SPECIMEN POLICY

NATIONAL FAMILY CARE LIFE INSURANCE COMPANY

13530 INWOOD ROAD DALLAS, TX 75244
AN OLD LINE LEGAL RESERVE COMPANY

LUMP SUM CRITICAL ILLNESS POLICY

This Policy is a legal contract between You and Us. READ YOUR POLICY CAREFULLY. If there is any error or omission, contact Us at Our Office address within thirty (30) days.

This Policy is issued to You based on the first premium You pay and the information provided in Your signed Application.

IMPORTANT NOTICE: The issuance of this Policy and any Riders is based upon Your correct and complete answers to all questions and any other information on Your signed Application. This Policy is subject to denial of a claim and cancellation by Us if the application contains misrepresentations, omissions, or incorrect statements that are fraudulent. Please review the entire contract, including the copy of Your Application. If any information on the Application is not correct and complete, contact Us at Our Office address within thirty (30) days.

10 DAY RIGHT TO EXAMINE AND CANCEL POLICY
You should read this entire Policy carefully and refer to the Definitions section to understand the meaning of defined words. If You are not satisfied for any reason, You may cancel this Policy by returning it to Us [or to Our authorized agent] and giving written notice of cancellation any time before 12:01 a.m. standard time at Your home address of the 10th day following receipt of this Policy. In such case, this Policy will be considered void as though it was never issued and You will receive a full refund of any premium paid.

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE SUBJECT TO THE COMPANY'S RIGHT TO CHANGE PREMIUMS. THIS POLICY MAY BE SUBJECT TO A PREMIUM INCREASE ON ANY POLICY ANNIVERSARY DATE.

You may keep this Policy in force for life by paying premiums when they are due or during the Grace Period. If premiums are paid on time, We cannot cancel, refuse to renew, or place any restrictions on the Policy. Send your premiums to Us at Our Administrative Office. We reserve the right to change premiums from time to time. If We do change the premiums, We will do so only if We change premiums for all policies of this class in Your issue state, and such change is in accordance with the laws in Your state. We will give You advance written notice as required by Your state prior to any premium change.

The laws of the State of Texas govern this Policy. You and We agree to all of the terms of this Policy.

NOTICE TO BUYER: This Policy provides limited benefits for the Diagnosis of illnesses or performance of procedures specified and defined in this Policy. Benefits are supplemental and not intended to cover all medical expenses. It does not pay benefits for loss from any other cause.

THIS POLICY CONTAINS A PRE-EXISTING CONDITION EXCLUSION.

THIS POLICY IS NOT MAJOR MEDICAL OR MEDICAL EXPENSE INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE. LACK OF MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE MAY RESULT IN AN ADDITIONAL TAX LIABILITY.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If You are eligible for Medicare, You should review the Guide to Health Insurance for People with Medicare available from the Company.

IN WITNESS WHEREOF, National Family Care Insurance Company has caused this Policy to be executed, with coverage taking effect on the Policy Effective Date.

[President]

SPECIMEN POLICY

TABLE OF CONTENTS

SPECIMEN POLICY

POLICY SCHEDULE

INSURED PERSON: [John Doe]
[Spouse] [Jane Doe]
[Child] [Mary Doe]

TYPE OF COVERAGE: [Individual, Individual +1, Family, Domestic, Civil Union Partner]

POLICY NUMBER: [0123456]

EFFECTIVE DATE: [mm/dd/yyyy]

RENEWAL DATE: [mm/dd/yyyy]

POLICY CLASS: [Tobacco/Nicotine or Non-Tobacco/Nicotine]

TOTAL [MONTHLY] PREMIUM: Monthly is default, allow for semi-annual & annual [XX.XX]

Covered Person:	Name:	Face Amount of Insurance:	Maximum Benefit Amount:	Issue Age:
Individual	[John Doe]	$5,000 - $25,000	3 times the Face Amount	[XX]
Individual +1	[Jane Doe]	50% to 100% of Face Amount of Insurance for Insured Person	3 times the Face Amount	[XX]]
Family	[Mary Doe]	25% to 50% of Face Amount of Insurance for Insured Person	3 times the Face Amount	[XX]]

Waiting Period: Default is 30, allow for 60,90 & 120 [30-120] days
Benefit Reduction: On the Insured Person's 70th birthday, the Amount of Insurance for Covered Persons will be reduced by 50%. The available Maximum Benefit Amount for Covered Persons will be reduced by 50%.

Covered Conditions and Covered Procedures	Percentage of Face Amount
Heart Attack (Myocardial Infarction)	100%
Coronary Artery Bypass Graft Surgery	25%
Angioplasty	25%
Heart Valve Transcatheter	100%
Implantable Cardioverter	100%
Heart Valve Open Heart Surgery	100%
Pacemaker Placement	100%
Benign Brain Tumor	100%
Stroke	100%
End Stage Renal Disease (ERSD)	100%
Major Organ Transplant • Heart Transplant • Kidney Transplant • Liver Transplant • Lung Transplant • Pancreas Transplant	 100% 100% 100% 100% 100%
Multiple Sclerosis	100%
Permanent Paralysis	100%
Loss of Two or More Limbs • Loss of Both Hands or Both Feet • Loss of Both Arms or Both Legs • Loss of One Arm and One Leg	 100% 100% 100%
Severe Burns	100%
Loss of Sight, Hearing, Speech	100%
Loss of Sight in Both Eyes	100%

DEFINITIONS

Amount of Insurance means the amount shown on the Policy Schedule for each Covered Person.

Angioplasty means surgical repair or unblocking of a blood vessel, especially a coronary artery.

Benign Brain Tumor means a diagnosis of a non-malignant tumor of 1cm or greater, located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumor must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of benign brain tumor must be made by a Physician. The tumor, including its size, should be documented on an MRI of the brain (with and without contrast) or by pathological diagnosis. If the Covered Person is unable to undergo an MRI of the brain (the study is deemed inappropriate for safety reasons such as the presence of metallic foreign bodies; mechanical reasons such as body habitus; or unavailability), then the tumor should be documented by a CT scan of the head, with and without contrast.

Coronary Artery Bypass Graft Surgery means open-heart surgery to correct narrowing or blockage of one or more coronary arteries due to coronary artery disease or acute coronary syndrome with bypass grafts, but excluding procedures such as but not limited to coronary angioplasty, valve replacement surgery, stent placement, laser relief, or other surgical or nonsurgical procedures.

Covered Person means You or a person who:
1. is eligible for coverage as your Spouse or Child(ren).
2. is accepted for coverage or is automatically added.
3. has paid the required premium.
4. whose coverage has become effective and has not been terminated.

Critical Illness means the conditions and/or covered procedures specified within this Policy or any attached riders, for which benefits may be payable.

Date of Diagnosis means the date the Diagnosis is established by a Physician, who is a board-certified specialist where required under this Policy, through the use of clinical and/or laboratory findings as supported by the Covered Person's medical records. For a covered procedure, it is the date the Covered Person undergoes the procedure.

Diagnosis means the definitive establishment of a Critical Illness through the use of clinical and/or laboratory findings. The Diagnosis must be made by a Physician who is a board-certified specialist where required under this Policy.

Due Date means the date renewal premiums are due.

Effective Date means the date coverage on any Covered Person begins and the Policy goes into effect. The Effective Date is shown in the Policy Schedule. For persons accepted for coverage under this Policy after it is issued, the Effective Date of coverage will be shown in an endorsement.

End Stage Renal Disease (ESRD) means chronic irreversible failure of the function of both kidneys such that the Covered Person must undergo at least weekly hemodialysis or peritoneal dialysis.

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle resulting from blockage of one or more coronary arteries. The term Heart Attack does not include the following:
1. an EKG change consistent with transient ischemic change;
2. angina;
3. chance finding of EKG changes suggestive of a previous Heart Attack; or
4. the death of the heart muscle coincidental with death from other causes.

Heart Valve Transcatheter means a procedure performed through the blood vessels to repair or replace one or more of the heart valves due to significant valvular heart disease that is diagnosed after a Covered Person's Effective Date of insurance.

He, His, Him refers to any individual, male or female.

Hospital means an institution in the United States or Canada which meets all of the following requirements:

1. operates pursuant to state or provincial law for Hospitals located in the United States or Canada;
2. operates primarily for the care and treatment of sick or injured persons as inpatients;
3. provides 24-hour nursing service;
4. has facilities available for diagnosis and surgery either on its own premises or in facilities available to the Hospital on a pre-arranged basis; and
5. has a staff of at least one licensed Physician available at all times.

Implantable (or Internal) Cardioverter Defibrillator (ICD) means the initial placement of an implantable cardioverter-defibrillator (ICD) due to ventricular tachycardia or fibrillation causing the Covered Person to be deemed at high risk for cardiac arrest that is diagnosed after a Covered Person's Effective Date of insurance.

Insured Person means the person who has completed and signed the Application and who has been accepted for coverage by Us.

Issue Date means the date the Insured Person first becomes insured for the benefits of this Policy or attached riders, if any, as listed on the Policy Schedule, rider Schedule or as later amended.

Loss means You have been diagnosed as having a Critical Illness or are experiencing a Critical Illness procedure, as applicable, for which We pay benefits under this Policy.

Loss of Both Arms or Both Legs means complete Severance through and above the elbow joint or knee joint.

Loss of Both Hands or Feet means complete Severance through or above the wrist or ankle joint.

Loss of Hearing, Sight or Speech. "Loss of Hearing" means total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by use of any hearing aid or device shall not be considered an irrevocable loss. "Loss of Sight" means total and irreversible loss of sight in both eyes. "Loss of Speech" means damage to vocal cords due to injury that results in the total and permanent inability to speak. The Loss of Hearing, Sight or Speech must be diagnosed by a Physician after the Effective Date. If We pay one of the following conditions: Loss of Hearing, Sight or Speech for a Covered Person, We will not pay for the other two conditions for that Covered Person.

Loss of One Arm means complete Severance through and above the elbow joint.

Loss of One Leg means complete Severance through and above the knee joint.

Loss of Sight in Both Eyes means clinically proven, irreversible reduction of sight in both eyes as a result of a Critical Illness. The corrected visual acuity must be:
1. less than 20/200; or
2. a visual field restriction to 20 degrees or less in both eyes.

Major Organ Transplant The clinical evidence of major organ failure, which requires the malfunctioning organ or tissue of the Covered Person to be replaced with an organ or tissue from a suitable human donor under generally accepted medical procedures. The organs and tissues covered by this definition are limited to liver, kidney, lung, entire heart, and pancreas. In order for the major organ transplant to be covered, the Covered Person must be placed on the United Network for Organ Sharing (UNOS) registry.

A benefit will be paid upon the Covered Person being placed on the registry with UNOS as a potential recipient of an organ transplant. The Date of Diagnosis is the date the Covered Person is placed on the registry with UNOS.

The remainder of any applicable benefit will be paid upon the completion of the organ transplant surgery. The Date of Diagnosis is the date the Covered Person undergoes transplant surgery.

Maximum Benefit Amount means the amount shown on the Policy Schedule. Total benefits payable under this Policy are limited to the Maximum Benefit Amount for each Covered Person.

Multiple Sclerosis means the occurrence of at least two episodes of well-defined neurological abnormalities, with objective evidence of lesions at more than one site within the central nervous system. In order for Multiple Sclerosis to be covered under this Policy, a Neurologist must make a definitive diagnosis of Multiple Sclerosis, supported by modern imaging and/or

investigative techniques. A Neurologist means a Doctor of Medicine certified by the American Board of Psychiatry and Neurology.

Open Heart Surgery means a surgical procedure that requires an incision through the chest and an incision in the heart and/or attached blood vessels to repair or replace one or more of the heart valves due to significant valvular heart disease that is diagnosed after a Covered Person's Effective Date of insurance.

Pacemaker Placement means the initial placement of a permanent pacemaker due to symptomatic sinus node dysfunction, high-grade atrioventricular (AV) block, or other serious cardiac arrhythmia that is diagnosed after a Covered Person's Effective Date of insurance.

Permanent Paralysis "Permanent Paralysis" means complete and irrecoverable loss of sensory and motor functions of two or more limbs which is diagnosed by a Physician after the Effective Date. If We pay for one of the following conditions: Permanent Paralysis or Loss of Two or More Limbs for a Covered Person, We will not pay for the other condition for that Covered Person.

Physician means a person who is a legally qualified practitioner of the healing arts. As such, he must be acting within the scope of his license under the laws in the jurisdiction in which he practices and providing only those services which are within the scope of his license.

[Pre-existing Condition means a sickness or physical condition for which, during the [6-12] months before the Issue Date, or last Reinstatement Date, the Covered Person received medical consultation, Diagnosis, advice or Treatment from a Physician or had taken prescribed medication. The Pre-existing Condition limitation will not be greater than 6 months for an individual who is issued coverage at the age of 65 years or older.]

Renewal Date means the date premiums are paid and the date the next premium (renewal premium) is due.

Severance means complete separation and dismemberment of the part from the body.

Severe Burns means that the Covered Person has sustained third degree burns covering at least {20 to 75}% of the surface area of His body. Third degree means the destruction of the skin through the entire thickness or depth of the dermis and the layer of tissue below the skin (subcutaneous tissue).

Stroke means a sudden impairment of brain function, due to acute cerebral hemorrhage, or acute cerebral occlusion that results in permanent damage, diagnosed by a Physician, based on abnormal neurologic findings on physical examination, or new abnormalities on CNS imaging studies. Stroke does not mean head injury, concussion, transient ischemic attack, or chronic cerebrovascular insufficiency.

Waiting Period means the period of time following the Effective Date during which no benefits are available. The Waiting Period is shown on the Policy Schedule.

We, Our, Us or the Company means National Family Care Insurance Company.

You or Your means the Insured Person named in the Policy Schedule.

ELIGIBILITY

You, Your Spouse and your Child(ren) are eligible to be Covered Persons under this Policy. For each Covered Person, We must receive an application and payment of the required premium. Each person must be acceptable to Us based on Our rules in effect at the time of application. All persons covered under this Policy are shown in the Policy Schedule (see TYPE OF COVERAGE) or in an attached endorsement.

If this is an Individual Policy, We insure You the Insured Person only.
If this is an Individual and Spouse Policy, We insure You and Your Spouse.
If this is a Family Policy, We insure You, Your Spouse and Your Child(ren).

Spouse means the lawful spouse of the Insured Person. “Spouse” also means a partner in any relationship that provides substantially all of the same rights and benefits of marriage, including but not limited to civil union partnerships.

Child means:
1. The unmarried child, stepchild, or grandchild of the Insured Person if the child is under 26 years of age. “Child” includes a child of blood, marriage, or civil union, or named in a court order duly entered. A Child is an Insured Person’s Child if the Insured Person is a party to a suit in which the Insured Person seeks to adopt the child.
2. The unmarried child or grandchild of the Insured Person, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, or physical handicap and who became so incapable prior to the age at which dependent coverage would otherwise terminate, subject to any Pre-existing Conditions limitation.

Coverage of Your newborn child begins from the moment of birth. Coverage for Your adopted child begins when You are a party to a suit in which You seek to adopt the Child. If this Policy is in force as an Individual Policy or Individual and Spouse Policy, a newborn or newly adopted Child will be covered for a period of 31 days after the birth or adoption. In order to continue coverage beyond this 31-day period, You must notify Us within 31 days of such birth or adoption and pay any additional premium due.

If the Policy in force is a Family policy, there is no additional premium for a newborn or newly adopted child.

TERMINATION OF INSURANCE

This Policy terminates at the earliest of:
1. the last day of the Grace Period for the payment of the premium for the Policy; or
2. the next Renewal Date after the Insured Person’s request to terminate the Policy; or
3. the date each Covered Person has received the Maximum Benefit Amount shown in the Policy Schedule.

If the Insured Person’s Spouse is a Covered Person, the Spouse’s coverage terminates upon the final divorce or annulment of marriage. Divorce also means dissolution of any relationship that provided substantially all of the same rights and benefits of marriage, including but not limited to civil union partnerships

If a Child is a Covered Person, the Child’s coverage terminates on the policy anniversary on or immediately following the date the Child:
1. marries; or
2. reaches the limiting age as described in the Eligibility section.

Coverage will not terminate on an unmarried Child who:
1. is incapable of self-sustaining employment by reason of mental illness, developmental disability, or physical handicap;
2. became so incapacitated prior to the age at which dependent coverage would otherwise terminate; and
3. is chiefly dependent upon You for support and maintenance.

Dependent coverage continues as long as this Policy remains in force and the Child remains in such condition. Proof of incapacity and continued dependence on You must be provided to Us within 60 days of the Child’s attainment of the limiting age. After this 60-day period, such proof must be provided to Us as often as may be required but not more frequently than annually after the second anniversary of the date the Child attains the limiting age.

If We accept a premium for coverage extending beyond the date, age, or event specified for termination as to a Covered Person, then coverage continues during the period for which premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

The Insured Person’s Spouse, if a Covered Person, will become the Insured Person upon the Insured Person’s death. The Spouse may continue coverage for all Covered Persons under this Policy. Written request to continue coverage for all Covered Persons and the applicable premium must be received by Us within 31 days after the date of the Insured Person’s death. If We do not receive such request and premium within 31 days, the Policy will terminate.

Termination of coverage by Us is without prejudice to any claim for loss which commenced while the Policy was in force.

Cancellation by the Insured

You may cancel this Policy at any time by written notice to Us at Our Home Office. Cancellation will be effective upon Our receipt of such notice or on a later date as may be specified in such notice. We will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the Effective Date of cancellation.

Conversion Privilege

If coverage of Your Spouse terminates due to divorce or annulment, or if coverage of a Child terminates due to the Child reaching the limiting age as stated in the Termination of Insurance provision, such covered Spouse or Child can obtain a new policy of insurance, without evidence of insurability, subject to the following conditions:

1. Authorization by law to issue such a policy at the time and in the jurisdiction the person applying for conversion resides.
2. Written application for the new policy and payment of the premium must be made to Us within 31 days after the date on which such person's coverage under the Policy terminates. The Effective Date of the new policy will be the date on which coverage under this Policy terminated.
3. The premium for the new policy will be at the rate for the class of risk at the applicant's age and tobacco/nicotine usage status for the type and amount of insurance provided as of the effective date of the new policy.
4. Any conditions excluded in this Policy are excluded in the new policy. The Waiting Period, Pre-existing Condition Limitation and the Time Limit on Certain Defenses provision is waived to the extent that such period has been met under this Policy. Benefits payable to the applicant under the new policy are reduced by benefits payable under this Policy.
5. The new policy will be the most similar policy then available for sale by us, or an available policy providing lesser benefits at the applicant's option.

When conversion is due to divorce or annulment, Children who are covered under this Policy may remain covered under this Policy or be covered under the new policy as elected by You and Your former spouse. Children may not be covered under both policies.

The premiums appropriate for the converted policy must be paid in order to have it issued and maintained in force.

If this Policy or a conversion policy is in force on You or your former spouse, and either remarries, such new spouse may apply to be covered under the appropriate policy. We must be advised of the remarriage by the completion of a new application for such new spouse. The new application is subject to Our underwriting and approval.

A Covered Person whose dependency has terminated and who desires to continue coverage under a new separate policy may do so by notifying Us in writing and paying the required premium.

If this is a Family policy, We will notify You of a dependent's right to convert at least 15 days but not more than 60 days prior to the termination of coverage. We will not send such notice for a newborn Child or Child adopted by You or Your Spouse after the Effective Date, unless You have notified Us of such birth or adoption.

CRITICAL ILLNESS BENEFITS

All benefits will be paid to You in a lump sum. Benefits are paid only for the Critical Illnesses, diseases and/or conditions shown in the Policy Schedule. No benefit will be paid for any other illness, disease or condition unless specifically stated. **THE FACE AMOUNT(S) AND MAXIMUM BENEFIT AMOUNT(S) WILL REDUCE BY 50% ON THE FIRST POLICY ANNIVERSARY AFTER THE INSURED PERSON ATTAINS AGE 70.**

We will pay the benefit amounts in the Policy Schedule if a Covered Person is diagnosed with one of the covered Critical Illnesses shown in the Policy Schedule when:

1. the Date of Diagnosis is after Waiting Period;
2. the Date of Diagnosis is while coverage under the Policy is in force; and
3. the Critical Illness is not otherwise excluded.

We will pay the benefit for Coronary Artery Bypass Graft Surgery only once per lifetime per Covered Person.

We will pay the benefit for Angioplasty only once per lifetime per Covered Person.

The sum of all benefits payable for any Covered Person shall not exceed the Maximum Benefit Amount shown in the Policy Schedule.

If the Date of Diagnosis of a Critical Illness occurs during the Waiting Period, We will refund all premiums paid and terminate the Policy.

The Covered Person can only receive benefits for a Critical Illness listed in the Policy Schedule one time except as described in the Additional Occurrence Benefit and Recurrence Benefit provisions.

Additional Occurrence Benefit If a Covered Person has been diagnosed with and received a benefit for a Critical Illness shown in the Policy Schedule and is subsequently diagnosed with a different Critical Illness, We will pay the full benefit for that Critical Illness as shown on the Policy Schedule up to the Maximum Benefit Amount if:
1. the Date of Diagnosis is at least 6 months after any previous Date of Diagnosis of a Critical Illness;
2. the Date of Diagnosis of the subsequent Critical Illness occurs while coverage under the Policy is in force; and
3. the subsequent Critical Illness is not otherwise excluded.

Recurrence Benefit If a Covered Person has been diagnosed with and received a benefit for a Critical Illness shown in the Policy Schedule and is subsequently diagnosed with the same Critical Illness (other than Coronary Artery Bypass Graft Surgery and Angioplasty), We will pay the full benefit for that Critical Illness as shown on the Policy Schedule up to the Maximum Benefit Amount if:
1. the Date of Diagnosis of the recurrence is at least 12 months after any previous Date of Diagnosis of the same Critical Illness and the Covered Person has not received treatment (excluding follow-up visits to the Covered Person's Physician and medications) during the 12 months between the Dates of Diagnosis for the same Critical Illness; and
2. the Date of Diagnosis for the recurrence occurs while coverage under the Policy is in force; and
3. the recurrent Critical Illness is not otherwise excluded.

We will not pay any further benefits after the first recurrence.

Claims for benefits under this Policy not satisfying all the criteria for diagnosis are subject to review by an independent physician consultant chosen by us. Diagnosis must be submitted to support each claim.

LIMITATIONS AND EXCLUSIONS

Pre-existing Condition Limitation
We will not pay benefits for a Critical Illness caused or contributed to by, or resulting from, a Pre-existing Condition.

This Limitation will not apply to a Critical Illness that occurs after coverage under this Policy is in force for the Covered Person for at least 12 months after the Covered Person's most recent Effective Date. This limitation will not be greater than 6 months for an individual who is issued coverage at the age of 65 years or older.

If coverage under this Policy replaces a prior plan of critical illness insurance, a person who is otherwise eligible under the Policy shall be covered without regard to any evidence of insurability requirement if:
1. such person was validly covered under the prior plan on the Effective Date;
2. the applicable premium is paid; and
3. the prior coverage is terminated upon issuance of this coverage.

If coverage under this Policy replaces a prior plan of Critical Illness insurance and the Covered Person does not satisfy this Policy's Pre-existing Condition limitation, but can satisfy their prior plan's pre-existing condition limitation giving credit for all time insured under both policies, then We will pay the lesser of:
1. benefits under this Policy without application of the Pre-existing Conditions limitation; or
2. benefits of the prior plan.

The following conditions must be met:
1. The Covered Person was validly covered under the prior plan on the Effective Date;
2. the applicable premium is paid; and

3. the prior coverage is terminated upon issuance of this coverage.

Waiting Period
We will not pay any benefits for a Loss that occurs within the Waiting Period shown in the Policy Schedule following the Effective Date of this Policy. If a Loss occurs within the Waiting Period shown in the Policy Schedule and would otherwise be covered under this Policy, You have the option to return the policy and receive a refund of all premiums paid.

Exclusions
We will not pay benefits for Loss contributed to, caused by or resulting from Your:

1. Having or being diagnosed with any other disease, sickness or incapacity, even if the disease or condition was caused, complicated or aggravated by the specified Critical Illness.
2. Being diagnosed with a Critical Illness during the Waiting Period.
3. Having a Pre-Existing Condition subject to the pre-existing conditions limitation.
4. Participating or attempting to participate in an illegal act or working at an illegal job.
5. Being under the influence of any narcotic unless administered on the advice of a Physician.
6. Injuring or attempting to injure yourself intentionally, regardless of mental capacity.
7. Committing or attempting to commit suicide, regardless of mental capacity.
8. Participating in any sporting event for pay or prize money.
9. Being exposed to war or any act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
10. Alcoholism or drug addiction.
11. Services or treatment rendered by a Physician, psychiatrist, or psychologist who is the Covered Person or His spouse, Children, brothers, sisters, or parents, any other person related to the Covered Person by blood or marriage, or any person residing in His household.

PREMIUM PROVISIONS

The first premium is due on the policy Effective Date. Each premium after the first is due on the last day of the period for which the most recent premium was paid. Premiums must be accepted by Us at Our Home Office. Coverage will remain in effect as long as premiums are paid when due or on the last day of the grace period. Premiums will be at the premium rates then in effect on the Renewal Date.

We cannot, without Your consent, cancel, refuse to renew or restrict this Policy as long as You pay the premium on time, except to make changes in premium rates.

We may change the premium rates for this Policy on any policy anniversary. However, We may do so only if We change it for all policies in Your class. We will send written notice at least 31 days in advance of any change in renewal premium. The notice will be mailed to Your last known address on record. No change in premiums is effective unless this notice is mailed.

Grace Period
We will grant a grace period of 31 days for the payment of each premium falling due after the first premium. During the grace period, the Policy continues in force. If the premium is not paid by the end of the grace period, coverage will be terminated.

Reinstatement
If any premium is not paid before the grace period ends, this Policy will lapse. If We later accept premium without an application for reinstatement, the Policy will be reinstated upon Our receipt of the premium due.

If an application for reinstatement is required for reinstatement, We will issue a conditional receipt for the premium paid and received by us. The Policy will then be reinstated upon the earlier of:
1. The day We approve your application for reinstatement; or
2. 45 days from the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval of your application for reinstatement.

The reinstated policy will cover a Critical Illness diagnosed after the date of reinstatement only. All other rights and privileges under the reinstated Policy remain the same subject to any provisions of the reinstatement.

Premium will be applied to a period for which premiums have not been previously paid. We will not apply any premium to any period more than 60 days before the reinstatement date.

Refund of Unearned Premium
If this Policy terminates due to death, We will refund the portion of any premiums paid which were applied to periods following the date of the Covered Person's death to the beneficiary.

Unpaid Premiums
When a claim is paid, any premium then due and unpaid may be deducted by Us from the claim payment and applied to the premium due. If the premium due is more than the amount payable for the claim, no benefit is payable.

CLAIMS PROCEDURES

Notice of Claim
Written notice of claim must be given to Us within 20 calendar days after a loss covered by this Policy occurs, or as soon as reasonably possible. Notice given by or on behalf of the Insured Person or the beneficiary to Us at Our Home Office [13530 Inwood Rd. Dallas, TX 75244], or to Our authorized agent with information sufficient to identify the Insured Person will be deemed notice to Us. The notice should include the Policy Number as shown on the Policy Schedule and the name of the Covered Person. Notice should also include the name and address of the individual submitting the notice along with a description of their relationship to the Covered Person, if different, and a statement that payment of a claim is being requested.

Claim Forms
When We receive the notice of claim, We will send You the forms for filing the required proof of loss. If We do not send these forms within 15 calendar days, it shall be deemed You met the proof of loss requirement by giving Us written proof of the cause, nature and extent of the loss within the time limit stated in the Proof of Loss section.

Proof of Loss
Written proof of loss satisfactory to Us must be given to Us within 90 calendar days after such loss. If it is not possible to give written proof in the time required, We will not reduce or deny the claim for this reason if such proof is filed as soon as reasonably possible. In any event, the proof required must be given to Us no later than one year after the time proof is otherwise required, unless You are legally incapacitated.

Timely Payment of Claim
Benefits for any loss covered by this Policy will be paid immediately after We receive written proof satisfactory to Us and all other provisions herein are met.

Payment of Claim
All benefits will be paid to You, if living, or to the beneficiary. If no beneficiary is living, benefits will be paid to Your estate. If benefits are payable to Your estate, We may pay up to $1,000 to any relative of Yours who We find is entitled to it. Any payment made in good faith will fully discharge Us to the extent of the payment.

If You provide Us with a written release to do so, we may, at Our option, pay benefits directly to the institution or person rendering treatment or services covered under the Policy.

Overpayment Reimbursement
We have the right to recoup or recover any overpayment We make, for any reason, in processing a claim. We can only do so no later than two years after the date of the error, unless the overpayment was a result of fraud. We will notify You within 15 days after We discover the error. Such notice will clearly state the nature of the error and the amount of the overpayment. We must be reimbursed in full for the amount of the overpayment.

Claim Review If We deny a claim, We will provide written notice of Our reason(s) for the denial and the provision(s) herein that We relied upon within 15 days of Our decision. You have the right to ask Us to review the claim and the right to submit additional information to Us that might change Our decision.

GENERAL PROVISIONS

Entire Contract
This Policy, the attached application for the Policy, and any attached endorsements, amendments, or riders, if any, are the entire contract. No change in this Policy is effective unless approved by an officer of Ours. This approval must be attached to this Policy. No agent may change this Policy or waive any of its provisions.

Time Limit On Certain Defenses
After this Policy is in effect for 2 years during the lifetime of the Covered Person, no misstatements, except fraudulent misstatements, contained in the application shall be used to void the Policy or deny any claim for loss commencing after such 2-year period.

No claim for loss incurred commencing after 12 months from the Policy Effective Date, will be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed prior to the Policy Effective Date.

Assignment
You, or any Covered Person, may assign His rights, privileges and benefits under this Policy to the institution or person rendering services as allowed in the Payment of Claims provision. We will be bound by an assignment of the Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person as assignor or any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy for the assignor remains in force. The assignee takes only such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of this Policy.

When We furnish You written acknowledgement of the assignment, the assignment becomes effective on the date You signed Our form unless You specify a later date. We are not liable for payments made or action taken prior to Our written acknowledgement of the assignment.

Change of Beneficiary
Unless You indicate that a Beneficiary cannot be changed, you may change the Beneficiary at any time by written request. The Beneficiary's consent is not needed. This change will take effect on the date the notice is signed. Any payment by Us prior to receipt of such change will fully discharge Us to the extent of such payment.

Conformity with State and Federal Law
The laws of the federal government and Your state of residence on the Issue Date apply. If this Policy conflicts with the laws of the federal government or Your state on the Issue Date, they are considered changed to meet those laws. The change will be to the law's minimum requirement.

Duty of Cooperation
You, the Covered Person and any Beneficiary shall reasonably cooperate during any investigation or adjudication of a claim. This cooperation shall include providing information We request and authorizing the release of medical records to Us.

Legal Action
You cannot bring a legal action to recover benefits under this Policy for at least 60 days after You have given Us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

Misstatement of Age and/or Gender
If the Covered Person's age and/or gender has been misstated, an adjustment in premiums, coverage or both will be made based on the correct age and/or gender. If, according to the correct age, the coverage provided by this Policy would not have become effective or would have ceased, Our only liability during the period in which the Covered Person was not eligible for coverage shall be limited to a refund of premiums.

Misstatement of Tobacco/Nicotine Use
If, during the first two years of this Policy, the tobacco/nicotine status of the Covered Person has been misstated, We will revise this Policy and any applicable riders' benefit amounts to the amount the premium paid would have purchased using the correct tobacco/nicotine status on the Issue Date.

Physical Examination and Autopsy
We have the right to have any Covered Person examined when and as often as is reasonable while a claim is pending and to have an autopsy performed where it is not forbidden by law. If We initiate the request, either or both will be done at Our expense.

Time of Coverage
Coverage starts on the Issue Date at 12:01 a.m. in the time zone of Your permanent residence. It ends at 12:01 a.m. in the same time zone on the renewal date, subject to the Grace Period. Each time this Policy is renewed, the new term begins when the old term ends.