR, or SC). I understand failure to disclose a proposed insured person's true health condition may void this policy.

Be sure to complete the Medical Information on page 2/reverse side.

Signed at: _____ (City and State) Date of Application _____ (Month, Day, Year)

Date Received Home Office

X _____ Agent's Signature

X _____ Applicant's Signature

CIP2-APP-TN (2-10)

X _____ Spouse's Signature (if required)

Employee's Name (Last, First, M.I.)	Social Security #	Employer

CRITICAL ILLNESS — MONTHLY PREMIUMS PER $5,000 UNIT

CRITICAL ILLNESS WITH CANCER					CRITICAL ILLNESS WITHOUT CANCER				
	INCLUDES RECURRENT BENEFIT		WITHOUT RECURRENT BENEFIT			INCLUDES RECURRENT BENEFIT		WITHOUT RECURRENT BENEFIT	
Issue Age	**Non-Tobacco**	**Tobacco**	**Non-Tobacco**	**Tobacco**	**Issue Age**	**Non-Tobacco**	**Tobacco**	**Non-Tobacco**	**Tobacco**
All Children	$1.66	$1.66	$1.46	$1.46	All Children	$1.00	$1.00	$0.82	$0.82
18 - 29	2.50	5.22	2.22	4.58	18 – 29	1.76	3.06	1.48	2.52
30 - 39	4.08	9.56	3.62	8.38	30 – 39	2.74	5.72	2.30	4.68
40 - 49	6.44	16.92	5.68	14.80	40 – 49	4.20	10.06	3.50	8.18
50 - 59	9.92	27.10	8.74	23.68	50 – 59	6.30	15.82	5.20	12.82
60 - 64	13.36	34.06	11.74	29.74	60 – 64	8.36	19.96	6.88	16.16

SECTION 4 – BENEFICIARY

☐ **Name Beneficiary** ☐ **Change of Beneficiary**

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Relationship	Date of Birth	Primary or Secondary	Indicate % Distribution
			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ Secondary	

SECTION 5 – MEDICAL INFORMATION

NOTE: If Spouse or Children coverage IS NOT being requested answer questions only as applies to applicant.

1. Has any person to be insured ever been diagnosed with or advised to take a diagnostic test, been treated by a member of the medical profession, or taken medication for:

	Yes	No
(a) Any form of internal cancer, carcinoma in-situ, malignant melanoma, or other precancerous findings?	☐	☐
(b) Any chronic or progressive disease or disorder of the heart, kidneys, liver, lungs, pancreas, or bone marrow?	☐	☐
(c) Quadriplegia, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease?	☐	☐
(d) Alcohol or substance abuse (in the last 5 years)?	☐	☐
(e) Heart Attack or heart disease, stroke or transient ischemic attack (TIA), or been advised to have coronary bypass surgery, stent insertion, or laser treatment to coronary arteries?	☐	☐
(f) Diabetes (except during a pregnancy), or any blood pressure reading recorded in the last three months exceeding 149/94?	☐	☐
(g) Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)?	☐	☐

2. Has any person to be insured ever been diagnosed by a member of the medical profession with, or does anyone currently have:

	Yes	No
(a) Any abnormal cancer screening tests currently being followed by your doctor?	☐	☐
(b) Any cysts, growths, lumps, or any mole or freckle that has bled, become painful, changed color, increased in size, required medical attention or evaluation for which you have not yet sought medical advice?	☐	☐
(c) Carotid artery stenosis, peripheral vascular disease, chronic atrial fibrillation, or chest pain not evaluated by a medical doctor and determined to be non-cardiac?	☐	☐
(d) Multiple sclerosis, memory loss, schizophrenia, systemic lupus erythematosus, pulmonary or cystic fibrosis?	☐	☐

3. Has any person to be insured had any two or more natural parents, brothers, or sisters diagnosed with coronary artery disease, diabetes, or the same cancer (other than skin cancer) prior to age 55? Or, has any person to be insured had one or more natural parents, brothers, or sisters diagnosed with coronary artery disease or colorectal cancer prior to age 45? ☐ Yes ☐ No
4. Is any person to be insured currently taking any prescription medicine(s) or have they taken prescription medicine(s) in the last three (3) years? ☐ Yes ☐ No
5. Has any person to be insured had any abnormal tests (including blood test, urinalysis, X-ray, MRI, ultrasound, stress test, echocardiogram) not found to be normal or benign on further testing, or requiring follow-up by a physician? ☐ Yes ☐ No
6. Does any person to be insured have any consultation, surgery, or test scheduled or anticipated? ☐ Yes ☐ No
7. Has any person to be insured ever been diagnosed by a member of the medical profession with a benign tumor, disorder of blood or autoimmune disorder, digestive disorder, urinary system or reproduction organs disorder, heart or circulatory disorder, hypertension (list last two blood pressure readings and dates), mental or nervous disorder, neurological disorder, or respiratory disorder? ☐ Yes ☐ No
8. Has any person to be insured had any application for critical illness, disability, health, or life insurance modified, rated, or declined in the last 5 years? ☐ Yes ☐ No
9. Give details to any "Yes" answers, including name of person, prescription medicine(s), diagnosis, and dates of treatment: _____

_____

10. Name, address, and phone number of the personal physician(s) of all applicants with date last seen, reason for visit, and results:

_____

_____

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; and (2) The first modal premium is paid. I understand that my policy will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

Insurance Fraud Warning - It is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

USAble Life

P.O. Box 1650
Little Rock, AR 72203

NOTICE FOR PROPOSED INSURED

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

Federal Fair Credit Reporting Act Notice

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

Medical Information Bureau Disclosure Notice

Information regarding your insurability will be treated as confidential. USAble Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

USAble Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

USAble Life

PO Box 1650 • Little Rock, AR 72203-1650

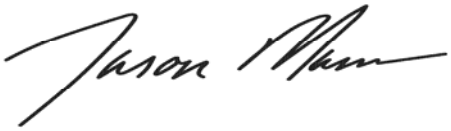
CRITICAL ILLNESS POLICY ELIMINATION RIDER

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

In consideration of the issuance or reinstatement of the Policy to which this Rider is attached, it is hereby understood and agreed that we will not be liable under the Policy for any loss affecting _____,
who is (are) completely excluded from coverage under the Policy.

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

USAble Life



President

Accepted by: _____
Signature of Applicant