Cigna Supplemental Solutions℠
Insured by Loyal American Life Insurance Company

Application Booklet for OHIO

CANCER *and* HEART ATTACK & STROKE *with* SPECIFIED DISEASE *option*

- APPLICATION
- ELECTRONIC FUNDS TRANSFER FORM
- HIPAA NOTICE
- REPLACEMENT NOTICE
- DISCLOSURE FOR SALE/SOLICITATION OF MEDICARE SUPPLEMENT, ACCIDENT, AND HEALTH INSURANCE POLICIES

BEING TRUE TO **YOURSELF** IS THE FIRST STEP TO BEING TRULY **HEALTHY.**

GO YOU.®

Application for First Diagnosis Cancer Insurance Policy and/or First Diagnosis Heart and Stroke Insurance Policy

PO Box 559015, Austin, TX 78755-9015 • 866-459-4272

Application is for: ☐ New Business ☐ Reinstatement ☐ Benefit Change ☐ Add Dependent ☐ Conversion

Requested Effective Date ______________ Existing Policy Number ______________ PV Case #______________

SECTION A: APPLICANT'S INFORMATION (PLEASE PRINT)

First	MI	Last

Date of Birth Month	Day	Year	Sex	Age	Height (Ft./In.)	Weight	Social Security #

Mailing Address ______________ City ______________ State ______ Zip ______

Work Phone ______________ Home Phone ______________ Email ______________

Best Time to Call (provide a 2+ hour time period): from ________ ☐ AM ☐ PM to ________ ☐ AM ☐ PM

Beneficiary (Full Name) ______________ Relationship ______________

☐ Payor Name (if other than Applicant) ______________ Relationship ______________

Payor Mailing Address ______________ City ______________ State ______ Zip ______

SECTION B: DEPENDENT INFORMATION (PLEASE PRINT)

SPOUSE TO BE COVERED

First	MI	Last

Date of Birth Month	Day	Year	Sex	Age	Height (Ft./In.)	Weight	Social Security #

Work Phone ______________ Home Phone ______________

Best Time to Call (provide a 2+ hour time period): from ________ ☐ AM ☐ PM to ________ ☐ AM ☐ PM

CHILD(REN) TO BE COVERED (Please attach a separate sheet if needed.)

	Name (First, MI, Last)	Social Security #	Sex (M/F)	Age	Date of Birth Month/Day/Year	Full-time Student?
Child # 1						☐Y ☐N
Child # 2						☐Y ☐N
Child # 3						☐Y ☐N
Child # 4						☐Y ☐N

SECTION C: EMPLOYMENT STATUS

	Applicant	Spouse
Do you work outside your home a minimum of 30 hours per week?	☐ Yes ☐ No ☐ N/A Retired	☐ Yes ☐ No ☐ N/A Retired
If yes, have you been actively at work for the last 30 days?	☐ Yes ☐ No	☐ Yes ☐ No

If no, please explain:

Applicant: ______________ Spouse: ______________

Applicant Employer/Job: ______________ Title/Duties: ______________

Spouse Employer/Job: ______________ Title/Duties: ______________

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

BASE COVERAGE SELECTION

☐ First Diagnosis Cancer (FDC) Policy* Benefit Amount $__________ Base Modal Premium $__________
(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)

☐ First Diagnosis Heart/Stroke (FDH) Policy** Benefit Amount $__________ Base Modal Premium $__________
(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)

**FDC Policy cannot be written with FDC Rider; **FDH Policy cannot be written with FDH Rider*

Total Base Modal Premium $__________

OPTIONAL RIDERS SELECTION *(for additional premium)*

☐ First Diagnosis Cancer (FDC) Rider* Benefit Amount $__________ Rider Modal Premium $__________
(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)

☐ First Diagnosis Heart/Stroke (FDH) Rider** Benefit Amount $__________ Rider Modal Premium $__________
(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)

**FDC Rider cannot be written with FDC Policy; **FDH Rider cannot be written with FDH Policy*

☐ Specified Disease Rider Benefit Amount $__________ Rider Modal Premium $__________
(if applying, Child(ren) benefit amount is the lesser of $10,000 or the parent benefit amount.)

☐ Accidental Death & Dismemberment Rider ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000
(if applying, Child(ren) benefit is $25,000) Rider Modal Premium $__________

Total Optional Riders Modal Premium $__________

SECTION F: TOTAL MODAL PREMIUM

Total Base + Optional Riders = Modal Premium $__________

Total Premium with Application $__________

Make checks payable to ***Loyal American Life Insurance Company***

SECTION G: NON-MEDICAL QUESTIONS

Question	YES	NO
1. Does any Applicant currently have any Accident, Cancer, or Heart insurance coverage in force? .... If yes, list the name of Company and Policy Number and Coverage Amount. ______________________________	☐	☐
2. Is the Insurance applied for here intended to replace any existing or pending Accident, Cancer, or Heart insurance? .... If yes, complete the provided Replacement Form, and list the name of Company and Policy Number. ______________________________	☐	☐
3. During the past five (5) years, has any Applicant had an Accident, Cancer, or Heart insurance application postponed, rated up or declined, or had insurance renewal or reinstatement refused?.....................	☐	☐
4. Is any Applicant eligible for Medicare?	☐	☐
5. Is any Applicant currently covered by any Title XIX program (Medicaid or any similar name)?	☐	☐

SECTION H: TOBACCO USE

	Applicant	Spouse
Have you used tobacco within the last five (5) years?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION I: MEDICAL QUESTIONS

(If the answer to any question in this section is "YES", the Applicant is not eligible for coverage.)

ALL POLICIES AND RIDERS (***Please answer questions 1 - 2***)

	YES	NO
1. Have you or any Applicant ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection?	☐	☐
2. Within the past five (5) years, have you or any Applicant received, been advised to receive, or sought any medical advice, examination, or treatment for drug or alcohol abuse, addiction, or dependency?	☐	☐

FIRST DIAGNOSIS CANCER POLICY/RIDER (***Please answer questions 3 - 5***)

	YES	NO
3. Have you or any Applicant ever been diagnosed with or received medical advice or treatment for Internal Cancer, Blood Cancer, Melanoma, Malignant Tumors, or Carcinoma in Situ?	☐	☐
4. Have you or any Applicant ever been advised to have any diagnostic tests related to cancer which have not been completed or for which results have not been received or are other than normal?	☐	☐
5. Have you or any Applicant ever had elevated PSA levels greater than 6.0 or been diagnosed with Dysplasia of the cervix classified as level 3.0 or higher?	☐	☐

FIRST DIAGNOSIS HEART/STROKE POLICY/RIDER AND SPECIFIED DISEASE RIDER
(Please answer questions 6 - 7)

	YES	NO
6. Have you or any Applicant ever:		
a. been diagnosed with or received medical advice or treatment for Heart Attack, Angina, Arrhythmia, Congenital Heart Defect, Cardiomyopathy, Congestive Heart Failure, Coronary Artery Disease (CAD), Carotid Artery Disease, Peripheral Vascular Disease, Cardiac or Vascular Angioplasty, Stroke, Transient Ischemic Attack (TIA), Pulmonary Hypertension, Blood Clots, or Disease or Disorder of the Heart or Circulatory System not listed?	☐	☐
b. had or been advised to have any form of Heart or Heart Valve Surgery, Coronary Artery Surgery, Bypass Surgery, Endarterectomy, Arteriogram, Cardiac or Vascular Angioplasty, Stent Placement, or Implantation of Cardiac Pacemaker or Defibrillator?	☐	☐
c. been diagnosed with or received medical advice or treatment for Insulin Dependent Diabetes (excluding Gestational Diabetes), Diabetes with Neuropathy or Retinopathy, or Connective Tissue Disorders such as Cystic Fibrosis?	☐	☐
d. been prescribed three (3) or more medications to be taken concurrently for High Blood Pressure?	☐	☐
7. Within the last six (6) months, have you or any Applicant:		
a. been advised of the need to have diagnostic tests performed to evaluate symptoms of chest pain, shortness of breath, blackouts, fainting, or dizziness?	☐	☐
b. had three (3) or more blood pressure readings over 140/90?	☐	☐
c. been advised that your blood pressure is uncontrolled and/or advised to take blood pressure medication due to uncontrolled blood pressure?	☐	☐

SPECIFIED DISEASE RIDER ***(Please answer questions 8 - 9)*** **YES NO**

8. Have you or any Applicant ever been diagnosed with or received medical advice or treatment for any of the following conditions?
   a. Kidney Disease requiring dialysis, Renal Insufficiency, Renal Failure, or Polycystic Kidney Disease? ..... ☐ ☐
   b. Liver Disease including Cirrhosis or Hepatitis (other than A)? .... ☐ ☐
   c. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, Chronic Obstructive Lung Disease (COLD) excluding Asthma, Pulmonary Fibrosis, or any lung or respiratory disorder requiring the use of oxygen? .... ☐ ☐
   d. Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS), or paralysis? .... ☐ ☐

9. Have you or any Applicant ever had an organ transplant, bone marrow transplant, or been advised of a need for a transplant? .... ☐ ☐

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER ***(Please answer questions 10 - 11)*** **YES NO**

10. Has any Applicant been charged with driving under the influence (DUI) of drugs or alcohol within the last five (5) years? .... ☐ ☐

11. Has any Applicant participated in or intend to participate in, and/or is currently participating in piloting, parachuting, sky diving, hang-gliding, motor racing, sporting activity(ies) for wage, compensation or profit, or any other hazardous activity(ies)? .... ☐ ☐

SECTION J: MEDICATION(S) *(REQUIRED FOR POLICY AND RIDERS)*

Please list any prescription medications that you or any Applicant have taken within the past two (2) years.

Applicant Name	Medication	Dates Taken	Condition Taken for

Please attach a separate sheet if needed

SECTION K: APPLICANT'S STATEMENTS AND AGREEMENTS

I hereby apply to Loyal American Life Insurance Company ("the Company") for insurance for 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 Applicant is covered by any Title XIX program (Medicaid or any similar name.); (3) No insurance will be effective until (a) my application has been approved by the Company; (b) the initial premium has been paid; and (c) the policy has been issued by the Company; and (4) 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*.

THIS POLICY PROVIDES LIMITED BENEFITS, REVIEW YOUR POLICY CAREFULLY.

FRAUD WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I understand that the policy applied for will not pay benefits for the first twelve (12) months after the issue date for cancer that I or any Applicant now have or have had in the past twelve (12) months or any loss caused by a pre-existing condition which I or any Applicant now have or have had in the past twelve (12) months.

Signature of Applicant (Proposed Named Insured): ______________________ **Date:** ____________

SECTION L: AFFIDAVIT FOR AGENT(S) USE ONLY

I hereby certify that I have accurately recorded in this application all of the information known to me and as supplied by the Applicant. The Applicant has read or had read to him or her the completed application.

I also certify that this application ☐ ***does*** ☐ ***does not*** replace or change any existing coverage.

☐ I certify that I have provided the Applicant with the documents outlined in the Applicant 's Statements and Agreements.

Was the application completed by you in the Applicant's physical presence?.. ☐ Yes ☐ No

Was the application completed by you over the phone?.. ☐ Yes ☐ No

I further certify that on ______________ (Date), I delivered the documents to the Applicant ☐ In Person ☐ By Mail ☐ By Email ☐ By Fax (check all that apply, must select at least one)

Printed Name of 1st Agent	Signature of 1st Agent	Writing Number	Percentage

Printed Name of 2nd Agent	Signature of 2nd 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 checking/savings account

☐ Change in financial institution ☐ 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.

TAPE VOIDED CHECK HERE 0101

PAY TO THE ORDER OF ______ $

Dollars

VOID

The Routing number is 9 digits between the ⑆ ⑆ symbols.

The Account number is usually to the left of ⑈. If check number is left of account number, ignore check number.

The Check number should match the upper right corner.

⑆123456789⑆ 34567890⑈ 0101

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 associations 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 associations 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

____
Applicant's Social Security Number

____
Signature of Applicant — Date

____
Signature of Company's Agent — Date

____
Name of Applicant's Personal Representative, if applicable

____
Relationship of Personal Representative to the Applicant

____
Signature of Personal Representative — 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)

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO Box 559015, Austin, TX 78755-9015
(866) 459-4272

STATE OF OHIO REQUIRED DISCLOSURE FOR SALE AND SOLICITATION OF MEDICARE SUPPLEMENT, ACCIDENT, AND HEALTH INSURANCE POLICIES

The below-named Insurance Agent or Broker certifies:

- That I am licensed as an insurance agent by the state of Ohio.
- That I am appointed to represent Loyal American.
- That I am making the solicitation or sale on behalf of Loyal American.
- That neither myself or Loyal American has any connection or affiliation with, and are not in any way sponsored by, the federal or state government, the Social Security Administration, the Centers for Medicare and Medicaid Services, or the Department of Health and Human Services.

Agent Name____ Agent Phone No.________________________

Address of Agent ____

You, the applicant, have a right to:

- Verify the information provided above by contacting the Ohio Department of Insurance at:

  Ohio Department of Insurance
  50 W. Town Street, 3rd Floor, Suite 300
  Columbus, OH 43215

- Contact the agent or broker making the solicitation or sale at both an address and telephone number provided above.
- Contact the insurance company or insurance companies on behalf of which the solicitation or sale was made at an address and telephone number provided by the agent or broker.

Payments for insurance premiums should always be made payable to the insurance company.

Cigna Supplemental Solutions℠
Insured by Loyal American Life Insurance Company

Client Information Booklet for **OHIO**

CANCER *and* HEART ATTACK & STROKE *with* SPECIFIED DISEASE *option*

- OUTLINE(S) OF COVERAGE
- IMPORTANT NOTICE TO PERSONS ON MEDICARE
- REPLACEMENT NOTICE

BEING TRUE TO YOURSELF IS THE FIRST STEP TO BEING TRULY HEALTHY.

GO YOU®

THIS PAGE INTENTIONALLY LEFT BLANK

P.O. Box 26580, Austin, TX 78755-0580
Toll Free: 866-459-4272

OUTLINE OF COVERAGE FOR
FIRST DIAGNOSIS CANCER INSURANCE POLICY
FORM SERIES LY-FDC-BA

SPECIFIED DISEASE COVERAGE
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. This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

2. ***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.

3. ***SPECIFIED DISEASE COVERAGE*** is designed to provide, to persons insured, restricted coverage providing benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

4. ***BENEFITS PROVIDED BY THE POLICY***

FIRST DIAGNOSIS BENEFIT: Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a First Ever Diagnosis of Cancer from a Physician, We will pay You the First Diagnosis Benefit Amount, shown on the Policy Schedule Page, reduced by the Carcinoma in Situ Benefit if previously paid for that Insured Person.

If an Insured Person receives a First Ever Diagnosis of Carcinoma in Situ, We will pay You a partial First Diagnosis Benefit Amount equal to 25% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. Any First Diagnosis Benefit amount payable for Cancer shall be reduced, dollar-for-dollar, by any amounts previously paid for Carcinoma in Situ. The partial First Diagnosis Benefit for Carcinoma in Situ is payable once per Insured Person's lifetime.

RECURRENCE BENEFIT: Subject to the Benefit Payment Conditions listed below, a Recurrence Benefit is payable each time an Insured person receives a Diagnosis for the recurrence of Cancer or Carcinoma in Situ. However, for the Recurrence Benefit to be payable:

1. 100% of the First Diagnosis Benefit Amount shall have been previously paid for the Insured Person;
2. the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

The Recurrence Benefit Amount payable is the percentage shown in the chart below times the First Diagnosis Benefit Amount shown on the Policy Schedule Page. If a percentage of the Recurrence Benefit Amount is paid and the Insured Person then becomes eligible for a subsequent Recurrence Benefit, the amount payable for the subsequent Recurrence Benefit is the lesser of the percentage amount payable or 100% minus the percentage of the Recurrence Benefit Amount received for all previous Recurrence Benefits.

The maximum total percentage of the Recurrence Benefit Amount payable is an additional 100% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

Time Period Without Advice or Treatment	% of Recurrence Benefit Amount Payable for Cancer	% of Recurrence Benefit Amount Payable for Carcinoma in Situ*	Maximum Percentage of the Recurrence Benefit Amount
Less than 24 months	0%	0%	100%
24 months or more but less than 5 years	25%	10%	
5 years or more but less than 10 years	75%	25%	
10 years or more	100%	25%	

* We will pay the Recurrence Benefit Amount for Carcinoma in Situ only once in an Insured Person's lifetime.

After payment of the maximum percentage of the Recurrence Benefit Amount for an Insured Person shown in the chart above, We will not pay any additional Recurrence Benefits for the same Insured Person.

BENEFIT PAYMENT CONDITIONS: Payment of the First Diagnosis Benefit Amount, any partial First Diagnosis Benefit Amount or Recurrence Benefit Amount shall be subject to the following conditions:

1. Diagnosis must be made within the United States; and
2. the Date of Diagnosis shall occur while the Insured Person is covered by this policy; and
3. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE: The Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ shall be reduced during the first thirty (30) days immediately following the Effective Date of the policy. The reduced Benefit Amount for Cancer will be 10% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. The reduced Benefit Amount for Carcinoma in Situ will be 2.5% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

In the event a benefit is paid for Cancer or Carcinoma in Situ within the first thirty (30) days following this policy's Effective Date, coverage for the Insured Person under the this policy will end.

5. ***EXCLUSIONS AND LIMITATIONS***

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy:

1. for any disease, Sickness or incapacity other than Cancer and Carcinoma in Situ as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Cancer or Carcinoma in Situ;
2. loss that begins prior to the Effective Date of coverage;
3. Diagnosis and treatment received outside the United States or its territories; or
4. any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S): The benefits of this Policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

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

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. 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.

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

☐ **FIRST DIAGNOSIS HEART AND STROKE BENEFIT RIDER (Form # LY-FDH-RD)**

We will pay You a benefit if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Qualifying Events shown in the chart below and subject to the following conditions:

1. The First Ever Diagnosis or Procedure must be made and performed within the United States; and
2. the Date of Diagnosis or procedure shall occur while the Insured Person is covered by this rider; and
3. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this rider (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

The amount payable for each Qualifying Event is the percentage times the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page. The percentage of the Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

*We will pay the benefit for Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent only once in an Insured Person's lifetime.

If a percentage of the First Diagnosis Heart and Stroke Benefit Amount for one (1) Qualifying Event in the chart above is paid and the Insured Person then becomes eligible for benefits for another Qualifying Event, the amount payable for the subsequent Qualifying Event is the lesser of the percentage amount payable or 100% minus the percentage of the First Diagnosis Heart and Stroke Benefit Amount received for all previous Qualifying Events.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same day, We will pay only one (1) First Diagnosis Heart and Stroke Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same day.

After payment of 100% of the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Qualifying Events for the same Insured Person.

No benefits are payable for conditions other than the Qualifying Events defined in this rider. Payment of benefits is subject to all terms and conditions of this rider and the policy to which it is attached.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this rider for:

1. any disease, Sickness or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by a Qualifying Event;
2. intentionally self-inflicted injury or Sickness;
3. suicide or attempted suicide, while sane or insane;
4. loss that begins prior to the Effective Date of coverage;
5. Diagnosis and treatment received outside the United States or its territories;

6. any injury or Sickness sustained or contracted due to an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
7. any disease, condition or procedure specifically excluded from the definitions of Qualifying Events listed in this rider.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

☐ **SPECIFIED DISEASE RIDER (Form # LY-SD-RD)**

We will pay You the Specified Disease Benefit Amount, shown on the Policy Schedule Page, if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Specified Diseases shown in the chart below and subject to the following conditions:

1. Diagnosis must be made within the United States; and
2. the Date of Diagnosis or Procedure shall occur while the Insured Person is covered by this rider.

Specified Diseases
Amyotrophic Lateral Sclerosis (ALS)
Coma
End Stage Renal Failure
Major Organ Transplant
Multiple Sclerosis (MS)
Paralysis
Severe Burns

Each Insured Person is limited to one (1) Specified Disease Benefit Amount under the terms of this rider. After payment of the Specified Disease Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Specified Diseases covered by this rider for the same Insured Person.

If the Date of Diagnosis or Procedure of two (2) or more Specified Diseases is the same day, We will pay only one (1) Specified Disease benefit.

No benefits are payable for conditions other than the Specified Diseases defined in this rider. Payment of the Specified Disease benefit is subject to all terms and conditions of this rider and the policy to which it is attached.

EXCLUSIONS AND LIMITATIONS

This Rider does not cover any disease, Sickness, incapacity or procedure other than the Specified Diseases defined above, even though another disease or incapacity may have been complicated, aggravated or directly affected by the Specified Disease or its treatment.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for any Sickness or Injury resulting, whether directly or indirectly, from any of the following:

1. intentionally self-inflicted Sickness or Injury;
2. suicide or attempted suicide, while sane or insane;
3. loss that begins prior to the Effective Date of coverage;
4. care and treatment received outside the United States or its territories;
5. an act of declared or undeclared war;
6. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
7. committing or attempting to commit a felony or engaging in an illegal occupation or activity;
8. participation in any sport or sporting activity for wage, compensation or profit;
9. operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
10. engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
11. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
12. any illness specifically excluded from the definition of any Specified Disease.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

☐ **ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT RIDER (Form # LY-ADD-RD3)**

TABLE OF BENEFITS

In the Event of Loss of:	The Benefit Will Be:
Life	100% of the Benefit Amount
One Eye, Hand, Foot, Arm or Leg	10% of the Benefit Amount
More Than One Eye, Hand, Foot, Arm or Leg	20% of the Benefit Amount

ACCIDENTAL DEATH BENEFIT:
We will pay the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of life due to Injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

ACCIDENTAL DISMEMBERMENT BENEFIT:
We will pay a percentage of the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of sight or limb(s) due to injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. The loss of hand or foot means the complete severance at or above the wrist or ankle joint. Loss of eye means total and irrecoverable sight. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

LIMIT ON PAYMENT OF BENEFIT AMOUNT:
The total amount payable under this benefit for all losses resulting from any one Covered Accident shall not exceed the amount payable for loss of life. The amount will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page, for the Insured Person suffering multiple losses. If an Insured Person suffers multiple losses under subsequent Covered Accidents, the amount payable for all subsequent Covered Accidents will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for an Injury resulting, whether directly or indirectly, from any of the following:
1. Injuries that are intentionally self-inflicted;
2. suicide or attempted suicide, while sane or insane;
3. a Covered Accident which occurs outside the United States or its territories;
4. an act of declared or undeclared war;
5. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
6. committing or attempting to commit a felony or engaging in an illegal occupation or activity;
7. participation in any sport or sporting activity for wage, compensation or profit;
8. operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
9. engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
10. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
11. a work-related condition that is eligible for benefits under Workman's Compensation, Employers' Liability or similar laws even when the Insured Person does not file a claim for benefits. This exclusion will not apply to an Insured Person who is not required to have coverage under any Workman's Compensation, Employers' Liability or similar law and does not have such coverage.

8. ***YOUR TOTAL ANNUAL PREMIUM* (at time of application)**:

	Tobacco	Gender	Age	FDC Policy	FDH Rider	SD Rider	AD&D Rider
SELF	☐Y / ☐N	☐M / ☐F					
SPOUSE	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
TOTAL ANNUAL PREMIUM				$	$	$	$

(Please attach a separate sheet if needed.)

THIS PAGE INTENTIONALLY LEFT BLANK

P.O. Box 26580, Austin, TX 78755-0580
Toll Free: 866-459-4272

OUTLINE OF COVERAGE FOR
FIRST DIAGNOSIS HEART INSURANCE POLICY
FORM SERIES LY-FDH-BA

SPECIFIED DISEASE COVERAGE
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. This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

2. ***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.

3. ***SPECIFIED DISEASE COVERAGE*** is designed to provide, to persons insured, restricted coverage providing benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

4. ***BENEFITS PROVIDED BY THE POLICY***

We will pay You a benefit if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Qualifying Events shown in the chart below and subject to the following conditions:

1. The First Ever Diagnosis or Procedure must be made and performed within the United States; and
2. the Date of Diagnosis or procedure shall occur while the Insured Person is covered by this policy; and
3. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this policy (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

The amount payable for each Qualifying Event is the percentage times the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page. The percentage of the Benefit Amount payable for each Qualifying Event is shown beside the event in the chart below.

Qualifying Events	Percentage of Benefit Amount Payable for each Qualifying Event	Maximum Percentage of Benefit Amount Payable
Heart Attack	100%	100%
Heart Transplant	100%	
Stroke	100%	
Coronary Artery Bypass Surgery*	25%	
Aortic Surgery*	25%	
Heart Valve Replacement/Repair Surgery*	25%	
Angioplasty*	10%	
Stent*	10%	

*We will pay the benefit for Coronary Artery Bypass Surgery, Aortic Surgery, Heart Valve Replacement/Repair Surgery, Angioplasty, and Stent only once in an Insured Person's lifetime.

If a percentage of the First Diagnosis Heart and Stroke Benefit Amount for one (1) Qualifying Event in the chart above is paid and the Insured Person then becomes eligible for benefits for another Qualifying Event, the amount payable for the subsequent Qualifying Event is the lesser of the percentage amount payable or 100% minus the percentage of the First Diagnosis Heart and Stroke Benefit Amount received for all previous Qualifying Events.

If the Date of Diagnosis of two (2) or more Qualifying Events is the same day, We will pay only one (1) First Diagnosis Heart and Stroke Benefit Amount. We will pay the larger of the Qualifying Event benefits Diagnosed on the same day.

After payment of 100% of the First Diagnosis Heart and Stroke Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Qualifying Events for the same Insured Person.

No benefits are payable for conditions other than the Qualifying Events defined in this policy. Payment of benefits is subject to all terms and conditions of this policy.

5. *EXCLUSIONS AND LIMITATIONS*

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this policy for:

1. any disease, Sickness or incapacity other than Qualifying Events as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by a Qualifying Event;
2. intentionally self-inflicted injury or Sickness;
3. suicide or attempted suicide, while sane or insane;
4. loss that begins prior to the Effective Date of coverage;
5. Diagnosis and treatment received outside the United States or its territories;

6. any injury or Sickness sustained or contracted due to an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her injury or Sickness, irrespective of whether the injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity; or
7. any disease, condition or procedure specifically excluded from the definitions of Qualifying Events listed in this policy.

PRE-EXISTING CONDITION(S): The benefits of this Policy will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

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

GUARANTEED RENEWABLE FOR LIFE. This policy is guaranteed renewable for life. You may keep the coverage in force during Your lifetime by paying the premiums on time. 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.

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

☐ **FIRST DIAGNOSIS CANCER BENEFIT RIDER (Form # LY-FDC-RD)**

Subject to the Reduction Schedule and Benefit Payment Conditions listed below, if an Insured Person receives a First Ever Diagnosis of Cancer from a Physician We will pay You the First Diagnosis Benefit Amount, shown on the Policy Schedule Page, reduced by the Carcinoma in Situ Benefit if previously paid for that Insured Person.

If an Insured Person receives a First Ever Diagnosis of Carcinoma in Situ, We will pay You a partial First Diagnosis Benefit Amount equal to 25% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. Any First Diagnosis Benefit amount payable for Cancer shall be reduced, dollar-for-dollar, by any amounts previously paid for Carcinoma in Situ. The partial First Diagnosis Benefit for Carcinoma in Situ is payable once per Insured Person's lifetime.

RECURRENCE BENEFIT: Subject to the Benefit Payment Conditions listed below, a Recurrence Benefit is payable each time an Insured Person receives a Diagnosis for the recurrence of Cancer or Carcinoma in Situ. However, for the Recurrence Benefit to be payable:

1. 100% of the First Diagnosis Benefit Amount shall have been previously paid for the Insured Person;
2. the Insured Person shall not have received any Advice or Treatment for at least twenty-four (24) consecutive months prior to the Date of Diagnosis for the recurrence of Cancer or Carcinoma in Situ.

The Recurrence Benefit Amount payable is the percentage shown in the chart below times the First Diagnosis Benefit Amount shown on the Policy Schedule Page. If a percentage of the Recurrence Benefit Amount is paid and the Insured Person then becomes eligible for a subsequent Recurrence Benefit, the amount payable for the subsequent Recurrence Benefit is the lesser of the percentage amount payable or 100% minus the percentage of the Recurrence Benefit Amount received for all previous Recurrence Benefits.

The maximum total percentage of the Recurrence Benefit Amount payable is an additional 100% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

Time Period Without Advice or Treatment	% of Recurrence Benefit Amount Payable for Cancer	% of Recurrence Benefit Amount Payable for Carcinoma in Situ*	Maximum Percentage of the Recurrence Benefit Amount
Less than 24 months	0%	0%	100%
24 months or more but less than 5 years	25%	10%	
5 years or more but less than 10 years	75%	25%	
10 years or more	100%	25%	

* We will pay the Recurrence Benefit Amount for Carcinoma in Situ only once in an Insured Person's lifetime.

After payment of the maximum percentage of the Recurrence Benefit Amount for an Insured Person shown in the chart above, We will not pay any additional Recurrence Benefits for the same Insured Person.

BENEFIT PAYMENT CONDITIONS: Payment of the First Diagnosis Benefit Amount, any partial First Diagnosis Benefit Amount or Recurrence Benefit Amount shall be subject to the following conditions:

1. Diagnosis must be made within the United States; and
2. the Date of Diagnosis shall occur while the Insured Person is covered by this rider; and
3. payment shall be precluded by any general or specific exclusion, limitation or reduction set forth in or attached to this rider (including, without limitation, the exclusion for any Pre-Existing Condition) or any failure by the Insured Person to meet any condition precedent.

REDUCTION SCHEDULE: The Benefit Amount for a First Ever Diagnosis of Cancer or Carcinoma in Situ shall be reduced during the first thirty (30) days immediately following the Effective Date of the rider. The reduced Benefit Amount for Cancer will be 10% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page. The reduced Benefit Amount for Carcinoma in Situ will be 2.5% of the First Diagnosis Benefit Amount shown on the Policy Schedule Page.

In the event a benefit is paid for Cancer or Carcinoma in Situ within the first thirty (30) days following this rider's Effective Date, coverage for the Insured Person under the this rider will end.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: No benefits will be payable under this rider for:

1. any disease, Sickness or incapacity other than Cancer and Carcinoma in Situ as defined; this is so even though such disease, Sickness or incapacity may have been complicated, affected (directly or indirectly) or caused by Cancer or Carcinoma in Situ;
2. loss that begins prior to the Effective Date of coverage;
3. Diagnosis and treatment received outside the United States or its territories; or
4. any illness specifically excluded from the definition of Cancer or Carcinoma in Situ.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

☐ **SPECIFIED DISEASE RIDER (Form # LY-SD-RD)**

We will pay You the Specified Disease Benefit Amount, shown on the Policy Schedule Page, if an Insured Person receives a First Ever Diagnosis or Procedure from a Physician for one (1) of the Specified Diseases shown in the chart below and subject to the following conditions:

1. Diagnosis must be made within the United States; and
2. the Date of Diagnosis or Procedure shall occur while the Insured Person is covered by this rider.

Specified Diseases
Amyotrophic Lateral Sclerosis (ALS)
Coma
End Stage Renal Failure
Major Organ Transplant
Multiple Sclerosis (MS)
Paralysis
Severe Burns

Each Insured Person is limited to one (1) Specified Disease Benefit Amount under the terms of this rider. After payment of the Specified Disease Benefit Amount shown on the Policy Schedule Page for an Insured Person, We will not pay any additional benefits for any additional Specified Diseases covered by this rider for the same Insured Person.

If the Date of Diagnosis or Procedure of two (2) or more Specified Diseases is the same day, We will pay only one (1) Specified Disease benefit.

No benefits are payable for conditions other than the Specified Diseases defined in this rider. Payment of the Specified Disease benefit is subject to all terms and conditions of this rider and the policy to which it is attached.

EXCLUSIONS AND LIMITATIONS

This Rider does not cover any disease, Sickness, incapacity or procedure other than the Specified Diseases defined above, even though another disease or incapacity may have been complicated, aggravated or directly affected by the Specified Disease or its treatment.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for any Sickness or Injury resulting, whether directly or indirectly, from any of the following:

1. intentionally self-inflicted Sickness or Injury;
2. suicide or attempted suicide, while sane or insane;
3. loss that begins prior to the Effective Date of coverage;
4. care and treatment received outside the United States or its territories;
5. an act of declared or undeclared war;
6. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
7. committing or attempting to commit a felony or engaging in an illegal occupation or activity;
8. participation in any sport or sporting activity for wage, compensation or profit;
9. operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
10. engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
11. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
12. any illness specifically excluded from the definition of any Specified Disease.

PRE-EXISTING CONDITION(S): The benefits of this rider will not be payable during the first twelve (12) months that coverage is in force with respect to an Insured Person for any loss caused by Pre-Existing Condition(s). This twelve (12) month period is measured from the Effective Date of coverage for each Insured Person.

☐ **ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT RIDER (Form # LY-ADD-RD3)**

TABLE OF BENEFITS

In the Event of Loss of:	**The Benefit Will Be:**
Life	100% of the Benefit Amount
One Eye, Hand, Foot, Arm or Leg	10% of the Benefit Amount
More Than One Eye, Hand, Foot, Arm or Leg	20% of the Benefit Amount

ACCIDENTAL DEATH BENEFIT:
We will pay the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of life due to Injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

ACCIDENTAL DISMEMBERMENT BENEFIT:
We will pay a percentage of the Benefit Amount shown on the Policy Schedule Page if an Insured Person suffers loss of sight or limb(s) due to injuries received in a Covered Accident. The loss must occur no later than ninety (90) days after the date of the Covered Accident. The loss of hand or foot means the complete severance at or above the wrist or ankle joint. Loss of eye means total and irrecoverable sight. Payment of the applicable benefit amount will be subject to the Limit on Payment of Benefit Amount.

LIMIT ON PAYMENT OF BENEFIT AMOUNT:
The total amount payable under this benefit for all losses resulting from any one Covered Accident shall not exceed the amount payable for loss of life. The amount will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page, for the Insured Person suffering multiple losses. If an Insured Person suffers multiple losses under subsequent Covered Accidents, the amount payable for all subsequent Covered Accidents will not exceed the applicable Benefit Amount, shown on the Policy Schedule Page.

EXCLUSIONS – WHAT WE WILL NOT PAY FOR: We will not pay benefits for an Injury resulting, whether directly or indirectly, from any of the following:

1. Injuries that are intentionally self-inflicted;
2. suicide or attempted suicide, while sane or insane;
3. a Covered Accident which occurs outside the United States or its territories;
4. an act of declared or undeclared war;
5. an Insured Person's being intoxicated, as determined and defined by the laws and jurisdiction of the geographical area in which the Injury or Sickness or cause of Injury or Sickness was incurred, or under the influence of any narcotic unless administered under the advice of a Physician. The Insured Person's alcohol or narcotic impairment must be the cause or contributing cause of his or her Injury or Sickness, irrespective of whether the Injury or Sickness occurred while the Insured Person was driving a motor vehicle or engaged in any other activity;
6. committing or attempting to commit a felony or engaging in an illegal occupation or activity;
7. participation in any sport or sporting activity for wage, compensation or profit;
8. operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven;
9. engaging in hang gliding, bungee jumping, parachuting, sailgliding, parakiting, or hot air ballooning;
10. riding in or driving any motor-driven vehicle in a race, stunt show or speed test; or
11. a work-related condition that is eligible for benefits under Workman's Compensation, Employers' Liability or similar laws even when the Insured Person does not file a claim for benefits. This exclusion will not apply to an Insured Person who is not required to have coverage under any Workman's Compensation, Employers' Liability or similar law and does not have such coverage.

8. *<u>YOUR TOTAL ANNUAL PREMIUM</u>* <u>(at time of application)</u>:

	Tobacco	Gender	Age	FDH Policy	FDC Rider	SD Rider	AD&D Rider
SELF	☐Y / ☐N	☐M / ☐F					
SPOUSE	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
CHILD	☐Y / ☐N	☐M / ☐F					
TOTAL ANNUAL PREMIUM				$	$	$	$

(Please attach a separate sheet if needed.)

LOYAL AMERICAN LIFE INSURANCE COMPANY®

P.O. Box 559015 ● Austin, Texas 78755-9015

SPECIFIED CRITICAL ILLNESS INSURANCE
MEDICARE DUPLICATION NOTICE

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

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specified diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnosis named in the policy.

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

- hospitalization
- physician services
- hospice
- 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 health insurance assistance 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.**