Allstate
Benefits

July 23, 2015

I would like to personally thank you for choosing Allstate Benefits to help you prepare for the future.

Your Cancer coverage is designed to supplement your primary health coverage, and pays benefits directly to you, unless otherwise assigned. Since the benefits are paid directly to you, they can be used for any expenses, related or unrelated that you might incur. Your coverage becomes effective on the date described in your policy or certificate.

You may visit our website at www.allstatebenefits.com/mybenefits for information or claim forms. If you need additional information or service, you may call our Customer Care Center at 1-800-521-3535.

Welcome to the Allstate Benefits family!

Sincerely,

Gregory J. Guidos
President

POLICY/CERTIFICATE NUMBER	: 80M7627502
INSURED NAME	: CHAD C SMITH
AGENT NAME	: FRANCISCO COMBES
AGENT NUMBER	: 4KYG0
TELEPHONE NO.	: (770)361-9808
ADDRESS	: 426 COLLEGIATE DR POWDER SPRINGS GA 30127

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan's customers' Protected Health Information, to provide those customers with notice of our legal duties and privacy practices with respect to Protected Health Information, and to send notification to affected customers if there is a breach of unsecured Protected Health Information. If your state provides privacy protections that are more stringent than those provided by HIPAA, we will maintain your Protected Health Information in accordance with the more stringent state standard.

This Notice applies to "Protected Health Information" associated with "Health Plans" issued by American Heritage Life Insurance Company.

This Notice describes how we may use and disclose Protected Health Information to perform claims handling, payment, general insurance operations, and for other purposes that are permitted or required by law. Use or disclosure of your Protected Health Information for the purposes described in this Notice may be made in writing, orally, or by electronic means.

We are required to abide by the terms of this Notice. However, we may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all of your Protected Health Information that we maintain, including any information we created or received prior to issuing the new notice. If we make a material revision to our Privacy Notice, copies will be sent to you if you are then currently insured under our Plan.

Protected Health Information means information about you that is created or received by us and during the administration of coverage under the Plan, which identifies you or for which there is a reasonable basis to believe the information can be used to identify you and that relates to:

1) the past, present or future physical or mental health condition of the individual; or
2) the provision of health care to the individual; or
3) the past, present or future payment for the provision of health care to the individual.

Uses and Disclosures of Protected Health Information With Your Written Authorization

Except as described in the next section of this Notice, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. For example, most uses and disclosures of psychotherapy notes, uses and disclosures of Protected Health Information for marketing purposes, and disclosures that constitute a sale of Protected Health Information will be made only with your authorization. You have the right to revoke that authorization in writing at any

time, except to the extent that we have already taken action in reliance on the authorization; or the authorization was obtained as a condition of obtaining coverage, to the extent that other law allows the insurer to contest a claim under the policy or the policy itself.

Uses and Disclosures of Protected Health Information Without Your Written Authorization

For Payment. We may make use of and disclose your Protected Health Information without your written authorization as may be necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims or certify these services are covered under your Plan.

For Plan Administrative Operations. We may make use of and disclose your Protected Health Information without your written authorization as necessary for our Plan administrative operations. Plan administrative operations include our usual business activities, examples of which are management, licensing, peer review, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, claims handling, complaint handling and other functions related to your Plan. We are prohibited from using or disclosing genetic information for underwriting purposes.

To Individuals Involved In Your Care. We may, without your written authorization, for the purposes of treatment, payment or Plan administrative operations, disclose the fact that you are covered under a Plan or that payment has been processed to a family member, other relative, your close personal friend or any other person you may identify. In these circumstances, we would not disclose any Protected Health Information which is not directly relevant to that person's involvement with your care or with payment for your care.

If you have designated a person to receive information regarding payment of the premium or pay premium via credit card, we may inform that person or credit card facility when your premium has not been paid or received by us.

We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

To Our Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these may include, but are not limited to our duly appointed insurance agents, financial auditors, reinsurers, legal services, enrollment and billing services, claim payment and medical management services. We may provide access to your Protected Health Information without your written authorization to one or more of these outside persons or organizations who assist us with payment or Plan administrative operations. We require these business associates to appropriately safeguard the privacy of your information.

To Plan Sponsors. If you are enrolled in a group health plan, we may share summary health information with your employer, union, or other employee organization that sponsors and maintains the group health plan, for purposes of obtaining premium bids; or modifying, amending, or terminating the group health plan; or enrollment and disenrollment information. Summary health information excludes genetic information.

For Other Products and Services. We may contact you without your written authorization to provide information regarding Plan upgrades or additional benefits that may be of interest to you. For example, we may use the fact that you currently are insured under a Plan for the purpose of communicating to you about changes to our Plan or products that could enhance or add value to existing coverage.

For Disclosure With Authorization. Unless otherwise excluded in this notice, we will not disclose any other Protected Health Information to any person or entity not specifically mentioned elsewhere in this Notice without your express written authorization.

For Other Uses and Disclosures. We are permitted or required by law to make some other uses and disclosures of your Protected Health Information without your authorization. We may release your Protected Health Information:

- if required by law to a government authorized health oversight agency or company conducting audits, investigations, or civil or criminal proceedings.
- if required to do so by a court or administrative ordered subpoena or discovery request. In most cases you will have notice of such a release.
- for public health activities, such as required reporting of disease, injury, birth and death and for required public health investigations.
- as required by law if we suspect child abuse or neglect or if we believe you to be a victim of abuse, neglect or domestic violence.
- to the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls.
- to law enforcement officials as required by law to report wounds, injuries or crimes.
- to coroners, medical examiners and/or funeral directors consistent with law.
- for a national security or intelligence activity or, if you are a member of the military, as required by the armed forces.
- to workers' compensation agencies or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Your Rights

Right to Inspect and Copy Your Protected Health Information. You may have access to our records that contain your Protected Health Information in order to inspect and obtain copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from our Privacy Officer and submit the completed form to our Privacy Office. If you request copies, we may charge you copying and mailing costs. If you request a copy of your Protected Health Information in electronic form, we will provide it to you electronically only if the record is readily producible in electronic form.

Right to Amend Your Protected Health Information. You have the right to request that we amend your Protected Health Information maintained in our enrollment, payment, claims adjudication and case or medical management records, or other records we use to make decisions about you. If you desire to amend these records, please obtain an amendment request form from our Privacy Officer and submit the completed form to our Privacy Office. We will comply with your request unless special circumstances apply. If your physician or other health care provider created the information that you desire to amend, you should contact the provider to amend the information.

Right to an Accounting of the Disclosures of Your Protected Health Information. Upon request, you may obtain an accounting of certain disclosures of your Protected Health Information made by us on or after April 14, 2003, excluding disclosures made earlier than six years before the date of your request. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for the subsequent accounting statements.

Right to Request Confidential Communications. We will accommodate your reasonable request to receive communications of your Protected Health Information from us by alternative means of communication or at alternative locations if the request clearly states that disclosure of that information could endanger you.

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Right to Request Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your Protected Health Information to family members and others involved in your care or payment for care; or some of our uses and disclosures used to carry out treatment, payment, or Plan administrative operations, by notifying us of your request for a restriction in writing mailed to the contact identified at the end of this Notice. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate your requests. We retain the right to terminate an agreed-to restriction. In the event of a termination of an agreed-to restriction by us, we will notify you of such termination, but the termination will only be effective for Protected Health Information we receive after we have notified you of the termination. You also have the right to terminate any agreed-to restriction by contacting us using the "Contact Information" provided at the end of this Notice.

Personal Representatives. You may exercise your rights through a personal representative who will be required to produce evidence of his or her authority to act on your behalf. Proof of authority may be made by a notarized power of attorney, a court order of appointment of the person as your legal guardian or conservator, or if you are the parent of a minor child. We reserve the right to deny access to your personal representative.

Right to Receive Paper Copy of this Notice. You may obtain a copy of this Notice. You may obtain a paper copy of this Notice even if you agreed to receive such notice electronically. Please contact us and we will mail it to you.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, send it in writing to the "Contact Information" at the address listed at the end of this Notice. There will be no retaliation for filing a complaint.

You may obtain a copy of this Notice by writing to us at the contact address below.

Contact Information

If you have questions or need further assistance regarding this Notice, you may contact:

Allstate Benefits
Attn: HIPAA Privacy Officer
1776 American Heritage Life Drive
Jacksonville, Florida 32224

Or, you may telephone the Customer Care Center at 1-800-521-3535.

Allstate Benefits

Important Privacy Policy Notice

At Allstate Benefits ("AB"), we value you as a customer. We also share your concerns about privacy. We are sending this notice to explain how we treat personal information ("customer information") that is not public. This is information that we obtain from you or other sources when we provide you with products and services.

We want you to know that: we respect your privacy; and we protect your information.

- We do not sell customer information.
- We do not share your information with: persons; companies; or organizations outside of AB that would use that information to contact you about their products and services.
- We expect persons or organizations that provide services on our behalf to keep your information confidential. We also expect them to use your information only to provide the services we've asked them to perform.
- We communicate to our employees about the need to protect your information. We have established safeguards (these are physical, electronic and procedural) to protect this information.

Below are answers to questions that you might have about privacy. You may be wondering...

What do we do with your information?

AB does not sell your customer or medical information to anyone. We do not share it with companies or organizations outside of AB that would use that information to contact you about their own products and services. If this were to change, we would offer you the option to opt out of this type of information sharing. Also, we would obtain your consent before we share medical information for marketing purposes.

Your agent or broker may use your information to help you with your insurance needs. We may also communicate with you about products, features, and options in which you have expressed an interest. Without your consent, we may provide your information to persons or organizations in and out of AB. This would be done as permitted or required by law. We may do this to:

- Fulfill a transaction you have requested.
- Service your policy.
- Market our products to you.
- Investigate or handle claims.
- Detect or prevent fraud.
- Participate in insurance support organizations (Information from a report by an insurance support organization may be retained by that organization and distributed to other persons.).
- Comply with lawful requests from regulatory and law enforcement authorities.

These persons or organizations may include:

- Our affiliated companies.
- Companies that perform services, including marketing, on our behalf.
- Other financial institutions with which we have an agreement for the sale of financial products.
- Other insurance companies to perform their role in an insurance transaction involving you.
- Businesses that conduct actuarial or research studies.
- Persons requesting information pursuant to a subpoena or court order.
- Your agent or broker.
- An employer, if your premiums are payroll deducted.
- The creditor who sold you insurance, if your policy is credit insurance.

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What kind of customer information do we have, and where did we get it?
Much of the information that we have about you comes from you. When you perform certain transactions, you may give us information such as your name, address, and Social Security number. These transactions include when you submit: an application for insurance; a request for insurance; a request for products and services we offer; or a request for an insurance quote. We may have contacted you by telephone or mail for additional information. We keep information about the types of services you purchase from us and our affiliates. Examples of this include premiums, fund values, and payment history. We may collect information from outside sources such as consumer reporting agencies and health care providers. The information we collect may include the following:

- Motor vehicle reports.
- Credit reports.
- Medical information.

How do we protect your customer information?
We expect any company with whom we share your information to use it only to provide the service we have asked them to perform. Information about you is also available within AB to those individuals who may need to use it to fulfill and service the needs of our customers. We communicate the need to protect your information to all employees and agents. We especially communicate this need to individuals who have access to it. Plus, we have established physical, electronic, and procedural safeguards to protect your information. Note that if your relationship with us ends, your information will remain protected. This protection will be provided according to our privacy practices outlined in this Important Notice.

How can you find out what information we have about you?
You may request to see, or obtain by mail, the information about you in our records. If you believe that our information is incomplete or inaccurate, you may request that we correct, add to, or delete from the disputed information. In order to fulfill your request, we may make arrangements to copy and disclose your information to you on our behalf. This may be done with an insurance support organization or a consumer reporting agency. You may also request a more complete description of the entities to which we disclose your information, or the conditions that might warrant such disclosures. Please send any of the requests listed above in writing to:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

If you are an Internet user …
Our website, www.allstatebenefits.com, provides information about AB, our products, and the agencies and brokers that represent us. You may also perform certain transactions on the website. When accessing www.allstatebenefits.com, please be sure to read the Privacy Statement that appears there. To learn more, the www.allstatebenefits.com Privacy Statement provides information relating to your use of the website. This includes, for example:

1) our use of online collecting devices known as “cookies”;
2) how we collect information such as IP address (the number assigned to your computer when you use the Internet), browser and platform types, domain names, access times, referral data, and your activity while using our site;
3) who should use our website;
4) the security of information over the Internet;
5) links and co-branded sites.

We hope you have found this notice helpful. If you have any questions or would like more information, please don’t hesitate to contact your agent or write us at:

AB
Policyholder Services (Privacy Section)
1776 American Heritage Life Drive
Jacksonville, FL 32224-6687

This notice is being provided on behalf of the following companies:

American Heritage Life Insurance Company
Bluegrass Life Insurance Company
Acme United Insurance Company
SMA Life Assurance Company
Holiday Life Insurance Company
Kentucky Home Mutual
Keystone State Life
National Guardian Life

Allstate Benefits

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive Jacksonville, FL 32224-6688

REQUIRED OUTLINE OF COVERAGE FOR HOSPITAL INTENSIVE CARE RIDER ICR2GA

Supplemental Benefit Insurance, Providing Coverage for Hospital Intensive Care Confinement

The coverage described in this outline provides supplemental coverage and is issued only to supplement coverage already in force.

RETAIN THIS FOR YOUR RECORDS!

Read Your Contract Carefully! This outline of coverage provides a brief description of some of the important features of the rider. This is not the insurance contract and only the actual policy and rider provisions control. The policy and rider set forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR CONTRACT CAREFULLY!**

Supplemental Benefit Coverage – This coverage is designed to provide you with supplemental hospital intensive care coverage. It provides benefits only when a covered person is confined in a Hospital Intensive Care Unit. It does not provide for daily hospital expenses.

BENEFITS

Hospital Intensive Care Unit Confinement. $100 per day, per unit, up to 45 days for each period of continuous hospital intensive care unit confinement. Benefit reduces to 50% at covered person's age 70.

Ambulance. Actual charges for transporting a covered person to the hospital for admission to a hospital intensive care unit. Not paid if Ambulance benefit is paid under the policy.

WAITING PERIOD/EXCEPTIONS/ LIMITATIONS

Waiting Period. The rider has a 30 day waiting period for confinement due to cancer or specified diseases. No benefits are payable for cancer or a specified disease for 2 years from the rider date, if cancer or specified disease is diagnosed prior to the end of the waiting period.

No benefits are payable under this rider for a continuous confinement that occurs during a hospitalization that began before the rider date.

No benefits are payable under this rider if a covered person's admission to a hospital intensive care unit is due to:

1. attempted suicide or intentional self-inflicted injury; or
2. intoxication or being under the influence of drugs not prescribed by a physician; or
3. alcoholism or drug addiction.

No benefits are payable under this rider for confinements in:

1. progressive care units; or
2. sub-acute intensive care units; or
3. intermediate care units; or
4. private room with monitoring; or
5. step-down units; or
6. any other lesser care treatment units.

EFFECTIVE DATE

The effective date of the rider is the policy date assigned by the home office, not the date of application.

RENEWABILITY

This rider is guaranteed renewable for life subject to change in premiums by class.

GRACE PERIOD

Provides for 31 days from the due date to pay premiums.

PREMIUMS

Premiums may change on a class basis. A notice is mailed 60 days in advance of any change. A grace period is granted for payment of each premium after the first. The rider remains in force during the grace period. Family Plan coverage may include you, your spouse and your unmarried dependent children.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

REQUIRED OUTLINE OF COVERAGE FOR WELLNESS BENEFIT RIDER WBR5
RETAIN THIS FOR YOUR RECORDS!

This coverage is not MEDICARE SUPPLEMENT coverage. If you are eligible for Medicare, review the *Medicare Supplement Buyer's Guide,* which is available from the Company.

READ YOUR CONTRACT CAREFULLY- This outline provides a brief description of some of the important features of your contract. This is not the insurance contract and only the contract provisions control. The contract itself sets forth, in detail, the rights and obligations of both you and the Company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

Supplemental Benefit Coverage. This coverage is designed to provide you with supplemental wellness benefit coverage.

BENEFITS

Wellness Benefit. We pay this benefit if a covered person has an eligible wellness benefit performed. We pay the amount shown on page 3 of the policy per calendar year per covered person for one of the eligible wellness benefits. Each covered person is covered for no more than the amount shown on page 3 of the policy per calendar year.

The eligible wellness benefits are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

EXCEPTIONS

The exceptions and limitations provision of the policy applies to the rider.

TERMINATION

The rider terminates at the earliest of: the end of the grace period for the payment of the premium for the policy or the rider; or when the policy terminates. If we accept a premium that extends coverage past the termination date, coverage continues until the end of that premium period.

RENEWABILITY

The renewability provision of the policy applies to the rider, subject to the termination provision of the rider.

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CP10 CANCER AND SPECIFIED DISEASE POLICY

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, FL 32224-6688

REQUIRED OUTLINE OF COVERAGE FOR CANCER AND SPECIFIED DISEASE INSURANCE POLICY FORM CP10BGA

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the Company.

RETAIN THIS FOR YOUR RECORDS!

Read Your Policy Carefully! This outline of coverage provides a brief description of some of the important features of the policy. This is not the insurance contract and only the actual policy provisions control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Limited Benefit Health Coverage – Policies of this category are designed to provide persons insured limited or supplemental coverage. This policy is designed to provide coverage paying benefits only when certain losses occur as a result of cancer or a specified disease (Muscular Dystrophy; Poliomyelitis; Multiple Sclerosis; Encephalitis; Rabies; Tetanus; Tuberculosis; Osteomyelitis; Diphtheria; Scarlet Fever; Epidemic Cerebrospinal Meningitis; Undulant Fever; Sickle Cell Anemia; Rocky Mountain Spotted Fever; Smallpox; Addison's Disease; Hansen's Disease; Tularemia; Bubonic Plague; Typhoid Fever) first diagnosed on or after the effective date, subject to the Waiting Period, Exceptions and Limitations. Coverage is provided for the benefits outlined in the benefits section.

BENEFITS

Hospital Confinement. $200 per day up to 70 days for one confinement.

Inpatient Drugs and Medicine. Actual in-hospital charges, up to $10 per day.

Surgery. Surgical fee: up to $3,000, based on the surgical table in the policy. Outpatient surgery pays 150% of surgical benefit.

Second Surgical Opinion. Actual charges up to $200, after diagnosis and before surgery.

Physician's Attendance. Actual charges up to $30 per day while hospital confined. Limited to one visit per day by one doctor.

Private Duty Nursing Services. Actual charges up to $100 per day while hospital confined.

Radiation Therapy, Radio-Active Isotopes Therapy, Chemotherapy, Immunotherapy. Actual charges up to $10,000 per 12 month period.

Blood, Plasma and Platelets. Actual charges for: blood, plasma, platelets, and transfusions (including administration charges); processing and procurement costs; and crossmatching up to $10,000 per 12 month period. Donor replaced blood is not covered.

Ambulance. Actual charges up to $200 per continuous confinement for transporting a covered person.

Anesthesia. Actual charges up to 25% of the surgical benefit paid. Maximum skin cancer benefit $100.

Non-local Transportation. Actual cost of round trip coach fare by common carrier or $.40 per mile for round trip personal vehicle transportation over 70 miles, not to exceed 700 miles.

Family Member Lodging and Transportation.

1) *Lodging.* Actual cost of a single room in a motel, hotel, etc., up to $100 per day. Maximum: 60 days per confinement; and
2) *Transportation.* Actual cost of round trip coach fare by common carrier, or $.40 per mile personal vehicle allowance for round trips between 70 and 700 miles. Family Member Transportation is not paid if personal vehicle transportation benefit is paid under the Non-local Transportation benefit when the family member lives in the same city or town as the covered person.

Outpatient Lodging. Actual cost of a single room in a motel, hotel, etc., up to $100 per day, for outpatient radiation or chemotherapy treatment at a non-local treatment facility more than 100 miles from covered person's home. Limited to $4,000 per 12 month period beginning from 1st day of treatment.

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Prosthesis. Actual charges up to $2,000 for prosthetic devices prescribed as a direct result of surgical cancer or specified disease treatment, and which require surgical implantation. Limited to $2,000 per covered person, per amputation.

Extended Care Facility. Actual charges up to $100 per day. Confinement period is limited to the number of days the Hospital Confinement benefit was paid. Confinement must begin within 14 days after hospital confinement.

Skin Cancer. Actual charges for skin cancer surgery up to $120 when a physician who is not a pathologist diagnoses it. If more than one skin cancer is removed at the same time, $60 is paid per skin cancer removed after the first. Skin cancers diagnosed by a pathologist are eligible for other policy benefits.

Government or Charity Hospital. $100 per day in lieu of all other benefits.

Ambulatory Surgical Center. Actual charges, up to $250 per day, when surgery is performed.

New or Experimental Treatment. Actual charges when the attending physician judges such treatment necessary and superior to generally accepted treatments. Limited to $10,000 per 12 month period.

Hospice Care. One of the following for persons diagnosed as terminally ill:

1) *Freestanding Hospice Care Center.* Actual cost for confinement in a licensed hospice care center, up to $100 per day.
2) *Hospice Care Team.* Actual cost, up to $100 per visit for hospice care services in patient's home.

Physical or Speech Therapy. Actual charges up to $25 per day.

Extended Benefits. If hospital confinement is more than 70 days, we pay the actual hospital charges, up to $200 per day, for confinements which begin on the 71st day until discharge. This benefit is paid in lieu of all other benefits.

At Home Nursing. Actual charges up to $100 per day. Must be required and authorized by the attending physician. Limited to the number of days that the Hospital Confinement Benefit is paid.

Waiver of Premium. Premiums are waived after insured is disabled for 90 days as long as the insured remains disabled. Disability must be a direct result of cancer.

WAITING PERIOD/ EXCEPTIONS/ LIMITATIONS

Waiting Period. This policy has a 30 day waiting period for confinements due to cancer or specified diseases. No benefits are payable for cancer or a specified disease for 2 years from the policy date, if cancer or a specified disease is diagnosed after you sign the application and before the end of the waiting period.

Exceptions. We will not pay for: losses not directly due to cancer or specified disease, subject to the Incontestability provision; or any disease or incapacity that has been caused, complicated, worsened, or affected by cancer or a specified disease or as a result of cancer or specified disease treatment.

EFFECTIVE DATE

The effective date of the policy is the policy date assigned by the home office, not the date of the application.

RENEWABILITY

This policy is guaranteed renewable for life subject to change in premiums by class.

PREMIUMS

Premiums may change on a class basis. A notice is mailed in advance of any change. A grace period of 31 days is granted for payment of each premium after the first. The policy remains in force during the grace period. Family Plan coverage may include you, your spouse and your unmarried dependent children.

AMERICAN HERITAGE LIFE INSURANCE COMPANY
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(904) 992-1776

A Stock Company

REQUIRED OUTLINE OF COVERAGE FOR CANCER INITIAL DIAGNOSIS LEVEL BENEFIT RIDER FORM CLR1 CANCER INITIAL DIAGNOSIS PROGRESSIVE BENEFIT RIDER FORM CPR1

SUPPLEMENTAL COVERAGE TO CANCER AND SPECIFIED DISEASE POLICIES

THIS IS NOT A MEDICARE SUPPLEMENT RIDER. If you are eligible for Medicare, review the Medicare Supplement Buyers Guide available from the Company.

RETAIN THIS FOR YOUR RECORDS!

YOUR POLICY CONTAINS ONE OR MORE OF THE FOLLOWING INITIAL DIAGNOSIS RIDERS. PLEASE SEE THE POLICY SPECIFICATIONS (PAGE 3) OF YOUR POLICY FOR INFORMATION REGARDING YOUR ADDITIONAL BENEFITS, NUMBER OF UNITS AND PREMIUMS.

Read Your Contract Carefully! This outline of coverage provides a brief description of some of the important features of the riders that may be attached to your policy. This is not the insurance contract and only the actual policy and rider provisions control. The policy and riders set forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR CONTRACT CAREFULLY!**

Supplemental Benefit Health Coverage - Coverages of this category are designed to provide persons insured limited or supplemental coverage. These riders are designed to provide you with coverage paying benefits only when certain losses occur as a result of cancer first diagnosed on or after the rider date. Coverage is provided for the benefits outlined in the benefits section. The benefits described in the benefits section may be limited by the Waiting Period/Exceptions section.

CLR1 – CANCER INITIAL DIAGNOSIS LEVEL BENEFIT RIDER

This rider may or may not be a part of your contract – see page 3 of your policy.

BENEFIT

Initial Diagnosis Benefit. Pays a one-time benefit of $500, per person, per unit, when a covered person is first diagnosed as having cancer (other than skin cancer). Payable only once per covered person.

Termination. This rider terminates: after the grace period when the premium is not paid; or if the base policy terminates; or on the next renewal date after termination is requested; or when a benefit is paid on all covered persons.

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CPR1 – CANCER INITIAL DIAGNOSIS PROGRESSIVE BENEFIT RIDER

This rider may or may not be a part of your contract – see page 3 of your policy.

BENEFIT

Progressive Benefit. Pays a one-time benefit of $400, per unit, for each complete policy year the rider is in force, when a covered person is first diagnosed as having cancer (other than skin cancer). Payable only once per covered person and stops increasing at primary insured's age 65.

Termination. This rider terminates: after the grace period when the premium is not paid; or if the base policy terminates; or on the next renewal date after termination is requested; or when a benefit is paid on all covered persons.

WAITING PERIOD/EXCEPTIONS

These riders have a 30 day waiting period that begins on the rider date. We do not pay benefits for a covered person if diagnosed as having cancer prior to the end of the 30 day waiting period.

The benefits in these riders are subject to all the terms, conditions and provisions of the base policy.

The Waiting Period/Exceptions provision of the policy applies to these riders.

RENEWABILITY

These riders are guaranteed renewable for life subject to change in premiums by class.

PREMIUMS

Premiums may change on a class basis. A notice is mailed 60 days in advance of any change. A grace period is granted for payment of each premium after the first. The policy remains in force during the grace period.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

RATES ARE SUBJECT TO CHANGE

We pay covered expenses incurred for treatment of cancer and specified diseases as defined in this policy. All payments are subject to the terms of this policy. This policy is issued in consideration of the application and payment of the premium. A copy of the application is attached to this policy and made a part of it.

This policy is effective from 12:01 a.m. Standard Time in the state you reside in on the effective date. It expires at 12:01 a.m. on the end of the grace period unless you pay the next renewal premium.

NOTICE OF THIRTY (30) DAY RIGHT TO EXAMINE POLICY

You may, within 30 days after receipt of this policy, return it to us or to our agent. Upon such return of the policy it will be void as of the effective date; any premium paid will be refunded.

RENEWABILITY

This policy remains in effect when premiums are paid as they are due or during the grace period. Renewal premiums will be at the premium rates in effect on the renewal date. We can change the premium rates on premiums becoming due after the first premium. However, we can only change the rate on this policy by making the rate change for all policies in a class. We cannot place any restrictive riders or cancel or refuse to renew this policy if it is maintained continuously in force. If rates change on all like policies in your class, we will mail notice of this change. This notice is mailed at least 45 days before the change. It is mailed to the address shown on our records. No change in premiums is effective unless this notice is mailed.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office on the effective date.

Secretary

President

LIMITED BENEFIT HEALTH COVERAGE
THIS IS A LIMITED BENEFIT SPECIFIED DISEASE POLICY WHICH ONLY PROVIDES BENEFITS FOR LOSS DUE TO CANCER AND SPECIFIED DISEASES AS DEFINED IN SECTION I.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.
SUBJECT TO THE INCONTESTABILITY PROVISION.
THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE SUBJECT TO THE COMPANY'S RIGHT TO CHANGE PREMIUMS ON A CLASS BASIS.
NON-PARTICIPATING
CANCER AND SPECIFIED DISEASE EXPENSE POLICY

2400080M76275020201507 24WPL01175353

POLICY CONTENTS

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville Florida 32224

POLICY SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	PREMIUMS NUMBER OF YEARS PAYABLE	ANNUAL AMOUNT
CP10BGA	CANCER AND SPECIFIED DISEASE EXPENSE POLICY FAMILY COVERAGE - PLAN B HOSPITAL CONFINEMENT DAILY BENEFIT - $200	LIFE	$286.88
ICR2GA	* 6.0 UNITS INTENSIVE CARE-FAMILY	LIFE	$133.20
	* BENEFITS REDUCE 50% AT THE COVERED PERSONS AGE 70		
CLR1	INITIAL DIAGNOSIS LEVEL BENEFIT RIDER 4.00 UNITS-FAMILY LEVEL BENEFIT = $2,000.00	LIFE	$35.60
WBR5	WELLNESS BENEFIT RIDER - FAMILY	LIFE	$39.99
	$75.00 PER YEAR PER COVERED PERSON		
		TOTAL	$495.67

The effective date and issue age of each benefit is the Policy Date and Issue Age of the policy unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
$495.67	$257.74	$131.35	$44.61	$20.60

Premium Payment Method: PAYROLL ALLOTMENT BI-WEEKLY

Premium Class: STANDARD

INSURED: CHAD C SMITH

ISSUE AGE: 42

BENEFICIARY: AS NAMED IN APPLICATION

POLICY NUMBER: M7627502

POLICY DATE: AUGUST 01, 2015

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SECTION I - DEFINITIONS

The following terms are defined as used in this policy:

Ambulatory Surgical Center. A licensed surgical center consisting of: an operating room; facilities for the administration of general anesthesia; and a post surgery recovery room that the patient is admitted to and discharged from within the same working day.

Cancer. The disease manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes: Hodgkin's Disease; leukemia; lymphoma; carcinoma; sarcoma; or malignant tumor. It does not include other conditions which may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions.

Chemotherapist. One who is licensed to administer chemotherapy or immunotherapy and who is certified by either the American Board of Internal Medicine, Radiology, or Hematology.

Class. Any group of persons insured individually under this policy who have a common bond, such as age, sex, occupation, premium payment method or geographical area.

Common Carrier. Only the following: commercial airlines; passenger trains; or intercity bus lines. It does not include taxis, intracity bus lines or private charter planes.

Continuous Hospital Confinement. One continuous confinement or two or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered Person. Any of the following:

1. any eligible family member named in the application (including the insured) and acceptable for coverage by us; or
2. any eligible family member added to this policy by endorsement after the effective date; or
3. a newborn child (see Section III).

Date of Diagnosis. The earliest of the date of: tentative diagnosis; clinical diagnosis; or the day the tissue specimen, culture(s) and/or titer(s) are taken, upon which the positive or tentative diagnosis of cancer or specified disease is made.

Effective Date. The policy date shown on page 3. This date is assigned by the Home Office in accordance with our policy dating rules in effect at the time this policy is issued.

Extended Care Facility. A licensed nursing facility under the direction of a physician which provides continuous skilled nursing service under the supervision of a graduate registered nurse (R.N.) and maintains daily medical records on each patient. It does not include any institution, or part thereof, used primarily as a place for the aged, drug addicts, alcoholics, or rest.

Family Policy. Coverage that includes any covered person as defined above.

Freestanding Hospice Care Center. A center which is not a hospital, or a wing or section of a hospital, providing 24 hour a day care for the terminally ill under the medical direction of a physician.

Hospital. A legally operated institution with established facilities (either on its premises or available to the hospital on a contractual, pre-arranged basis and under the supervision of a staff of one or more duly licensed physicians), for the care and treatment of sick and injured persons for diagnosis, surgery, and 24 hour nursing service.

Hospital does not include:

1. any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged; or
2. any institution which is mainly for the care and treatment of alcoholics or drug addicts, or mental or nervous disorders.

Individual Policy. Coverage that includes only the insured as defined below.

Insured. The person accepted for coverage by us who has completed and signed the application and whose name appears on the Policy Specifications (page 3).

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SECTION I - DEFINITIONS (CON'T)

Nurse. Any one of the following who is not a member of your immediate family or employed by the hospital where you are confined:

1. licensed practical nurse (L.P.N.); or
2. licensed vocational nurse (L.V.N.); or
3. graduate registered nurse (R.N.).

Oncologist. A legally licensed Doctor of Medicine certified to practice in the field of Oncology.

Pathologist. A legally licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy.

Physician. Any person, other than you, or your immediate family, duly licensed as a physician, acting within the scope of that license, to treat the injury or sickness for which claim is made.

Positive Diagnosis (of cancer). A diagnosis by a licensed doctor of medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on a microscopic examination of fixed tissue, or preparations from the hemic system (except for skin cancer). We accept clinical diagnosis of cancer as evidence that cancer existed in a covered person when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis and the covered person received definitive treatment for the cancer.

Positive Diagnosis (of a specified disease). A diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

Radiologist. One who is licensed to administer X-ray therapy, radium therapy, or radioactive isotopes therapy and is certified by the American Board of Radiology.

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

Specified Disease. Only any one of the following:

(1) Muscular Dystrophy
(2) Poliomyelitis
(3) Multiple Sclerosis
(4) Encephalitis
(5) Rabies
(6) Tetanus
(7) Tuberculosis
(8) Osteomyelitis
(9) Diphtheria
(10) Scarlet Fever
(11) Epidemic Cerebrospinal Meningitis
(12) Undulant Fever
(13) Sickle Cell Anemia
(14) Rocky Mountain Spotted Fever
(15) Smallpox
(16) Addison's Disease
(17) Hansen's Disease
(18) Tularemia
(19) Bubonic Plague
(20) Typhoid Fever

Tentative Diagnosis. A tentative diagnosis is established based upon dated medical records which indicate a diagnosis of a probable or possible cancer or specified disease.

Usual and Customary. The normal, reasonable charge for a service, an apparatus, etc., in the geographic area where provided.

We, Our, Us or Company. American Heritage Life Insurance Company.

You or Your. The insured or any covered person under a family policy.

SECTION II - WAITING PERIOD\EXCEPTIONS\LIMITATIONS

Waiting Period. This policy contains a 30-day waiting period that begins on the effective date. No benefits are payable for any covered person who has cancer or a specified disease diagnosed before coverage has been in force for 30 days from the effective date, except as provided below. If a covered person has cancer or a specified disease first diagnosed after you sign the application and before the end of the waiting period, benefits for treatment of that cancer or specified disease will apply only to loss commencing after 2 years from the effective date of the policy; or, at your option, you may elect to void the policy from the beginning and receive a full refund of premium, in accordance with the Notice of 30 Day Right to Examine Policy provision on page 1.

Exceptions/Limitations. We do not pay for:

1. any loss except for losses due directly from cancer or a specified disease, subject to the Incontestability provision. Diagnosis must be submitted to support each claim.
2. any disease or incapacity that has been: caused; complicated; worsened; or affected by cancer or a specified disease or as a result of cancer or speci-fied disease treatment.

SECTION III - ELIGIBILITY

Family members eligible to be covered persons are:

1. you;
2. your spouse on the effective date;
3. unmarried children of you or your spouse, including adopted children, children during pendency of adoption procedures and stepchildren, who are under 21 years old and living with you, or under 25 years old and full-time students at an educational institution of higher learning beyond high school.

A child born to or adopted by you and your covered spouse, while this policy is in force as a family policy, will be a covered person. This coverage begins at the moment of birth, or from the date of final decree of adoption of such child for benefits otherwise payable to a covered person under this policy. Coverage for newly born or adopted children consists of coverage of sickness due to cancer and specified diseases, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities when due to cancer and specified diseases. Any person who becomes a family member after the effective date (except newborns) must be added by endorsement. No additional premium will be required for newborns or family members added by endorsement if this policy is in force as a family policy.

SECTION IV - PAYMENT OF BENEFITS

If cancer or a specified disease is diagnosed on or after the effective date, we pay according to the benefits provisions in this policy, subject to the waiting period and all other provisions contained in this policy.

If cancer or a specified disease is diagnosed while hospital confined, benefits begin on the day of admission or 10 days prior to the date of diagnosis if this is more favorable. This does not apply if confinement is for a non-covered condition and cancer or a specified disease is treated which would normally be treated on an outpatient basis.

If positive diagnosis is made for cancer or a specified disease within 12 months after a tentative diagnosis, benefits are paid from the date of tentative diagnosis if the tentative diagnosis is made on or after the effective date, subject to the waiting period provision.

If the diagnosis of cancer or a specified disease can only be confirmed post-mortem, then benefits begin on the first day of confinement for the terminal admission for up to 45 days.

SECTION V - SCHEDULE OF BENEFITS - PLAN B

We pay the following benefits for the necessary treatment of cancer or a specified disease. Treatment must be received in the United States or its territories.

A. Hospital Confinement. We pay $200 per day, for each day a covered person is admitted to and confined as an inpatient in a hospital. The maximum number of days payable is 70 days for each period of continuous hospital confinement.

B. Inpatient Drugs and Medicine. We pay actual charges made by the hospital for drugs and medicine while hospital confined up to $10 per day, for each day of continuous confinement.

C. Surgery. We pay the surgeon's fee for a surgical operation and post operative attendance not to exceed $3,000 as shown in the Schedule of Operations. Two or more procedures done at the same time through one incision is considered one operation; we pay the amount shown in the Schedule of Operations for the one operation with the largest benefit. If any operation for the treatment of cancer or a specified disease other than those listed in the Schedule of Operations is performed, we pay the actual surgeon's fee not to exceed the unit value for the operation as set forth in the 1964 California Relative Value Schedule (C.R.V.S.) multiplied by a factor of 20. If the surgical procedure has no unit value or is not shown in the 1964 C.R.V.S., we pay the usual and customary fee for such procedure. Payment will never exceed the maximum amount indicated on the applicable table. Assistant or co-surgeons are not covered for this benefit. Surgery performed on an outpatient basis is paid at 150% of the scheduled benefit.

D. Second Surgical Opinion. We pay actual charges for a second surgical opinion up to $200. These charges must be incurred after diagnosis and before surgery.

E. Physician's Attendance. We pay actual charges for a visit by a physician during hospital confinement up to $30 per day. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician. Admission to the hospital as an inpatient is required.

F. Private Duty Nursing Services. We pay actual charges for private nursing care and attendance by a nurse up to $100 per day while hospital confined. Nursing services must be required and authorized by the attending physician. Nursing services in a facility other than a hospital are not covered.

G. Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. We pay actual charges, up to the limit stated below, for treatment techniques used for modification or destruction of cancerous tissue, as follows:

1. teleradio therapy using either natural or artificially propagated radiation;
2. interstitial or intracavity application of radium or radioactive isotopes in sealed or non-sealed sources;
3. chemical substances and their administration, including hormonal therapy;
4. antigenic preparation or immunosuppressive techniques.

This benefit is limited to $10,000 per 12 month period beginning with the first day of benefit under this provision. Hospital confinement is not necessary to receive this benefit. Treatment must be administered by a Radiologist, Chemotherapist or Oncologist.

Unless specified elsewhere in the policy, we do not pay for:

1. treatment room charges;
2. dressings;
3. medications other than chemotherapeutic drugs;
4. emergency room charges;
5. medical supplies;
6. X-rays, scans and their interpretations.

H. Blood, Plasma and Platelets. We pay actual charges, up to the limit stated below, for:

1. blood, plasma and platelets (including transfusions and administration charges);
2. processing and procurement costs;
3. cross-matching.

This benefit is limited to $10,000 per 12 month period beginning with the first day of benefit under this provision. We do not pay for blood replaced by donors.

I. Ambulance. We pay actual charges up to $200 per continuous confinement for transportation by a licensed ambulance service or a hospital owned ambulance for transporting a covered person.

J. Anesthesia. We pay actual charges of an anesthetist not to exceed 25% of the amount paid for surgery. The maximum benefit paid for skin cancers is $100.

K. Non-Local Transportation. We pay the following benefit for treatment at a Hospital (inpatient or outpatient); Radiation Therapy Center; Chemotherapy or Oncology Clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally:

1. actual cost of round trip coach fare on a common carrier; or
2. $.40 per mile, up to 700 miles, for round trip personal vehicle transportation. Mileage is measured from the covered person's home to the nearest treatment facility as described above.

"Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

L. Family Member Lodging and Transportation. We pay the following benefits for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment:

1. *Lodging* - The actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to $100 per day. This benefit is limited to 60 days for each period of continuous hospital confinement; and
2. *Transportation* - The actual cost of round trip coach fare on a common carrier or a personal vehicle allowance of $.40 per mile, up to 700 miles per continuous hospital confinement. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the Family Member Transportation benefit if the personal vehicle transportation benefit is paid under Non-Local Transportation (benefit K.), when the family member lives in the same city or town as the covered person.

M. Outpatient Lodging. We pay a daily lodging benefit when a covered person receives radiation or chemo-therapy treatment (benefit G.) on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. The benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to $100 per day during treatment. This benefit is limited to $4,000 per 12 month period beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

N. Prosthesis. We pay actual charges up to $2,000 for prosthetic devices which are prescribed as a direct result of surgery for cancer or specified disease treatment and which requires surgical implantation. This benefit is limited to $2,000 per covered person, per amputation.

O. Extended Care Facility. We pay actual charges up to $100 per day for each day a covered person is confined in an extended care facility. Confinement in the extended care facility must be at the direction of the attending physician and must begin within 14 days after a hospital confinement. This benefit is limited to the number of days of the previous continuous hospital confinement.

P. Skin Cancer. We pay actual charges up to $120 for the removal of skin cancer when diagnosis is made by a physician other than a legally qualified pathologist. If more than one skin cancer is removed at the same time, we pay $60 per skin cancer removed after the first. If diagnosis is made by a legally qualified pathologist, we pay benefits as provided in the other benefit provisions.

Q. Government or Charity Hospital. In lieu of all other benefits in this policy, we pay $100 per day for each day a covered person is confined to:

1. a hospital operated by or for the U. S. Government (including the Veteran's Administration); or
2. a hospital that does not charge for the services it provides (charity).

R. Ambulatory Surgical Center. We pay surgical center charges for surgery performed at an Ambulatory Surgical Center up to $250 per day.

S. New or Experimental Treatment. We pay actual charges, up to the limit stated below, for new or experimental treatment when:

1. the treatment is judged necessary by the attending physician; and
2. no other generally accepted treatment produces superior results in the opinion of the attending physician.

This benefit is limited to $10,000 per 12 month period beginning with the first day of treatment under this provision.

T. Hospice Care. We pay one of the following two benefits for hospice care:

(1) *Freestanding Hospice Care Center.* We pay actual charges up to $100 per day for confinement in a licensed freestanding hospice care center. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the confinement. This benefit is payable only if a covered person is admitted to a freestanding hospice care center within 14 days after a period of inpatient hospital confinement. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

(2) *Hospice Care Team.* We pay actual charges up to $100 per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. This benefit is payable only if: the covered person has been diagnosed as terminally ill; the attending physician has approved such services; and home care services begin within 14 days after a period of hospital confinement. We do not pay for: food services or meals other than dietary counseling; services related to well-baby care; services provided by volunteers; or support for the family after the death of the covered person.

U. Physical or Speech Therapy. We pay actual charges up to $25 per day, for physical or speech therapy for restoration of normal body function.

V. Extended Benefits. If a covered person is confined in a hospital for the treatment of cancer or a specified disease for more than 70 days of continuous hospital confinement, we pay actual charges up to $200 per day for: hospital room and board; medicine; laboratory tests; and other hospital charges. This benefit begins on the 71st day of continuous hospital confinement. This benefit is payable in lieu of all other benefits payable under the Schedule of Benefits. This benefit continues as long as the covered person is continuously hospital confined.

W. At Home Nursing. We pay actual charges up to $100 per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician and must begin within 14 days after confinement as an inpatient in a hospital. This benefit is limited to the number of days of the previous continuous hospital confinement.

X. Waiver of Premium Benefit. If, while this policy is in force, the insured becomes disabled due to cancer first diagnosed after the waiting period and remains disabled for 90 days, we pay premiums due after such 90 days for as long as the insured remains disabled. The term "disabled" means that the insured is: (a) unable to work at any job for which he or she is qualified by education, training or experience; (b) not working at any job for pay or benefits; and (c) under the care of a physician for the treatment of cancer.

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SECTION V - SCHEDULE OF BENEFITS - PLAN B (CON'T)

SCHEDULE OF OPERATIONS

ABDOMEN

Complete resection of the stomach	$2,000
Partial resection of the stomach	$1,600
Resection of the small bowel	$1,400
Resection of the ascending or transverse colon	$1,200
Combined abdominal perineal resection for cancer of the rectum or sigmoid	$2,000
Colostomy or ileostomy	$1,000
Resection of esophagus	$2,400
Gastrostomy	$ 800
Splenectomy	$1,200
Splenectomy with staging biopsies for lymphomas or Hodgkin's	$1,600
Complete cystectomy with ureteral transplant	$2,400
Simple excision of the bladder	$1,400

AMPUTATIONS

Thigh through Femur	$1,200
Arm, forearm, entire hand, leg or entire foot	$ 800
Fingers or toes, each	$ 300
Leg through Tibia or Fibula	$1,000

BRAIN

Complete removal of cancer of brain	$3,000

BREAST

Amputation of one breast	
(a) simple	$ 600
with immediate reconstruction	$1,100
(b) modified radical	$1,200
Amputation of both breasts	
(a) simple	$ 900
with immediate reconstruction	$1,300
(b) modified radical	$1,500
Delayed reconstruction, complete, one stage	
One breast	$2,000
Both breasts	$3,000
Multiple stage including nipple	
One breast	$1,800
Both breasts	$2,300

CHEST

Complete lobectomy or Pneumonectomy	$2,000
Wedge resection or Subtotal Lobectomy	$1,600
Excision Intracardiac Tumor with bypass	$3,000

TRANSPLANT

Bone Marrow Harvesting	$ 800
Bone Marrow Transplant	$1,200

SECTION V - SCHEDULE OF BENEFITS - PLAN B (CON'T)

SCHEDULE OF OPERATIONS (CON'T)

EXTERNAL GENITALIA
Female
Complete excision for removal of the vulva or vagina with regional lymph nodes $1,600
Cauterizaton of the cervix ..... $ 60
Laser Cauterization ..... $ 60
Male
Cancer of penis - complete excision with regional lymph nodes $2,000
Orchiectomy -- i.e. removal of testicles ..... $ 800

EYE
Enucleation with complete resection ..... $ 900

GENITO URINARY TRACT
Removal of kidney with lymphadenectomy $2,000
Transurethral Resection Prostate with bilateral Lymphadenectomy - one stage $1,600
two stage $2,000
Prostatectomy subtotal $1,600
total $2,000
Removal of uterus, tubes and ovaries $1,300
with bilateral lymphadenectomy $2,000

NECK
Complete resection of glands of the neck $2,000

RECTUM
Proctectomy $2,000

SKIN
Cutting operation for removal from: (excluding biopsy) including resection
Lip ..... $ 300
Ear ..... $ 300
Nose ..... $ 300
Mouth, tongue, tonsil, mucous membrane of mouth ..... $ 800
with neck dissection $1,800

SPINAL
Operation with removal of portion of vertebra or vertebrae or laminectomy $2,000

THROAT
Excision of larynx - complete $2,000
with neck dissection $2,800
Subtotal Thyroidectomy $1,200
Total Thyroidectomy $1,600
with neck dissection $2,000

SECTION VI - TERMINATION OF INSURANCE

If the insured's spouse is a covered person, the spouse's coverage ends upon valid decree of divorce.

If your child is a covered person, the child's coverage ends on the policy anniversary next following the date the child is no longer eligible, which is either when the child marries or reaches age 21 (25 if a full-time student at an educational institution of higher learning beyond high school). Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity;
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon you for support and maintenance.

Dependent coverage continues as long as this policy remains in force and the dependent remains in such condition.

Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the first 2 years after the child's attainment of the limiting age for eligibility.

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 such premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

Termination of the policy by us is without prejudice to any continuous loss which commenced while the policy was in force. This does not apply if termination is due to nonpayment of premiums. The insured's spouse, if a covered person, becomes the new insured upon the insured's death.

SECTION VII - CONVERSION PRIVILEGE

If coverage of a spouse covered under this policy terminates due to divorce, or if coverage of a covered child terminates due to the child becoming married or reaching age 21 (25 if a full-time student), such covered person can obtain a policy of insurance (called the converted policy), without evidence of insurability. Obtaining that policy is subject to the following conditions:

1. Application for the converted policy must be made to us within 31 days after the coverage terminates. The effective date of the converted policy will be the date on which coverage under this policy terminates.
2. The converted policy premium is at the rate for the class of risk at the applicant's age for insurance provided as of the date of the conversion.
3. Any conditions excluded in this policy are excluded in the converted policy. No other pre-existing conditions are excluded. The Waiting Period and Contestability provisions are waived to the extent that such periods have been met under this policy. Benefits payable to the applicant under the converted policy are reduced by benefits payable under this policy.
4. The converted policy will be a similar policy or a policy providing lesser benefits at the applicant's option.

When conversion is due to divorce, other dependents covered under this policy may be covered under such new policy or under this policy as you and your former spouse may elect. They may not be covered under both policies.

If either this policy or a new policy is in force on you or your former spouse, and either of you remarry, such new spouse may be covered under the appropriate policy. We must be advised of the remarriage by the completion of a new application for such new spouse. This new application is subject to our approval.

You or your former spouse must pay the premiums appropriate to such new policy in order to have it issued and maintained in force.

SECTION VIII - GENERAL PROVISIONS

Entire Contract; Changes. This policy, with the application and attached papers, if any, is the entire contract between you and us. No change in this policy is effective until 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.

Incontestability. After this policy is in force for a period of 2 years during the lifetime of the insured (excluding any period during which the insured is disabled), it becomes incontestable as to the statements contained in the application.

No claim for loss incurred or disability, commencing after 2 years from the effective date, is 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 effective date.

Grace Period. We 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.

Reinstatement. If the renewal premium is not paid before the grace period ends, the policy lapses. Later acceptance of the premium by us or by an agent authorized by us to accept payment, without requiring an application for reinstatement, reinstates the policy.

If we or our agent require an application for reinstatement and issues a conditional receipt for the premium tendered, the policy is reinstated upon approval of the application by us or, lacking approval, upon the 45th day following the date of the conditional receipt unless we have previously notified you in writing of our disapproval of the application.

The reinstated policy covers only loss due to cancer or specified disease incurred after the date of reinstatement. In all other respects, you and we have the same rights as were under the policy immediately before the due date of the premium, subject to any provisions endorsed on or attached to, in connection with the reinstatement. Any premium accepted in connection with a reinstatement is applied to a period for which premiums have not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Notice of Claim. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this policy, or as soon as is reasonably possible. Notice given by or on behalf of you or the beneficiary to us at 1776 American Heritage Life Drive, Jacksonville, Florida or to any authorized agent of ours, with the insured's name and policy number, is notice to us.

Claim Forms. When we receive notice of claim, we send forms for filing proof of loss. If these forms are not sent within 10 days, the proof of loss requirements are met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

Proofs of Loss. If this policy provides for periodic payment of a continuing loss, written proof of loss must be furnished to us within 90 days after the end of each period for which we are liable. For any other loss, written proof must be given to us within 90 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

Time of Payment of Claims. Amounts due under this policy other than for loss of time are payable immediately upon receipt of proof of loss. With respect to amounts payable for other than loss of time, we will send notice to you within 15 days of receipt of due written proof of loss. If we do not pay the loss immediately upon receipt, this notice will state the reasons for withholding payment of the claim and will also provide you an itemization of any information needed to process the claim or any portions of the claim which have not been paid. When all the requested information needed to process the claim has been received, we will then have 15 working days to process the claim or deny it, in whole or in part, giving you the reasons we may have for denying the claim or any portion of the claim. We will pay you interest at the rate of 18% per year on the amounts due under the terms of the policy if payments are not made in compliance with the requirements of the provision.

Payment of Claims. All benefits are paid to the insured unless he or she assigns them. Any amounts unpaid at the insured's death may, at our option, be paid either to the named beneficiary or to the insured's estate.

If benefits are payable to the insured's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to an amount of $1,000, to someone related to the insured or beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Assignment. An assignment of this policy is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our Home Office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record it. An assignment may not change the owner or beneficiary.

Non-Participating. This policy is issued on a non-participating basis and does not share in surplus earnings of ours.

Physical Examinations and Autopsy. We, at our own expense, shall have the right and the opportunity to examine the person of any covered person as often as it may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after 3 years from the time written proof of loss is required to be given.

Change of Beneficiary. Unless the insured makes an irrevocable designation of beneficiary, the consent of the beneficiary or beneficiaries is not required to surrender, assign or change beneficiaries, or to make any other changes in this policy.

Misstatement of Age. If the age of the insured has been misstated, all amounts payable under this policy are as the premium paid would have purchased at the correct age.

Unpaid Premium. Upon the payment of a claim under this policy, any unpaid premium may be deducted.

Conformity with State Statutes. Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which you reside on such date is hereby amended to conform to the minimum requirements of such statutes.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224-6688

CANCER INITIAL DIAGNOSIS LEVEL BENEFIT RIDER

This rider is issued in consideration of the rider premium and the application for the rider. The benefit is paid in addition to the benefits of the policy subject to the Waiting Period/Exceptions provision.

The benefit is subject to all the terms, conditions, and provisions of the policy.

All terms defined and used in the policy apply to this rider.

Definitions

Rider Date - The effective date of coverage under this rider. The rider date is the policy date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the date the application for this rider is approved by us.

Policy - The policy to which this rider is attached.

Unit - The benefits in this rider. The number of units of this rider is shown on the Policy Specifications (page 3). All benefit amounts are calculated according to the number of units purchased.

We, us, our - American Heritage Life Insurance Company.

You, your - The person named as primary insured in the application for this rider.

Benefit

We pay the following benefit for cancer (other than skin cancer) as defined in the policy.

Initial Diagnosis Benefit - We pay a one-time benefit when a covered person is diagnosed for the first time as having cancer (other than skin cancer) as defined in the policy. The first diagnosis must occur after the waiting period. The benefit is $500 per covered person, per unit. This benefit is payable only once per covered person.

Waiting Period/Exceptions

This rider has a 30 day waiting period that begins on the rider date. We do not pay any benefits under this rider for a covered person if that covered person is diagnosed as having cancer prior to the end of the waiting period.

The Exceptions and Other Limitations provision of the policy applies to this rider.

Termination

This rider terminates:

1. at the end of the grace period for the payment of the premium for the policy or this rider; or
2. if the policy terminates; or
3. on the next renewal date after a request for termination; or
4. if a benefit is paid on all covered persons.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary

President

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687

WELLNESS BENEFIT RIDER

This rider is issued in consideration of the rider premium and the application for the rider. The benefit is paid in addition to the benefits of the policy.

The benefit is subject to the provisions of this rider and the policy. All terms defined and used in the policy apply to this rider.

DEFINITIONS

Rider Date. The effective date of coverage under this rider. The rider date is the policy date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our Home Office in accordance with our policy dating rules in effect at the time this rider is issued.

Policy. The policy to which this rider is attached.

BENEFITS

Wellness Benefit. We pay this benefit if a covered person has an eligible wellness benefit performed. We pay the amount shown on page 3 of the policy per calendar year per covered person for one of the eligible wellness benefits. Each covered person is covered for no more than the amount shown on page 3 of the policy per calendar year.

The eligible wellness benefits are:

1. Biopsy for skin cancer; and
2. Blood test for triglycerides; and
3. Bone Marrow Testing; and
4. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
5. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
6. CEA (carcinoembryonic antigen – blood test for colon cancer); and
7. Chest X-ray; and
8. Colonoscopy; and
9. Doppler screening for carotids; and
10. Doppler screening for peripheral vascular disease; and
11. Echocardiogram; and
12. EKG (Electrocardiogram); and
13. Flexible sigmoidoscopy; and
14. Hemocult stool analysis; and
15. HPV (Human Papillomavirus) Vaccination; and
16. Lipid panel (total cholesterol count); and
17. Mammography, including Breast Ultrasound; and
18. Pap Smear, including ThinPrep Pap Test; and
19. PSA (prostate specific antigen – blood test for prostate cancer); and
20. Serum Protein Electrophoresis (test for myeloma); and
21. Stress test on bike or treadmill; and
22. Thermography; and
23. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms.

TERMINATION

This rider terminates at the earliest of: (a) the end of the grace period for the payment of the premium for the policy or this rider; or (b) when the policy terminates.

If we accept a premium that extends coverage past the termination date, coverage continues until the end of that premium period.

RENEWABILITY

The Renewability provision of the policy applies to this rider, subject to the Termination provision of this rider.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Gary S Stein
Secretary

WBR5

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224-6688

HOSPITAL INTENSIVE CARE RIDER
CONFINEMENT BENEFIT REDUCES 50% AT COVERED PERSON'S AGE 70

We pay the benefits in this rider for sickness or injury not specifically excluded from coverage. Benefits are payable for a covered confinement in a hospital intensive care unit that occurs on or after the rider date, subject to the Waiting Period/Exclusions/Limitations provision. This rider is issued in consideration of the rider premium and the application for this rider. Benefits are paid in addition to the benefits of the policy. Benefits are subject to all of the terms, conditions and provisions of the policy. All terms defined and used in the policy apply to this rider unless otherwise defined in this rider.

DEFINITIONS

Continuous Hospital Intensive Care Confinement. One continuous confinement or a period of 2 or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Hospital Intensive Care Unit. A hospital area of special care that includes cardiac or coronary care units which, at the time of admission, is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition, the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; and
2. direction and/or supervision by a full-time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

Intoxication. A condition as determined by the laws of the state in which the loss occurred.

Policy. The policy to which this rider is attached.

Rider Date. The effective date of coverage under this rider. The rider date is the policy date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the date the application for this rider is approved by us.

Unit. All benefit amounts are calculated according to the number of units of coverage. The number of units of coverage is shown on page 3 of the policy.

We, us, our. American Heritage Life Insurance Company.

You, your. The person named as primary insured in the application.

SCHEDULE OF BENEFITS

1. **Hospital Intensive Care Unit Confinement.** We pay $100 per day, per unit of coverage, for each day a covered person is admitted to and confined in a hospital intensive care unit. The maximum number of days payable is 45 days for each period of continuous hospital intensive care confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid. This benefit reduces to $50.00 per day, per unit of coverage, at the covered person's age 70.
2. **Ambulance.** We pay the actual charges for the cost of transportation by a licensed ambulance service or a hospital owned ambulance for transporting a covered person to the hospital for admission to an intensive care unit for a covered confinement. We do not pay this benefit if an ambulance benefit is paid under the policy.

WAITING PERIOD/EXCLUSIONS/LIMITATIONS

This rider has a 30 day waiting period that begins on the rider date for confinement due to cancer or specified diseases. We do not pay any benefits under this rider for hospital intensive care unit confinements due to cancer or a specified disease for 2 years from the rider date, if cancer or a specified disease is diagnosed prior to the end of the waiting period.

We do not pay benefits under this rider if a covered person is admitted to a hospital intensive care unit due to:

1. an attempted suicide or intentional self-inflicted injury; or
2. intoxication or being under the influence of drugs not prescribed by a physician; or
3. alcoholism or drug addiction.

We do not pay benefits under this rider for continuous hospital intensive care unit confinements that occur during a hospitalization that begins before the rider date.

We do not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. The following do not qualify as "hospital intensive care units":

1. progressive care units; or
2. sub-acute intensive care units; or
3. intermediate care units; or
4. private rooms with monitoring; or
5. step-down units; or
6. any other lesser care treatment units.

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TERMINATION

This rider terminates at the earliest of:

1. the end of the grace period for the payment of the premium for the policy or this rider; or
2. the date the policy terminates; or
3. the next renewal date after your request to terminate this rider.

If we accept a premium which extends coverage past the termination date, coverage continues until the end of that premium period.

RENEWABILITY

The Renewability provision of the policy applies to this rider, subject to the Termination provision of this rider.

Signed for us at our Home Office in Jacksonville, Florida

Secretary

President

Allstate Benefits

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Jacksonville, Florida 32224

Amendment

Any reference to a notification of change in premium rates by class in the Policy and/or Rider that this Amendment is attached to is deleted in its entirety and replaced with the following language:

This notice will be mailed at least 60 days before the change.

This Amendment will not change, alter or amend the policy and/or rider it is attached to except as stated.

This Amendment becomes effective as of the policy and/or rider date.

Secretary

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

Endorsement

This Endorsement is made part of the Policy and/or Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Policy, not inconsistent with this Endorsement.

All references to the eligibility and termination of dependents are revised to the following:

Eligible dependents are:
1. your legal spouse; and
2. your children.

A child is a person under age 26 who is:
1. your natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

Coverage for your child will end on the issue day of the month that follows when the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent child who:
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the policy/certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the 2 year period following the child's attainment of the limiting age for eligibility.

Issue day means the same day of the month as the policy date.

All other requirements of the policy and/or certificate not specifically stated within this endorsement still apply.

Secretary

2400080M762750202015072 4WPL02275364

AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

AMENDMENT

The Policy to which this Amendment is attached is amended as follows:

I. The following is added to the **DEFINITIONS** section:

Chemotherapeutic Drug. A drug which directly modifies or destroys cancerous tissue. Drugs that are supportive or protective of, necessary for use with, or used in conjunction with, drugs that directly modify or destroy cancerous tissue but which do not themselves directly modify or destroy cancerous tissue are not chemotherapeutic drugs.

II. The **Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy** benefit is deleted in its entirety and replaced with the following:

G. Radiation Therapy, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. We pay actual charges, up to the limit stated below, for only those individual charges, within the following treatment techniques, that are directly for the modification or destruction of cancerous tissue:

1. teleradio therapy using either natural or artificially propagated radiation;
2. interstitial or intracavity application of radium or radioactive isotopes in sealed or non-sealed sources;
3. chemical substances, including hormonal therapy;
4. antigenic preparation or immunosuppressive techniques.

This benefit is limited to $10,000 per 12 month period beginning with the first day of benefit under this provision. Hospital confinement is not necessary to receive this benefit. Treatment must be administered by a Radiologist, Chemotherapist or Oncologist.

Unless specified elsewhere in the policy, we do not pay for:

1. treatment planning, consultation, or management;
2. the design and construction of treatment devices;
3. medications or drugs, other than chemotherapeutic drugs;
4. emergency or treatment room charges;
5. supplies or devices related to treatment;
6. X-rays, scans and their interpretations;
7. charges or expenses that do not directly modify or destroy cancerous tissue, even though they may be supportive or protective of, necessary for use with, or used in conjunction with, drugs, charges or expenses that directly modify or destroy cancerous tissue.

This Amendment will not change, alter, or amend the Policy it is attached to except as stated.

This Amendment becomes effective as of the issue date of the Policy.

Secretary

2400080M76275020201507 24WPL02375365

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

Amendment

The Policy and/or Rider that this Amendment is attached to is amended as follows:

The policy and/or rider contains an exclusion for loss resulting from being intoxicated or under the influence of drugs. This exclusion is deleted and replaced with the following:

The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

This Amendment will not change, alter or amend the policy and/or rider it is attached to except as stated.

This Amendment becomes effective as of the policy and/or rider date.

Secretary

2400080M76275020201507 24WPL02475366

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

AMENDMENT

The following provision is added to the General Provisions of the policy to which this amendment is attached:

> **Receipt of Premiums.** You will be given credit for premiums under this policy at the time the premiums are actually received by us or our authorized agent. Financial institutions (such as banks and credit unions) and employers who send your premiums to us directly at your request, are not our agents, and premiums paid by those parties are not credited until actually received by us.

This Amendment does not change, alter or amend the policy except as stated above.

This Amendment becomes effective as of the policy date.

Secretary

2400080M76275020201507 24WPL02575367

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

AMENDMENT

The following is added to the General Provisions of the policy/certificate to which it is attached:

> **Cooperation of Beneficiary.** The beneficiary must reasonably cooperate during any investigation and/or adjudication of a claim. This includes the authorization for the release of medical records and other information.

This Amendment does not change, alter, or amend the policy/certificate except as stated.

This Amendment becomes effective as of the policy/certificate date.

Secretary

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CBA1

☒ Producer Assisted ☐ Self Enrollment ☒ New Policy ☐ Change/Increase Policy #_____

APPLICATION FOR LIFE AND HEALTH INSURANCE TO: American Heritage Life Insurance Company (AHL) 1776 American Heritage Life Drive, Jacksonville, Florida 32224

EMPLOYEE INFORMATION

Employee/Payor (if other than Proposed Insured)	Employee's Date of Birth	Employee/Payor Social Security Number	Employee's I.D. Number	Date Hired
SMITH CHAD C	08/31/1972	252-39-4909		10/14/2002

PROPOSED INSURED INFORMATION

Proposed Insured (Last, First, M.I.)			Social Security Number
SMITH CHAD C	☒ M ☐ F	☒ Employee ☐ Spouse ☐ Child ☐ Other	252-39-4909

Residence Address	City	State	Zip	Phone Number
1009 Baldwin Heights	Baldwin	GA	30511	(706) 894-1975

Employer	Occupation
City of Cornelia	

Owner's Name and Address (if different than Proposed Insured's)	City	State	Zip	Owner's Phone Number

Owner's Date of Birth (if different than Proposed Insured's)	Owner's Social Security Number or Tax I.D. Number (if different than Proposed Insured's)	Owner's Email Address

Primary Beneficiary's Full Name and Address	City	State	Zip	Relationship	Phone Number	Date of Birth	Social Security Number

Contingent Beneficiary's Full Name and Address	City	State	Zip	Relationship	Phone Number	Date of Birth	Social Security Number

COMPLETE THIS SECTION FOR PERSONS TO BE INSURED

Relationship to Employee	Last Name	First Name	Date of Birth	Sex	Relationship	Actively at Work*^	Full Time Student^	Tobacco Use 1^
Employee	SMITH	CHAD	(See Addendum 1)	M	Employee	☒ Yes ☐ No	N/A	** ☐ Yes ☐ No
Spouse	Smith	Summer	(See Addendum 2)	F	Spouse	☒ Yes ☐ No	N/A	** ☐ Yes ☐ No
Dependent	Smith	Grayson	(See Addendum 3)	F	(See Addendum 6)	☐ Yes ☐ No	☐ Yes ☐ No	^ ☐ Yes ☐ No
Dependent	Smith	Gentry	(See Addendum 4)	F	(See Addendum 7)	☐ Yes ☐ No	☐ Yes ☐ No	^ ☐ Yes ☐ No
Dependent	Smith	Grantley	(See Addendum 5)	M	(See Addendum 8)	☐ Yes ☐ No	☐ Yes ☐ No	^ ☐ Yes ☐ No

*Actively at work means that he/she is actively at work now for wage or profit and has worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

1Has anyone to be insured used tobacco in the last 12 months? (**If applying for Life or Critical Illness. ^For dependents ages 19 and older, if applying for Life.)

INSURANCE PLANS

Abbreviations: GI - Guaranteed Issue CGI - Contingent Guaranteed Issue SI - Simplified Issue

Accident _____ ☐ GI ☐ CGI ☐ SI (Plan Type and Units)	☐ AP2 ☐ AP3	☐ Individual ☐ Family	Monthly Salary $_____	Section 125 ☐ Yes ☐ No	Mode Premium $_____		
Riders	Rider APDIR	Rider APBER	Rider APEXT	Rider APOPTR1	Rider APHCR1	Rider	Rider	Rider
Units/Amt								

Cancer CP10 Cancer B (Plan Type)	☐ CP10A ☐ CBP ☒ CP10B	☐ Individual ☒ Family	Section 125 ☒ Yes ☐ No	Mode Premium $ 20.60			
Riders	Rider CABR	Rider ICR	Rider CLR	Rider CPR	Rider WBR	Rider	Rider	Rider
Units/Amt		6.00	4.00		3.00			

Critical Illness _____ ☐ GI ☐ SI (Plan Type)	Basic Benefit Amount $_____	☐ Individual ☐ Family ☐ Single Parent Family	Section 125 ☐ Yes ☐ No	Mode Premium $_____			
Riders	Rider	Rider	Rider	Rider	Rider	Rider	Rider	Rider
Units/Amt								

Disability (DI) _____ ☐ GI ☐ CGI ☐ SI	Monthly Salary $_____	Elimination Period _____ Days Acc. _____ Days Sick.	Section 125 ☐ Yes ☐ No	Mode Premium $_____
Occupation Class ☐ Preferred ☐ Standard	Monthly Benefit $_____	Benefit Period _____ Months	On The Job Rider ☐ Yes ☐ No	Accident Rider ☐ Yes ☐ No Units _____ ☐ Individual ☐ Family

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Hospital Indemnity (SHOP) _____ (Plan Type) Units _____ ☐ CGI ☐ SI	☐ Individual ☐ Individual & Children ☐ Individual & Spouse ☐ Family	Section 125 ☐ Yes ☐ No	Mode Premium $_____

Riders	Rider IHR1	Rider SAR1	Rider IPBR1	Rider OPBR1	Rider OEAR1	Rider AHNR	Rider TR1	Rider ADIR1	Rider
Units/Amt									

Life ☐	☐ Universal (UL20) ☐ Universal (UL21) ☐ GI (Employee Only) ☐ CGI ☐ SI	☐ Term	Death Benefit Option ☐1 ☐ 2 Universal Life ONLY	Face Amount $_____	Mode Premium $_____

Riders	Rider ADB	Rider PW	Rider STR	Rider CTR	Rider LBR	Rider FPOR	Rider LTC	Rider OIR	Rider TIR	Rider
Units/Amt		☐			☐	☐	☐			

Billing Method ☒ Payroll Deduction ☐ Bank/Credit Union Draft (Authorization Required)* *Complete form ABJ062	Name on Bank/Credit Union Account _____ Bank/Credit Union Account Number _____ Routing Number _____ Draft Date	Billing Mode: ☐ Monthly ☐ Semi-Monthly ☒ Bi-weekly ☐ Weekly ☐ Other Other	Coverage Effective Date 08/01/2015 Date of First Deduction 08/15/2015	Total Mode Premium: $ 20.60

Remarks	Account (Case) Name	Account (Case) Number
	City of Cornelia	09198

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 3.

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

	UNDERWRITING QUESTIONS	EE	SP	CH
CGI & SI Accident w/ Sickness DI Rider, Cancer, SI Critical Illness, CGI & SI Disability, Hospital Indemnity & CGI & SI Life	1. Has any person to be insured, in the last 10 years, been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antigens or antibodies to an AIDS virus?	☐Y ☒N	☐Y ☒N	☐Y ☒N
All CGI	2. Has any person to be insured, in the last 6 months, been disabled or hospitalized for anything other than normal pregnancy, lacerations or broken bones due to an accident?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer, SI Critical Illness Cancer Rider & SI Hospital Indemnity	3a. Has any person to be insured, in the last 10 years, been diagnosed with or treated by a member of the medical profession for any type of cancer, other than basal cell carcinoma?	☐Y ☒N	☐Y ☒N	☐Y ☒N
	3b. If the answer to 3a. is yes, has that person(s) been diagnosed with or treated by a member of the medical profession for Leukemia, Hodgkin's Disease, Lymphoma, or Cancer with any lymph node involvement or more than one metastasis?	☐Y ☐N	☐Y ☐N	☐Y ☐N
	3c. If the answer to 3a. is yes, has that person(s), in the last 5 years, been diagnosed with or treated by a member of the medical profession for any other type of cancer (other than those listed in 3b. and/or basal cell carcinoma)?	☐Y ☐N	☐Y ☐N	☐Y ☐N
Cancer w/ Intensive Care & SI Hospital Indemnity	4. Has any person to be insured, in the last 5 years, been diagnosed with or treated by a member of the medical profession for a stroke or transient ischemic attack (TIA), a heart attack, a heart condition, heart trouble, any other heart disorder, or any artery disease?	☐Y ☒N	☐Y ☒N	☐Y ☒N
SI Life	5. Has any person to be insured, in the last 2 years, been diagnosed or treated by a member of the medical profession for any of the following? · Anemia (other than iron deficiency) · Anxiety, depression or other mental or nervous illness (that would include hospitalizations, disability from work, or suicide attempts) · Asthma (other than taking non-steroidal medication as needed with no hospitalizations), or any other lung disorder · Cancer, except basal cell carcinoma · Diabetes · Epilepsy with a seizure · Heart attack, cardiomyopathy, congestive heart failure, heart murmur (and taking medication(s)), angioplasty, coronary artery bypass surgery, coronary artery disease, stent, pacemaker, heart valve replacement or any other heart disorder · Hemophilia · Hepatitis · Kidney Disease involving dialysis or chronic renal failure · Liver Disease · Lou Gehrig's Disease (ALS) · Lupus · Multiple Sclerosis · Muscular Dystrophy · Parkinson's Disease, scleroderma, polymyositis, or fibromyalgia · Stroke including aneurysm, transient ischemic attack (TIA), or arteriovenous malformation · Transplant of any organ · Counseling for, or excessive use of, alcohol or any type of drugs	☐Y ☐N	☐Y ☐N	☐Y ☐N

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IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 3.

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

	UNDERWRITING QUESTIONS (Continued)	EE	SP	CH
SI Accident w/ Sickness DI Rider, SI Critical Illness, SI Disability, SI Hospital Indemnity & SI Life	6. Has any person to be insured, in the last 5 years, had any medical or surgical procedures (including organ transplant) advised or recommended by a member of the medical profession, but not done at this time?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
SI Life	7. Has any person to be insured, in the last 3 years: had his/her driver's license suspended or revoked; been convicted of reckless or drunken driving; or been involved in 3 or more motor vehicle accidents?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
SI Accident w/ Sickness DI Rider, Cancer w/ Intensive Care, SI Critical Illness, SI Disability, Hospital Indemnity & SI Life	8. Has any person to be insured, in the last year, been diagnosed by a member of the medical profession with a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once?	☐ Y ☒ N	☐ Y ☒ N	☐ Y ☒ N
SI Accident w/ Sickness DI Rider & SI Disability	9. Has any person to be insured, in the last 2 years, had any disease, impairment of, or treatment by a member of the medical profession (other than minor illness) for the following? · Any disorder of the back or neck · Asthma	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
SI Accident w/ Sickness DI Rider, SI Critical Illness & SI Disability	10. Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following? · Central Nervous System Disease or disorder (to include Multiple Sclerosis or Muscular Dystrophy) · Liver Disease · Chronic Fatigue Syndrome · Lung Disease · Diabetes · Lupus · Emphysema · Optic Neuritis · Fibromyalgia · Parkinson's Disease · Heart Disease · Paralysis · Rheumatoid Arthritis	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
SI Accident w/ Sickness DI Rider & SI Disability	11. Has any person to be insured, in the last 2 years, had or been diagnosed with or treated by a member of the medical profession for any of the following? · Counseling for alcohol or drug abuse · Pancreas Disease	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
SI Accident w/ Sickness DI Rider, Cancer w/ Intensive Care, SI Critical Illness, SI Disability, SI Hospital Indemnity & SI Life	12. Provide Height and Weight of Proposed Insured: Height: 6 ' 3 " Weight: 265			
SI Critical Illness (over $50,000) & SI Life (over $150,000)	13. Provide the names and addresses of all physicians (or other members of the medical profession) for each person to be insured; the required health history section may be used if additional space is needed. ☐ ☐ ☐			
Required Health History	14. Provide health history for any "Yes" answers to the Underwriting questions. Include physician's (or other members of the medical profession) name, address and telephone number:			

IF REQUESTING GUARANTEED ISSUE, PLEASE PROCEED TO QUESTION 15 BELOW. FOR ALL OTHER ENROLLMENTS, IF ANY UNDERWRITING QUESTIONS BELOW ARE ANSWERED "YES", PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 14 ON PAGE 3.

Abbreviations: EE - Employee SP - Spouse CH - Child(ren) Y - Yes N - No

UNDERWRITING QUESTIONS (Continued)			EE	SP	CH
All-Replacement	15.	Is this insurance to replace or change any existing life (if applied for) or health (if applied for) coverage? If yes, indicate product being replaced or changed and complete replacement form provided if required by your state.	☐Y ☒ N	☐Y ☐ N	☐ Y ☐ N
All-Existing Insurance	16.	If you are applying for the type of coverage listed, is there any other (not listed in question 15) insurance of that type in force or applied for (other than this application) on any person to be insured: Coverage Type: life, cancer, disability, hospital, critical illness or accident? If yes, list company name, policy number, year issued, type of coverage, and amount of benefit.	☐Y ☒N	☐ Y ☐ N	☐Y ☐N
All Health	17.	I have received an Outline of Coverage for each health coverage.	☒ Y☐ N	☐ Y☐ N	N/A
All Critical Illness	18.	Do you currently have major medical coverage? If you answered "No", you may not apply for Critical Illness Coverage. **Critical Illness coverage should not be purchased as a replacement for any major medical policy.**	☐ Y☐ N	☐ Y☐ N	N/A

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ELECTRONIC ACCEPTANCE (Please check YES or NO)

By checking the "Yes" box, I elect electronic delivery of my policy(ies), including all documents accompanying my policy(ies). If electronically delivered, I understand that I will receive instructions at the email address I have provided on how to receive my policy and accompanying documents at: www.allstatebenefits.com/mybenefits.

☐ Yes ☒ No

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 5.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my policy(ies), free of charge, by calling toll-free: 1-800-521-3535; or by writing to: Customer Care Center, American Heritage Life Insurance Company, 1776 American Heritage Life Drive, Jacksonville, Florida, 32224.

REPRESENTATION. I have read or had read to me the completed application and understand that any material misstatement or misrepresentation in the application may result in loss of coverage. I represent that statements and answers given on this application are true, complete, and correctly recorded. **UNDERSTANDING. I UNDERSTAND THAT CRITICAL ILLNESS COVERAGE IS CONSIDERED A LIMITED BENEFIT TYPE OF COVERAGE AND IS MEANT TO SUPPLEMENT, NOT BE A SUBSTITUTE OR REPLACEMENT FOR MAJOR MEDICAL INSURANCE.** I understand that: if premiums for the coverage(s) is (are) to be paid by payroll deductions, these deductions may start before the "effective date" of coverage(s) and that this does not change the effective date of coverage; and the "effective date" for health insurance coverages will be the date recorded on the policy/certificate/benefit statement, not the date the application is signed. If the coverage(s) is (are) not issued, American Heritage Life will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind AHL in any way by making any promise or representation that is not set out in writing in this application. **PREMIUM DEDUCTION AUTHORIZATION. I AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. **AUTHORIZATION TO OBTAIN AND DISCLOSE CERTAIN DATA (FOR SI LIFE AND CRITICAL ILLNESS).** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, Pharmacy Benefit Managers, insurance company, the Medical Information Bureau (MIB, Inc.) or other organization, institution or person, that has records or knowledge of me or my health including my prescription medication history to give to AHL, its subsidiaries or its reinsurers any information. I also authorize AHL, or its reinsurers, to make a brief report of my health information to MIB, Inc. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I acknowledge receipt of the Important Notice About Privacy and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying AHL in writing of my desire to do so.

Signed at: City/State Cornelia GA Date Signed 7/7/2015

Signature of Proposed Insured _____

Signature of Owner, if other than Insured _____

Signature of Employee/Payor, if not Insured or Owner _____

SOLICITING PRODUCER MUST COMPLETE AND SIGN WHEN APPLICATION IS PRODUCER ASSISTED

All-Replacement	1. To your knowledge, is change or replacement involved?	☐ Yes ☒ No
All-Existing Insurance	2. To your knowledge, does any person to be insured have existing coverage in force?	☐ Yes ☒ No

Producer's Statement. I certify that to the best of my knowledge and belief the information on this form is complete, accurate and correctly recorded.

Signature of Soliciting Producer _____ Print Soliciting Producer Name 4KYG0 COMBES (See Addendum 9)

To be completed by home office or producer, prior to issue:

Producer Name	Producer Number	National Producer Number (NPN)	Percentage Credit
Servicing Producer: 4KYG0 COMBES (See Addendum 10)	4KYG0		100.0 %
Soliciting Producer: 4KYG0 COMBES (See Addendum 11)	4KYG0		0.0 %
			%
			%

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Addendum 1
08/31/1972

Addendum 2
09/17/1974

Addendum 3
10/20/2000

Addendum 4
03/12/2003

Addendum 5
11/10/2010

Addendum 6
Natural Child

Addendum 7
Natural Child

Addendum 8
Natural Child

Addendum 9
4KYG0 COMBES FRANCISCO

Addendum 10
4KYG0 COMBES FRANCISCO

Addendum 11
4KYG0 COMBES FRANCISCO

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

LIMITED BENEFIT HEALTH COVERAGE
THIS IS A LIMITED BENEFIT SPECIFIED DISEASE POLICY WHICH ONLY PROVIDES BENEFITS FOR LOSS DUE TO CANCER AND SPECIFIED DISEASES AS DEFINED IN SECTION I.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION
SUBJECT TO THE INCONTESTABILITY PROVISION.
THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE SUBJECT TO THE COMPANY'S RIGHT TO CHANGE PREMIUMS ON A CLASS BASIS.
NON-PARTICIPATING
CANCER AND SPECIFIED DISEASE EXPENSE POLICY