Transamerica Life Insurance Company *("Insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 869094
Plano, TX 75086-9817

CancerSelect® Plus Employee Application

❒ First Application ❒ Add Dependents – Certificate # ______ ❒ Change Plans – Certificate # ______

Group Name	Group Number	Location

Applicant (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	Date of marriage
Spouse (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	

Date of hire	Avg hours worked per week	Annual salary	Occupation	Applicant ID

Home address	Work phone/ext.

City	State	Zip code	Home phone

Child(ren) name	Date of birth	Child(ren) name	Date of birth

Payroll Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other________________________

I Am Applying For: ☐ Individual ☐ Single Parent Family ☐ Family **Premium per pay period***

Cancer Only Insurance	Plan (if applicable)	$
If increasing coverage, enter the **TOTAL** new Premium.	Total Premium	$

Eligibility Questions

1. Are you actively at work [on a full time basis] and able to perform the regular duties of your occupation? ☐ Yes ☐ No
   If "No", you and your dependents are not eligible for coverage.
2. Is any proposed insured covered by any Title XIX program (e.g. Medicaid)? ☐ Yes ☐ No
   If "Yes", List name(s)____ , who will be excluded from coverage.

Evidence of Insurability Questions

3. Has any proposed insured had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease? ☐ Yes ☐ No
   If "Yes", List name(s)____ , who will be excluded from coverage, unless included by special endorsement.
4. In the ten years prior to the application date, has any proposed insured been diagnosed as having or been treated for any form of internal cancer, or malignancy (excluding basal cell skin cancer) which includes leukemia, Hodgkin's Disease, carcinoma, sarcoma, lymphoma, or malignant tumors? ☐ Yes ☐ No
   If "Yes", List name(s)____ , who will be excluded from coverage, unless included by special endorsement.
5. In the past 12 months, has any proposed insured been recommended for any medical treatment that has not yet been completed, undergone a biopsy or other diagnostic test, or is now scheduled for such to determine whether any form of cancer or malignancy exists, other than a regular Pap Smear, Mammogram, Colonoscopy, or PSA test? ☐ Yes ☐ No
   If "Yes", List name(s)____ , who will be excluded from coverage, unless included by special endorsement.

APPLICANT'S STATEMENTS AND AGREEMENTS:

For residents of CA, MA, or MN only:

Are all proposed insureds covered under major medical, hospital, or medical expense insurance, or an HMO contract? ☐ Yes ☐ No

If "No", list names ____________________, who will be excluded from coverage.

Coverage will not be issued to anyone who does not have comprehensive medical coverage. If applicant answers "No", no coverage will be issued.

I have read or had read to me the completed application. **I represent** that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

I understand that any person who, knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) I must satisfactorily answer all questions on this form; d) I must be actively at work on the effective date (according to the insurer's rules); and e) the first months premium must have been received by the underwriting company at its administrative office. **Lastly, I understand** that completion of this application in no way implies that I will be accepted for insurance coverage.

I understand that the insurance I am applying for contains a Pre-Existing Condition Limitation and that pre-existing conditions will not be covered for the period stated in the certificate.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau*, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. **I understand** the information obtained by use of this Authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Transamerica Life Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau*, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I authorize. **I know** that I may request to receive a copy of this Authorization. **I agree** that a photographic copy of this Authorization shall be as valid as the original. **I agree** that this Authorization shall be valid for two years from the date shown below.

Signed in (City/State) ____________________ This __________ Day of (Month/Year) ____________________ .

Applicant's Signature ____________________ Spouse's Signature (if applicable) ____________________

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded in this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

Licensed Representative's Name ____________________ Licensed Representative's Signature ____________________ Agent # __________

*Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number (617) 426-3660. Transamerica Life Insurance Company, 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.

SED-4 (R 01/10)

Transamerica Life Insurance Company

State of Louisiana Employee Payroll Deduction Authorization

Employee Name	Soc. Sec. No.	Employee No. (for agency use)

Agency No.	Department/Agency/Section Name

I hereby authorize my employer to deduct a total of $____________, monthly rate, from my salary until further notice and remit same to **Transamerica Life Ins**. A TOTAL Semi-Monthly Deduction in the amount of $ ____________ represents one half of the total monthly premium required for the coverage(s) detailed below.

The Office of State Uniform Payroll and the employing agency are **not** representatives or agents of the employee or the vendor. It is the responsibility of the **employee** to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between the **employee and the vendor** to ensure that the amount of any payroll deduction is correct and is properly credited to the appropriate policy. Cancellation of a policy must be submitted by the employee in a written request to **both** the vendor **and** his/her agency's payroll office. An employee signed SED-4 stopping the deduction may be required before the deduction can be stopped in the ISIS HR payroll system. Statewide vendor deductions that are not taken due to an employee being on LWOP, not being due any wages, or not being paid enough wages to take the deduction **are the employee's responsibility** to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the employee **and** the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.

DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS

PRODUCT NAME	PLAN PART CD	PLAN PART YES	PLAN PART NO	125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.
Cancer	25		N	Y	$	**NA**	$	
Cancer	25	P		Y	$	**PA**		$
Heart	16		N	Y	$	**NC**	$	
Heart	16	P		Y	$	**PC**		$
SUBTOTALS						**Non-Part. - Part.**	**$**	**$**
Accident	27		N	N	$	**NT**	$	
Cancer C/V - N/S	80		N	N	$	**NM**	$	
Heart C/V - N/S	82		N	N	$	**NP**	$	

	Total Mo. Prem.	$
PP Begin Date	Total Semi-Mo. **Ineligible**	$
	Total Semi-Mo. **Non-Part.**	$
Date Authorized	Total Semi-Mo. **Part.**	$
By: ____________________ Employee Signature	**TOTAL SEMI-MONTHLY**	$

(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)

Presentation and deduction authorization processed by:

____________________ Transamerica Life Representative ____________ Phone ____________ Date

____________________ Address

GROUP CANCER-ONLY INSURANCE

Underwitten by Transamerica Life Insurance Company, Home Office, Cedar Rapids, Iowa.

State Of Louisiana - Custom Plan Design

Semi-Monthly Premium	Low	Medium	High	
Individual	$11.47	$14.58	$17.68	
Single-Parent Family	$13.15	$16.57	$19.99	
Family	$20.86	$26.39	$31.92	
Wellness and Non-Medical Benefits	**Low**	**Medium**	**High**	**Policy Pays**
Wellness	$100	$100	$100	per calendar year for cancer screening tests
Magnetic Resonance Imaging (MRI) Scans	$100	$100	$100	per calendar year for MRI scan used as diagnostic tool for breast cancer, in addition to Wellness Benefit
Non-Local Transportation	✓	✓	✓	actual round-trip charges or private vehicle allowance, up to 750 miles at $.40 per mile, when required non-local hospital confinement is more than 50 miles from residence for covered person and an adult, immediate family member during confinement; payable once per hospital confinement period
Family Member Lodging	$100	$100	$100	per day for lodging expenses for adult, immediate family when non-local hospital confinement is required; 50-day maximum
Physical Therapy and Speech Therapy	$50	$50	$50	per treatment; limit one per day
At-Home Nursing	$100	$100	$100	per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge
Waiver of Premium	✓	✓	✓	waives premiums for remainder of total disability due to cancer for insured employee after totally disabled for 60 days
Outpatient Lodging	$100	$100	$100	per day for lodging expenses; 50-day maximum per 12 months
Hospital Benefits	**Low**	**Medium**	**High**	**Policy Pays**
Hospital Confinement	$100	$100	$100	per day; up to 90 days of covered confinement
Extended Benefits	$200	$200	$200	per day of hospital confinement in lieu of all other benefits (except surgery and anesthesia); begins on day 91 of continuous confinement
Attending Physician	$20	$20	$20	per day during hospital confinement
Inpatient Drugs and Medicines	$15	$15	$15	per day during hospital confinement
Private-Duty Nurse *(excluding hospital staff and family members)*	$100	$100	$100	per day during hospital confinement
Ambulance	$100	$100	$100	for service by a licensed professional ambulance service for transportation to a hospital to which the covered person is admitted
Extended Care Facility	$100	$100	$100	per day; up to the number of days for the prior hospital stay when admitted within 14 days of hospital discharge
Government or Charity Hospital	$100	$100	$100	per day of covered hospital confinement in lieu of all other benefits
Hospice Care	$100	$100	$100	per day when confined in a hospice center or hospice home care by a hospice team; 100-day lifetime maximum

CCP01C-C(LA)-0209

TRANSAMERICA WORKSITE MARKETING

Generic form number CPCAN200.
Customer Service: (888) 763-7474

Surgery Benefits		Low	Medium	High	Policy Pays
Surgery	Inpatient	$3,000	$4,000	$5,000	up to selected amount for surgeries as scheduled in the certificate
	Outpatient	$4,500	$6,000	$7,500	
Anesthesia		25%	25%	25%	of covered surgery benefit as scheduled in the certificate
Prosthesis		$1,500	$2,000	$2,500	actual charges,* up to selected amount, per device requiring implantation
Hair Prosthesis		$150	$200	$250	actual charges,* up to selected amount, for wig or hair piece for hair loss from cancer treatment
Reconstructive Surgery		$750	$1,000	$1,250	up to selected amount for reconstructive surgery within two years of the initial cancer removal
Second Surgical Opinion		$300	$400	$500	when surgery is prescribed treatment
Ambulatory Surgical Center		$450	$600	$750	up to selected amount per day for outpatient surgery at an ambulatory surgical center
Skin Cancer	One removal	$225	$300	$375	up to selected per diagnosis
	Per additional removal	$105	$140	$175	
Radiation and Chemotherapy Benefits		**Low**	**Medium**	**High**	**Policy Pays per 12 month period**
Radiation and Chemotherapy		$10,000	$15,000	$20,000	actual charges,* up to selected amount, for radiation and chemotherapy treatments
Associated Radiation and Chemotherapy Expenses		$500	$750	$1,000	selected amount for treatment consultation and planning, radiation management, physical exams, checkups, laboratory or diagnostic tests when authorized by a radiologist, chemotherapist or oncologist
Blood, Plasma, Blood Components, Bone Marrow and Stem Cell Transplant		$10,000	$15,000	$20,000	actual charges,* up to selected amount, for bone marrow and stem cell transplants, blood, plasma, and blood components, *(except when replaced by donated blood when there is no charge to the covered person)*
Associated Blood, Plasma and Blood Components Expenses		$500	$750	$1,000	selected amount for treatment consultation and planning, administration of blood plasma and blood components; transfusions, processing and procurement, cross-matching, physical exams, checkups, and laboratory or diagnostic tests and authorized by the covered person's physician
New or Experimental Treatment		$10,000	$15,000	$20,000	actual charges,* up to selected amount, for experimental or investigational treatment defined as drugs or chemicals approved by the FDA or surgery or therapy approved by either the NCI or ACS for experimental studies
Cancer Maintenance Therapy Benefit		**Low**	**Medium**	**High**	**Policy Pays**
Cancer Suppressive Therapy, Hematological Drugs, Anti-Nausea Drugs and Motility Agents		$3,000	$4,000	$5,000	actual charges,* up to selected amount for any combination of listed cancer maintenance therapy expenses; per 12 months

** ....As the amount actually paid by or on behalf of the insured and accepted by the provider as payment in full for services provided.*

Optional Riders	Low	Medium	High	Rider Pays
First Occurrence Benefit	$1,000	$1,000	$1,000	one-time, lump-sum benefit when an individual's cancer is first diagnosed
Specified Disease Rider	✓	✓	✓	provides benefits for losses that are the direct result of any covered specified diseases
Hospital Confinement	$100	$100	$100	pays per day for up to 90 days of covered confinement
Extended Benefits	$200	$200	$200	beginning with the 91st day of continuous confinement, pays for hospital confinement in lieu of all other benefits *(except surgery and anesthesia, which remain the same)*
Attending Physician (other than the surgeon)	$20	$20	$20	pays per day for during hospital confinement
Inpatient Drugs and Medicines	$15	$15	$15	pays per day for during hospital confinement
Private-duty Nurse (other than hospital staff or family member)	$100	$100	$100	pays per day for during hospital confinement
Ambulance	$100	$100	$100	pays amount selected per continuous confinement for transportation to a hospital and transportation between hospitals by a licensed professional ambulance service
Extended Care Facility	$100	$100	$100	pays amount selected per day, up to the number of days of the hospital stay when admitted to the extended care facility within 14 days of hospital discharge
Government or Charity Hospital	$100	$100	$100	pays amount selected per day—in lieu of all other benefits—for hospital treatment where the insured is not required to pay for most services
Hospice Care	$100	$100	$100	pays amount selected per day when confined in a hospice center or for hospice care at home by a hospice team; Benefit is limited to a lifetime maximum of 100 days per covered person
Surgery	$1,000	$1,000	$1,000	pays up to amount selected for in-hospital surgery as scheduled in the certificate; For in-hospital surgery performed for the treatment of cancer not in the surgical schedule - pays the lesser of 1) Amount determined by multiplying the work relative value unit obtained from the current Medicare fee schedule by $25 or 2) $1,000 per unit); Treatment must be approved by the attending physician
Outpatient Surgery	$1,500	$1,500	$1,500	pays up to amount selected for outpatient surgery as scheduled in the certificate; For outpatient surgery performed not in the surgical schedule - pays the lesser of 1) amount determined by multiplying the work relative value unit obtained from the current Medicare fee schedule by $37.50 or 2) $1,500 per unit); Treatment must be approved by the attending physician
Anesthesia	25%	25%	25%	pays percentage selected of Surgery Benefit scheduled in the certificate
2nd Surgical Opinion	$100	$100	$100	pays amount selected for a second opinion when the prescribed treatment is surgery as determined by the first opinion
Ambulatory Surgical Center	$150	$150	$150	pays charges up to amount selected per day for surgery performed at an ambulatory surgical center or at a hospital when the patient is covered as an outpatient; This benefit is paid in addition to the outpatient surgery benefit
Intensive Care Rider	✓	✓	✓	provides benefits for loss from sickness or injury resulting from the covered person's confinement in an Intensive Care Unit or Step Down Unit; During any one period of intensive care confinement, payments will not exceed 45 days for sickness or injury
Daily Indemnity Benefit	$100	$100	$100	pays amount selected for each day of confinement in an intensive care unit such as cardiac care units, burn units or neonatal units
Step-Down Unit	$50	$50	$50	pays one-half the Daily Benefit for progressive care, sub-acute care, and intermediate care in a step-down unit for any covered accident or sickness
Ambulance	$200	$200	$200	pays actual charges by a licensed professional ambulance service, up to the amount listed per period of intensive care confinement, for transportation to or between medical facilities

CancerSelect® Plus
Voluntary Group Cancer-Only Insurance Policy

Wellness and Non-Medical Benefits

Wellness: Pays amount selected per unit per calendar year for covered cancer screening tests: mammograms, pap smears, flexible sigmoidoscopy, prostate-specific antigen tests, chest x-rays, hemocult stool specimen, ultrasounds, CEA, CA125, biopsy, thermography, colonoscopy, serum protein electrophoresis, bone marrow testing, and blood screenings. Services must be under the supervision of or recommended by a physician, and charge must be incurred.

Magnetic Resonance Imaging (MRI) Scans: In addition to Wellness Benefit, amount selected per calendar year for an MRI Scan when used as a diagnostic tool for breast cancer.

Non-Local Transportation: When prescribed treatment is not available locally and non-local hospital confinement (more than 50 miles from the covered person's residence) is required, we will pay either the actual roundtrip charges by a common carrier or a private vehicle allowance of $.40 per mile (up to 750 miles), round-trip for covered person and an adult, immediate family member during confinement; payable once per hospital confinement period.

Physical Therapy and Speech Therapy: Amount selected per treatment (limited to one session per day).

Family Member Lodging: When non-local hospital confinement is required, this benefit pays amount selected per day for lodging expenses for an adult member of your immediate family for a maximum of 50 days per 12 month period.

At Home Nursing: Amount selected per day, up to the number of days of the prior hospital confinement when admitted within 14 days of hospital discharge.

Waiver of Premium: After you (the insured employee) have been totally disabled due to cancer for 60 days, all premiums due will be waived for the remainder of the total disability. This benefit applies only to the Insured, not to the spouse or children on family coverage.

Outpatient Lodging: Amount selected per day for a maximum of 50 days per 12 month period for lodging expenses provided treatment is authorized by attending physician and can not be obtained locally.

Surgery Benefits

Surgery: Up to amount selected for in-hospital surgery as scheduled in the certificate. Up to amount selected for outpatient surgery as scheduled in the certificate.

Anesthesia: Percentage selected of covered Surgery Benefit as scheduled in the certificate.

Prosthesis: Actual charges* of up to amount selected per prosthetic device that requires implantation.

Hair Prosthesis: Actual charges* of up to amount selected for a wig or hair piece for hair loss from cancer treatment.

Reconstructive Surgery: Up to amount selected as scheduled in the certificate for reconstructive surgery within two years of the initial cancer removal.

Second Surgical Opinion: Amount selected when the prescribed treatment is surgery as determined by the first opinion.

Ambulatory Surgical Center: Up to amount selected per day for surgery performed at an ambulatory surgical center or hospital as an outpatient.

Skin Cancer: Amount selected per diagnosis for one removal of skin cancer; amount selected for each additional removal.

Hospital Benefits

Hospital Confinement: Amount selected per day for up to 90 days of covered confinement.

Extended Benefits: Beginning with the 91st day of continuous confinement, CancerSelect Plus will pay amount selected per day of hospital confinement in lieu of all other benefits (except surgery and anesthesia, which remain the same).

Attending Physician: Amount selected per day during hospital confinement.

Inpatient Drugs and Medicines: Amount selected per day per hospital confinement.

Private-Duty Nurse: Amount selected per day during hospital confinement *(excludes hospital staff and family members)*.

Ambulance: Amount selected per continuous confinement for service by a licensed professional ambulance service for transportation to a hospital to which the covered person is admitted.

Extended Care Facility: Amount selected per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge.

Government or Charity Hospital: For hospital treatment where you are not required to pay for most services—in lieu of all other benefits—CancerSelect Plus will pay amount selected per day of covered hospital confinement.

Hospice Care: Amount selected per day when confined in a hospice center or for hospice care at home by a hospice team. Benefit is limited to a lifetime maximum of 100 days per covered person.

Cancer Maintenance Therapy Benefits

Actual charges* not to exceed amount selected per 12 month period for any combination of the following listed Cancer Maintenance Therapy expenses:

Cancer Suppressive Therapy: Treatment to keep cancer in check or after acute chemotherapy treatment

Hematological Drugs: Benefits for drugs aimed to boost cell lines such as white blood cell counts, red blood cell counts and platelets

Anti-Nausea Drugs: Benefits for drugs used to reduce the symptoms brought about as a result of chemotherapy or radiation

Motility Agents: Benefits for drugs used to improve motility or treat side effects caused by chemotherapy or radiation

Radiation and Chemotherapy Benefits

Radiation and Chemotherapy: Actual charges* not to exceed amount selected for radiation and chemotherapy treatments per 12 month period.

Associated Radiation and Chemotherapy Expenses: Amount selected per 12 month period for treatment consultation and planning, radiation management, physical exams, checkups, laboratory or diagnostic tests when authorized by a radiologist, chemotherapist, or oncologist.

Blood, Plasma, and Blood Components (e.g., Platelets), Bone Marrow Transplant and Stem Cell Transplant: Actual charges* not to exceed amount selected per 12 month period for bone marrow and stem cell transplants, blood, plasma, and blood components, (except when replaced by donated blood when there is no charge to the covered person).

Associated Blood, Plasma and Blood Components (e.g., Platelets) Expenses: Amount selected per 12 month period for treatment consultation and planning, administration of blood plasma and blood components; transfusions, processing and procurement, cross-matching, physical exams, checkups, and laboratory or diagnostic tests and authorized by the covered person’s physician.

New or Experimental Treatment: Actual charges* not to exceed amount selected per 12 month period for experimental or investigational treatment. This is defined as drugs or chemicals approved by the FDA or surgery or therapy approved by either the NCI or ACS for experimental studies. Treatment must be received in a U.S. hospital and authorized by the attending physician.

** As the amount actually paid by or on behalf of the insured, and accepted by a provider for services provided*

Optional Benefits Riders

This is an optional benefit riders summary. Consult the contract for complete details and the state approval list for availability.

First Occurrence Rider (Rider Form Series CROCC200)

Provides a lump-sum benefit when proof of cancer is first positively diagnosed (not skin cancer) while the policy is in force. This benefit is payable only once for each insured and is in addition to any other benefits payable under the certificate or rider.

Specified Disease Rider (Rider Form Series CRSPD200)

This rider provides the benefits listed below for losses that are the direct result of any of the following diseases (excludes any disease or incapacity that is caused, complicated, worsened or affected by or as a result of any of these diseases):

Adrenal Hypofunction (Addison's Disease)	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
Botulism	Brucellosis
Budd-Chiari Syndrome	Cerebral Palsy
Cholera	Cystic Fibrosis
Diphtheria	Encephalitis
Hansen's Disease	Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
Histoplasmosis	Huntington's Chorea
Legionnaires' Disease	Lupus
Lyme Disease	Mad Cow Disease
Malaria	Meningitis
Muscular Dystrophy	Myasthenia Gravis
Necrotizing Fascitis	Osteomyelitis
Poliomyelitis	Primary Biliary Cirrhosis
Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)	Q Fever
Rabies	Reye's Syndrome
Rheumatic Fever	Rocky Mountain Spotted Fever
Scarlet Fever	Scleroderma
Sickle Cell Anemia	Tay-Sachs Disease
Tetanus	Thallasemia
Toxic Epidermal Necrolysis	Toxic Shock Syndrome
Trichinosis	Tuberculosis
Tularemia	Typhoid Fever
Whooping Cough (Pertussis)	

Hospital Confinement: Pays amount selected per day for up to 90 days of covered confinement.

Ambulance: Pays amount selected per continuous confinement for transportation to a hospital and transportation between hospitals.

Extended Benefits: Beginning with the 91st day of continuous confinement, pays amount selected of hospital confinement in lieu of all other benefits (except surgery and anesthesia, which remain the same).

Extended Care Facility: Pays amount selected per day, up to the number of days of the hospital stay when admitted to the extended care facility within 14 days of hospital discharge.

Inpatient Drugs and Medicines: Pays amount selected per day for during hospital confinement.

Government or Charity Hospital: Pays amount selected per day—in lieu of all other benefits—for hospital treatment where the insured is not required to pay for most services.

Attending Physician (other than the surgeon): Pays amount selected per day during hospital confinement.

Anesthesia: Pays percentage selected of Surgery Benefit scheduled in the certificate.

Private-duty Nurse (other than staff member of the hospital or family member)**:** Pays amount selected per day during hospital confinement.

Hospice Care: Pays amount selected per day when confined in a hospice center or for hospice care at home by a hospice team. Benefit is limited to a lifetime maximum of 100 days per covered person.

Outpatient Surgery: Pays up to amount selected for outpatient surgery as scheduled in the certificate. For outpatient surgery performed not in the surgical schedule— pays the lesser of 1) amount determined by multiplying the work relative value unit obtained from the current Medicare fee schedule by $37.50 or 2) $1,500 per unit). Treatment must be approved by the attending physician.

Ambulatory Surgical Center: Pays charges not to exceed amount selected per day for surgery performed at an ambulatory surgical center or at a hospital when the patient is covered as an outpatient. This benefit is paid in addition to the outpatient surgery benefit.

2nd Surgical Opinion: Pays amount selected for a second opinion when the prescribed treatment is surgery as determined by the first opinion

Intensive Care Rider (Rider Form Series CRICU200)

This rider provides the benefits listed below for loss from sickness or injury resulting from the covered person's confinement in an

Intensive Care Unit or Step Down Unit: During any one period of intensive care confinement, payments will not exceed 45 days for sickness or injury.

Daily Benefit: Pays amount selected for each day of confinement in an intensive care unit such as cardiac care units, burn units or neonatal units.

Step-Down Unit: Pays one-half the Daily Benefit for progressive care, sub-acute care, and intermediate care in a step-down unit for any covered accident or sickness.

Ambulance: Pays actual charges by a licensed professional ambulance service, not to exceed $200 per intensive care confinement, for transportation to a medical facility or between medical facilities

Exceptions and Limitations

The certificate provides benefits only for cancer as defined herein, which is positively diagnosed while this certificate is in force. It does not provide benefits for any other illness or disease.

1. We may reduce or deny a claim or void the certificate for loss incurred by a covered person
    a. During the first 2 years from the effective date of such coverage for any misstatements in the application which would have materially affected our acceptance of the risk; or
    b. At any time for fraudulent misstatements in the application
2. We will only pay for loss as a direct result of cancer. Proof of positive diagnosis must be submitted to us for each new claim. We will not pay for any other disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of, cancer.
3. If a covered hospital confinement is due to more than one covered disease or condition, benefits will be payable as though the confinement or expense were due to one disease or condition. If a hospital confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the art of the hospital confinement or expense due to the covered disease or condition.
4. Under no condition will we pay any benefits for losses or medical expenses incurred prior to the effective date.

Pre-Existing Conditions

If the insured has a Pre-Existing Condition (a sickness or physical condition for which the insured had treatment, incurred expense, took medication, or received a diagnosis or advice from a physician, or a condition that manifests itself in a way that could cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment) during the 12 months period prior to the effective date of coverage, any claims related to it will not be covered until the insured has been continuously covered under the policy for one year.

First Occurrence Rider

Benefits are not payable:

- for expenses incurred prior to the effective date of this rider;
- during the first 12 months for any cancer diagnosed within 12 months prior to the effective date of such person's coverage;
- for any other illness or disease other than internal cancer; and
- for skin cancer or any cancer excluded from coverage by name or specific description.

Specified Disease Rider

This rider provides benefits for the initially positively diagnosed specified illness or disease defined in this rider on or after the effective date of this rider. It does not provide benefits for any other illness or disease.

We will only pay for loss as a direct result of a specified illness or disease. Proof of positive diagnosis must be submitted with each new claim. We will not pay for any disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of a specified illness or disease or its treatment,

Benefits under "waiver of premium" of the contract do not apply to this rider for total disability due to a specified illness or disease.

With respect to the benefits offered this rider, the "time limit on certain defenses" provision of the contract will apply from the effective date of this rider.

Intensive Care Rider

We will not pay benefits for loss resulting from:

- a specifically excluded diseases or conditions in the contract or in this rider; or
- an attempted suicide while sane or insane or an intentionally self-inflicted injury (while sane, in MO);
- any act of war, either declared or undeclared; or
- alcoholism or drug addiction; or
- mental or nervous disorders; or
- an overdose of drugs, narcotics, or hallucinogens, unless administered on the advice of a physician; or
- intoxication, or being under the influence of any intoxicant or narcotic, unless administered on the advice of a
- physician (narcotic only, in Oklahoma);
- injury received while engaging in an illegal occupation or activity.

Important Information

Pre-Existing Conditions
A pre-existing condition is defined as a sickness or physical condition for which the insured:

1. Had treatment;
2. Incurred expense;
3. Took medication; or
4. Received a diagnosis or advice from a physician, during the 12-month period immediately before the effective date of the insured's coverage.

The term "Pre-existing Condition" will also include a condition that manifests itself in a way that would cause a person to seek medical advice, diagnosis, care or treatment.

Extension of Benefits
Whenever termination of coverage under this section occurs due to termination of your employment or membership, such termination will be without prejudice to:

1. Any hospital confinement which began while coverage was in force; or
2. Any covered treatment or service for which benefits would be provided and which began while coverage was in force; provided, however, that the covered person is and continues to be hospital confined or receiving treatment.

Such extension of benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the covered person is no longer hospitalized or receiving treatment

Family Coverage
Family coverage includes the insured, his or her spouse, and all dependent, unmarried children under age 25. Newborn children are automatically covered under the terms of the certificate from the moment of birth. Single-Parent Coverage includes the insured and all dependent, unmarried children under age 25. (Definition of children varies by state.)

Termination of Coverage
Subject to the Portability Option, your insurance will cease on the earliest of:

1. The last day of the payroll deduction period during which you cease to be eligible for coverage;
2. The end of the last period for which premium payment has been made to us;
3. The last day of the payroll deduction period during which you terminate employment;
4. The date the group master policy terminates; or
5. The date you send us a written notice that you want to cancel coverage.

The insurance on a dependent will cease on the earliest of:

1. The date your coverage terminates; or
2. The end of the last period for which premium payment has been made to us;
3. The date the dependent no longer meets the definition of dependent;
4. The date the policy is modified so as to exclude dependent coverage; or
5. The date you send us a written notice that you want to cancel your dependent's coverage.

We will have the right to terminate the coverage of any covered person who submits a fraudulent claim under the policy.

Portability Option
If you lose eligibility for this insurance for any reason other than nonpayment of premiums, you will have the option to continue the coverage (including any riders, if applicable) by paying the premiums directly to the company or at our administrative office within 31 days after this insurance terminates. We will bill you directly for these premiums after you notify us to continue coverage. If you stop paying the premiums under this option, this coverage will continue, subject to the terms of the grace period.