ACCIDENT EXPENSE INSURANCE

Insured by Loyal American Life Insurance Company

Application Booklet for INDIANA

- APPLICATION
- ELECTRONIC FUNDS TRANSFER AGREEMENT
- HIPAA NOTICE
- REPLACEMENT NOTICE

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ACCIDENT EXPENSE INSURANCE

Insured by Loyal American Life Insurance Company
PO Box 559015, Austin, TX 78755-9015 • (866) 459-4272

Primary Applicant's Name _____
PV Case # _____

Indiana Application for Insurance

Section A. Accident Expense Coverage Options

1. Applying for: ☐ New Coverage ☐ Reinstatement ☐ Change in Benefit Coverage
   ☐ Add Rider(s) to existing policy* ☐ Add Dependent(s) to existing policy*
   *Policyowner's Name _____
2. Requested Effective Date _____

Section B. Applicant(s) applying for coverage: For Accident Expense coverage, the maximum age for Applicants applying for coverage is up to age 74. Children are eligible for coverage up to age 26. The Primary Applicant and Spouse's parent(s) are eligible to apply for coverage from age 40 to age 74.

Last Name	First Name	M. I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
Primary Applicant					☐ Male ☐ Female	
Spouse					☐ Male ☐ Female	
Child 1					☐ Male ☐ Female	
Child 2					☐ Male ☐ Female	
Child 3					☐ Male ☐ Female	
Child 4					☐ Male ☐ Female	
Parent 1					☐ Male ☐ Female	
Parent 2					☐ Male ☐ Female	

Section C. Primary Applicant's Information

Home Address Required:

Street/PO Box

City State ZIP Code

Mailing Address *(if different from Home Address):*

Street/PO Box

City State ZIP Code

Preferred Email Address

Cell Phone ( ) Home Phone ( ) Work Phone ( )

Primary Applicant's marital status: ☐ Married ☐ Single

If Primary Applicant is a Minor, the Parent or Guardian must complete the following information:

Parent/Guardian's Last Name	Parent/Guardian's First Name	M. I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
					☐ Male ☐ Female	

ACCIDENT EXPENSE INSURANCE

Insured by Loyal American Life Insurance Company Primary Applicant's Name _____

Section D. Premium Payment Method

Select one of the following:

☐ Electronic Funds Transfer (Bank Draft) *(complete the Electronic Funds Transfer Authorization form)*
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ Direct Bill
Premium Mode: ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ List Bill
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually ☐ 26 Pay ☐ 52 Pay

Group Name _____ Group Number _____ Is this a Section 125? ☐ Yes ☐ No

Section E. Benefit Selection

Accident Policy

Enter Benefit Amount $_____

Enter Deductible Amount $_____

Base Modal Premium $_____

Optional Riders Selection *(for additional premium)*

☐ **Parent Rider** *(issue ages 40-74)* **Rider Modal Premium $**_____
(if applying, the Parent Rider benefit amount is equal to the Accident Only Policy benefit amount selected above)

☐ **Declining Deductible Rider** *(not available with Child Only Policies)* **Rider Modal Premium $**_____
(only available with selected Accident Deductible Amounts between $100 and $1,000)

☐ **Catastrophic Accidental Injury Rider** *(maximum issue age 74)* **Rider Modal Premium $**_____
(not available to individuals covered under the Parent Rider or with Child Only policies)

☐ **Vehicular Accidental Injury Cash Benefit Rider** *(issue ages 25-64)* **Rider Modal Premium $**_____
(not available to individuals covered under the Parent Rider)
Enter Benefit Amount $_____

☐ **Critical Illness Rider** *(maximum issue age 70)* **Rider Modal Premium $**_____
(not available to individuals covered under the Parent Rider or with Child Only policies)
Enter Benefit Amount $_____

Total Optional Riders Modal Premium $_____

☐ Sold with a new or existing Qualifying Individual Product

☐ Draft Bank Account for First Premium ☐ Check Enclosed *(make checks Payable to **Loyal American Life Insurance Company**)*

Total Base and Optional Riders Modal Premium $_____

Section F. Prior or Other Coverage

	YES	NO
Is the Insurance applied for here intended to replace any existing or pending accident or sickness insurance?	☐	☐

If YES, please provide the following (and complete the Replacement Form):

Note: An Accident Expense policy is not an appropriate replacement for other health and sickness policy types.

Name of Company _____ **Policy Number** _____

ACCIDENT EXPENSE INSURANCE

Insured by Loyal American Life Insurance Company

Primary Applicant's Name _____

Section G. Health History Information

Applicants applying for the Critical Illness Benefit Rider must answer questions 1 – 6 listed below:

	YES	NO
1. Have you or your Spouse utilized tobacco within the past five (5) years? ..... If YES, please indicate who has used tobacco: ☐ Primary Applicant ☐ Spouse	☐	☐
2. Within the last five (5) years, has any Applicant been diagnosed with or received medical advice or treatment for: a. cancer including carcinoma in situ, internal cancer, blood cancer, melanoma, or other malignant tumor? ..... If YES, who? _____ *(Any Applicant named will be excluded from coverage under this rider.)*	☐	☐
b. disease or disorder of the heart, including heart valves (excluding mitral valve prolapse) or circulatory system (other than high blood pressure), stroke, Transient Ischemic Attack, aneurysm, blood clot, or insulin-dependent diabetes? ..... If YES, who? _____ *(Any Applicant named will be excluded from coverage under this rider.)*	☐	☐
3. Within the last five (5) years, has any Applicant been advised to have a diagnostic test(s) related to cancer which have not been completed or for which results have not been received or are other than normal? ..... If YES, who? _____ *(Any Applicant named will be excluded from coverage under this rider.)*	☐	☐
4. Within the last six (6) months, has any Applicant had or been advised to have diagnostic testing performed to evaluate symptoms of chest pains, shortness of breath, blackouts, fainting, or dizziness? ..... If YES, who? _____ *(Any Applicant named will be excluded from coverage under this rider.)*	☐	☐
5. Within the last five (5) years, has any Applicant been prescribed three (3) or more medications (not including a potassium supplement) to be taken concurrently to control high blood pressure? ..... If YES, who? _____ *(Any Applicant named will be excluded from coverage under this rider.)*	☐	☐
6. Within the last five (5) years, has any Applicant been diagnosed with or received medical advice or treatment from a Physician or an appropriately-licensed clinical professional acting within the scope of their license for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection? ..... If YES, who? _____ *(Any Applicant named will be excluded from coverage under this rider.)*	☐	☐

Section H. Beneficiary Information: Please provide beneficiary information for the Primary Applicant and Spouse, if applicable. The Primary Applicant will automatically be named the beneficiary for Child(ren) named in the Application. The Parent or Guardian will automatically be named the beneficiary if the Primary Applicant is a minor.

Applicant Name	Name of Beneficiary	Date of Birth (MM/DD/YYYY)	Relationship to Applicant	Primary or Contingent	Percentage of Benefit

Section I. Important Coverage Information

Loyal American Life Insurance Company may decline coverage under the Critical Illness Benefit Rider for any of the Applicants identified on this Application based on answers to questions about current or past health status. Loyal will provide coverage to all eligible family members unless otherwise instructed as noted below:

☐ I, the Primary Applicant, instruct that Loyal not provide coverage to any eligible Applicants unless ALL family members are approved for coverage.

OR ☐ I, the Primary Applicant, instruct Loyal to provide coverage for all approved Applicants if an Applicant is declined coverage.

ACCIDENT EXPENSE INSURANCE

Insured by Loyal American Life Insurance Company Primary Applicant's Name _____

Section J. Policyowner's Statements and Agreements

I hereby apply to Loyal American Life Insurance Company for insurance coverage to be issued based upon the truth and completeness of the answers to the above questions and understand and agree that: (1) no Agent has the authority to waive the answer to any questions on the Application; (2) no insurance will be effective until (a) this signed Application has been accepted upon review of the answers I have provided and any medical information reviewed by Loyal, (b) the initial premium has been paid, and (c) a contract has been issued by Loyal American Life Insurance Company; and (3) I have received the Outline of Coverage for the policy applied for, the Replacement Notice form, if applicable, and, if eligible for Medicare, the required Guide to Health Insurance for People with Medicare.

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

The Primary Applicant must sign and date, acknowledging their understanding and agreement to the conditions listed herein. The above statements are true and complete. I understand and agree that for all Applicants these statements shall be the basis for determination of acceptance for coverage under my applicable Loyal policy. I acknowledge and agree that any material misrepresentation or material omission of any Applicant may render this contract null and void from its date of issue in accordance with applicable law. If coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. Loyal will return all paid premiums and fees less any claim payments.

As an alternative to court action, any matter in dispute between me and the Company may be subject to binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction.

Any Applicant who is currently covered by Medicaid should not purchase this coverage.

Primary Applicant's Signature or Parent or Guardian if Applicant is a minor (Policyowner)	Today's Date (MM/DD/YYYY)

Section K. Agent(s) Certification

Agent shall list any health insurance policies they have sold to the Primary Applicant.

1. List policies sold which are still in force (if this does not apply, state "None") _____
   _____
2. List policies sold in the past five (5) years which are no longer in force (if this does anot apply, state "None") _____
   _____

	YES	NO
3. Have you submitted any Applications or have knowledge of any Applications submitted for the Primary Applicant that have been declined? ..... If YES, please explain _____ _____	☐	☐
4. Have you reviewed the Application for correctness and omissions?	☐	☐
5. Was the Application completed by you in the Primary Applicant's physical presence?	☐	☐
6. Was the Application completed by you over the phone?	☐	☐
7. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?	☐	☐

8. I certify that I have provided the Primary Applicant with the following documents:
   a. Application Packet *(Phone Sales only)* b. Outline of Coverage c. Other _____
   I further certify that I have delivered the documents to the Primary Applicant *(check all that apply; must select at least one)*:
   ☐ In person *Date* _____ ☐ Mail *Date* _____ ☐ Email *Date* _____ ☐ Fax *Date* _____
   ☐ Other *(explain)* _____ *Date* _____

I certify that I have interviewed the Primary Applicant, asked all of the questions as written on the Application, and I have truly and accurately recorded on the Application the information supplied to me by the Primary Applicant.

Printed Name of Licensed Agent	Signature of Licensed Agent	Writing Number	Percentage
Printed Name of 2nd Licensed Agent	Signature of 2nd Licensed Agent	Writing Number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

LOYAL AMERICAN LIFE INSURANCE COMPANY® • PO BOX 559015 • AUSTIN, TX 78755-9015

Proposed Insured's Name		Policy Number (if available)
Financial Institution Name and Telephone Number		
Financial Institution Address		
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization
☐ Change in financial institution
☐ Change in checking/savings account
☐ Change in existing coverage

For Checking Account: Please tape a VOIDED check in this box.

For Savings Account: Please attach a letter from the bank stating the account and routing number of your savings account.

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Loyal American Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Loyal American Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Loyal American Life Insurance Company mistakenly deposits funds into my account, I authorize Loyal American Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR LOYAL AMERICAN LIFE INSURANCE COMPANY: It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Loyal American Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Loyal American Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Loyal American Life Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured) **Payor's Address**

Print name of Depositor (as it appears on account) **Signature of Depositor** **Date**

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company®; or Central Reserve Life Insurance Company; or Loyal American Life Insurance Company®; or Provident American Life & Health Insurance Company.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 26580, Austin, Texas 78755-0580.
5. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
6. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
8. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

Applicant's Name

Name of Applicant's Personal Representative, if applicable

Applicant's Social Security Number

Relationship of Personal Representative to the Applicant

Signature of Applicant **Date**

Signature of Personal Representative **Date**

Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

Loyal American Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015 • Toll Free: 866-459-4272

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy provides 30 days in which you may decide, without cost, whether or not you decide to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1) Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's Signature

ACCIDENT EXPENSE INSURANCE

Insured by Loyal American Life Insurance Company

Customer Booklet for INDIANA

- OUTLINE OF COVERAGE
- IMPORTANT NOTICE TO PERSONS ON MEDICARE
- REPLACEMENT NOTICE

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Loyal American
Life Insurance Company®
PO Box 26580, Austin, TX 78755-0580
Toll Free: 866-459-4272

OUTLINE OF COVERAGE FOR ACCIDENT EXPENSE POLICY FORM LY-ACC-BA-B-IN

THIS POLICY PROVIDES LIMITED BENEFITS.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

If an Insured Person is eligible for Medicare, please review the "*Guide to Health Insurance for People with Medicare*" which is available from the Company.

1. ***READ YOUR POLICY CAREFULLY!*** This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance policy and only the actual provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth, in detail, those rights and obligations applicable to both You and LOYAL AMERICAN LIFE INSURANCE COMPANY. It is very important therefore, that you READ YOUR POLICY CAREFULLY.

2. ***ACCIDENT ONLY*** Accident-only coverage is designed to provide, to person insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3. ***BENEFITS PROVIDED BY THE POLICY***

PAYMENT CONDITIONS

We will pay the benefits for covered services listed under Accident Benefits below, subject to the conditions, amounts, exclusions, limitations, and Deductible stated in this policy. The Maximum Annual Benefit Amount and Deductible are shown on the Policy Schedule Page.

Payment of benefits is subject to all of the following conditions:

(1) The Covered Injury and Care occurs on or after the Insured Person's Effective Date of coverage and while this policy is in force;

(2) Care must begin within the Initial Treatment Period, as shown on the Policy Schedule Page;

(3) Care for the Covered Injury is received within the United States;

(4) The Maximum Annual Benefit Amount is not exhausted; and

(5) The benefit payment is not precluded by any general or specific exclusion, limitation, condition, description, definitions, or any failure to meet any requirement stated in this policy.

We may require that a Physician of our choice review any Diagnosis in the event of a dispute or disagreement regarding the appropriateness or correctness of a Diagnosis. We also may require that an Insured Person submit to an examination to confirm a disputed Covered Injury. We may request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed Diagnosis. We will pay for any such requested examination or review.

ACCIDENT BENEFITS

Maximum Annual Benefit Amount

Your Maximum Annual Benefit Amount represents the total dollar benefit amount available per Insured Person under this policy for covered services rendered each calendar year. The Policy Schedule Page shows the Maximum Annual Benefit Amount You selected. Your Maximum Annual Benefit Amount will be reduced by all benefit amounts paid. The Maximum Annual Benefit Amount will not be reduced by the Deductible. On January 1st of each year, We will restore Your Maximum Annual Benefit Amount to the full amount shown on the Policy Schedule Page.

Deductible

The Deductible is the dollar amount that must be paid in full by You each calendar year (for either an individual or a family) before any benefits are payable by Us. The Individual Deductible Amount shown on the Policy Schedule Page must be satisfied by each Insured Person.

For family coverage, which means two (2) or more Insured Persons, all payments applied to each Insured Person's Individual Deductible Amount will be applied toward the Family Deductible Amount. The Family Deductible Amount shown on the Policy Schedule Page is equal to two (2) times the Individual Deductible Amount. No Insured Person will contribute more than the Individual Deductible Amount to the Family Deductible Amount which means that two (2) or more Insured Persons must contribute to the Family Deductible Amount. When the Family Deductible Amount is paid in full, no further Individual Deductible Amounts will have to be satisfied for the remainder of the calendar year.

Covered Services

We will pay for the covered services listed below, not to exceed the Maximum Annual Benefit Amount shown in the Policy Schedule Page, when We receive due proof of the expenses that an Insured Person, as a patient, is charged. The following criteria must all be met for any benefits to be payable:

(1) the Deductible under this policy, if applicable, must be satisfied;

(2) any applicable provider network discounts and any other billing adjustments, under any applicable medical or health plan, must be applied to the billed charges;

(3) the covered services rendered must be due to a Covered Accident; and

(4) Care must begin within the Initial Treatment Period as shown on the Policy Schedule Page. If no treatment for the Covered Injury is rendered within the Initial Treatment Period, any subsequent charges for treatment of the Covered Injury are not eligible for benefits under this policy.

Ambulance

We will pay charges incurred for transportation of an Insured Person in an ambulance to a Hospital or Emergency Room by a licensed ambulance company. This benefit is only payable for transportation to a Hospital or Emergency Room for Care resulting from a Covered Accident, subject to the Maximum Annual Benefit Amount.

Drugs

We will only pay charges incurred for drugs that are administered in a Hospital, Emergency Room, Urgent Care Center, or Physician's office during the Care given for a Covered Accident, subject to the Maximum Annual Benefit Amount. There is no payment for a drug prescribed to be taken or used after the initial Care.

Durable Medical Equipment

We will pay charges incurred for the rental or purchase of Durable Medical Equipment that has been prescribed by a Physician within ninety (90) days of the Covered Accident, subject to the Maximum Annual Benefit Amount. Coverage for a rental item will not exceed the purchase price.

Emergency Care Services
We will pay charges incurred for emergency care services incurred within the first ninety (90) days following a Covered Accident, subject to the Maximum Annual Benefit Amount, if the services satisfy all of the following conditions, which are:

(1) given for Care of a Covered Injury;

(2) performed by a Physician;

(3) received in a Hospital, an Emergency Room, Urgent Care Center, or Physician's office; and

(4) not psychiatric treatment.

Follow-up Care Services
We will pay charges incurred for follow-up care services if an Insured Person requires additional Care after emergency care services were rendered, subject to the Maximum Annual Benefit Amount. Benefits will be payable if all of the following conditions are met:

(1) must occur within ninety (90) days of the Covered Accident or discharge from the Hospital;

(2) is limited to one (1) follow-up visit per day, not to exceed a maximum of ten (10) follow-up visits, per Insured Person for each Covered Accident;

(3) must be provided by a Physician in a Physician's office or in a Hospital on an Outpatient basis; and

(4) cannot be on the same day emergency care services were received.

Major Diagnostic Exams
We will pay charges incurred for Major Diagnostic Exams, if an Insured Person requires any of the exams listed below to render a Diagnosis for a Covered Injury sustained in a Covered Accident, subject to the Maximum Annual Benefit Amount. This benefit is limited to two (2) Major Diagnostic Exams per Covered Accident. The exam must be performed within ninety (90) days of the Covered Accident and be any of the following:

(1) Computerized Tomography (CT or CAT) scan;

(2) Magnetic Resonance Imaging (MRI);

(3) Magnetic Resonance Angiography (MRA);

(4) Positron Emission Tomography (PET) scan; or

(5) Electroencephalogram (EEG).

Prosthetic Devices
We will pay charges incurred if an Insured Person receives a Prosthetic Device prescribed by a Physician for functional purposes when such Insured Person suffers the Loss of a Hand, Foot, Arm, Leg, or Speech due to a Covered Accident, subject to the Maximum Annual Benefit Amount. This benefit is limited to one (1) Prosthetic Device per severed limb received within one (1) year of the Covered Accident.

Coverage for repair, replacement, or duplicate equipment is not provided.

Rehabilitative Therapy
We will pay charges incurred if an Insured Person is advised by a Physician to seek and subsequently receives Rehabilitative Therapy as the result of a Covered Accident, subject to the Maximum Annual Benefit

Amount. Benefits are limited to one (1) Rehabilitative Therapy visit per day, not to exceed ten (10) visits for each Covered Accident. Rehabilitative Therapy benefits will be payable if all of the following conditions are met:

(1) Rehabilitative Therapy is prescribed by a Physician;

(2) is provided by a licensed or certified physical, occupational or speech therapist or licensed chiropractor in an office or Hospital on an Inpatient or Outpatient basis;

(3) begins within thirty (30) days of the Covered Accident or discharge from the Hospital; and

(4) is completed within six (6) months after the Covered Accident.

Surgery
We will pay charges incurred related to surgery, including but not limited to the surgeon, assistant surgeon, second opinion, anesthesia, supplies, and surgery facility charges, subject to the Maximum Annual Benefit Amount. The surgery must be Medically Necessary as a result of the Covered Accident. Surgeries can be performed in a Hospital, Emergency Room, Physician's office or an appropriate Outpatient facility. Benefits are limited to surgeries occurring within the initial ninety (90) days following a Covered Accident.

Tests and X-rays
We will pay charges incurred for tests and x-rays required as a result of the Covered Accident. Tests and x-rays must be performed within ninety (90) days of the Covered Accident, subject to the Maximum Annual Benefit Amount. Benefits will be payable only for the tests listed below:

(1) blood tests;

(2) echocardiography;

(3) electrocardiography (EKG); and

(4) ultrasound.

This benefit is limited to a combined ten (10) tests and x-rays per Covered Accident. If two (2) or more x-rays are performed on one (1) joint or body part during the same day, they will be considered one (1) x-ray for the purpose of determining this limit.

ACCIDENTAL DEATH BENEFIT
If an Insured Person dies as a direct result of a Covered Accident, We will pay the Accidental Death Benefit Amount shown on the Policy Schedule Page for the applicable deceased Insured Person if all of the following requirements are met:

(1) Accidental Death occurs on or after the Insured Person's Effective Date of coverage and while this policy is in force;

(2) We receive due Proof of Loss of the Insured Person's death;

(3) the Proof shows that death resulted directly from a Covered Injury caused solely as a result of a Covered Accident;

(4) Accidental Death occurred within the first ninety (90) days after the Covered Accident; and

(5) the benefit payment is not precluded by any general or specific exclusion, description, definitions, or any failure to meet any requirement stated in this policy.

ACCIDENTAL DISMEMBERMENT BENEFIT

We will pay an Accidental Dismemberment Benefit to You, depending on the type of dismemberment as shown on the Policy Schedule Page, if all of the following requirements are met:

(1) the Covered Accident and Accidental Dismemberment occur on or after the Insured Person's Effective Date of coverage and while this policy is in force;

(2) the first treatment or medical evaluation for the Accidental Dismemberment occurs within the Initial Treatment Period shown on the Policy Schedule Page;

(3) Care for the Covered Injury is received within the United States;

(4) the Accidental Dismemberment occurs within ninety (90) days of the date the Covered Accident occurred; and

(5) The benefit payment is not precluded by any general or specific exclusion, description, definitions, or any failure to meet any requirement stated in this policy.

The Accidental Dismemberment Benefit will be paid even if the severed body part is subsequently reattached.

Only Accidental Dismemberments shown on the Policy Schedule Page are eligible for benefits under this policy. Any dismemberment not listed on the Policy Schedule Page is not eligible for Accidental Dismemberment Benefits under this policy. No more than two (2) benefit amounts will be paid per lifetime per Insured Person under this policy. For purposes of this policy, irrevocable Loss of Speech, Loss of Hearing in both ears, or Loss of Vision due to a Covered Accident is eligible for Accidental Dismemberment Benefits as shown on the Policy Schedule Page.

4. EXCLUSIONS AND LIMITATIONS

In addition to any benefit-specific conditions, limitations, or exclusions, benefits will not be paid for any Covered Accident and/or Covered Injury which directly or indirectly, in whole or in part, is caused by or results from any of the following, unless coverage is specifically provided for by name in the applicable policy section:

(1) suicide (while sane or insane), attempted suicide, or intentionally self-inflicted injury;

(2) war or act of war (whether declared or undeclared);

(3) commission or attempt to commit an illegal activity or a felony;

(4) commission of or active participation in a riot, insurrection, rebellion or police action;

(5) active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any Premium paid during the Insured Person's time of active duty. Reserve or National Guard active duty training is not excluded, unless it extends beyond thirty-one (31) days;

(6) voluntary self-administration of any narcotic, drug, poison, gas, or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;

(7) operating any type of vehicle while under the influence of alcohol or any drug, narcotic, or other intoxicant. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated as defined by the law of the state in which the Covered Accident or Covered Injury occurred;

(8) mental or emotional disorders, alcoholism, and drug addiction;

(9) treatment outside the United States unless otherwise specified in the policy;

(10) travel or activity outside the United States;

(11) participation in any motorized race or contest of speed on sea, land, or air;

(12) travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;

(13) intoxication as determined according to the laws of the jurisdiction in which the Covered Accident and/or Covered Injury occurred;

(14) participation in any high-risk activities such as bungee jumping, parachuting, skydiving, parasailing, hang-gliding, deep-sea scuba diving, parkour, free running, sail gliding, parakiting, or any similar activity;

(15) flight in, boarding, or alighting from an aircraft or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly-scheduled commercial or charter airline;

(16) medical mishap or negligence, including malpractice;

(17) sickness, disease, bodily or mental infirmity, bacterial or viral infection, or any condition resulting from insect, arachnid, or other arthropod bites or stings, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;

(18) practicing for or participating in any semi-professional or professional competitive athletic contest for which such Insured Person receives any compensation or remuneration; or

(19) operating a motor vehicle without a valid motor vehicle operator's license, except while participating in a driver's education program.

The following conditions, treatment, and/or services are **not covered** in the Policy:

(1) care, services or supplies received without charge or legal obligation to pay;

(2) prescription and over-the-counter products, drugs, or medicines, even if prescribed by a doctor except as described in the policy;

(3) cosmetic services, treatment that is not Medically Necessary, or treatment, services and supplies for Experimental, Investigational or Unproven purposes;

(4) dental treatment of the teeth, gums, or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints, and services for dental malocclusion for any condition are not covered, except if provided for or in connection with a Covered Injury to sound natural teeth and a continuous course of dental treatment is started within six (6) months of the Covered Injury. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch;

(5) treatment or services from a masseur, massage therapist, or rolfer, massage therapy and any type of holistic therapy which include, but are not limited to, meditation, aromatherapy and relaxation therapy; or

(6) repetitive or cumulative motions or stress traumas, which include, but are not limited to, carpal tunnel syndrome, tennis elbow, and thoracic outlet syndrome.

5. *TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED*

GUARANTEED RENEWABLE TO AGE 80 - This policy is guaranteed renewable for each Insured Person until the next premium due date after each Insured Person's eightieth (80th) birthday. We cannot cancel or refuse to renew this policy for any reason other than nonpayment of premium. At no time while You continue this policy in force may We place any restrictive Riders on it without Your permission.

6. ***OPTIONAL BENEFIT RIDERS (additional Premiums required)*** **-** A checkmark in any of the boxes below indicates that You have selected the following optional coverage(s):

☐ ***DECLINING DEDUCTIBLE BENEFIT RIDER (LY-DED-RD)***

Your Deductible will decrease by twenty-five percent (25%) on January 1 of each calendar year Your policy is in force if no claims for covered services rendered were payable in the preceding calendar year. Your policy must be in force for at least six (6) full months before the first adjustment to the Deductible will occur. If any claims were payable during a calendar year in which Your Deductible had been previously adjusted, Your Deductible will adjust on the following January 1 to either the original amount in force on the Policy Effective Date or the amount in force for the preceding calendar year, whichever is lower. The twenty-five percent (25%) adjustment is based on the original Deductible amount at policy issue, not on the balance of the Deductible remaining after an adjustment. If no claims are payable in four (4) consecutive calendar years, Your Deductible will be eliminated beginning with the next calendar year. Once Your Deductible reaches zero dollars ($0), it will not change or adjust further, provided that this Rider remains in force and premiums continue to be paid.

Declining Deductible Examples

The examples below illustrate how an initial $500 Deductible might adjust under the Declining Deductible Rider.

Year	1	2	3	4	5	6	7	8	9
No Claim	$500	$375	$250	$125	$0	$0	$0	$0	$0
Claim: Year 2	$500	$375	$500	$375	$250	$125	$0	$0	$0
Claim: Year(s) 4 & 5	$500	$375	$250	$125	$250	$375	$250	$125	$0

Conditions for the Declining Deductible Benefit

The Declining Deductible Benefit will only apply if the Rider is in force. If You cancel this Rider, Your original issue Deductible amount will be reinstated.

Exclusions and Limitations

The exclusions and limitations that apply to this Rider are the same as the Exclusions and Limitations of the Policy.

☐ ***CATASTROPHIC ACCIDENTAL INJURY BENEFIT RIDER (LY-CAT-RD)***

We will pay the Catastrophic Accidental Injury Benefit Amount, as shown on the Policy Schedule Page, in a lump-sum to You for an Insured Person's Covered Loss while coverage is in force under this Rider, subject to the Conditions for the Catastrophic Accidental Injury Benefit as defined below and any terms, conditions, limitations, and exclusions set forth in this Rider and the base Policy.

Conditions for the Catastrophic Accidental Injury Benefit
The Catastrophic Accidental Injury Benefit will only be payable if all of the following conditions are met:

(1) the Insured Person suffers a Covered Loss that results directly, independent from all other causes, from a Covered Accident;

(2) the Covered Accident occurs after the Rider Effective Date;

(3) the first treatment or medical evaluation for the Covered Accident resulting in the Covered Loss occurs within the Initial Treatment Period shown on the Policy Schedule Page;

(4) the Covered Loss occurs within ninety (90) days of the Covered Accident; and

(5) a Physician determines the Covered Loss has been sustained throughout the Catastrophic Accident Waiting Period as shown on the Policy Schedule Page.

If the Insured Person experiences more than one (1) Covered Loss related to the same Covered Accident, We will only pay one (1) Catastrophic Accidental Injury Benefit Amount for all Covered Losses.

No benefits will be paid for a Covered Loss that is not sustained throughout the Catastrophic Accident Waiting Period.

No more than one (1) Catastrophic Accidental Injury Benefit Amount will be paid per lifetime per Insured Person under this Rider.

Exclusions and Limitations
This Rider is subject to the following Exclusions and Limitations, in addition to those outlined in the Policy.

No benefits will be payable under this Rider for:

- a Covered Loss that is not sustained throughout the Catastrophic Accident Waiting Period, as shown on the Policy Schedule Page.

☐ ***VEHICULAR ACCIDENTAL INJURY CASH BENEFIT RIDER (LY-VEH-RD)***

We will pay the Vehicular Accidental Injury Cash Benefit Amount shown on the Policy Schedule Page, in one lump-sum payment to You, if all of the following conditions are met:

(1) the Insured Person suffers a Covered Injury that results, directly and independently of all other causes, from a Covered Vehicular Accident while driving, riding as a passenger in, or getting in or out of, a Private Passenger Automobile, Motorcycle, or Boat;

(2) the Covered Injury results within thirty (30) days of a Covered Accident;

(3) the Insured Person is under the appropriate Care of a Physician for the Covered Injury sustained in a Covered Vehicular Accident;

(4) the Insured Person has satisfied the Vehicular Accidental Injury Cash Benefit Waiting Period;

(5) due proof is submitted to Us showing that the Covered Vehicular Accident was reported to police or any other appropriate law enforcement agency; and

(6) satisfactory evidence, as determined by Us, shows that the Insured Person's Covered Injury resulted directly from the Covered Vehicular Accident. Evidence may include information on the claim form and applicable police or any other appropriate law enforcement agency report.

Exclusions and Limitations
This Rider is subject to the following Exclusions and Limitations in addition to those outlined in the policy:

(1) Benefits will not be paid if the Insured Person was the driver, operator, or passenger and was not wearing a helmet as required by the laws of the state in which the Covered Vehicular Accident occurred.

(2) Benefits will not be paid if the Insured Person was the driver, operator, or passenger and was not wearing a seatbelt as required by the laws of the state in which the Covered Vehicular Accident occurred.

(3) Benefits will not be paid for a Covered Vehicular Accident that occurs during the Vehicular Accidental Injury Cash Benefit Waiting Period, as shown on the Policy Schedule Page.

(4) No more than one Vehicular Accidental Injury Cash Benefit Amount will be paid per the lifetime of each Insured Person.

☐ ***PARENT BENEFIT RIDER (LY-PRT-RD)***

The benefits as described in Section 3: Benefits Provided By The Policy, specifically the Accident Benefits, Accidental Death Benefit, and Accidental Dismemberment Benefit, will be paid for a Parent subject to the Maximum Annual Benefit Amount and the applicable Deductible amount.

Exclusions and Limitations
The exclusions and limitations that apply to this Rider are the same as the Exclusions and Limitations of the Policy.

☐ ***CRITICAL ILLNESS BENEFIT (LY-CRI-RD)***

We will pay the Critical Illness Benefit Amount shown on the Policy Schedule Page to You in one lump-sum payment, subject to the Diagnostic Requirements and Benefit Payment Conditions discussed below, for an Insured Person's Diagnosis of any of the Covered Critical Illnesses under this Rider. No more than one (1) Critical Illness Benefit Amount will be paid per lifetime per Insured Person. The Covered Critical Illness must be Incurred (or Manifest) and be Diagnosed after the Critical Illness Waiting Period expires and while coverage is in force, subject to the definitions, terms, conditions, limitations, and exclusions set forth in this Rider and the Policy.

We may require You to undergo a physical examination to review Your Diagnosis by a Physician of Our choosing. This Physician must:

(1) have specialty training and board certification in the field of medicine specific to the Covered Critical Illness being Diagnosed; and

(2) must follow all routinely-accepted procedures and protocols in the Diagnosis of the Covered Critical Illness.

DIAGNOSTIC REQUIREMENTS

Invasive Cancer Diagnostic Requirements
Invasive Cancer must be Diagnosed by Pathological Diagnosis. The date of Diagnosis is the date the tissue specimen, blood sample(s), and/or titer(s) are taken on which the Diagnosis of Invasive Cancer is based.

A Clinical Diagnosis will be accepted only if:

(1) a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;

(2) there is medical evidence to support the Diagnosis; and

(3) a Physician is treating the Insured Person for Invasive Cancer.

Heart Attack Diagnostic Requirements
The date of Diagnosis is the date that all of the following criteria for myocardial infarction are met and documented by a licensed Physician who is trained and qualified in cardiovascular diseases:

(1) typical clinical symptoms such as chest pain, shortness of breath, sweating, nausea, or vomiting;

(2) electrocardiographic (EKG) changes indicative of myocardial infarction such as pathologic Q waves or ST-segment elevation or depression; and

(3) elevation of standard biochemical markers indicating myocardial necrosis.

In the event of death, an autopsy confirmation and/or death certificate identifying myocardial infarction as the cause of death will be accepted.

Stroke Diagnostic Requirements
The date of Diagnosis for a Stroke is the date a Stroke occurred, as documented by a licensed Physician who is trained and qualified in neurovascular diseases, and is based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic studies, or the date of the first onset of new neurological deficits persisting for a period of at least thirty (30) days.

The Diagnosis must be supported by:

(1) permanent neurological deficit with persisting clinical symptoms confirmed by a Physician at least thirty (30) days after the initial event; and

(2) confirmatory neuroimaging studies such as MRI, CT, or similar imaging study consistent with the Diagnosis of a new Stroke, if performed.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

BENEFIT PAYMENT CONDITIONS
The Critical Illness Benefit will only be payable if all of the following conditions are satisfied:

(1) the date of Diagnosis occurs while the Insured Person's coverage under this Rider is in force;

(2) it is the first Diagnosis of the Covered Critical Illness under this Rider following the Insured Person's Rider Effective Date;

(3) the date of Diagnosis occurs after the Critical Illness Waiting Period;

(4) the Covered Critical Illness satisfies the Rider definition for that condition; and

(5) payment is not precluded by any general or specific exclusion or limitation set forth in the Policy or this Rider or by any failure to meet any condition set forth in the Policy.

Exclusions and Limitations
This Rider is subject to the following Exclusions and Limitations, in addition to those outlined in the Policy.

No benefits will be payable under this Rider for:

(1) conditions Diagnosed outside of the United States, unless the Diagnosis is confirmed by a Physician in the United States;

(2) any illness, loss, or condition specifically excluded from the Rider definition of any Covered Critical Illness;

(3) any Covered Critical Illness that was Incurred, Manifested, or Diagnosed prior to an Insured Person's Rider Effective Date; or

(4) any Covered Critical Illness Incurred, Manifested, or Diagnosed during the Critical Illness Waiting Period, as shown on the Policy Schedule Page.

7. YOUR TOTAL ANNUAL PREMIUM (at time of Application)

The modal premiums for the coverage(s) outlined above are:

	AGE	LY-ACC-BA-IN Policy	LY-DED-RD Rider	LY-CAT-RD Rider	LY-VEH-RD Rider	LY-PRT-RD Rider	LY-CRI-RD Rider
Primary Applicant							
Spouse							
Child							
Child							
Child							
Child							
Parent							
Parent							
Total Premium		$	$	$	$	$	$

(Please attach a separate sheet if needed.)

8. BINDING ARBITRATION PROVISION **–** Your Policy contains a Binding Arbitration Provision which may affect your rights. Please read your Policy and all attached Riders carefully.

LOYAL AMERICAN LIFE INSURANCE COMPANY®
PO Box 26580 • Austin, Texas 78755-0580

ACCIDENTAL INJURY INSURANCE POLICY
MEDICARE DUPLICATION NOTICE

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Loyal American Life Insurance Company®
PO Box 559015, Austin, TX 78755-9015 • Toll Free: 866-459-4272

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Loyal American Life Insurance Company®. Your new policy provides 30 days in which you may decide, without cost, whether or not you decide to keep this policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1) Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's Signature

New Business Submission Form/FaxApp

To: Cigna Supplemental Benefits **Fax #: 877-704-8186**

AGENT INFORMATION *(Required)*

FROM:	
PHONE #:	**FAX #:**
WRITING #:	**EMAIL:**
DATE:	**NUMBER OF PAGES:** **+ cover**

APPLICANT INFORMATION *(Required)*

NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**
NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**
NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**
NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**
NAME:	**SS#:**	☐ **Combo** ☐ **CWA** ☐ **Draft**

All applications submitted with a single cover sheet must be from the same writing agent.

PROCEDURES

For the fastest service, send one application per cover sheet and only one application per transmission, unless sending a combo application. Check the Combo box if you are submitting multiple applications for one applicant. You may send up to five applications with a single cover sheet per transmission. **However, do not exceed 25 pages per transmission.**

Simply complete the application, and fax the following to **877-704-8186**.

- FaxApp Cover Sheet
- Application in numeric page order
- Any state-specific or replacement forms, if applicable
- **Copy of the initial premium check, if collected from the customer at the point of sale**

Medicare supplement under age 65 (disabled) cases are not eligible for the FaxApp Program. You must mail the completed application with a check for the first month's premium to the Imaging – New Business address below.

PREMIUM

- Agents are encouraged to utilize the Bank Draft Authorization form to draft for the first premium in lieu of collecting the initial premium from the applicant.
- If you collected initial premium from the applicant, **please indicate the case number on the check** and mail the check, stapled to the top of the FaxApp cover sheet, to:

Imaging – New Business
P.O. Box 559015, Austin, TX 78755-9015

We must receive the premium within 10 days of receipt of the application. If it is not received within 10 days, we will send you a letter stating that the money for the policy must be submitted immediately. If we do not receive the check after 20 days, a letter will be sent stating that the contract will be cancelled in 5 days, unless we receive payment for the issued contract. **If we do not receive payment after 25 days, a letter will be sent to you and the applicant stating that the file has been closed and the policy has been cancelled due to non-payment of premium.**