



Toll Free: 1-800-276-7619, Ext. 4264

AssureLINK Address: <http://assurelink.assurity.com>

South Carolina Application for Acci-Flex Insurance

This application includes all forms needed to apply for Acci-Flex Insurance.

Thank you for your interest in writing business with Assurity Life Insurance Company.

To enable us to process your application more quickly, please review the following checklist:

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state in which the application is signed**.
- ✓ Use the appropriate application **for the state in which the application is to be signed**. Applications and state forms can be found on AssureLINK.
- ✓ Print the application in black ink for faxing and photo copying purposes.
- ✓ Please verify that all questions on the application are answered.
- ✓ Use **age last birthday** when preparing illustrations and/or calculating insurance premiums.
- ✓ Obtain all required signatures.
- ✓ Have the Proposed Insured initial any changes. (Corrections with white correction fluid/tape are not acceptable.)
- ✓ Comply with all state regulations
 1. NAIC Model Illustration or disclosure statement must accompany any Acci-Flex application.
 2. Complete all other pertinent and applicable forms padded together in this application.

If faxing an application directly to the Home Office, fax to (877) 864-6630.

- ✓ If mailing directly to the Home Office, address to: **Assurity Life Insurance Company**
Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

TO CHECK THE STATUS OF AN APPLICATION, ASK QUESTIONS RELATING TO UNDERWRITING (INCLUDING "WHAT IF" SCENARIOS) CALL TOLL FREE 800-276-7619, EXT. 4264 OR EMAIL TO underwriting@assurity.com.



1. PROPOSED INSURED

Legal Name <i>First Middle Last</i>			Date of Birth <i>(MM/DD/YYYY)</i> / /	
Social Security No. - -	<input type="checkbox"/> Male <input type="checkbox"/> Female	E-mail	Age	
Home Address <i>Street Address</i>		<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Personal Phone No. ()	Birth State/Country	Gross monthly income \$		
Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident (<i>green card</i>) status? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If YES, and you have permanent resident status, please list your permanent resident (<i>green card</i>) number _____				
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number _____				
Policyowner <i>First Middle Last</i>		Home Address <i>Street Address</i>	<i>City</i>	<i>State</i> <i>ZIP+4</i>
Social Security No. - -	Relationship to Insured	Birth State/Country	Date of Birth <i>(MM/DD/YYYY)</i> / /	

2. BENEFICIARIES—If additional space is needed, attach a separate sheet of paper.

Primary Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Social Security No.	Date of Birth (<i>MM/DD/YYYY</i>)	Share %
			/ /	
			/ /	
Contingent Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Social Security No.	Date of Birth (<i>MM/DD/YYYY</i>)	Share %
			/ /	
			/ /	

3. PRODUCT INFORMATION

Base Amount \$ _____ Premium Payment Mode: Annual Semi-Annual Monthly (*Auto Bank Withdrawal*) Monthly (*Credit Card*)

Optional Benefits: Waiver of Premium Rider Return of Premium Rider Accident Only Disability Income Benefit Rider \$ _____ Monthly Benefit

4. RIDER INFORMATION

If the Proposed Insured is applying for the Accident Only Disability Income Rider and/or the Waiver of Premium Rider: *Years Months*

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? Yes No Length of employment /

Primary Employer *Company Name, Occupation, Duties*

5. STATEMENT OF HEALTH

Has the Proposed Insured ever been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*), or had a positive test for human immunodeficiency virus (*HIV*) antibodies? Yes No

6. OTHER INSURANCE INFORMATION—If additional space is needed, attach a separate sheet of paper.

1. Does the Proposed Insured have any other insurance coverage in force? If YES, please provide details below. Yes No

Insurance Company Name	Pending or In Force	Life Insurance or Annuity Amt.	Disability Insurance Amt.	Being Replaced?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

2. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? Yes No



7. AGREEMENT

I (We) agree that:

1. All answers in this application are complete and true to the best of my (our) knowledge and belief and will be relied upon to determine insurability.
2. The first premium is equal to the full premium for the premium payment mode selected. If the first premium is paid on the date this application is signed, the insurance applied for becomes effective on that date subject to: **a.** the Company's underwriting requirements, **b.** the terms of the attached conditional receipt, and **c.** the terms of the policy applied for.
3. If the first premium is not paid on the date of this application, no insurance will be in effect unless: **a.** such policy is issued, delivered to and accepted by me (us), and the entire first premium is paid during the Proposed Insured's lifetime, and **b.** at the time of such delivery, acceptance or payment, whichever is later, all information furnished in this application remains true and complete to the best of my (our) knowledge.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

I acknowledge that I was provided an Outline of Coverage at the time this application for insurance was taken.

Signed at _____ on _____
City State Date (MM/DD/YYYY)

Signature of Proposed Insured Signature of Policyowner (if other than Proposed Insured)

8. AGENT'S STATEMENT AND AGREEMENT

1. What amount was collected with this application? \$ _____
2. Has a Conditional Receipt been given to the Policyowner? Yes No
3. Has the Proposed Insured signed a Confidential Information Authorization and been given a Fair Credit and MIB Notification? Yes No

I hereby certify that I have accurately recorded in this application all information supplied by the Proposed Insured/Policyowner. The Proposed Insured/Policyowner has read the completed application, or has had the completed application read to them. I also certify that this insurance does does not replace or change any existing life, health or annuity coverage.

Signature of Soliciting Agent Date (MM/DD/YYYY) () / () Business Phone No. and Fax No.

Soliciting Agent's Printed Name Agent No. Agent's E-mail





Name of Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Name of Additional Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant Child(ren)			
<i>Name</i>	<i>Date of Birth</i>	<i>Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company (*Assurity*), its reinsurers and/or consumer reporting agencies and their authorized representatives (*provided, however, consumer reporting agencies may not collect information under this authorization from the MIB*):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases (**Except information about human immunodeficiency virus (*HIV*) infection for Individuals residing in Maine or Vermont.** **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four (24) months from the date of signature below (**Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Date (MM/DD/YYYY)

Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

Signature of Additional Applicant/Insured/Claimant or Legal Representative

Signature of Applicant/Insured/Claimant Child (if age 18 or older)

Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)





MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Assurity or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, Assurity will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices, please direct your requests to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, Assurity Life Insurance Company (Assurity) may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation Assurity requests. Please direct this written request to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Upon receipt of such a request, Assurity will respond by mail within five business days.

Telephone Interview Information

Assurity may require that you complete a confidential telephone interview as a part of your application for insurance. The interview will be conducted by a trained professional and may include (*but is not limited to*) the following topics: occupation, job history, income, personal and business financial information and medical history. All information obtained will be used for underwriting purposes only and will not be released without your written consent.



Conditional Receipt

including notices required by the
Fair Credit Reporting Act
and the
Medical Information Bureau (MIB)

The following Conditional Receipt is issued by Assurity Life Insurance Company when the full initial premium is collected from the Proposed Insured/Owner at the time the application is completed. The full initial premium may be collected when the amount of in-force and applied for individual life coverage, including the present value of future benefits of any reversionary annuity policy, with Assurity Life Insurance Company does not exceed \$500,000. This \$500,000 limit applies to applications on which the Proposed Insured has fully and accurately answered all health questions indicating no significant health problems. Individual life applications may be accepted without the health questions answered if the Proposed Insured is to be medically examined. However, in these cases, the full initial premium can be collected only when the in-force and applied for coverage, including the present value of future benefits of any reversionary annuity policy, does not exceed \$100,000 with Assurity Life Insurance Company. The full initial premium may also be collected for individual disability coverage when the amount of in-force and applied for individual disability coverage (base policy Monthly Benefits plus SDIR Monthly Benefit) with Assurity Life Insurance Company does not exceed \$2,500 per month. Applications with in-force and applied for amounts that exceed these limits, or where the Proposed Insured has significant health problems, must be handled on a Cash On Delivery (C.O.D.) basis.

In addition to the above insurance limits, issuing a Conditional Receipt requires **full modal payment** (including PAC authorization and sample check for PAC mode, if applicable). A Conditional Receipt may **not** be issued in exchange for a postdated check or a partial premium payment. **Payment in this manner in no way conditionally binds Assurity Life Insurance Company.**

Following the Conditional Receipt are two notices required to be given to the Proposed Insured. The federal **Fair Credit Reporting Act** notice explains the nature of investigative consumer reports, and explains the Proposed Insured's rights if such a report is requested. The disclosure regarding the **Medical Information Bureau (MIB)** informs the Proposed Insured of restrictions on obtaining and disclosing confidential medical information.

Conditional Receipt

Assurity Life Insurance Company • Lincoln, Nebraska

The Proposed Insured/Owner's payment of the full initial premium and acceptance of this Conditional Receipt constitutes the Proposed Insured/Owner's acceptance of its terms and conditions. Unless all terms and conditions are fulfilled exactly, no insurance will become effective prior to policy delivery. In all events, any insurance provided is subject to the stated limits. No agent is authorized to change or waive any conditions or limits. Please make **all** premium checks payable to "Assurity Life Insurance Company". Please **do not** make checks payable to the agent or leave "payee" blank.

1. The sum of \$_____ is received of _____ by Assurity Life Insurance Company ("The Company") as payment of the full initial premium on insurance applied for on this date. Payment is accepted subject to the terms and limitations of this Conditional Receipt ("Receipt"). It is expressly understood and agreed that unless all conditions set forth in this Receipt are satisfied, or that unless the coverage applied for is issued within 60 days of the date of application, no insurance shall ever take effect. In such case, the Company's only liability and obligation is to promptly refund the premium payment received.
2. If, on the applicable date, the Proposed Insured was acceptable for the plan and amount of insurance applied for, without modification, under Assurity's rules, limits and standards of insurability, coverage will be effective the later of i) the date of application, or ii) the date any medical examination of the Proposed Insured is completed, if required by the Company. Insurance will be issued at Assurity's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.
- 3a. Assurity Life Insurance Company has NO liability for life insurance coverage if the answers to the health questions on the application indicate any significant health problems. Otherwise, the Company's total life insurance liability, including the present value of future benefits for any reversionary annuity policy, for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company, including the present value of future benefits for any reversionary annuity policy, on the Proposed Insured's behalf (including that for which this Receipt is given) shall not exceed \$500,000 if all application health questions are answered, and shall not exceed \$100,000 if no application health questions are answered.
- b. Assurity Life Insurance Company has NO liability for health insurance coverage and this Receipt is void for any insurance if any health questions on the application have not been answered and no medical examination is required of the Proposed Insured. Otherwise, the Company's total health insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that which this Receipt is given) shall not exceed \$2,500 per month.

These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.
4. This Receipt must not be detached and used unless the full amount of the first premium is paid on the date of the application. Payment cannot be accepted with the application if any person proposed for coverage has been treated for or had any known heart trouble, stroke or cancer within the past twelve months. This Receipt is void if exchanged for any check or draft that is not honored upon first presentation for collection through usual banking facilities.

Dated: _____

Agent: _____



NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application (*information you have furnished*), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy issued by Assurity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. In particular, study the comparison statement which your agent is required to furnish you upon taking your application.

1. Health conditions that you may presently have (*pre-existing conditions*), may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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

_____ *Date (MM/DD/YYYY)*

_____ *Applicant's Signature and Printed Name*

**Signed form to be returned to the home office
 Applicant to receive a copy of the signed form at the time the application is taken**



COMPARATIVE INFORMATION

BENEFITS	EXISTING POLICY	PROPOSED POLICY
Monthly Amount	\$ _____	\$ _____
Elimination Period	_____	_____
Benefit Period	_____	_____
RENEWABILITY		
Guaranteed Renewable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-cancellable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRE-EXISTING DEFINITION

Existing Policy: _____

PROPOSED POLICY

If your **Total Disability** is within 2 years from the **Issue Date** and is due to a **Pre-existing Condition**, **Benefits** will not be paid unless the condition:

- was disclosed and not misrepresented on **Your Application**; and
- is not excluded by a **Policy Amendment Rider**.

Pre-existing Condition: A sickness or physical condition for which, before the Issue date:

- symptoms existed which causes an ordinary prudent person to seek diagnosis, care or treatment; or
- medical advice was recommended by or received from a **Physician**.

Applicant to receive a completed copy





NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application (*information you have furnished*), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy issued by Assurity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. In particular, study the comparison statement which your agent is required to furnish you upon taking your application.

1. Health conditions that you may presently have (*pre-existing conditions*), may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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

_____ *Date (MM/DD/YYYY)*

_____ *Applicant's Signature and Printed Name*

**Signed form to be returned to the home office
 Applicant to receive a copy of the signed form at the time the application is taken**



COMPARATIVE INFORMATION

	EXISTING POLICY	PROPOSED POLICY
BENEFITS		
Monthly Amount	\$ _____	\$ _____
Elimination Period	_____	_____
Benefit Period	_____	_____
RENEWABILITY		
Guaranteed Renewable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Non-cancellable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRE-EXISTING DEFINITION

Existing Policy: _____

PROPOSED POLICY

If your **Total Disability** is within 2 years from the **Issue Date** and is due to a **Pre-existing Condition**, **Benefits** will not be paid unless the condition:

- was disclosed and not misrepresented on **Your Application**; and
- is not excluded by a **Policy Amendment Rider**.

Pre-existing Condition: A sickness or physical condition for which, before the Issue date:

- symptoms existed which causes an ordinary prudent person to seek diagnosis, care or treatment; or
- medical advice was recommended by or received from a **Physician**.

Applicant to receive a completed copy



ASSURITY LIFE INSURANCE COMPANY
P.O. Box 82533 – Lincoln, Nebraska 68501-2533
Toll free (800) 869-0355

ACCIDENTAL DEATH BENEFIT INSURANCE
OUTLINE OF COVERAGE

A. READ YOUR POLICY CAREFULLY! This Outline of Coverage provides a very brief description of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.

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

C. BENEFITS. We will pay the Proceeds of Your Policy to Your Beneficiary(s) if the Insured dies as a result of an accidental bodily injury that happens while this Policy is in force. We will ask for satisfactory proof of the Insured's death and the return of the Policy before the Proceeds are paid. We will pay Proceeds in one lump sum or under a Payment Option.

Accidental death is death that results directly from an accidental bodily injury, independent of all other causes. Accidental Death must occur within 90 days of the date of the Insured's accidental bodily injury, and prior to the Policy Anniversary nearest the Insured's 75th birthday.

D. EXCLUSIONS. We will not pay the face amount if death results from the Insured:

- engaging in or attempting to commit a felony;
- engaging in an illegal occupation;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide; whether sane or insane;
- involved in any period of armed conflict, whether declared or not;
- using drugs or alcohol, except for prescribed drugs taken as prescribed;
- piloting a non-commercial aircraft more than 150 hours annually;
- "flying for pay" an aircraft outside of established air routes in the United States and Canada;
- involved in motor vehicle or boat racing, hang gliding, sky diving, mountain or rock climbing, underwater diving and pro sports;
- traveling outside of the United States or Canada for more than 14 days; or
- operating a motor vehicle while under the influence of alcohol or drugs.

E. RENEWABILITY. Your Policy must be Renewed to keep its coverage in force without submitting further Evidence of Insurability. You Renew Your Policy by paying all Premiums when due. Renewal may continue until the earlier of the date of the Insured's death or the Policy Anniversary nearest the date the Insured attains age 75. The Policy Schedule, page 3 of the Policy, shows the amount of each Premium payable for Renewal.

F. OPTIONAL BENEFIT RIDERS

Accident Only Disability Income Benefit Rider – We will pay the Monthly Benefit for the duration of the Total Disability or until the end of the Maximum Benefit Period, whichever is first, if:

- the Insured is Totally Disabled due to an Accidental Injury;
- the Insured's Total Disability begins while this Rider is in force;
- the Insured's Total Disability begins within 180 days of the Accidental Injury causing the Total Disability;
- the Insured has satisfied the Elimination Period; and
- the Insured's Total Disability began prior to the Policy anniversary following the Insured's 65th birthday.

Return of Premium Rider – This rider provides a return of premium benefit that equals a portion of or all of the premiums paid for the policy and riders (if applicable).

Disability Waiver of Premium – We will waive the premiums for this policy and any attached riders if the Insured becomes Totally Disabled.