Critical Illness Policy

Limited Benefit Insurance
Critical Illness Policy – Outline of Coverage
Policy Form CIP2-R (7-07) and CIP2-WC-R (7-07)

READ YOUR POLICY CAREFULLY - This outline of coverage provides a 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 sets forth, in detail, the rights and obligations of any covered person and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. This is a limited benefit policy and is designed to provide coverage ONLY when certain losses occur as a result of the specified critical illnesses as defined below and more fully in the policy. This policy does not provide for basic hospital, basic medical-surgical or major medical expenses. This policy provides benefits only if the date of diagnosis of specified critical illness is while the policy is in force for the covered person so diagnosed AND after the waiting period has been satisfied by that covered person. Important: Benefits received under this policy may be taxable. You should consult your personal tax advisor to determine whether or not payments received are subject to taxation.

BENEFITS

- Lump sum payments paid directly to you upon first diagnosis of one of the covered critical illnesses shown below.
- Choice of two plans and face amounts from $10,000 - $30,000, in $10,000 increments.
- Coverage available for individual and family members.

<table>
<thead>
<tr>
<th>Covered Illnesses</th>
<th>With Cancer CIP2-WC (7-07)</th>
<th>Without Cancer CIP2 (7-07)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>100%</td>
<td>n/a</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Major Organ Transplant Surgery</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surgery*</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Balloon Angioplasty, Stent, or Laser Relief Procedure*</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Carcinoma in Situ*</td>
<td>10%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*The Coronary Artery Bypass Surgery, Balloon Angioplasty, Stent, or Laser Relief Procedure, or Carcinoma in Situ benefits are each payable only once per covered person. If one or more of these benefits are paid, the remaining amount payable will be the original face amount reduced by all prior benefit payments.
**WELLNESS BENEFIT**

We will pay a total of $75 per calendar year for a covered person to undergo one of the covered tests or exams listed below:

- Mammography
- Flexible Sigmoidoscopy
- Chest X-Ray
- EKG
- Pap Smear
- Cholesterol & Diabetes Screening
- Colonoscopy
- PSA (Blood Test for Prostate Cancer)
- Screening
- Breast Ultrasound
- CA 15-3 for Breast Cancer
- CA 125 for Ovarian Cancer
- CEA Blood Test for Colon Cancer
- Thermography
- Bone Marrow Testing
- Serum Protein Electrophoresis
- Fasting Blood Glucose Test
- Hemocult Stool Analysis
- Blood Test for Triglycerides

*This benefit is payable once per covered person per calendar year and two times per family per calendar year.*

**BENEFIT PAYMENT INFORMATION**

On the policy anniversary following attainment of age 75, the face amount of all benefits will be restated as 50% of the remaining amount payable. The covered person’s coverage terminates when 100% of the face amount has been paid.

**Waiting Period** – No benefits will be paid for a specified critical illness diagnosed during the first 30 days following any covered person’s effective date of coverage. *If the date of diagnosis of any covered person’s specified critical illness occurs during the waiting period, the policy or any increase in coverage will be cancelled and all premiums returned.*

**DEFINITIONS**

*These definitions provide a brief description of the specified critical illness covered by your policy. Only the actual policy definitions will control.*

**Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)** is a progressive wasting of motor neuron of the brain and spinal column.

**Balloon Angioplasty, Stent, or Laser Relief Obstruction Procedures** are therapeutic procedures used to correct narrowing or blockage of one or more coronary arteries.

**Cancer** is a disease characterized by the spread of malignant cells and must be positively diagnosed with histopathological confirmation by a medical practitioner. (See Exceptions and Limitations)

**Carcinoma in Situ** is a disease characterized by malignant neoplasm of epithelial origin that is confined to the basement membrane. Carcinoma in situ must be diagnosed with histopathological confirmation. Pre-malignant lesions and carcinoma in situ of the skin, including melanoma in situ, are excluded. (See Exceptions and Limitations)

**Coronary Artery Bypass Surgery** is a major surgical procedure requiring median sternotomy to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

**End Stage Renal Disease (ESRD)** is chronic irreversible failure of both kidneys to function which requires at least weekly hemodialysis or peritoneal dialysis or transplantation.

**Heart Attack** is characterized by diagnosis of the death of a portion of the heart muscle resulting from inadequate blood supply.

**Major Organ Transplant** is human to human organ transplant of the liver, heart, lung, pancreas or the transplantation of bone marrow from a donor to covered person.

**Quadriplegia** means the complete, irreversible paralysis and loss of use of both upper and lower limbs without severance.

**Stroke** is a cerebrovascular event resulting in permanent neurological deficit.
EXCEPTIONS AND LIMITATIONS

EXCEPTIONS - WHAT WE WILL NOT PAY FOR:

This policy pays only for loss resulting from specified critical illnesses or surgeries as defined in the policy. We will not pay benefits for a specified critical illness or surgery that occurs as a result of the following:

1. Conditions other than the specified critical illnesses or surgeries defined in this policy, unless directly caused or aggravated by said specified critical illness surgery.
2. The covered person being diagnosed with a specified critical illness during the waiting period.
3. The covered person voluntarily participating or attempting to participate in an illegal activity.
4. The covered person intentionally causing a self-inflicted injury.
5. The covered person committing or attempting to commit suicide, whether sane or insane.
6. The covered person's voluntary involvement in any period of armed conflict, even if it is not declared.
7. Surgeries performed outside of the United States or its Territories.
8. Other Exclusions: We will not pay the Specified Critical Illness Benefit for the following:
   - Cerebral symptoms due to transient ischemic attack (TIA), migraine, cerebral injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions.
   - Leukemia, other than chronic lymphocytic leukemia, if there is no generalized dissemination of leukemia cells in the blood-forming bone marrow.
   - All skin cancers, unless there is evidence of metastasis or the tumor is a malignant melanoma of greater than 1.5 mm maximum thickness as determined by histological examination using the Breslow method.
   - All tumors which are histologically described as pre-malignant or non-invasive (including cervical dysplasia CIN-1, CIN-2, CIN-3), except carcinoma in situ.
   - Non life-threatening cancers, such as prostate cancers which are histologically described as TNM Classification T1(a), or T1(b), or are of another equivalent or lesser classification.
   - Papillary micro-carcinoma of the thyroid.
   - Non-invasive papillary cancer of the bladder histologically described as TaNOMO or a lesser classification.
   - Chronic lymphocytic leukemia less than RAI stage I or Binet Stage A-I.

PRE-EXISTING CONDITIONS LIMITATIONS FOR CERTAIN CONDITIONS

The benefits of the policy will not be payable for any loss caused by a pre-existing condition during the first 24 months the policy is in force. After this 24-month period, however, loss due to such conditions will be payable unless specifically excluded from coverage. This 24-month period is measured from the effective date of coverage for each covered person.

A pre-existing condition means a specified critical illness that is diagnosed or for which treatment is received within 24 months prior to the effective date of coverage for each insured person. “Treatment” means consultation, care, or services provided by a physician including diagnostic measures and taking prescription drugs and medicines. If the issuance of an insured person’s coverage was based on the medical history disclosed on the application, such conditions which were fully disclosed and not excluded or limited by us are not considered pre-existing conditions.
RENEWABILITY AND CONTINUATION

The policy is guaranteed renewable during the covered person’s lifetime. USABLE Life may change the premium rate, but only if the rate is changed for all policies in the covered person’s state.

This policy will not be issued to anyone 65 years of age or over on the initial effective date. If the covered person purchases the policy prior to his 65th birthday, he may continue coverage after age 65 as long as he continues to pay the premium rate by the due date or during the 31 days that follow.

Children born while the policy is in force will be covered immediately from the moment of birth under the Individual and Family plans. If you wish to continue coverage on newborn children under the Individual or Individual/Spouse Plan, you must apply within 90 days of the child’s birth date.

A Covered dependent who no longer meets eligibility requirements may convert to an individual policy without evidence of insurability. A covered person’s spouse’s coverage will terminate at the time of divorce.

YOU HAVE APPLIED FOR:

- Critical Illness With Cancer
- Critical Illness Without Cancer
- Individual
- Individual/Spouse
- 1 Parent & Family
- Full Family

APPLICANT FACE AMOUNT $ _______________

SPouse FACE AMOUNT $ _______________

CHILDREN FACE AMOUNT $ _______________
CRITICAL ILLNESS APPLICATION

SECTION 1 - APPLICANT INFORMATION

Name (First, MI, Last)  For Name Change, Give Prior Last Name  Social Security No.

Home Address  City  State  Zip  County

Date of Birth  Age  Birth State or Country  Gender  Male  Female  Height (ft-in.)  Weight (lbs.)

Occupation  Applicant’s email address (if any)

Name of Employer  Type of Business

Have you used any tobacco products within the past 36 months?  Yes  No

1. Are you a US citizen?  Yes  No

2. If no to question 1, have you been issued a permanent residency VISA?  Yes  No

3. If yes to question 2, have you lived continuously in the US or Canada for the last 6 months?  Yes  No

SPouse & CHILDREN INFORMATION – Complete if Applying for Dependent’s Coverage

Date of Birth  Full Name  Occupation  Gender  mo  day  yr  Birth State or Country  Height ft/in  Weight lbs

Spouse

Child

Child

Child

Has your spouse used any tobacco products within the past 36 months?  Yes  No

SECTION 2 – PLAN SELECTION

Select Type of Policy:

- Critical Illness With Cancer
- Critical Illness Without Cancer

I hereby apply for the following coverage:

- Applicant Only
- Applicant & Spouse
- Applicant & Children
- Applicant, Spouse & Children

Face Amount Applying For (Increments of $10,000)  Number of Units ($5,000 per Unit)  Rate  Monthly Premium

Applicant  X  =  $

Spouse*  X  =  $

Children**  5,000  X  =  $

Children**  10,000  X  =  $

* Spouse’s signature required if amount exceeds $25,000.

** The maximum amount of Children’s coverage is $10,000.

TOTAL PREMIUM AMOUNT  $

SECTION 3 – BENEFICIARY

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name  Relationship  Date of Birth  Primary or Contingent  Indicate % Distribution

Primary or  Contingent

Primary or  Contingent

Total must equal 100% =
## SECTION 4 – MEDICAL INFORMATION

**NOTE:** If Spouse or Children coverage IS NOT being requested answer questions only as applies to applicant.

1. Has any person to be insured ever been diagnosed with or advised to take a diagnostic test, been treated by a member of the medical profession, or taken medication for:

   (a) Any form of internal cancer, carcinoma in-situ, malignant melanoma, or other precancerous findings? [ ] Yes [ ] No
   (b) Any chronic or progressive disease or disorder of the heart, kidneys, liver, lungs, pancreas, or bone marrow? [ ] Yes [ ] No
   (c) Quadriplegia, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease? [ ] Yes [ ] No
   (d) Alcohol or substance abuse (in the last 5 years)? [ ] Yes [ ] No
   (e) Heart Attack or heart disease, stroke or transient ischemic attack (TIA), or been advised to have coronary bypass surgery, stent insertion, or laser treatment to coronary arteries? [ ] Yes [ ] No
   (f) Diabetes (except during a pregnancy), or any blood pressure reading recorded in the last three months exceeding 149/94? [ ] Yes [ ] No
   (g) Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)? [ ] Yes [ ] No

2. Has any person to be insured ever been diagnosed by a member of the medical profession with, or does anyone currently have:

   (a) Any abnormal cancer screening tests currently being followed by your doctor? [ ] Yes [ ] No
   (b) Any cysts, growths, lumps, or any mole or freckle that has bled, become painful, changed color, increased in size, required medical attention or evaluation for which you have not yet sought medical advice? [ ] Yes [ ] No
   (c) Carotid artery stenosis, peripheral vascular disease, chronic atrial fibrillation, or chest pain not evaluated by a medical doctor and determined to be non-cardiac? [ ] Yes [ ] No
   (d) Multiple sclerosis, memory loss, schizophrenia, systemic lupus erythematosus, pulmonary or cystic fibrosis? [ ] Yes [ ] No

3. Has any person to be insured had any two or more natural parents, brothers, or sisters diagnosed with coronary artery disease, diabetes, or the same cancer (other than skin cancer) prior to age 55? Or, has any person to be insured had one or more natural parents, brothers, or sisters diagnosed with coronary artery disease or colorectal cancer prior to age 45? [ ] Yes [ ] No

4. Is any person to be insured currently taking any prescription medicine(s) or have they taken prescription medicine(s) in the last three (3) years? [ ] Yes [ ] No

5. Has any person to be insured had any abnormal tests (including blood test, urinalysis, X-ray, MRI, ultrasound, stress test, echocardiogram) not found to be normal or benign on further testing, or requiring follow-up by a physician? [ ] Yes [ ] No

6. Does any person to be insured have any consultation, surgery, or test scheduled or anticipated? [ ] Yes [ ] No

7. Has any person to be insured ever been diagnosed by a member of the medical profession with a benign tumor, disorder of blood or autoimmune disorder, digestive disorder, urinary system or reproduction organs disorder, heart or circulatory disorder, hypertension (list last two blood pressure readings and dates), mental or nervous disorder, neurological disorder, or respiratory disorder? [ ] Yes [ ] No

8. Has any person to be insured had any application for critical illness, disability, health, or life insurance modified, rated, or declined in the last 5 years? [ ] Yes [ ] No

9. Give details to any “Yes” answers, including name of person, prescription medicine(s), diagnosis, and dates of treatment: __________________________________________

   __________________________________________

10. Name, address, and phone number of the personal physician(s) of all applicants with date last seen, reason for visit, and results: __________________________________________

    __________________________________________
SECTION 5 – AUTHORIZATION

1. Does any person applying for coverage currently have a Critical Illness or Cancer Policy with us or any other insurance company?  ☐ Yes ☐ No
   If yes, give name of company, list type of policy and amount of coverage.

2. REPLACEMENT: Is this insurance to replace or Change other insurance?  ☐ Yes ☐ No   If “Yes”, give details including name of company.

3. OUTLINE: Have you received the Outline of Coverage (in those states required by law)? ☐ Yes ☐ No (check one)

   In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the “Important Note” and the “Insurance Fraud Warning” below; (c) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurers, company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (d) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (e) agree that this authorization shall be valid for two (2) years from the application date; (f) know that I or my authorized representative may revoke this authorization at any time; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (h) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. I understand no person to be insured is also covered by any Title XIX program – Medicaid or any similar name (Not applicable to residents of AZ, MO, NC, OR, or SC). I understand failure to disclose a proposed insured person’s true health condition may void this policy.

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modul premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application. I understand that my policy will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy. I understand and accept that the coverage I am purchasing does not include dependent (child) coverage except for the initial 90 days from birth or adoption as stated in the policy and that no dependent (child) will be covered for an additional time period without the prior express written consent and approval of USAble Life.

Insurance Fraud Warning – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

X ____________________________  Signed at: ____________________________
   Applicant’s Signature            (City and State)

X ____________________________  Date of Application: ____________________________
   Spouse’s Signature (if required)  (Month, Day, Year)

   I have truly and accurately recorded the information supplied by the applicant.

X ____________________________  Agent’s Signature

   Agent’s Printed Name

   Agent’s License ID Number