

**AMERICAN HEALTH SOLUTIONS SERIES  
CATASTROPHIC HOSPITAL INSURANCE  
WITH OPTIONAL BENEFIT RIDERS\***



**Individually Underwritten  
Catastrophic Hospital Insurance  
Underwritten By Standard Life and Accident Insurance Company  
Administrative Offices, Galveston, Texas**



\*This Policy provides limited benefits that are less than the minimum standard for benefits for Hospital Medical Surgical expense coverage as prescribed by the Insurance Regulatory Authority of Texas. Deductibles are greater than as shown in the minimum standards.

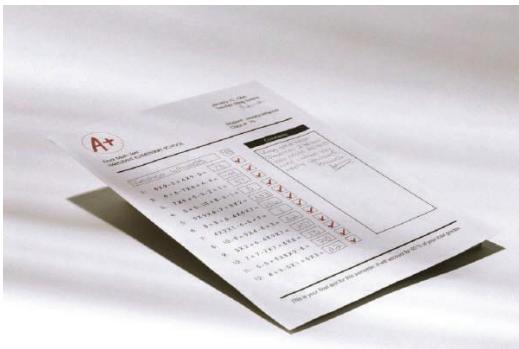
The American Health Solutions Series Catastrophic Hospital Insurance plans are underwritten by **Standard Life and Accident Insurance Company** a member of the American National family of companies. Administrative Offices in Galveston, TX.

Standard Life and Accident Insurance Company ("Standard Life") has been evaluated and assigned the following ratings by nationally recognized, independent rating agencies. The ratings are current as of December 2007.

<b>A.M. Best</b>	<b>A</b> (Excellent)	3 <sup>rd</sup> highest of 13 active company ratings <sup>1</sup>
<b>Standard &amp; Poor's</b>	<b>AA-</b> (Very Strong)	4 <sup>th</sup> highest of 20 active company ratings <sup>2</sup>

Ratings reflect current independent opinions of the financial capacity of an insurance organization to meet the obligations of its insurance policies and contracts in accordance with their terms. They are based on comprehensive quantitative and qualitative evaluations of the company and its management strategy. The rating agencies do not provide ratings as a recommendation to purchase insurance or annuities. The ratings are **not a warranty** of an insurer's current or future ability to meet its contractual obligations.

Ratings may be changed, suspended, or withdrawn at any time. For the most current ratings visit Standard Life's Internet site at [www.slaico.com](http://www.slaico.com).



<sup>1</sup> A.M. Best's active company rating scale is: A++ (Superior), A+ (Superior), A (Excellent), A- (Excellent), B++ (Very Good), B+ (Very Good), B (Adequate), B- (Adequate), C++ (Fair), C+ (Fair), C (Marginal), C- (Marginal) and D (Poor).

<sup>2</sup> Standard & Poor's active company rating scale is: AAA (Extremely Strong), AA (Very Strong), A (Strong), BBB (Good), BB (Marginal), B (Weak), CCC (Very Weak) and CC (Extremely Weak). Plus (+) or Minus (-) modifiers show the relative standing within the categories from AA to CCC.

**These ratings are provided to you so that you may make a comparison of Standard Life and Accident Insurance Company to other companies. They are not provided as a recommendation by the rating companies to purchase this coverage.**

**Notice – The insurance policy described in this brochure is not intended to be an employer sponsored health insurance plan.**

**Plan Design:**

Indemnity or Preferred Provider Option

**Issue Ages:**

0-63 ½

**Maximum Lifetime Benefit Per Covered Person:**

\$5,000,000  
\$1,000,000 for each Injury or Sickness

**Coinsurance Options:**

100% or 80%

**Stop-Loss Amounts:**

\$5,000 or \$10,000 (With coinsurance options 80%)

**Calendar Year Cash Deductibles:**

\$750; \$1,500; \$2,000; \$2,500; \$5,000; \$10,000 or \$15,000

**Special Deductible Features:**

- No more than 3 Cash Deductible Amounts per family per Calendar Year
- Only one Cash Deductible Amount must be met when two or more Covered Persons are injured in the same accident.

**WAIVER OF PREMIUM**

If You die We will waive further premium for Covered Persons, for a limited time. Beginning with the next Premium Due Date following Our receipt of due proof of Your death, We will waive premiums for a period of 12 months. During this premium waiver period no increases in benefits or additional Covered Persons, except newborns, will be considered. All provisions for Loss of Eligibility for Covered Persons will remain applicable during this premium waiver period. Upon expiration of the waiver period, Your spouse will be named the Policyholder and may continue coverage by making the required premium payments. If Your spouse was a Covered Person on the date of Your death, Your spouse will remain a Covered Person in accordance with the provisions of this Policy. If Your spouse was **NOT** a Covered Person on the date of Your death, coverage ends for all Covered Persons and this **WAIVER OF PREMIUM** provision does not apply.

**This Catastrophic Health Insurance is designed to provide benefits for high cost hospital confinements. Coverage for additional outpatient services can be obtained by adding riders, available for additional premium, to your base plan.**

This brochure contains a brief description of coverage under Policy Form SLA-C06 TX. The Policy is the contract of insurance. Your Policy describes in greater detail the rights and obligations of both You and the Company under the Policy. It is, therefore, important that You read Your Policy carefully. A sample is available, please ask Your agent.



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**Covers a Wide Range of Care:**

- Hospitals
- Same Day Surgery Facility
- Home Health Care
- In-Hospital Doctor Visits
- Surgery
- Assistant Surgeon
- Organ Transplants
- Blood, Blood Plasma and Derivatives
- Anesthesia
- Hospice
- Mammograms/PAP Smear
- Second Surgical Opinion
- Ambulance
- Childhood Immunizations
- Outpatient therapy
- Prostate Screening
- Texas resident benefits (refer to outline of coverage for details)



**Other Plan Features:**

- You cannot be singled out for rate increase
- 24 hour coverage-7 days a week
- No pre-admission certification required

**Restoration of Benefits:**

Each January 1<sup>st</sup>, We will restore the lesser of (a) the used portion of the Maximum Lifetime Benefit or (b) \$100,000.

**Human Organ Transplant:**

The Maximum Lifetime Benefit for all Organ Transplants combined is \$1,000,000 per Covered Person. When performed at a Transplant Center the Maximum Benefit will be up to the Policy Lifetime Maximum Benefit.

**Optional benefit riders for added protection: (for additional premium)**

Outpatient Accident Expense Benefit Rider

Outpatient Doctor Rider

Outpatient Prescription Drug Rider

This brochure contains a brief description of coverage under Policy Form SLA-C06 TX. The Policy is the contract of insurance. Your Policy describes in greater detail the rights and obligations of both You and the Company under the Policy. It is, therefore, important that You read Your Policy carefully. A sample is available, please ask Your agent.

**After You have met Your Cash Deductible and Your selected coinsurance is less than 100%, the plan pays 80% up to Your selected Stop Loss Amount. Once You have met this limit the plan pays 100% of the additional Eligible Expenses during the remainder of the Calendar Year.**

**Eligible Expenses While Hospital Confined or at a Same Day Surgical Facility including the Reasonable and Customary Charges for:**

- Daily average semi-private hospital room & board
- Hospital charges for **Intensive Care, Cardiac Care or Neonatal Intensive Care Unit**
- Miscellaneous In-hospital Expenses including operating room, recovery room, anesthesia, central supplies, x-rays, Lab, oxygen, medicines or drugs, splints or casts
- In-hospital Doctor visits for one visit per day
- Blood, blood plasma or blood derivatives
- Surgeon's fees
- Physiotherapy for physical therapy, speech therapy, or inhalation therapy
- Pathology and Radiology

**Eligible Expenses for services provided outside a Hospital or Ambulatory Surgical Facility**

- Reasonable and Customary charges for professional ambulance services (ground or air) to the nearest hospital qualified to treat the injuries or medical emergencies
- Home Health Care up to 60 visits per Calendar Year at \$40 per visit
- Reasonable and Customary charges for Hospice Care per Covered Person
- Outpatient therapy following a covered Hospital Confinement or Surgery

**SLA-PPO06-TX Preferred Provider Rider**

This rider reduces the cost of the base coverage. Cost of other optional riders is not affected by the addition of this Rider.

When You or a Covered Person is admitted to a Preferred Provider Hospital or Same Day Surgery Facility and receive treatment from Preferred Provider Doctors in such facilities; any resulting benefits payable under the Policy will be payable at the selected Coinsurance Percentage.

When You or a Covered Person is admitted to a Hospital that is not a Preferred Provider Hospital; use a Same Day Surgery Facility that is not part of Preferred Provider Same Day Surgery Facility; or receive treatment from a Doctor who is not a Preferred Provider Doctor; any benefits payable under the Policy will be payable at a coinsurance rate that is 20% less than the selected Coinsurance Percentage, unless such admission, use or treatment is the result of an Emergency.

**Optional Additional Benefit Riders: (for additional premium)**

**SLA-ACC06-TX Outpatient Accident Expense Rider** – If You or a Covered person is injured in an accident and treatment by a Doctor begins within 48 hours, We will pay the Reasonable and Customary Charges incurred for the Medically Necessary Outpatient Treatment of the Injury. Any treatment beyond the initial treatment must be received within 30 days of the Injury. THERE IS NO DEDUCTIBLE. Outpatient means not hospital Confined.

Your choice of benefits is \$400; \$800 or \$1,200 Maximum Benefit for each Covered Person for each accident.

**SLA-COPT06-TX Outpatient Doctor Rider** – After the Calendar Year Cash Deductible Amount of \$1,000 has been met this rider will pay 80% of the Reasonable and Customary Charges up to \$10,000 per Covered Person per Calendar Year for Eligible Expenses incurred on an Outpatient basis. Eligible Expenses include:

- Outpatient Doctor Charges;
- Hospital Emergency room or other Outpatient clinic charges;
- Outpatient Diagnostic tests;
- Administration of anesthesia to a Covered Person undergoing surgery in a Doctor's office, clinic, Hospital Emergency room or Urgent Care facility;
- Miscellaneous supplies including casts, splints and braces, hypodermics and crutches;
- Prescription drugs taken or administered within 30 days of a Hospital Stay for treatment of the condition for which You were Hospital Confined; or
- Eligible Expenses for spinal manipulations are limited to \$500 per Calendar Year

We do not pay benefits under this Rider for: hot or cold pack treatment; ultra sound treatment; radiation therapy, including treatment planning; chemotherapy, including treatment planning; physical therapy, speech therapy; occupational therapy or for the rental or purchase of durable medical equipment.

**SLA-OPRx06-TX Outpatient Prescription Drug Rider** – When selected, this Rider adds an outpatient Prescription Drug benefit to the Policy. After You meet the Prescription Drug Calendar Year Deductible Amount and Copayment, We pay the remaining Prescription Drug Eligible Expenses at the selected coinsurance. We do not cover Outpatient Prescription Drugs unless the optional Outpatient Drug Rider is in effect.

We consider a Prescription Drug Charge as an Eligible Expense when:

- A Doctor prescribes the drug for treatment of Injury or Sickness;
- The Policy does not exclude the Injury or Sickness for which the Doctor has prescribed the drug;
- The Outpatient Prescription Drug Rider does not exclude the drug; and
- A Pharmacy, which is not part of a Hospital or Ambulatory Surgical Center, dispenses the prescription Drug.

We do not cover drugs that are associated with an Injury or Sickness that We have excluded by name or description. We will not pay benefits under this Rider for drugs excluded by this rider.

**Payment for a Prescription Drug does not mean We have any liability under Eligible Expenses. Prescription by a Doctor does not automatically make treatment Medically Necessary.**

**Participating Pharmacy**

Prescription Drug  
Calendar Year  
Deductible:

Individual: \$500 or  
\$1,000

Family: \$1,000 or  
\$2,000

Copay:

Generic \$10, Brand Name \$25

**Non-Participating Pharmacy**

Prescription Drug  
Calendar Year  
Deductible:

Individual: \$1,000 or  
\$2,000

Family: \$2,000 or  
\$4,000

Copay:

Generic \$10, Brand Name \$25

**Note: There is no mail order available when ordering through a non-participating pharmacy.**

Coinsurance:

Generic: 100% after the Deductible and Copay

Brand Name when no generic equivalent available: 50% after the Deductible and Copay

Brand Name when Generic is available: After You meet the deductible and pay the \$10 Generic Copay, You are responsible for 100% of the difference between the cost of the Generic and Brand Name drug.



Eligible Expenses for Outpatient Prescription Drugs **DO NOT** include:

1. Any Ancillary Drug Charge included in the cost of the Prescription Drug.
2. The cost of any Prescription Drug dispensed in a quantity that exceeds a thirty-one (31) day supply unless the packaging of the manufacturer or the prescription requires a greater quantity.
3. DDAVP (desmopressin acetate) or other Prescription Drugs used in the treatment of primary nocturnal enuresis (bedwetting) for a Covered Person under the age of six.
4. Retin – A (tretinoin) for a Covered Person age 26 or older.
5. RU-486, which is taken to end pregnancy.
6. Devices or appliances including, but not limited to, blood glucose testing devices and support garments and bandages, except when Doctor prescribed.
7. Over-the-Counter (OTC) medications. An OTC medication means medication that a person can legally obtain without a Doctor's prescription; compounded drugs, unless they contain one 'legend' ingredient; unit dose drugs; dietary supplements, herbs and vitamins. We will not apply this Exception to prenatal vitamins a Doctor prescribes for pregnancy.
8. Prescription refills:
  - (a) In excess of the number specified in the Doctor's prescription; or
  - (b) Dispensed more than one year after the initial prescription date.
9. Prescription Drugs that a Doctor administers or dispenses while in his office or while a Covered Person is in a facility that provides medical care, including unit dose Prescription Drugs and any supplies.
10. Prescription Drugs that a Doctor prescribes for:
  - (a) Cosmetic purposes;
  - (b) Treatment of hair loss;
  - (c) Care, services or treatment that the Policy does not cover; or
  - (d) Treatment of an Injury or Sickness that the Policy does not cover.
11. Prescription Drugs used for the purpose of:
  - (a) Losing weight;
  - (b) Treating Acne (including Accutane);
  - (c) Promoting growth (for example: growth hormone);
  - (d) Treating sexual dysfunction or inadequacy; or
  - (e) Facilitating smoking cessation (including any Prescription Drug containing nicotine or its derivatives).
12. Prescription Drugs that a Doctor prescribes for the treatment of mental illness, chronic fatigue syndrome or fibromyalgia.
13. The Prescription Drug Viagra.

14. Any Prescription Drug that is not consistent with the diagnosis and treatment of the Covered Person's Injury or Sickness because:
- (a) The Prescription Drug is excessive in terms of the scope, duration or intensity of scope;
  - (b) The duration or intensity of Prescription Drug therapy is excessive in terms of what is needed to provide safe, adequate and appropriate care; or
  - (c) The Prescription Drug is solely for the Covered Person's, Covered Person's family or Doctor's convenience.
15. Prescription Drugs prescribed for the replacement of lost or stolen prescriptions.

**Information you should know:**

**When Coverage Begins** – We require evidence of insurability before coverage is provided. Once we have approved Your Application, and other conditions remain as described in the Application, coverage for You and those dependents listed in the Application and accepted by Us will begin on the Policy Date shown in the Policy Schedule.

**Addition of Covered Persons After Original Policy Date** – You may request addition of certain persons to the to the list of Covered Persons after the original Policy Date. These include Your spouse or a child of Yours or Your spouse, if the spouse is a Covered Person, including an adopted child, a step-child, a newborn natural child, a grandchild or a child for whom You or Your spouse must provide medical support under an order issued under Chapter 154, Family Code and its revisions. In all cases, except as stated below, addition of a spouse or a child is subject to the Company's underwriting and premium requirements in effect on the date the request is made. Coverage for a newborn natural child, adopted child or a child for whom You or Your spouse must provide medical support under an order issued under Chapter 154, Family Code and its revisions is not subject to underwriting if addition of such a child is made in accordance with the following requirements.



**Newborn Natural Child** – Coverage is provided for a Covered Person's Newborn Natural Child for 31 days from the date of its birth. You must notify the Company of the birth within this free coverage period. In order to continue such coverage beyond the free coverage period, the required premium, if any, must be paid within 62 days of the date of birth.

**Adopted Child** – Coverage is provided for a child You adopt for 31 days from the date a suit to adopt is filed. You must notify the Company of pending adoption within this free coverage period. In order to continue such coverage beyond the free coverage period, the required premium, if any, must be paid within 62 days of the date the suit to adopt is filed.

**Medical Support Child** – Coverage is provided for a child for whom You or Your spouse must provide medical support under an order issued under Chapter 154, Family Code and its revisions for 31 days from the notice of such order or date of the Company's receipt of such order. In order to continue such coverage beyond 31 days, the required premium, if any, must be paid within 62 days of the date the Company receives such order.

As long as You pay the extra premium, if any, the child will remain a Covered Person, subject to the sections titled **TERMINATION OF COVERAGE** and **LOSS OF ELIGIBILITY**.

**Pregnancy** – Coverage for a normal pregnancy is not provided. If a Covered Person suffers Complications or Pregnancy while covered under this Policy Medical Service charges incurred for the treatment of such Complications of Pregnancy will be considered for payment as if they had resulted from Sickness.

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**Foreign Emergency Treatment** – We will pay for benefits for Medical Services resulting from charges for Emergency treatment that a Covered Person receives in a foreign country. Benefits payable will be the lesser of: (1) the actual charges for the services; or (2) the Medical Service charges that We would have paid if the Covered Person had received the Emergency treatment where the Covered Person resides.

**Cosmetic Surgery** – We do not provide benefits for plastic, cosmetic or reconstructive surgery, including breast reduction and surgery to repair, replace or remove breast implants. However, we do provide benefits if surgery is:

Reasonable and Customary Charges for reconstructive surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease for a child who is younger than 18 years of age.

Reasonable and Customary Charges for (1) Reconstruction of the breast on which the mastectomy has been performed; (2) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and (3) Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

**Premium Changes** – We will NOT CHANGE Your premium prior to the first anniversary of this Policy Date, unless: (1) Coverage changes; or (2) Residence changes. After the first anniversary of coverage, We will change premiums in these three cases: (1) Annually, based on attained age; (2) When You move to a different rating zone; or (3) Anytime, and from time to time, that We decide to change rates for persons in Your or a Covered Person's class. We will apply the new rates to premiums that become due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 30 days notice before any premium change.

**PREEXISTING CONDITION** means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within twelve months before the Policy Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within twelve months before the Policy Date. The Company does not cover Pre-Existing Conditions for the first twelve months of coverage.

**Termination of Coverage** – We can terminate or non-renew coverage under this Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums or contributions in accordance with the terms of this Policy or We have not received timely premium payments;
2. You or a Covered Person have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
3. We are ceasing to offer coverage in the medical expense market in accordance with applicable State law;

Notice of termination will be provided in accordance with State law.

Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

**Exceptions:**

**WE DO NOT COVER AN INJURY OR SICKNESS THAT WE HAVE EXCLUDED BY NAME OR DESCRIPTION.**

**THIS POLICY DOES NOT PROVIDE COVERAGE FOR LOSS CAUSED BY, CONTRIBUTED TO OR RESULTING FROM:**

1. Injury or Sickness if the loss is covered under these or similar laws:  
Worker's Compensation Law;  
Employer's Liability Law; or  
Occupational Disease Law.
2. Injury or Sickness that results from war or an act of war, whether war is declared or not.
3. Care or supplies that a Covered Person receives in a Hospital or other facility that a government agency runs. However, We will not apply this Exception if:
  - (a) The Covered Person receives a charge that he has to pay by law; and
  - (b) The Hospital or facility would have made the charge even if no insurance existed.
4. Medical Service charges relating to the diagnosis and/or treatment of the adenoids, varicose veins, tonsils, gallbladder, reproductive organs, and hernia for the first six months of coverage. However, if We have excluded any one of these conditions by rider, We do not pay any benefit for the condition, regardless of when the treatment takes place; or if such condition is a Preexisting Condition, any benefit consideration will be in accordance with the Preexisting Conditions provision.
5. Medical Service charges resulting from procedures or treatments that are Experimental or Investigational Medicine.
6. Organ Transplants, except as otherwise provided under the section titled Organ Transplants.
7. Pregnancy and childbirth, except for Complications of Pregnancy.
8. Mental or Nervous Disorders, without demonstrable organic disease.
9. Plastic, cosmetic or reconstructive surgery, except as otherwise provided in this Policy
10. Dental Treatment unless due to Injury to a Covered Person's natural teeth.
11. Medical Service charges for a Pre-Existing Condition for the first 12 months of coverage.
12. Any attempt at suicide or any intentionally self-inflicted Injury.
13. A Covered Person's commission of or attempt to commit a felony, or an illegal act or being engaged in an illegal occupation.
14. Charges for, or relating to, any loss that results from:
  - (a) A Covered Person, voluntarily or involuntarily, administering, taking or injecting any drug, sedative or narcotic unless taken as a Doctor prescribes; or
  - (b) Injuries to a Covered Person while the person was operating a motor vehicle and his blood alcohol content exceeded [0.08%] by weight, whether or not the Covered Person's use of alcohol causes or contributes to the Injury.
15. Charges relating to radial keratotomy, laser surgery, or any type of surgery or procedure, for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices.
16. Charges relating to treatment of obesity, including exogenous, endogenous, morbid obesity, or weight reduction.

17. Mandibular or maxillofacial surgery to:

- (a) Correct growth defects;
- (b) Correct jaw disproportions or malocclusions;
- (c) Increase vertical dimension; or
- (d) Reconstruct occlusion after one year from a child's date of birth or a child's date of adoption.

We do not apply this Exception for the repair of a congenital anomaly or birth defect of a child covered under this Policy from birth.

- 18. Treatment provided outside the United States of America, its possessions and territories, except as otherwise provided under Foreign Emergency Treatment.
- 19. Diagnosis or treatment (including surgery) of sexual dysfunction disorder or inadequacy; transsexual surgery.
- 20. Care received in a Rehabilitation Facility, including services of this type rendered in a separate section of a building that houses an Acute Care Facility.
- 21. Routine newborn care, unless otherwise stated in this Policy.
- 22. Care in a nursing home, custodial institution or domiciliary care or rest cures.
- 23. Medical Services for charges that You or a Covered Person are not legally obligated to pay.
- 24. Benefits that Medicare pays.
- 25. Charges for which benefits are not specifically provided in this Policy.
- 26. Medicines or Drugs, treatment or procedure that either promotes or prevents contraception or prevents childbirth including and relating to, but not limited to: (a) artificial insemination; (b) in-vitro fertilization or any other diagnosis or treatment for the control, promotion or enhancement of fertility; (c) treatment for impotency, including Viagra; (d) sterilization or reversal of prior sterilization; or (e) elective or non-Medically Necessary and therapeutic abortion, including the Drug RU-486, unless the life of the mother would be endangered if the fetus were carried to term.
- 27. Medicines or Drugs or medicinal supplies when a Covered Person is not Hospital Confined, except as otherwise provided
- 28. Treatment of alcoholism.

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STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
(HEREIN REFERRED TO AS SLAICO)  
ADMINISTRATIVE OFFICE-ONE MOODY PLAZA  
GALVESTON, TEXAS 77550

LIMITED BENEFIT BASIC HOSPITAL MEDICAL SURGICAL EXPENSE INSURANCE POLICY  
OUTLINE OF COVERAGE  
FOR POLICY FORM SERIES SLA-C06-TX  
PREMIUMS ARE SUBJECT TO CHANGE – SEE PAGE 10 OF POLICY

**NOTICE:** At the Applicant's option, the Policy may contain PPO Care Requirements. If so, failure to comply with these requirements will result in a reduction of benefits otherwise payable. Refer to the Policy Schedule

- (1) **READ THE POLICY CAREFULLY.** This outline of coverage provides a very brief description of some of the important features of the Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and SLAICO. It is, therefore, important that you READ THE POLICY CAREFULLY.
- (2) **LIMITED BENEFIT BASIC HOSPITAL MEDICAL SURGICAL EXPENSE INSURANCE** is designed to provide you with coverage for hospital and surgical expenses which you incur as the result of a covered Injury or Sickness. Coverage is provided for the benefits outlined under Medical Services. Medical Services may be limited by EXCEPTIONS.
- (3) **BENEFITS.** We pay benefits at the Rate of Payment after a Covered Person incurs charges during a Calendar Year for Medical Services in excess of the Deductible Amount. If the selected Co-insurance Amount is less than 100%, You must meet the Stop-Loss before We begin to pay at a 100% Co-insurance Amount for the remainder of the Calendar Year. All benefits payable under the Policy are subject to the Policy Maximum Benefit Payments.

**Policy Amounts:** (Check Appropriate Boxes)

**Maximum Benefit Payment:** \$5,000,000

**Maximum Policy Benefit For Each Injury Or Sickness Per Covered Person:** \$1,000,000

**Deductible Amount:**  \$750  \$1,500  \$2,000  \$2,500  \$5,000

\$10,000  \$15,000

**Co-Insurance Amount:**  80%  100%

**Stop-Loss Amount:**  \$5,000  \$10,000

**Organ Transplants Maximum:** \$1,000,000 (Selected Maximum Benefit if performed at a Transplant Center)

The Deductible Amount is the amount of charges for Medical Services a Covered Person must incur each Calendar Year before We pay benefits. Once a Covered Person meets their Deductible Amount in a Calendar Year, no additional Deductible Amount required to be met by the same Covered Person during the remainder of the Calendar Year.

**(4.) MEDICAL SERVICES**

**WE PAY BENEFITS FOR CHARGES INCURRED FOR THE FOLLOWING MEDICAL SERVICES AT THE CO-INSURANCE AMOUNT, SUBJECT TO THE REASONABLE AND CUSTOMARY CHARGE MAXIMUM.** Benefits payable for Medical Services are subject to all terms, limits, and conditions of the Policy. In order for Us to pay any benefits, the charge must meet the three conditions set forth in the first paragraph of the **BENEFITS** section.

An expense is "incurred" on the date a provider renders the service or furnishes the supplies.

The following are Medical Services under the Policy:

**Hospital Stay** – Reasonable and Customary Charges made by the Hospital for each day a Covered Person is Hospital Confined. Such charges will include:

1. Room accommodations (up to the average semi-private room rate). The average semi-private room rate includes any separate charges such as room, nursing services, maintenance, utilities and similar items. If a Hospital has only private rooms, eligible Medical Service charges will be limited to 90% of the private room charge.
2. Charges for an Intensive Care Unit, Coronary Care Unit and Neonatal Intensive Care Unit confinement up to three times the average semi-private room rate.
3. Hospital charges for miscellaneous medical services and supplies that are necessary for the treatment of the Covered Person while Hospital Confined. These charges include: operating room, recovery room, anesthesia, surgical dressings, central supplies, casts and splints, Medicines or Drugs, x-ray photographs, laboratory service and oxygen, equipment and services, blood plasma, whole blood and blood derivatives.

All charges must be incurred while a Covered Person is Hospital Confined.

Medical Service charges **DO NOT** include: charges for take-home Medicines or Drugs (unless otherwise specifically provided by the Policy), personal and convenience items, or items that are not intended primarily for use while Hospital Confined.

**Surgery** – Reasonable and Customary Charges by a Doctor for the primary surgery performed on a Covered Person while Hospital Confined or in a Same Day Surgery Facility. This benefit includes routine care after the surgery.

We will pay other surgical procedures, done during this same session, at 50% of the Reasonable and Customary allowance.

A surgical procedure involving TMJ (Temporomandibular Joint Disorder) is limited to a Lifetime Maximum of \$2,500 per Covered Person.

**Assistant Surgeon** – Reasonable and Customary Charges for surgical assistance performed on a Covered Person while Hospital Confined or in a Same Day Surgery Facility. Eligible Assistant Surgeon expense is limited to 25% of the Medical Service charge allowance for the primary surgeon, when the assistance is rendered by a Doctor. This benefit reduces to 20%, when a Physician Assistant assists and to 15% if the assistance is by a Registered Nurse.

**Second Surgical Opinion** – Reasonable and Customary Charges for a Doctor providing a second surgical opinion regarding the advisability of surgery. If the initial and second surgical opinions conflict, We will pay benefits for a third surgical opinion. We do not subject charges for a second and third opinion to the Deductible Amount.

**Anesthesia Administration** – Reasonable and Customary Charges by an anesthesiologist for the administration of anesthesia to a Covered Person who is undergoing surgery while Hospital Confined or in a Same Day Surgery Facility.

The anesthesiologist must be at the operation solely to render the anesthesia service. We will reduce eligible benefits by 50% if a nurse anesthetist, operating surgeon or assistant surgeon administers the anesthesia and any incidental fluids as part of a covered surgical procedure.

Charges include the reasonable cost of hospitalization and general anesthesia in order for a Covered Person to safely receive dental care if he or she is under 8 years of age or is developmentally disabled.

**Doctor Visits** – Reasonable and Customary Charges by the primary attending Doctor for one visit per day while Hospital Confined.

**Pathology** – Reasonable and Customary Charges by a pathologist for the interpretation of diagnostic tests or studies while Hospital Confined or in a Same Day Surgery Facility.

**Physiotherapy** – Reasonable and Customary Charges for physical, speech or inhalation therapist services while Hospital Confined or in a Same Day Surgery Facility.

**Outpatient Therapy** – Reasonable and Customary charges for Therapy provided to a Covered Person who is not Hospital Confined. The Covered Person must require such Therapy for a Sickness or Injury that caused a covered Hospital Stay

or surgery, regardless of Hospital Confinement. "Therapy" includes the following services: Radiation therapy, including treatment planning; Chemotherapy, including treatment planning; Physical therapy; Speech therapy; and Occupational therapy.

**Radiology** – Reasonable and Customary Charges by a radiologist for the interpretation of diagnostic tests or studies while Hospital Confined or in a Same Day Surgery Facility.

**Same Day Surgery Facility** – Reasonable and Customary Charges for care received in a Same Day Surgery Facility. Medical Service charges will be the fees for the use of the facility and other miscellaneous charges made by the facility. If the Covered Person stays in the Ambulatory Surgical Center for 18 or more hours, We will pay Medical Service charges up to the average semi-private room rate for the use of the facility. The semi-private room rate will be consistent with Hospital charges in the area where the Ambulatory Surgical Center is located.

## **Organ Transplants**

**The Policy Schedule shows the Maximum Benefit for Organ Transplants per Covered Person.**

The organ being transplanted must be the organ of primary disease and must be one of the following organs:

1. Heart;
2. Lung;
3. Liver;
4. Cornea;
5. Pancreas;
6. Kidney; or
7. Bone Marrow and/or stem cells harvested from bone marrow or peripheral blood. (Stem cell or bone marrow transplants do not have to be the organ of primary disease).

We will pay benefits for the Medical Service charges that result from charges related to, caused by, contributed to or resulting from an Organ Transplant. The Covered Person must incur the charges during the Transplant Period. We will not pay for charges the Covered Person incurs outside the Transplant Period, except for anti-rejection Drug charges.

When You or a Covered Person are legally responsible for donor charges, We will pay benefits for donor charges up to the maximum benefit for an Organ Transplant, shown in the Policy Schedule, less the total benefits paid on behalf of the Covered Person for the Organ Transplant.

**Transplant Centers** – We have contracted with certain specified transplant centers to provide Organ Transplants at a negotiated rate. If a Covered Person utilizes a specified transplant center, We will waive the \$1,000,000 Maximum Benefit for an Organ Transplant and the charges will instead be applied towards the Policy Maximum. All other provisions of the Policy will continue to apply.

You or a Covered Person may send a written request to Our Case Management Department for a copy of the maximums.

**Hospice Care Benefit** – Reasonable and Customary Charges for Hospice Care provided by a Hospice agency. We will not pay benefits under this provision and under another benefit provision of the Policy. We only pay benefits for Hospice Care when:

1. The Hospice Care is provided to reduce or abate pain and not for cure; and
2. The Covered Person's Doctor certifies that the Covered Person's life expectancy is less than six months.

This benefit is not subject to the Deductible Amount or any Rate of Payment that is less than 100%.

**Home Health Care** – Reasonable and Customary Charges for Home Health Care up to [\$40] per visit. There is a limit of one visit per day and [60] Home Health Care visits in each Calendar Year. We count the following as one Home Health Care Visit:

1. When a Home Health Care provider visits the home to evaluate the need for developing a Home Health Care plan;  
or
2. Up to four consecutive hours of Home Health Care.

The Home Health Care must begin within 7 days of a prior Hospital Stay of at least 3 days. The Home Health Care must be provided in lieu of a Hospital Stay. The Home Health Care must be for treatment of the same Sickness or Injury for which the Covered Person was Hospital Confined.

Home Health Care includes the following Medical Services:

1. Registered Professional Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) services/supplies;
2. Qualified physiotherapist, speech therapist or inhalation therapist services/supplies;
3. Medical social services worker services/supplies. The services/supplies must be Medically Necessary to understand the emotional, social and environmental factors affecting the Covered Person's Sickness;
4. Home health aide services/supplies when under a R.N.'s direct supervision;
5. Nutritional guidance when Medically Necessary;
6. Oxygen and its administration.

This benefit is not subject to the Deductible Amount or any Rate of Payment less than 100%.

**Mammogram** – Reasonable and Customary Charges in excess of \$25 for one annual screening mammogram per Calendar Year. We pay the benefit whether or not the Covered Person is Hospital Confined. We do not apply charges to the Deductible Amount or any Rate of Payment less than 100%.

**Professional Ambulance Service** – Reasonable and Customary Charges for transportation to the nearest Hospital qualified to treat Injuries or medical Emergencies.

#### **Complications of Pregnancy**

If a Covered Person suffers Complications of Pregnancy while covered under the Policy, Medical Service charges incurred for treatment of such Complications of Pregnancy will be considered for payment as if they had resulted from Sickness.

#### **Foreign Emergency Treatment**

We will pay for benefits for Medical Services resulting from charges for Emergency treatment that a Covered Person receives in a foreign country. Benefits payable will be the lesser of: (1) the actual charges for the services; or (2) the Medical Service charges that We would have paid if the Covered Person had received the Emergency treatment where the Covered Person resides.

**TEXAS RESIDENT BENEFITS** – The following benefits apply only when described services are provided to a Covered Person who is a Texas resident. Except as otherwise stated, they are subject to all the terms and conditions of the Policy except, the following Texas Resident Benefits are payable regardless of whether a Covered Person is Hospital Confined.

**ACQUIRED BRAIN INJURY** – Reasonable and Customary Charges for the diagnosis and treatment of Acquired Brain Injury including: cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an Acquired Brain Injury.

**CHILDHOOD IMMUNIZATIONS** – Reasonable and Customary Charges for Covered Persons under the age of seven for immunizations that are required by law for a child. Charges are not subject to any Deductible Amount or Rate of Payment limit.

**COLORECTAL CANCER EXAM** – Reasonable and Customary Charges for colorectal cancer examination and laboratory tests for cancer for any person, in accordance with the American Cancer Society Guidelines.

**DEVELOPMENTAL DELAY** – Reasonable and Customary Charges for Developmental Delay Services provided for the treatment of Developmental Delay in a Covered Person who is younger than 3 years. Treatment must be provided in accordance with an Individualized Family Service Plan and includes, but is not limited to, the following:

1. Service coordination services;
2. Developmental services;
3. Medical services only for diagnostic or evaluation purposes;
4. Early identification, screening, and assessment services, and the other early intervention services;
5. Family education;
6. Home visits;
7. Speech and language therapy;
8. Audiology;
9. Occupational therapy;
10. Transportation;
11. Assistive technology devices and assistive technology services;
12. Physical therapy;
13. Psychological services;
14. Family counseling;
15. Social work services;
16. Health services necessary to enable the child to benefit from the other early intervention services;
17. Nursing services;
18. Nutrition services; or
19. Vision services.

**DIABETES SELF-MANAGEMENT TRAINING AND PATIENT MANAGEMENT** – Reasonable and Customary Charges for treatment of diabetes for a Covered Person diagnosed with insulin dependent or non-insulin dependent diabetes or elevated blood glucose levels. Such treatment shall include diabetes:

1. Equipment, including replacement by new and improved equipment;
2. Supplies; and
3. Self-management training.

**MASTECTOMY AND LYMPH NODE DISECTION** – Hospital Confinement following a covered mastectomy of lymph node dissection is covered under the Policy for a minimum of:

1. 48 hours following a mastectomy; and
2. 24 hours following a lymph node dissection for the treatment of breast cancer.

**NEWBORN HEARING SCREENING** – Reasonable and Customary Charges for a screening test for hearing loss for a covered child from birth through the date the child is 30 days old. Coverage includes the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. We do not apply any Deductible Amount to this benefit.

**PELVIC EXAM** – Reasonable and Customary Charges for a pelvic examination and pap smear for any woman, in accordance with the American Cancer Society Guidelines.

**PROSTATE EXAM** – Reasonable and Customary Charges for a prostate examination and laboratory tests for cancer for any man, in accordance with recommendation of the American Urological Association or American Cancer Society Guidelines.

**RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES** – Reasonable and Customary Charges for reconstructive surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease for a child who is younger than 18 years of age.

**RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY** – Reasonable and Customary Charges for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

**TELEHEALTH AND TELEMEDICINE** – Reasonable and Customary Charges for services provided through Telehealth and Telemedicine.

## **(5.) EXCEPTIONS AND LIMITATIONS**

**WE DO NOT COVER AN INJURY OR SICKNESS THAT WE HAVE EXCLUDED BY NAME OR DESCRIPTION. THE POLICY DOES NOT PROVIDE COVERAGE FOR LOSS CAUSED BY, CONTRIBUTED TO OR RESULTING FROM:**

1. Injury or Sickness if the loss is covered under these or similar laws:  
Worker's Compensation Law;  
Employer's Liability Law; or  
Occupational Disease Law.
2. Injury or Sickness that results from war or an act of war, whether war is declared or not.
3. Care or supplies that a Covered Person receives in a Hospital or other facility that a government agency runs. However, We will not apply this Exception if:
  - (a) The Covered Person receives a charge that he has to pay by law; and
  - (b) The Hospital or facility would have made the charge even if no insurance existed.
4. Medical Service charges relating to the diagnosis and/or treatment of the adenoids, varicose veins, tonsils, gallbladder, reproductive organs, and hernia for the first six months of coverage. However, if We have excluded any one of these conditions by rider, We do not pay any benefit for the condition, regardless of when the treatment takes place; or if such condition is a Preexisting Condition, any benefit consideration will be in accordance with the Preexisting Conditions provision.
5. Medical Service charges resulting from procedures or treatments that are Experimental or Investigational Medicine.
6. Organ Transplants, except as otherwise provided under the section titled Organ Transplants.
7. Pregnancy and childbirth, except for Complications of Pregnancy.
8. Mental or Nervous Disorders, without demonstrable organic disease.
9. Plastic, cosmetic or reconstructive surgery, except as otherwise provided in the Policy.
10. Dental Treatment unless due to Injury to a Covered Person's natural teeth.
11. Medical Service charges for a Pre-Existing Condition for the first 12 months of coverage.
12. Any attempt at suicide or any intentionally self-inflicted Injury.
13. A Covered Person's commission of or attempt to commit a felony, or an illegal act or being engaged in an illegal occupation.
14. Charges for, or relating to, any loss that results from:
  - (a) A Covered Person, voluntarily or involuntarily, administering, taking or injecting any drug, sedative or narcotic unless taken as a Doctor prescribes; or
  - (b) Injuries to a Covered Person while the person was operating a motor vehicle and his blood alcohol content exceeded [0.08%] by weight, whether or not the Covered Person's use of alcohol causes or contributes to the Injury.
15. Charges relating to radial keratotomy, laser surgery, or any type of surgery or procedure, for refractive correction, eye refraction or the purchase or fitting of vision or hearing aids, Cochlear Implants and related devices.
16. Charges relating to treatment of obesity, including exogenous, endogenous, morbid obesity, or weight reduction.

17. Mandibular or maxillofacial surgery to:

- (a) Correct growth defects;
- (b) Correct jaw disproportions or malocclusions;
- (c) Increase vertical dimension; or
- (d) Reconstruct occlusion after one year from a child's date of birth or a child's date of adoption.

We do not apply this Exception for the repair of a congenital anomaly or birth defect of a child covered under the Policy from birth.

18. Treatment provided outside the United States of America, its possessions and territories, except as otherwise provided under Foreign Emergency Treatment.

19. Diagnosis or treatment (including surgery) of sexual dysfunction disorder or inadequacy; transsexual surgery.

20. Care received in a Rehabilitation Facility, including services of this type rendered in a separate section of a building that houses an Acute Care Facility.

21. Routine newborn care, unless otherwise stated in the Policy.

22. Care in a nursing home, custodial institution or domiciliary care or rest cures.

23. Medical Services for charges that You or a Covered Person are not legally obligated to pay.

24. Benefits that Medicare pays.

25. Charges for which benefits are not specifically provided in the Policy.

26. Medicines or Drugs, treatment or procedure that either promotes or prevents contraception or prevents childbirth including and relating to, but not limited to: (a) artificial insemination; (b) in-vitro fertilization or any other diagnosis or treatment for the control, promotion or enhancement of fertility; (c) treatment for impotency, including Viagra; (d) sterilization or reversal of prior sterilization; or (e) elective or non-Medically Necessary and therapeutic abortion, including the Drug RU-486, unless the life of the mother would be endangered if the fetus were carried to term.

27. Medicines or Drugs or medicinal supplies when a Covered Person is not Hospital Confined, except as otherwise provided.

28. Treatment of alcoholism.

## **(6.) LIMITATIONS**

Until the Policy has been in effect for two years, SLAICO may reduce or deny a claim or void the Policy if:

- 1. You make a misstatement in the application for the Policy.
- 2. A disease or physical condition existed prior to the effective date of coverage.

SLAICO may deny a claim or void the Policy at any time if you made a fraudulent material misstatement in the application for the Policy.

SLAICO may deny a claim if a Covered Person is hospitalized or receives treatment for a disease or physical condition which has been excluded from coverage by rider.

**PRE-EXISTING CONDITIONS** mean the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 12 month period preceding the effective date of coverage of the Covered Person or a condition for which medical advice or treatment was recommended by or received from a Doctor within a 12 month period preceding the effective date of coverage of the Covered Person. Expenses incurred by a Covered Person within two years following the effective date of coverage for treatment of a Pre-existing Condition will be excluded from coverage under the Policy.

**(7.) RENEWABILITY**

We can terminate or non-renew coverage under the Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums or contributions in accordance with the terms of the Policy or We have not received timely premium payments;
2. You or a Covered Person have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of the Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
3. We are ceasing to offer coverage in the medical expense market in accordance with applicable State law;

Notice of termination will be provided in accordance with State law.

Subject to the conditions listed above, We cannot refuse to renew coverage:

1. Just because of a change in a Covered Person's health or the type of work the Covered Person performs; or
2. Just because of the claims filed by or on behalf of a Covered Person, unless the claims are fraudulent.

**(8.)** Initial Annual Premium:                   \$ \_\_\_\_\_  
Mode of Payment Selected:                \$ \_\_\_\_\_  
Initial Modal Premium:                    \$ \_\_\_\_\_

**Premiums are subject to change.**

The Policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. This grace period will not apply if SLAICO has notified You, at least 30 days before the premium due date, in writing of its intent not to renew the Policy.

**THIS OUTLINE IS A BRIEF DESCRIPTION OF THE POLICY TERMS AND PROVISIONS.  
REFER TO THE POLICY FOR FURTHER DETAILS.**

**STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
ADMINISTRATIVE OFFICE-ONE MOODY PLAZA  
GALVESTON, TEXAS 77550  
TELEPHONE NUMBER: 1-800-899-6520**

**LIMITED BENEFIT BASIC HOSPITAL MEDICAL SURGICAL EXPENSE INSURANCE POLICY  
OPTIONAL PREFERRED PROVIDER COMPONENT  
PPO DISCLOSURE BROCHURE  
FOR POLICY FORM SERIES SLA-C06-TX and SLA-C06H-TX**

- 1.) **NOTICE:** If selected by the Applicant, the Policy contains PPO Admission and Care Requirements. Failure to comply with these requirements will result in a reduction of benefits otherwise payable.
- 2.) **PREFERRED PROVIDER** means a Hospital; Same Day Surgery Facility; or Doctor located in the United States that participates in a Preferred Provider Organization (PPO) to which the Company subscribes. The Company will provide periodic updates of changes in Preferred Providers in Your Service Area.
- 3.) **PREFERRED PROVIDER ORGANIZATION (PPO)** means: a group of Hospitals; other medical care facilities; or Doctors that offer their services at a discount to certain contracted groups. Your coverage is being provided as a PPO Plan. In order to receive the maximum benefit, a covered Hospital confinement must: be in a Preferred Provider Hospital; out-patient surgery must occur in a Preferred Provider Same Day Surgery Facility; and Doctor services must be provided by a Preferred Provider Doctor, unless such confinement, surgery or services are the result of Emergency or because covered services are not available through a Preferred Provider.
- 4.) **OUT OF NETWORK CARE** means Non-Emergency, Medically Necessary medical services covered under this Rider that are not received from a Preferred Provider. Treatment received out of network usually results in a reduction of benefits otherwise payable. Consult Your Policy for details.
- 5.) **EMERGENCY TREATMENT** – No reduction in benefits will occur for Emergency Treatment received out of network.
- 6.) **HEALTH INSURANCE COVERAGE PROVIDED UNDER THE POLICY AND OPTIONAL RIDERS** – The policy provides benefits for the Medically Necessary treatment of Injury and Sickness, subject to all the terms and conditions contained in the Policy and any attachments, primarily while a Covered Person is Hospital Confined. If optional benefits are selected, additional coverage may be provided for treatment provided on an outpatient basis. For details of coverage, exclusions and limitations, consult Your policy.
- 7.) **CONTINUITY OF TREATMENT** – Termination of a Preferred Provider's participation in the PPO, except for reason of medical competence or professional behavior, will not release the Provider from treating a Covered Person and cooperating in arranging for appropriate referrals when the Covered Person has Special Circumstances. Special Circumstances means a condition such that the treating Doctor or Provider reasonably believes that discontinuing care by the treating Doctor or Provider could cause harm to the Covered Person. The treating Doctor or Provider must request to continue to treat the Covered Person due to Special Circumstances. This continuity of treatment will be for no more than 90 days from the effective date of the Provider's termination with the PPO.
- 8.) **RETALIATION** – SLAICO is prohibited from retaliating against a Covered Person because the Covered Person or other person has filed a complaint on behalf of the Covered Person and against a Doctor or Provider who, on behalf of the Covered Person, has reasonably filed a complaint against SLAICO or appealed a decision of SLAICO.
- 9.) **PREFERRED PROVIDER INFORMATION** – Ask Your agent or contact SLAICO for a current list of Preferred Providers, complete with descriptions of the provider networks, including the names and locations of Doctors and Providers, the service area, and a disclosure of which Providers will not accept new patients.

**REFER TO YOUR POLICY FOR FURTHER DETAILS.**

## **Notice to Applicant**

This description of the Information Practices of Standard Life and Accident Insurance Company is being provided in accordance with the requirements of the Insurance Information and Privacy Protection Law in effect in your state of residence.

## **Fair Credit Reporting Act (FCRA) Pre-Notification**

Federal and state law requires notification that, in connection with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such a report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing proper identification, you may inspect or receive a copy of such report.

Typically, the report will contain information as to character, general reputation, personal characteristics and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs, if any, living conditions and type of community.

## **Medical Information Bureau (MIB) Pre-Notification**

Information regarding your insurability will be treated as confidential. Standard Life and Accident Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in you 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Standard Life and Accident Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

## **What is HIPAA?**

HIPAA is the Health Insurance Portability and Accountability Act of 1996; it was effective July 1, 1997. HIPAA provides certain Americans guaranteed access to health insurance coverage regardless of existing health conditions.

Eligible Individuals are the only people who have guaranteed access to health insurance under HIPAA. Eligible Individuals must be replacing Creditable Coverage. Creditable coverage is replacement of: group sponsored health plans, individual coverage by state law, Medicaid, Medicare, plans sponsored by the US Military, Indian Health Service, a high risk pool, US Government employee plans, and Peace Corp plan. Creditable Coverage must have been in force for 18 months and be replaced within a 63-day period after it terminates (may vary by state).

HIPAA requires health insurance carriers to allow guaranteed access to certain plans (Federal Fallback) unless a state adopts an Alternative Mechanism. These include high-risk pools, guaranteed issue requirements for available plans or other methods to assure the access requirements for HIPAA are followed.

## **Insurance Fraud**

Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**THIS PAGE TO BE LEFT WITH CLIENT AT POINT OF SALE**



**Application to  
Standard Life and Accident Insurance Company • Administrative Office • Galveston, Texas**

Print in Black  New  Reinstatement-Existing # \_\_\_\_\_  Change -Existing # \_\_\_\_\_

**Section I: Eligibility**

Home Office Use:

**1. Hospital-Surgical Plan**

**Plan Deductible Amount:**

\$750  \$1,500  \$2,000  \$2,500  
 \$5,000  \$10,000  \$15,000

**Lifetime Maximum Benefit**

\$5,000,000

**Coinsurance:**

100%  80%

**Stop-Loss Amount:**

\$5,000  \$10,000

**HSA Plan**

**Deductible Amount:**

\$ \_\_\_\_\_

**Rate of Payment:**

100%  80%

**PPO Rider:**

YES  NO

**Lifetime Maximum Benefit**

\$3,000,000

**2. Special Request:**

**Optional Benefits: (Not available with HSA Plan)**

**Accident Rider :**

\$400  \$800  \$1,200

**OP Doctor Rider:**

Yes  NO

**PPO Rider:**

Yes  NO

**OP Drug Rider:**

Individual Deductible

\$500  \$1,000

**3. Payment Mode:**  Annual  Semi-Annual  Quarterly  Monthly Electronic Debit (Funds to be withdrawn from the account number shown on a CWA check, otherwise, submit a copy of a voided check or deposit slip to establish a different account for premium withdrawal.)  
 Draft Initial Premium  Yes  No

Amount collected with Application:

\$ \_\_\_\_\_

Name and Address of Premium Payor if other than Applicant \_\_\_\_\_

**TO BE COMPLETED PERSONALLY BY THE APPLICANT AND SPOUSE, IF ANY.**

**4. Proposed Insured Information**

Proposed Insured(s) (Print Last Name, First Name, MI.)	Relationship	Marital Status		Sex	Age	Date of Birth				Build		Social Security Number
		Single	Married			Mo.	Day	Year	State	Height	Weight	
1	Applicant	<input type="checkbox"/>	<input type="checkbox"/>									
2	Spouse	<input type="checkbox"/>	<input type="checkbox"/>									
3												
4												
5												
6												

**5. Address** (Permanent U.S. residence of primary insured.)

Number and Street or R.F.D.

Phone: Hm( ) \_\_\_\_\_ Best time to call:

Work: ( ) \_\_\_\_\_  A.M.  P.M.

E-mail Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**6. Employment Data**

Employed Full-Time?

Name of Employer

Duties/Title

Avg. Monthly Earnings Last 12 Months

Person No. 1

Yes  No

\$ \_\_\_\_\_

Person No. 2

Yes  No

\$ \_\_\_\_\_

**7. Is any Proposed Insured or household member (including students away at school, whether or not now applying for coverage) currently pregnant?**  
 Yes  No (If "Yes", this coverage cannot be provided.)

**8. Has any Proposed Insured used any type of tobacco (including cigarettes, cigars, and /or smokeless tobacco) during the past 12 months?**  
 Yes  No (If "Yes", state whom, and form of use details.) \_\_\_\_\_

**9. Are all Proposed Insureds U.S. Citizens?**  Yes  No (If "No", state whom and how long a resident of U.S.A.) \_\_\_\_\_

**10. Does any Proposed Insured, immediate family, or household member intend to travel or reside outside the U.S.A.?**  Yes  No  
 (If "Yes", give details.) \_\_\_\_\_

**Section II: Other Insurance**

**11. Other Insurance Information:**

- A. Are any Proposed Insureds covered by, or has application been made for, any type of medical insurance? (“Medical insurance” includes: Blue Cross/Blue Shield, HMO, and medical expense and indemnity policies)  Yes  No
- B. Is any Proposed Insured currently covered by Medicare or Medicaid?  Yes  No
- C. Has any Proposed Insured been covered under a health insurance plan including COBRA within the last 18 months?  Yes  No
- D. Is the insurance applied for intended to replace any existing insurance or insurance which has been terminated with this company or any other company?  Yes  No
- E. Has any Proposed Insured ever been covered by, or made application to, SLAICO for other insurance coverage? (If “Yes”, give details)  Yes  No

**Complete the following for each “Yes” answer to questions 11A-E above and list all medical insurance applied for or now in force. This coverage is not available in addition to other medical plans.**

Person No.	Name of Company/Policy No.	Plan Type (COBRA, Group or Individual)	Hospital Indemnity Only	Hospital			Major Medical		Effective Date	Termination Date
				Rm & Brd	Misc.	Surgical	Deductible	Maximum		

- 12. Will proposed coverage replace or change any existing Medical insurance?**  Yes  No
- A. If Yes, give plan details above and provide reason for replacement such as carrier terminated coverage, lower rates, better coverage, etc.
  - B. **You should not cancel your existing health insurance coverage until you receive written notification of acceptance from SLAICO.** If accepted, do you agree to discontinue your current major medical plan?  Yes  No

- 13. Has any Proposed Insured applied for life, accident or health insurance or for reinstatement of such insurance, which was restricted, postponed, rescinded, cancelled, withdrawn or modified as to plan, amount, coverage or rate?**  
 Yes  No (If “Yes”, give details) \_\_\_\_\_

- 14. Has any Proposed Insured made claim or received benefits for any injury or sickness in the last 12 months or presently receive any government aid such as Medicaid, Medicare or SSDI?**  Yes  No (If “Yes”, state whom, name of insurer, month, year and nature of ailment.) \_\_\_\_\_

**Section III: Medical History and Related Information**

- 15. Has any Proposed Insured ever taken part in: skydiving, hang gliding, parachuting, bungee jumping, rock or mountain climbing, underwater diving, racing (any type); motorcycle riding; professional sports; piloting an aircraft, or rodeo events?**  Yes  No  
 (If “Yes”, circle activity and give details.) \_\_\_\_\_

- 16. Has any Proposed Insured had any arrests, a driver’s license suspended, traffic violations or prior DWI/DUI/OUT’s within the past 2 years?**  
 Yes  No (If “Yes”, give details and provide Driver’s License # and state of issue)  
 \_\_\_\_\_

**17. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each Proposed Insured:**

Name	Condition, injury symptoms, diagnosis	Onset Date Month/Year	Date of last treatment	Results/Degree of recovery	Name/Address of Attending Physician

**THIS QUESTION MUST BE ANSWERED COMPLETELY FOR ALL APPLICANTS**

**THE FOLLOWING QUESTIONS ARE TO BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.  
ANY MISSTATEMENTS MAY AFFECT YOUR COVERAGE — GIVE FULL DETAIL TO ALL “YES” ANSWERS IN THE SPACE PROVIDED.**

- |   |   |
|---|---|
| <p><b>18.</b> Within the last 10 years has any Proposed Insured had any indication of, diagnosis of, or treatment for:</p> <p>a. A Respiratory System disorder, including lung disease, hay fever, allergies, including desensitization, reactive airway disease, asthma, bronchitis, tuberculosis, pneumonia, emphysema or sleep apnea?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. A Circulatory System and heart disorder, including high blood pressure, high cholesterol, heart attack, heart valve disease or murmur, angioplasty/bypass, stent placement, chest pain, irregular heart rhythm, varicose veins, phlebitis, transient ischemic attack, stroke?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>c. The Immune System disorder, including blood or spleen disorder, anemia, leukemia, bleeding disorder, lymphoma, or connective tissue disease such as lupus and scleroderma?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>d. A Digestive/Gastrointestinal system disorder, including ulcer, gastritis, esophagitis, reflux disorder, ileitis, cellulitis, hepatitis, cirrhosis, hemorrhoids, hernia or any disorder of the pancreas, liver, rectum or gallbladder?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>e. A Nervous System disorder, including epilepsy/seizures, tremors, headaches, paralysis, stroke, transient ischemic attack (TIA), palsy or any disorder or injury of the brain, spinal cord, or nerves?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>f. A Mental/Nervous System disorder, including emotional problems, eating disorder, attention deficit disorder, anxiety, depression, autism, sleep disorder, developmental delay, or received psychiatric treatment or counseling?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>g. An Endocrine System disorder, including diabetes mellitus or insipidus, abnormal blood sugar, hypoglycemia or any disorder of the thyroid, parathyroid, pituitary, adrenal, thymus gland? <input type="checkbox"/> <input type="checkbox"/></p> <p>h. A Urinary System disorder, including kidney stones, bladder or kidney infections, renal reflux, blood, sugar, or albumin in the urine or sexually transmitted disease?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>i. A Muscular/Skeletal System disorder, including arthritis, gout, rheumatism, fibromyalgia, motor skill delay, a bone, joint, muscle disorder, a back/spine disorder to include disc disease and sciatica, or received manipulative/adjustment therapy?.. <input type="checkbox"/> <input type="checkbox"/></p> <p>j. A Facial/Bone/Jaw disorder including temporomandibular joint disorder (TMJ), cleft palate/lip, overbite or underbite?... <input type="checkbox"/> <input type="checkbox"/></p> <p>k. A Cancer in any forms including in situ and skin, tumor, cyst, polyp, or growth of any kind?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>l. An Eye, Ear, Nose, Throat disorder, including impaired vision, glaucoma, cataracts, ears infections, ear tubes, hearing, impairment, enlarged/infected tonsils, vertigo, speech impairment or sinusitis?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>m. A Skin/Subcutaneous Tissue disorder, including burns, s c a r s , dermatitis, acne, eczema, psoriasis, cellulitis, or hemangioma? <input type="checkbox"/> <input type="checkbox"/></p> <p>n. A Male Reproductive/Breast disorder including any disorder of the prostate, testicles, elevated PSA, infertility or impotence?.. <input type="checkbox"/> <input type="checkbox"/></p> <p><b>19.</b> Within the last ten (10) years, has any Proposed Insured ever been positively diagnosed or treated by a physician for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?..... <input type="checkbox"/> <input type="checkbox"/></p> | <p align="center"><b>Yes No</b></p> <p><b>20.</b> Within the past 12 months, has any Proposed Insured experienced or been treated by a physician for:</p> <p>a. Weight gain or loss of more than 12 pounds?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Recurrent episodes of Diarrhea?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Swollen or enlarged glands or lymph nodes?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Persistent cough, persistent or recurrent fever, 10 or more viral infections?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Chronic or recurrent skin rashes or lesions?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>21.</b> Within the past 5 years, has any Proposed Insured:</p> <p>a. Been hospital confined, had surgery, advised to undergo further testing, treatment, or surgery, including cosmetic or reconstructive surgery?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Had a heart, bone, or blood study, MRI, chest x-ray, ultrasound, or contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing healthcare services?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>22.</b> Has any Proposed Insured ever been:</p> <p>a. Treated or counseled for alcohol or drug use or attended a drug or alcohol support group?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Advised by a physician to seek treatment or discontinue or decrease alcohol or drug consumption?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Under the influence of marijuana, narcotics, barbituates, amphetamines, hallucinogens or used any other drugs not prescribed by a physician?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>23.</b> Does any Proposed Insured have any fixation/prosthetic devices present including but not limited to plates, screws, pins, implants, shunts, pacemakers or valve replacements or stents?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>24.</b> Does any Proposed Insured have a mental or physical impairment or deformity, or a congenital abnormality, disease or trait not previously disclosed?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>25.</b> Within the last six months, has any Proposed Insured taken any prescription medication or now taking prescription medication or receiving treatment of any kind for any condition not listed above?..... <input type="checkbox"/> <input type="checkbox"/></p> <p><b>26. FOR FEMALES ONLY: Questions 26. a-d</b></p> <p>a. Any disorder or condition of the female reproductive organs, abnormal Pap Smear, irregular or excessive menstruation, endometriosis, infertility, pregnancy complications including Cesarean Section Delivery, cystocele, rectocele, pelvic relaxation, dysmenorrhea, chronic pelvic pain or HPV (human papillomavirus)?.... <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Date of last Pap Smear _____<br/>Results _____</p> <p>c. Have you been instructed to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear?..... <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Breast disorder, disease, changes, condition or lump(s), aspiration(s), calcifications, biopsies including removal or placement of breast implants or mammoplasty?.... <input type="checkbox"/> <input type="checkbox"/></p> |
|---|---|

**COMPLETE THE FOLLOWING FOR EACH “YES” ANSWER TO QUESTIONS 18 THROUGH 26 ABOVE.**

Question Number	Name of Person	Date of Treatment		Reason for Check-up, Diagnosis, Illness or Condition, Frequency of Attacks	Treatment or Findings, Medication, Recommendations, Hospitalization and/or Surgery, Degree of Recovery	Name and Address of Each Physician, Practitioner and Medical Facility
		From	To			

If additional space is needed, please use the separate sheet provided, sign, date and return with the application.

**Section IV: Supplemental Information**

**THE HEALTH INSURANCE COVERAGE BEING APPLIED FOR IS NOT DESIGNED NOR INTENDED AS A HEALTH INSURANCE PLAN TO BE PROVIDED BY AN EMPLOYER FOR EMPLOYEES. THE FOLLOWING QUESTIONS ESTABLISH THAT NO EMPLOYER INVOLVEMENT WILL OCCUR IN THE PAYMENT OF YOUR PREMIUM. ANY FUTURE CHANGE IN THAT STATUS WILL CAUSE YOUR HEALTH INSURANCE TO TERMINATE, EFFECTIVE IMMEDIATELY.**

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED:

- 1. Are you the owner of an incorporated business?  Yes  No
- 2. Are you a sole proprietor or a partner in a partnership?  Yes  No
- 3. Are you an employee of a business?  Yes  No
  - a. Will your employer pay a portion of your health insurance premium?  Yes  No
  - b. Will you be reimbursed by your employer, through wage adjustments or otherwise, for any portion of the premium?  Yes  No
  - c. Will your health insurance plan be treated by you or your employer as part of a plan or program for the purposes of Section 106, 125 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106, 125 or 162)?  Yes  No

**Insurance Fraud** — Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

**APPLICATION DECLARATION & AGREEMENTS**

I, the undersigned Applicant and Spouse, if any, have personally completed this application and represent that the answers and statements in Sections I, II, III, and IV on this application are true, complete and correctly recorded and agree they will be used to determine my eligibility for coverage under the health insurance plan, indicated below (the "Plan"). I understand and agree that: 1) "Proposed Insured" means all persons named in questions 4 through 26; 2) all statements and answers in this application and in any supplements or amendments to it are complete and true; 3) I have inquired about and have personal knowledge of, the medical history of each Proposed Insured; 4) any incorrect or incomplete information on this application may result in loss of coverage or claim denial; 5) no insurance shall take effect unless the Policy is issued (or this application is made to change an existing Policy, unless the change is approved) and the Policy is actually delivered to the Proposed Insured and the first full premium paid during the lifetime and good health of all Proposed Insureds.

If any changes occur that affect the answers provided in Section IV above, I will notify and provide the Company with any evidence required by it to determine my future eligibility under the plan.

I understand and agree that:

- 1. a future change in my employment status may cause me to no longer be eligible for the Plan as of the date of coverage;
- 2. eligibility for the Plan does not constitute initial coverage under the Plan; and
- 3. initial coverage under the Plan is subject to the Company's underwriting criteria.

**ATTENTION APPLICANT:**

**After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded. I acknowledge receipt of an Outline of Coverage.**

Signed at \_\_\_\_\_ Date \_\_\_\_\_ Applicant's Signature \_\_\_\_\_  
City State

Soliciting Agent (Please Print) \_\_\_\_\_ Spouse's Signature \_\_\_\_\_

*For Agent: Each question on the application was completed by the applicant(s). I have personally witnessed/verified the reading, completion and signing of this application.*  Yes  No

*I have/have not collected the premiums as stated on the front of this application and have not left the applicant a Conditional Receipt.*

Soliciting Agent Signature \_\_\_\_\_ Personal Code/Writing No. \_\_\_\_\_ Field Office \_\_\_\_\_

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency, or an independent administrator, including medical record retrieval services, pharmaceutical services, acting on behalf of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY or its reinsurers behalf, information concerning advice, care or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claims examiners, reinsurers, attorneys or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it resulting in loss of protection by federal regulations. I understand that:

- (1) such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations.
- (2) I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage.
- (3) a picture copy or photocopy of this authorization shall be as valid as the original; and
- (4) any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months or until the person is no longer covered. I understand I may revoke the authorization at any time, except to the extent that actions have been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. I may inspect or copy any information used or disclosed under this authorization, if signed.

Date \_\_\_\_\_ Applicant's Signature \_\_\_\_\_  
Witness \_\_\_\_\_ Spouse Signature \_\_\_\_\_  
(if coverage is requested for Spouse)

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee representative, other \_\_\_\_\_ (Circle One)

**Agent's Section**

- a) How long have you known the Applicant? \_\_\_\_\_
- b) Who initiated the writing of this application?  Agent/Broker  Applicant
- c) As a field underwriter, do you have any additional information that you believe will be helpful in underwriting this case?  Yes  No
- d) As Agent/Broker, do you have any knowledge or reason to believe that replacement of existing insurance may be involved?  Yes  No
- e) As Agent/Broker, have you complied with State Replacement Regulations?  Yes  No

**Special Instructions To Home Office:**

Are Commissions to be Split 50/50?  Yes  No If yes, list both agents'/brokers' names and PC #'s:  
\_\_\_\_\_  
\_\_\_\_\_

Dated At \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, \_\_\_\_\_  
Soliciting Agent's/Broker's Signature  
Licensed Agent's/Broker's PC # \_\_\_\_\_ SS # \_\_\_\_\_ Branch Code \_\_\_\_\_  
Licensed Agent's/Broker's Fax # \_\_\_\_\_ Email Address \_\_\_\_\_  
Licensed Agent's telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

**Field Office Check List:**

- \* Has the application been reviewed for omissions and errors?  Yes  No  
If "Yes", by: (name) \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- \* Has the applicant signed the "Application Declaration & Agreements"?  Yes  No
- \* Have you printed, signed and dated the "Application Declaration & Agreements"?  Yes  No
- \* Have you left an Outline of Coverage with the applicant?  Yes  No
- \* If Pre-Authorized Check mode of payment, have you attached a voided sample check?  Yes  No
- \* Have you attached an initial premium of at least one month?  Yes  No
- \* If Preferred Risk Discount applied for, have you included form (ANL-2003a-1)?  Yes  No

**IMPORTANT NOTE TO AGENT**

**Do not collect any premium with this application, IF any proposed insured has:**

- 1. Within the past two years been diagnosed as having, or been treated for, heart disease, cancer, mental or nervous disorder, liver or kidney disease; or
- 2. Any medical condition or injury for which medical treatment or advice will be sought.

**Further, do not collect any premium with the application if,  
for any other reason in your best judgement, the Company would not want to issue the certificate**



**MODIFICATION OF HEALTH INSURANCE APPLICATION  
attached to Policy No.**

To STANDARD LIFE AND ACCIDENT INSURANCE COMPANY , Galveston, Texas:

I hereby agree that the application submitted by me for the Policy to which this modification Rider is attached be amended as follows:

This Amendment shall become a part of the Policy to which it is attached and be subject to the policy provisions.

Dated at \_\_\_\_\_ Date \_\_\_\_\_  
(City) (State)

Signed \_\_\_\_\_  
Applicant

Witness \_\_\_\_\_

In Witness, Whereof, STANDARD LIFE AND ACCIDENT INSURANCE COMPANY has caused this Amendment to be executed on the later of the Effective Date shown in the Schedule page of the Policy, or the Effective Date shown above.



Secretary



President

**EMPLOYEE CENSUS FORM**  
FOR  
STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Company Name: \_\_\_\_\_

Address : \_\_\_\_\_

Street

City

State

Zip Code

Mailing

Address: \_\_\_\_\_ ( ) \_\_\_\_\_ ( )

(If Different)

(Telephone Number)

(Fax Number)

Nature of Business: (Specific) \_\_\_\_\_

Type of Ownership:     Sole Proprietorship     Partnership     Corporation

Number of Employees: \_\_\_\_\_

I certify that the information furnished to the Company is correct and complete. I understand that the Company intends to rely on this information in determining the eligibility of the individual(s) who have made application for insurance. I further understand that the Company may periodically request information to determine continued eligibility and I agree to provide any information required for such determined.

By: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Please Print

Agent: \_\_\_\_\_ Agent Signature: \_\_\_\_\_  
Please Print

Agent Code: \_\_\_\_\_

# AUTOMATIC PAYMENT AUTHORIZATION

FOR THE PURPOSE OF HONORING CHARGES INITIATED BY  
STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
PRINT NAME OF DEPOSITOR AS IT APPEARS ON BANK RECORDS

Policy No. :	FULL NAME OF BANK	
Bank Acct. No. : BRANCH NAME AND NO. (IF ANY)	CITY AND STATE	TRANSIT NO. AND ROUTING SYMBOL

**To: STANDARD LIFE AND ACCIDENT INSURANCE COMPANY**

- (1) I hereby request and authorize either or each of you to draw on my checking account maintained at my bank, (named above) for the payment of monthly premiums on the above insurance policy. It is agreed that:  
You shall make such charge electronically or, at your discretion, in writing. It will not be necessary for your officer or employee of **STANDARD LIFE AND ACCIDENT INSURANCE COMPANY** to sign such items.
- (2) The issue and presentation for payment of such items shall be a waiver of any requirement for notices of premiums due. The cancelled check or other evidence of payment provided by my bank will constitute a premium receipt. The use of this plan shall in no way alter or amend the provisions of the policy with respect to termination of such policy upon non-payment of the premium due.
- (3) You shall incur no liability by reason of dishonor of any such item.
- (4) If this authorization pertains to a policy for which application is pending, it shall not become effective unless and until such policy is issued and delivered and shall relate only to premiums thereafter falling due.
- (5) If this authorization pertains to a policy previously issued, this shall constitute an election of this special mode of premium payment which shall continue in effect only so long as premiums are paid under this plan. Premiums will then revert to regular method payment, depending upon minimum premium requirements.
- (6) This agreement shall continue in effect unless terminated by you or me with 30 days written notice to the other party, except that you may terminate this agreement immediately if any item is not paid upon presentation.

**X**

DATE

BANK SIGNATURE OF DEPOSITOR

Make Checks Payable To:  
**Standard Life and Accident Insurance Company**

**ATTACHED AN UNSIGNED  
VOIDED CHECK**

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	16	15	14	13			

# AUTOMATIC PAYMENT AUTHORIZATION

FOR THE PURPOSE OF HONORING CHARGES INITIATED BY  
STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account items payable to the order of the Company, provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of the Company to sign any such item. I agree that your rights in respect to each such item shall be the same as if it were a check drawn to you and signed personally by me. I further authorize the Company to transmit such items to you electronically, if you are or become a member of the Automated Clearing House System, or in writing, if you are not such a member. I agree that all transactions shall be subject to the rules of the Automated Clearing House System. This authority is to remain in effect until revoke by me in writing, and until you actually receive such notice that I agree that you shall be fully protected in honoring such item.

I further agree that if any such item be dishonored, whether with or without cause and whether intentionally or inadvertently, neither you nor any bank participating under the Automated Clearing House Rules, shall be under any liability whatsoever even though such dishonor may result in the forfeiture of insurance.

Bank (You) \_\_\_\_\_ Name of Customer (me) \_\_\_\_\_  
Please Print

Branch \_\_\_\_\_ Bank Transit No. \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_ **X** \_\_\_\_\_  
CUSTOMER'S SIGNATURE

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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**To: THE BANK NAMED ON THE REVERSED SIDE**

So that you may comply with your depositor's authorization and direction as set forth on the reverse side hereof, the Company agrees:

- (1) To indemnify you and hold you harmless from any loss you may suffer as consequence of your actions resulting from or in connection with the execution, issuance, or transmission or any such item, whether or not genuine, purporting to be executed or transmitted by this Company and received by you in the regular course of business for the purpose of payment of such insurance premiums, including any costs or expenses reasonably incurred in connection therewith.
- (2) In the event that any such check shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in a forfeiture of the insurance.
- (3) To defend at our own cost and expense, any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY  
(THE COMPANY)



Secretary