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

A Stock Company

GROUP CRITICAL ILLNESS INSURANCE POLICY
NON-PARTICIPATING

American Heritage Life Insurance Company (referred to as we, us, our, or the company) will provide benefits under this policy. We make this promise subject to all of the provisions of this policy and any attached riders.

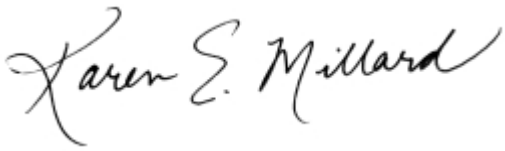
The policyholder should read this group policy carefully and contact us promptly with any questions. This group policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA), and consists of:

1. all policy provisions, any amendments, riders, and/or attachments issued; and
2. the policyholders' signed application.

This policy may be changed in whole or in part. The approval must be in writing, signed by one of our executive officers and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the Policy Effective Date.

This policy is a legal contract between the policyholder and the company.



Secretary



President

THIS IS A GROUP CRITICAL ILLNESS POLICY WHICH ONLY PROVIDES STATED BENEFITS FOR SPECIFIED CRITICAL ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED.

THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

Read Your Policy Carefully.

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POLICY SPECIFICATIONS

POLICYHOLDER: MERIDIAN PUBLIC SCHOOL DISTRICT

POLICY NUMBER: E1364

POLICY EFFECTIVE DATE: September 1, 2024

POLICY ANNIVERSARY DATE: September 1, 2025 and the first day of September each calendar year thereafter.

GOVERNING JURISDICTION: the state of Mississippi and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): All full-time active employees working at least 20 hours per week.

ELIGIBILITY WAITING PERIOD: None

EFFECTIVE DATES:

CERTIFICATE:	The First Of The Month
CHANGE IN COVERAGE:	The First Of The Month
TERMINATIONS:	The End Of The Month

REINSTATEMENT IF REHIRED: Within 30 Days

INITIAL CRITICAL ILLNESS BENEFITS

PLAN I- BASIC BENEFIT AMOUNT:		**GUARANTEED ISSUE LIMIT**:
Primary Insured	Amount selected by the primary insured	$10,000
Covered Spouse	50% of the primary insured's Basic Benefit Amount	$5,000
Covered Child(ren)	50% of the primary insured's Basic Benefit Amount	$5,000

ADDITIONAL BENEFITS:
Reoccurrence of Critical Illness Benefits
Cancer Critical Illness Benefits
Reoccurrence of Cancer Critical Illness Benefits

RIDERS:

Supplemental Critical Illness Rider	
Fixed Wellness Rider	$50 per year
Skin Cancer Rider	$250
Cardiopulmonary Enhancement Rider	

PLAN II- BASIC BENEFIT AMOUNT:		**GUARANTEED ISSUE LIMIT**:
Primary Insured	Amount selected by the primary insured	$20,000
Covered Spouse	50% of the primary insured's Basic Benefit Amount	$10,000
Covered Child(ren)	50% of the primary insured's Basic Benefit Amount	$10,000

ADDITIONAL BENEFITS:
Reoccurrence of Critical Illness Benefits
Cancer Critical Illness Benefits
Reoccurrence of Cancer Critical Illness Benefits

RIDERS:

Supplemental Critical Illness Rider	
Fixed Wellness Rider	$50 per year
Skin Cancer Rider	$250
Cardiopulmonary Enhancement Rider	

POLICY SPECIFICATIONS (Continued)

PLAN III- BASIC BENEFIT AMOUNT: **GUARANTEED ISSUE LIMIT**:

Primary Insured	Amount selected by the primary insured	$30,000
Covered Spouse	50% of the primary insured's Basic Benefit Amount	$15,000
Covered Child(ren)	50% of the primary insured's Basic Benefit Amount	$15,000

ADDITIONAL BENEFITS:
Reoccurrence of Critical Illness Benefits
Cancer Critical Illness Benefits
Reoccurrence of Cancer Critical Illness Benefits

RIDERS:

Supplemental Critical Illness Rider	
Fixed Wellness Rider	$50 per year
Skin Cancer Rider	$250
Cardiopulmonary Enhancement Rider	

PLAN I - INITIAL RATES:

MONTHLY PREMIUM RATES	ISSUE AGE	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	FAMILY
NON-TOBACCO	18-29	$5.04	$8.28	$5.04	$8.28
	30-39	$9.71	$15.41	$9.71	$15.41
	40-49	$18.49	$28.79	$18.49	$28.79
	50-59	$31.73	$48.91	$31.73	$48.91
	60-64	$42.34	$65.04	$42.34	$65.04
	65+	$66.65	$101.82	$66.65	$101.82
TOBACCO	18-29	$6.51	$10.47	$6.51	$10.47
	30-39	$13.52	$21.09	$13.52	$21.09
	40-49	$27.84	$42.81	$27.84	$42.81
	50-59	$49.08	$74.94	$49.08	$74.94
	60-64	$65.49	$99.76	$65.49	$99.76
	65+	$102.01	$154.86	$102.01	$154.86

PLAN II - INITIAL RATES:

MONTHLY PREMIUM RATES	ISSUE AGE	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	FAMILY
NON-TOBACCO	18-29	$8.70	$13.74	$8.70	$13.74
	30-39	$17.78	$27.47	$17.78	$27.47
	40-49	$34.90	$53.39	$34.90	$53.39
	50-59	$60.82	$92.55	$60.82	$92.55
	60-64	$81.65	$123.97	$81.65	$123.97
	65+	$129.58	$196.22	$129.58	$196.22
TOBACCO	18-29	$11.63	$18.15	$11.63	$18.15
	30-39	$25.38	$38.88	$25.38	$38.88
	40-49	$53.60	$81.44	$53.60	$81.44
	50-59	$95.49	$144.58	$95.49	$144.58
	60-64	$127.93	$193.42	$127.93	$193.42
	65+	$200.29	$302.29	$200.29	$302.29

POLICY SPECIFICATIONS (Continued)

PLAN III - INITIAL RATES:

MONTHLY PREMIUM RATES	ISSUE AGE	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE & CHILD(REN)	FAMILY
NON-TOBACCO	18-29	$12.33	$19.22	$12.33	$19.22
	30-39	$25.82	$39.59	$25.82	$39.59
	40-49	$51.30	$78.00	$51.32	$78.00
	50-59	$89.89	$136.17	$89.89	$136.17
	60-64	$120.92	$182.93	$120.92	$182.93
	65+	$192.49	$290.57	$192.49	$290.57
TOBACCO	18-29	$16.74	$25.82	$16.74	$25.82
	30-39	$37.23	$56.69	$37.23	$56.69
	40-49	$79.35	$120.10	$79.35	$120.10
	50-59	$141.92	$214.21	$141.92	$214.21
	60-64	$190.37	$287.11	$190.37	$287.11
	65+	$298.56	$449.69	$298.56	$449.69

POLICY SPECIFICATIONS (Continued)

RATE GUARANTEE DATE:
September 1, 2026

PREMIUM DUE:
September 1, 2024 and the first day of each calendar month thereafter.

All premiums must be sent to us on or before the premium due date. The premium must be paid in United States dollars.

COST OF COVERAGE:
The primary insured pays the cost of coverage.

DIVISIONS, SUBSIDIARIES, OR AFFILIATED COMPANIES:
These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these entities in all matters that pertain to this policy. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name	Location (City and State)
None	

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POLICYHOLDER PROVISIONS

RATE GUARANTEE
A change in premium rate will not take effect before the Rate Guarantee Date except for reasons which affect the risk assumed, including those reasons shown below:
1. a change occurs in this plan design;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of insured employees or members changes by 25% or more;
4. a new law or a change in any existing law is enacted which applies to this plan; or
5. less than 25% of those eligible for coverage are participating.

We will notify the policyholder in writing at least 60 days before a premium rate is changed. A change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES
Premium increases or decreases may take effect at any time, subject to the Rate Guarantee provision. If they take effect during a policy month, they are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

INFORMATION REQUIRED FROM THE POLICYHOLDER
The policyholder must provide us with the following on a regular basis:
1. information about employees or members:
    a. who are eligible to become insured;
    b. who are requesting a coverage change;
    c. whose coverage ends;
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

Policyholder records that have a bearing, in our opinion, on this policy will be available for review by us at any reasonable time.

CANCELING POLICY
This policy can be canceled:
1. by us; or
2. by the policyholder.

We may cancel or modify this policy, with at least 31 days written notice to the policyholder, if:
1. less than 25% of those eligible for coverage are participating;
2. this policy has been in effect longer than 12 months;
3. the policyholder does not promptly provide us with information that is reasonably required;
4. the policyholder fails to perform any of its obligations that relate to this policy;
5. fewer than 5 employees or members are insured; or
6. the policyholder fails to pay any premium due by the end of the grace period.

When both we and the policyholder agree, in writing, this policy may be modified on an earlier date.

If the premium is not paid during the grace period, this policy will terminate automatically on the due date of any unpaid premium. The policyholder is liable for the premium for coverage through the end of the grace period. The policyholder must pay us all premiums due for the full period this policy is in force.

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.
If this policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

WHEN AN ELIGIBLE EMPLOYEE OR MEMBER CAN ENROLL, CHANGE, OR DISCONTINUE COVERAGE

1. The employee or member may apply for coverage during:
   a. the initial enrollment period; or
   b. a re-enrollment period, subject to evidence of insurability
2. The primary insured may:
   a. increase coverage at any time, subject to evidence of insurability;
   b. decrease coverage at any time; or
   c. discontinue coverage at any time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required if:

1. the employee or member:
   a. voluntarily canceled coverage and is reapplying;
   b. is applying for an amount of coverage over the Guaranteed Issue Limit;
   c. is applying for the coverage, or an increase in the amount of coverage, at any time after his or her initial enrollment period;
2. an eligible spouse or domestic partner was not enrolled within 31 days of eligibility.

EFFECTIVE DATE OF COVERAGE

Coverage for each eligible employee or member will be effective at 12:01 a.m. on the effective date shown on page 3 of the certificate of insurance issued to him or her provided that he or she is actively employed on that date.

If the employee or member is not actively employed on that date due to a temporary layoff, leave of absence or Family and Medical Leave of Absence, coverage begins on the date he or she returns to active employment. This applies to initial coverage, as well as any increase in coverage that occurs after his or her initial coverage is effective.

For any change in coverage that is subject to evidence of insurability, the change in coverage is effective on the date we approve such change and in accordance with the Policy Specifications page.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective when we receive such request for change and as stated on the Policy Specifications page.

Any decrease in coverage will take effect on the first day of the calendar month that next follows the date the primary insured applies for the decrease, but will not affect a payable claim that occurs prior to the effective date of the decrease.

If an employee or member terminates employment and returns to work for the policyholder within the timeframe stated on the Policy Specifications page, this coverage may be reinstated without providing evidence of insurability.

CERTIFICATES OF INSURANCE

We will furnish to the policyholder a certificate of insurance for delivery to each primary insured that describes the terms of the coverage made available to the eligible employees or members of the policyholder and their eligible dependents. The certificate will provide a description of the insurance provided by this policy and will state:

1. the essential features of the insurance coverage; and
2. to whom benefits are payable.

If there is any discrepancy between the provisions of any certificate and the provisions of this policy or any attached riders, the provisions of this policy and any attached riders govern.

GENERAL PROVISIONS (Continued)

ELIGIBILITY OF DEPENDENTS

Eligible dependents are the primary insured's:

1. legal spouse or domestic partner; and
2. child(ren) and spouse's or domestic partner's children.

If the primary insured marries and desires coverage for his or her spouse, the policyholder must be notified of the marriage within 31 days of the marriage. Upon notice to us, we will change the coverage to include the spouse and provide notification of any additional premium due.

If the primary insured enters into a domestic partnership and desires coverage for his or her domestic partner, the policyholder must be notified of the domestic partnership within 31 days of the date the domestic partnership was formed. Upon notice to us, we will change the coverage to include the domestic partner and provide notification of the additional premium due.

A child born to the primary insured or his or her spouse or domestic partner, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other child insured under this policy. No additional premium will be required for newborns added.

An adopted child or child pending adoption will be covered as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the primary insured or his or her spouse or domestic partner has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by the primary insured or his or her spouse or domestic partner within 31 days after the date of birth and he or she has temporary custody, coverage is provided from the moment of birth.
3. Coverage shall begin from the moment of placement.

Coverage will be provided as long as the primary insured or his or her spouse or domestic partner has custody of the child pursuant to decree of the court.

TEMPORARY LAYOFF, LEAVE OF ABSENCE, OR FAMILY AND MEDICAL LEAVE OF ABSENCE

If the primary insured ceases active employment or membership in the union or association because of a temporary layoff or leave of absence while coverage is in force, we will continue the coverage in accordance with the personnel practices of the policyholder, if premium payments continue and the policyholder approved the leave in writing. Coverage will be continued for 3 months following the date he or she ceased active employment or membership in the union or association.

If his or her coverage ends while on a Family and Medical Leave of Absence, the coverage may be reinstated when he or she returns to active status.

We will not:

1. apply a new pre-existing conditions limitation; or
2. require evidence of insurability.

GENERAL PROVISIONS (Continued)

TERMINATION OF COVERAGE

The coverage under this policy ends on the earliest of:

1. the date this policy is canceled;
2. the last day of the period for which any required premium payments were made;
3. the last day the primary insured is actively employed with the employer or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence provision;
4. the date the primary insured is no longer in an eligible class;
5. the date the primary insured's class is no longer eligible; or
6. our discovery of fraud or material misrepresentation in the presentation of a claim under this policy or any attached rider.

Coverage for a covered person terminates when he or she has exhausted all available benefits under this policy and any attached riders.

We will provide coverage for a payable claim that occurs while a covered person is covered under this policy.

The primary insured or other qualifying dependents have the responsibility to inform us of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under this policy.

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

If the primary insured's domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or the primary insured's death.

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

Coverage does not end at age 26 for an incapacitated dependent 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 the primary insured for support and maintenance.

Coverage for an incapacitated dependent child continues as long as this policy 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 child's attainment of the limiting age for eligibility.

If we receive premium for coverage extending beyond the date or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid.

Coverage may be eligible for continuation as outlined in the Continuation of Insurance Coverage provision.

DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

The following applies only when the administration of this policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

We have the discretion and authority to construe disputed or seemingly inconsistent provisions of this policy and any attached riders and to make all decisions regarding eligibility and/or entitlement to coverage or benefits. Whenever we make reasonable determinations which are not arbitrary or capricious in the administration of this policy, such determinations shall be final and conclusive.

GENERAL PROVISIONS (Continued)

LEGAL ACTION
No legal action may be brought to obtain benefits under this policy:
1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time proof of loss is required to have been furnished.

INCONTESTABILITY
After 2 years from the effective date of this policy, no misstatement of the policyholder or covered person, made in any application, can be used to void this policy.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or a covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his or her personal representative, if any, if such written statement will be used in defense of a claim.

CLERICAL ERROR
Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force, nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums and/or benefits available. Complete proof must be supplied by the policyholder documenting any clerical errors.

AGENCY
For purposes of this policy, the policyholder acts on its own behalf or as the primary insured's agent. Under no circumstances will the policyholder be deemed the agent of American Heritage Life Insurance Company.

ENTIRE CONTRACT
The contract consists of the following items:
1. the group policy;
2. any amendments and endorsements;
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollments, evidence of insurability or other statements of the primary insured or a covered person.

CHANGE OF BENEFICIARY
Any change of beneficiary must be filed at our home office. It will not take effect unless so filed, but if so filed, will take effect on the date signed by the primary insured. This will be true whether or not the primary insured is living on the date it is filed. There will be no prejudice to us on account of any payment we make prior to its receipt by us at our home office.

The right to change a beneficiary is reserved to the primary insured. The consent of the beneficiary or beneficiaries will not be required to assign benefits or to change a beneficiary or beneficiaries, or to make any other changes, unless the designation of the beneficiary is irrevocable.

ASSIGNMENT
An assignment of benefit is not binding on us unless:
1. it is a written request; and
2. it is received by us at our home office.

An assignment will take effect when recorded at our home office. We are not responsible for the validity of any assignment.

EXCLUSIONS

We will not pay benefits for a critical illness that is, or is caused by, or contributed to by, or results from:

1. intentionally self-inflicted injury or action;
2. illegal activities or participation in an illegal occupation;
3. suicide while sane, or self-destruction while insane, or any attempt at either;
4. substance abuse, to include abuse of alcohol, alcoholism, abuse of legally obtained prescription medication, or illegal use of a non-prescribed drug or narcotic; or
5. the covered person being under the influence of alcohol, a drug, or a narcotic, unless administered and taken as prescribed by a physician.

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PRE-EXISTING CONDITION LIMITATION

We will not pay benefits for a critical illness that is, or is caused by, or contributed to by, or results from, a pre-existing condition when the date of diagnosis for the critical illness is within 12 months after the effective date of coverage.

A pre-existing condition is a sickness, injury or other condition, whether diagnosed or not, for which, during the 12 months just prior to the effective date of coverage, either:

1. symptoms existed; or
2. medical advice or treatment was recommended by or received from a physician or other member of the medical profession, acting within the scope of their license.

WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR GROUP INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior group policy if:

1. the claim would have satisfied the pre-existing condition limitation of the prior group policy; and
2. the primary insured:
   a. was actively employed on the effective date of this policy;
   b. has been continuously insured under this policy since its effective date;
   c. was insured under the prior group policy when it terminated; and
3. the covered person making the claim:
   a. has been continuously insured under this policy since its effective date;
   b. was insured under the prior group policy when it terminated; and
4. the prior group policy:
   a. had the same policyholder as this policy;
   b. provided coverage substantially similar to this policy;
   c. was issued before the effective date of this policy;
   d. terminated within 60 days of the effective date of this policy.

WAIVER OF PRE-EXISTING CONDITION LIMITATION FOR PRIOR INDIVIDUAL INSURANCE

We will waive the pre-existing condition limitation for a claim by a covered person who was insured under a prior individual policy if:

1. the claim would have satisfied the pre-existing condition limitation of the prior individual policy; and
2. the primary insured:
   a. was actively employed on the effective date of this policy;
   b. has been continuously insured under this policy since its effective date;
   c. was insured under the prior individual policy when it terminated; and
3. the covered person making the claim:
   a. has been continuously insured under this policy since its effective date;
   b. was insured under the prior individual policy when it terminated; and
4. the prior individual policy:
   a. provided coverage substantially similar to this policy;
   b. was issued before the effective date of this policy; and
   c. terminated within 60 days of the effective date of this policy.

CRITICAL ILLNESS BENEFITS

GENERAL
Subject to the conditions, limitations and exclusions of this policy and any attached riders, we will pay a benefit when a covered person is diagnosed with a critical illness described in this policy or any attached rider if:
1. the date of diagnosis for the critical illness or the date of loss is while the covered person is insured under this policy and any attached riders; and
2. the critical illness is not excluded by name or specific description.

A covered person can receive benefits for different critical illnesses or specified diseases described in this policy and any attached riders if the dates of diagnosis for each critical illness are separated by at least 30 days.

Each critical illness must be diagnosed by a physician qualified to make such diagnosis. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant.

We do not pay any benefit for any condition or loss not described in this policy or any attached rider.

INITIAL CRITICAL ILLNESS BENEFITS
A covered person can receive a benefit for each critical illness only once, unless the Reoccurrence of Critical Illness Benefits provision is included in the coverage.

A. BENEFIT AMOUNTS. The benefit amount for each Initial Critical Illness is the percentage shown below for that Initial Critical Illness multiplied by the Basic Benefit Amount for the Initial Critical Illness Benefit shown on the Policy Specifications page applicable to the covered person.

Initial Critical Illness	Percentage of Basic Benefit Amount
Heart Attack	100%
Stroke	100%
End Stage Renal Failure	100%
Major Organ Transplant	100%
Coronary Artery By-Pass Surgery	25%

B. BENEFIT DESCRIPTIONS. The Initial Critical Illnesses are:

1. **Heart Attack.** The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be based on both:
   a. new electrocardiographic changes; and
   b. elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

   Heart Attack does not include an established (old) myocardial infarction or cardiac arrest.

   The date of diagnosis for Heart Attack is the date of death (infarction) of a portion of the heart muscle.

2. **Stroke**. The death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit.

   Stroke does not include: transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency or reversible ischemic neurological deficits.

   The date of diagnosis for Stroke is the date the stroke occurred based on documented neurological deficits and neuroimaging studies.

B. BENEFIT DESCRIPTIONS. (Continued)

3. **End Stage Renal Failure.** The irreversible failure of both kidneys to perform their essential functions, with the covered person undergoing peritoneal dialysis or hemodialysis.

   End stage renal failure does not include renal failure caused by a traumatic event, including surgical traumas.

   The date of diagnosis for End Stage Renal Failure is the date renal dialysis first begins due to the irreversible failure of both kidneys to perform their essential functions.

4. **Major Organ Transplant.** Being placed on the National Transplant List or the performance of a surgical transplantation of a major organ.
   a. **Candidate Benefit.** A covered person is placed on the National Transplant List as an active or an inactive candidate for a major organ transplant.

      The Candidate Benefit is not payable if we have previously paid:
      i. the Candidate Benefit on the covered person, for any reason; or
      ii. the Surgery Benefit on the covered person for the same major organ.
   b. **Surgery Benefit.** A covered person undergoes a major organ transplant, performed by a physician.

      The Surgery Benefit is not payable if we have previously paid the Candidate Benefit on the covered person for the same major organ. If we paid the Candidate Benefit for a covered person listed as a candidate for multiple major organ transplants, only the first one of those major organs transplanted will be considered the same major organ.

      No benefit is payable for major organ transplants using mechanical or non-human organs.

   Major Organ means the heart, lungs, liver, pancreas, or kidneys. Lungs and kidneys are each one major organ regardless of whether one or both lungs, or one or both kidneys, are transplanted.

   Major organ transplant means the surgical transplant, by a physician, of a major organ. Each major organ transplanted is a major organ transplant eligible for the Surgery Benefit, even if multiple major organ transplants are performed in one surgical procedure.

   National Transplant List means the database containing information on all people in the United States and Puerto Rico who are waiting for one or more major organ transplants, as mandated by the National Organ Transplant Act.

   The date of loss for Major Organ Transplant is the date a covered person:
   a. is placed on the National Transplant List, as an active or an inactive candidate, for a major organ transplant; or
   b. undergoes the actual surgery for a major organ transplant.

5. **Coronary Artery By-Pass Surgery.** The surgical operation to correct narrowing or blockage of one or more coronary arteries with by-pass grafts on the advice of a cardiologist registered in the United States. Angiographic evidence to support the necessity for this surgery will be required.

   Coronary Artery By-Pass Surgery does not include: abdominal aortic bypass; balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

   The date of loss for Coronary Artery By-Pass Surgery is the date the actual coronary artery by-pass surgery occurs.

ADDITIONAL BENEFITS

REOCCURRENCE OF CRITICAL ILLNESS BENEFITS

We will pay a benefit for a reoccurrence of a critical illness if a covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the Initial Critical Illness Benefits provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the initial critical illness; and
2. the second date of diagnosis is while the covered person is insured under this policy.

The benefit amount is equal to the benefit amount previously paid for that initial critical illness. A covered person can receive a benefit for a reoccurrence of a critical illness only once for each initial critical illness.

Initial Critical Illness
Heart Attack
Stroke
End Stage Renal Failure
Major Organ Transplant
Coronary Artery By-Pass Surgery

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ADDITIONAL BENEFITS

CANCER CRITICAL ILLNESS BENEFITS

A. BENEFIT AMOUNTS. The benefit amount for each Cancer Critical Illness is the percentage shown below for that Cancer Critical Illness multiplied by the Basic Benefit Amount for the Initial Critical Illness Benefit shown on the Policy Specifications page applicable to the covered person.

Cancer Critical Illness	Percentage of Basic Benefit Amount
Carcinoma In Situ	25%
Invasive Cancer	100%

B. BENEFIT DESCRIPTIONS. The Cancer Critical Illnesses are:

1. **Carcinoma In Situ.** A cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma In Situ includes:
   a. early prostate cancer diagnosed as stages A, I or II or equivalent staging; and
   b. melanoma not invading the dermis.

   Carcinoma In Situ does not include:
   a. other skin malignancies;
   b. pre-malignant lesions (such as intraepithelial neoplasia); or
   c. benign tumors or polyps.
2. **Invasive Cancer.** A malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Invasive Cancer includes Leukemia and Lymphoma.

   Invasive Cancer does not include:
   a. Carcinoma In Situ;
   b. skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; or
   c. early prostate (stages A, I or II) cancer.

C. DIAGNOSIS REQUIREMENTS. A Cancer Critical Illness must be diagnosed in one of two ways:

1. **Pathological diagnosis** means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis is in keeping with the standards set by the American Board of Pathology.
2. **Clinical diagnosis** means a clinical identification of cancer based on history, laboratory study, and symptoms. We will pay benefits for a clinical diagnosis only if:
   a. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
   b. there is medical evidence to support the diagnosis.

The date of diagnosis for Cancer Critical Illness is the day the tissue specimen, culture and/or titer(s) are taken on which the first diagnosis of cancer is based.

The “first diagnosis of cancer” includes a diagnosis of a reoccurrence of a cancer that was previously diagnosed before the effective date of coverage if, after the previous diagnosis and before the date of diagnosis of the reoccurrence, the covered person is free of any symptoms and treatment of the cancer for the 12 consecutive months immediately preceding the effective date of coverage or any 12 consecutive months thereafter.

For purposes of this benefit, “treatment” does not include maintenance drug therapy or routine follow-up office visits to verify if the Cancer Critical Illness has returned.

“Maintenance drug therapy” means ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that may be given following the full remission of a cancer due to primary treatment. It is meant to decrease the risk of cancer reoccurrence rather than the palliation or suppression of a cancer that is still present.

ADDITIONAL BENEFITS

REOCCURRENCE OF CANCER CRITICAL ILLNESS BENEFITS

We will pay a benefit for a reoccurrence of cancer critical illness if a covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the Cancer Critical Illness Benefits provision if:

1. the second date of diagnosis is more than 12 months after the first date of diagnosis for the cancer critical illness;
2. the covered person did not receive treatment during that 12 month period; and
3. the second date of diagnosis is while the covered person is insured under this policy.

The benefit amount is equal to the benefit amount previously paid for that cancer critical illness. A covered person can receive a benefit for a reoccurrence of a cancer critical illness only once for each cancer critical Illness.

Cancer Critical Illness
Carcinoma In Situ
Invasive Cancer

For purposes of this benefit, “treatment” does not include maintenance drug therapy or routine follow-up office visits to verify if the cancer critical illness has returned.

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WAIVER OF PREMIUM BENEFIT

We will waive premiums for this coverage if, while covered under this policy and any attached riders, the primary insured:
1. becomes disabled due to a covered critical illness for which a benefit is paid; and
2. remains disabled for at least 90 consecutive days.

After the 90th day, we will waive the premiums due for the first 90 days and each consecutive day thereafter the primary insured is disabled, until the earliest of:
1. the date the primary insured is no longer disabled;
2. 2 years from the first day of disability; or
3. the date coverage ends according to the Termination of Coverage provision.

“Disabled” means the primary insured is:
1. unable to work;
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of a covered critical illness.

“Unable to work” means:
1. During the first 365 days of disability, the primary insured is unable to perform the material and substantial duties of the occupation he or she was performing when his or her disability began.
2. During the second 365 days of disability, the primary insured is unable to perform the material and substantial duties of any gainful occupation for which he or she is suited by education, training or experience.

This benefit is payable only for the disability of the primary insured. It does not apply to any other covered person. The primary insured must provide sufficient proof of disability at least once every 6 months.

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CONTINUATION OF INSURANCE COVERAGE

This section provides for automatic Continuation of Insurance Coverage, hereafter referred to as continuation coverage. It applies if a covered person suffers the loss of this group critical illness coverage due to one of the following events:

1. Termination of the primary insured's employment; or of a primary insured's eligibility due to reduction in his or her hours; or the date such primary insured is no longer in an eligible class; or the date such primary insured's class is no longer eligible. Insurance may be continued for any covered person.
2. The death of a primary insured. Insurance may be continued for any covered person.
3. Divorce or legal separation. Insurance may be continued for any covered person whose insurance would otherwise end.
4. The primary insured becoming eligible for Medicare. Insurance may be continued for any covered person who is not entitled to Medicare.
5. A child ceasing to be an eligible dependent as defined in this policy. Insurance may continue for that child.
6. The policyholder filing a Chapter 11 Bankruptcy petition. Insurance may be continued for any retired primary insured and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing of the bankruptcy.
7. Termination of the policy. (Benefits will be determined as if the policy had remained in full force and effect.)
8. Strike, layoff, leave of absence for personal reasons. Insurance may be continued for any covered person.
9. Military Service. The primary insured's leave of absence due to military service. Insurance may be continued for any covered person, except for the person who is in active military service.

Continuation coverage is not available for any person if coverage under the policy terminated due to his or her failure to make required premium payments.

To be eligible for continuation coverage, a person must be insured under the policy on the day before the event that caused loss of coverage. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

COVERAGE CONTINUED

A person will not be denied continuation coverage solely because he or she is covered under another group critical illness plan, or eligible for Medicare on the date of the event that caused loss of coverage.

The continuation coverage may include any eligible dependents who were covered under the policy. The coverage being continued is subject to all terms and provisions of the policy that do not conflict with this section. The coverage will be the same as that provided under the policy for other persons in the same insurance class in which such person would have been if the loss of coverage had not occurred. The coverage will be subject to any changes to the policy affecting the benefits of such class. The continuation coverage will be effective on the day after the coverage under the policy terminates.

NOTIFICATION AND PAYMENT REQUIREMENTS

The primary insured or other qualifying dependents have the responsibility to inform the insurer of: (a) divorce; (b) legal separation; or (c) a child losing eligibility under this policy. This notice must be made within 60 days of these events. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

The policyholder has the responsibility of notifying the insurer of: (a) a covered person's death; (b) termination of the primary insured's employment or reduction in hours; or (c) the policyholder's bankruptcy. This notice must be made within 30 days of the event.

The insurer will notify the qualifying person of the right to continue within 14 days of the notice described above.

The qualifying person will be required to pay a premium for the continuation coverage to the insurer.

CONTINUATION OF INSURANCE COVERAGE (Continued)

PREMIUMS
Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rate for the first 36 months of continuation coverage will not exceed 102% of the rate in effect under the policy covering a similarly situated class of primary insureds who have not elected continuation coverage. After the first 36 months, the premium rate may change for the class of persons covered under continuation coverage. Notice will be given at least 60 days before any change is to take effect.

GRACE PERIOD
The grace period, as defined, will apply to each certificate holder of continuation coverage as if such covered person is the policyholder.

TERMINATION OF INSURANCE
Insurance under continuation coverage will automatically end on the earliest of the following dates:
1. the date the covered person again becomes eligible for insurance under the policy;
2. the last day for which premiums have been paid, if the covered person fails to pay premiums when due, subject to the grace period;
3. with respect to insurance for dependents:
   a. the date the primary insured's insurance terminates; or
   b. the date the dependent ceases to be an eligible dependent under the policy.

A dependent child whose continuation coverage terminates when he or she reaches the age limit may apply for continuation coverage in his or her own name, if he or she is otherwise eligible.

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CLAIM INFORMATION

NOTICE OF CLAIM

We encourage the primary insured to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 30 days after the occurrence or commencement of any event or loss covered by this policy and any attached riders, or as soon as is reasonably possible. Notice must be given to us by, or on behalf of, the primary insured or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687 to the attention of the Claims Department, or to any authorized agent of ours, with the primary insured's name and certificate number.

The claim form can be requested from us. If the form is not received from us within 15 days of the request, written proof of claim may be sent to us without waiting for the form.

FILING A CLAIM

The primary insured must complete all applicable sections of the claim form and then give it to the covered person's attending physician. The physician should complete the attending physician's statement and send it directly to us.

PROOF OF CLAIM

Written proof of claim must be furnished to us within 90 days of each critical illness or payable loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim as long as it can be shown that it was not reasonably possible to provide the proof at an earlier date, and the proof is provided as soon as was reasonably possible. In any event, the proof required must be given to us no later than one (1) year from the time specified, unless the primary insured is legally incapacitated.

Written proof of the eligibility of dependent child(ren) may be required at the time of claim.

PHYSICAL EXAMINATION

We have the right, at our own expense, to have the covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending.

PAYMENT OF CLAIMS

After receiving a clean electronic claim, we pay all benefits then due under this policy within 25 days. After receiving a clean written claim, we pay all benefits then due under this policy within 35 days.

Should there be a delay in such payment, interest shall be payable on the claim commencing on the 26th day for clean electronic claims and the 36th day on clean written claims, at a rate of 1.5% per month thereof until the claim is paid. If we do not pay when due, the primary insured may bring action to recover such benefits and other damages. We will make payment to the primary insured, unless such payments are assigned. Any amounts unpaid at the primary insured's death will be paid to the named beneficiary.

If there is no named beneficiary, or the named beneficiary does not survive the primary insured, we will pay any benefits due in the following order:

1. to the primary insured's living spouse or domestic partner; otherwise
2. to the covered person's living children, in equal shares; otherwise
3. to the covered person's living parents, in equal shares; otherwise
4. to the covered person's living siblings, in equal shares; otherwise
5. to the covered person's estate.

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

CLAIM INFORMATION (Continued)

OVERPAID CLAIM
We have the right to recover any overpayments due to:
1. fraud; or
2. any error we make in processing a claim.

The primary insured must reimburse us in full. We will work with the primary insured to develop a reasonable method of repayment if he or she is financially unable to repay us in a lump sum.

We will not recover more money than the amount we overpaid.

UNPAID PREMIUM
Upon the payment of a claim under this policy and any attached riders, any unpaid premium may be deducted.

CLAIM REVIEW
If a claim is denied, we will give written notice of:
1. the reason for denial;
2. the policy or rider provision that relates to the denial;
3. the primary insured's right to ask for a review of the denial; and
4. the primary insured's right to submit any additional information that might allow us to change our decision.

He or she may, upon written request, have copies of any claim documents that are not confidential, for a fee.

APPEALS PROCEDURE
Prior to filing any lawsuit and within 60 days after denial of a claim, the primary insured or his or her beneficiary must appeal any denial of benefits under this policy or any attached riders by making a written request for review of the denial.

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GLOSSARY

(Glossary may contain terms that are not included in the coverage selected)

Accident means a sudden, unforeseen, and unexpected event which occurs without the covered person's intent.

Active employment or **actively employed** means the employee or member is working for his or her employer for earnings that are paid regularly and that he or she is performing the material and substantial duties of his or her regular occupation. For the purposes of this policy the employee or member:

1. must be working at least the minimum number of hours as described under Eligible Class(es); and
2. will be deemed to be in active employment on a day which is not the employer's scheduled work days only if he or she was actively employed on the preceding scheduled work day.

The employee or member's work site must be:

1. the employer's usual place of business;
2. an alternative work site at the direction of the employer; or
3. a location to which the job requires the employee or member to travel.

Normal vacation is considered active employment. However, if vacation days are used to cover disability, sickness or injury, those days are not considered active employment. Temporary and seasonal workers are excluded from coverage.

Calendar year means a consecutive 12 month period beginning on January 1st of each year and ending on December 31st of the same year.

Child means a person under age 26 who is the primary insured's or his or her spouse's or domestic partner primary insured's natural or adopted son or daughter, stepson or stepdaughter, or a foster child who is placed with the primary insured or his or her spouse or domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

Clean claim means a claim received by us for adjudication which requires no further information, adjustment or alteration by the provider of the services or the primary insured unless in order to be processed and paid by us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. A clean claim includes resubmitted claims with previously identified deficiencies corrected.

Covered person means any of the following:

1. any eligible family member (including the primary insured) named on the enrollment or evidence of insurability form and accepted for coverage by us;
2. any eligible family member added by endorsement after the effective date; or
3. a newborn or adopted child.

Critical illness means one of the critical illnesses described in the Critical Illness Benefits provision, any Additional Benefits, or any attached riders, for which a benefit may be paid.

Domestic partner means the primary insured's same-sex or opposite-sex partner who is eligible for coverage provided that:

1. both the primary insured and his or her same-sex or opposite-sex partner must be considered as domestic partners according to the law of the primary insured's state of residence; or
2. if the primary insured's state of residence has no domestic partnership law, he or she must satisfy the definition of domestic partner as defined by the policyholder.

GLOSSARY (Continued)

Eligibility waiting period means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible to enroll or apply for coverage.

Employee means a person who is: (a) a citizen or resident of the United States or one of its territories; and (b) in active employment with the employer or is a member in good standing in the labor union, association or other entity named as the policyholder.

Employer means the individual, company, or corporation where the employee or member is in active employment, and includes any division, subsidiary, or affiliated company named in this policy.

Evidence of insurability means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage.

Family Coverage means coverage that includes the primary insured, his or her eligible spouse or domestic partner, and his or her eligible child(ren).

Grace period means a period of 31 days for the payment of each premium falling due after the first premium.

Individual and Child(ren) Coverage means coverage that includes the primary insured and eligible children.

Initial enrollment period means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

1. if the employee or member is eligible for coverage on the policy effective date, a period before the policy effective date as set by us and the policyholder; or
2. if the employee or member becomes eligible for coverage after the policy effective date, the period ending 31 days after the date he or she is first eligible to apply for coverage.

Injury means accidental bodily harm or damage to a covered person, independent of disease, bodily infirmity, or any other cause.

Insured employee or member means the employee or member accepted for coverage by us who has completed and signed the enrollment form or evidence of insurability and whose name appears on the Certificate Specifications page.

Material and substantial duties means duties that:

1. are normally required for the performance of the primary insured's regular occupation; and
2. cannot be reasonably omitted or modified, unless the primary insured is required to work on average in excess of 40 hours per week, we will consider he or she is able to perform that requirement if he or she is working or has the capacity to work 40 hours per week.

Member means a member in good standing in a labor union, association or other entity named as the policyholder and who is: (a) a citizen or resident of the United States or its territories; and (b) is (1) engaged in , or (2) able to engage in and currently seeking, active employment.

Payable claim means a claim for which we are liable under the terms of this policy or any attached riders.

Physician means an individual who is licensed in the United States to practice medicine or treat illness in the state in which treatment is received. The physician cannot be the employee or member, a covered person or a member of the family by blood, marriage, or adoption.

GLOSSARY (Continued)

Policyholder means the legal entity to whom this policy is issued.

Primary insured means the insured employee or member covered under this policy, and for whom a certificate of insurance has been issued.

Re-enrollment period means a period of time as set by the policyholder and us during which the primary insured may apply, in writing, for coverage under this policy, or change existing coverage under this policy if he or she is currently enrolled.

Sickness means an illness or disease.

Spouse means a person to whom the employee or member is legally married. Spouse may also include the employee's or member's domestic partner if recognized under the law of the insured employee's or member's state of residence.

Symptoms means the subjective evidence of disease or physical disturbance observed by a physician or other member of the medical profession, acting within the scope of their license.

Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence means the employee or member is absent from active employment for a period of time that has been agreed to in advance in writing by the policyholder.

Normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Treatment means consultation, care, or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

We, **us**, and **our**, and **the company** means American Heritage Life Insurance Company.

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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

THIS IS A GROUP CRITICAL ILLNESS POLICY WHICH ONLY PROVIDES STATED BENEFITS FOR SPECIFIED CRITICAL ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED.

THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

Read Your Policy Carefully.

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

ENDORSEMENT

This endorsement is made part of the policy to which it is attached. Every definition, term, condition, and provision of the policy applies to this endorsement, unless otherwise defined or provided in this endorsement.

I. The following sentence is added to the end of the first paragraph in the PAYMENT OF CLAIMS provision under the CLAIM INFORMATION section:

> After receiving a resubmitted claim with the supporting documentation and information we requested, we pay all benefits then due within 20 days.

II. The interest rate referenced in the second paragraph of the PAYMENT OF CLAIMS provision under the CLAIM INFORMATION section is deleted and replaced with a rate of 3% per month.

III. The following sentence is added to the end of the second paragraph in the PAYMENT OF CLAIMS provision under the CLAIM INFORMATION section:

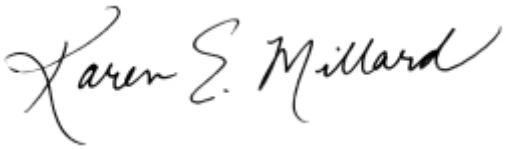
> If it is determined in such action that we acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, damages may be recovered in an amount up to 3 times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

IV. The following sentence is added to the end of the definition of “Clean claim” in the GLOSSARY section:

> Errors, such as system errors, attributable to us, do not change the clean claim status.

All other requirements of the policy not specifically stated within this endorsement still apply.

This endorsement will be attached to and form a part of the group policy, and will not be held to alter or affect any of the terms of such policy other than as specifically stated, but not unless the company has executed this endorsement.



Secretary

MS1911

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

AMENDMENT

This amendment is made part of the policy to which it is attached. Every definition, term, condition, and provision of the policy applies to this amendment, unless otherwise defined or provided in this amendment.

The “General” provision of the Critical Illness Benefits section is deleted and replaced with the following:

Subject to the conditions, limitations, and exclusions of this policy and any attached riders, we will pay a benefit when a covered person is diagnosed with a critical illness described in this policy or any attached rider if:

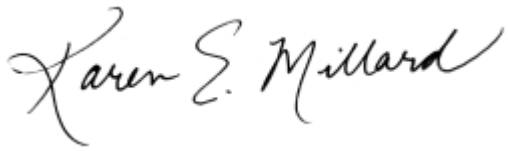
1. the date of diagnosis for the critical illness or the date of loss is while the covered person is insured under this policy or any attached riders; and
2. the critical illness is not excluded by name or specific description.

Each critical illness must be diagnosed by a physician qualified to make such diagnosis. Claims for benefits not satisfying all the criteria for diagnosis may be subject to review by an independent physician consultant.

We do not pay any benefit for any condition or loss not described in this policy or any attached rider.

All other requirements of the policy not specifically stated within this amendment still apply.

This amendment will be attached to and form a part of the group policy, and will not be held to alter or affect any of the terms of such policy other than as specifically stated, but not unless the company has executed this amendment.



Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

AMENDMENT

This amendment is made part of the policy to which it is attached. Every definition, term, condition, and provision of the policy applies to this amendment, unless otherwise defined or provided in this amendment.

The first paragraph of the “Reoccurrence of Critical Illness Benefits” provision of the Additional Benefits section is deleted and replaced with the following:

We will pay a benefit for a reoccurrence of a critical illness if a covered person is diagnosed for a second time with an initial critical illness for which a benefit was previously paid under the Initial Critical Illness Benefits provision if:

1. the second date of diagnosis is more than 6 months after the first date of diagnosis for the initial critical illness; and
2. the second date of diagnosis is while the covered person is insured under this policy.

All other requirements of the policy not specifically stated within this amendment still apply.

This amendment will be attached to and form a part of the group policy, and will not be held to alter or affect any of the terms of such policy other than as specifically stated, but not unless the company has executed this amendment.



Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

AMENDMENT

This amendment is made part of the policy to which it is attached. Every definition, term, condition, and provision of the policy applies to this amendment, unless otherwise defined or provided in this amendment.

The first paragraph of the “Reoccurrence of Cancer Critical Illness Benefits” provision of the Additional Benefits section is deleted and replaced with the following:

We will pay a benefit for a reoccurrence of cancer critical illness if a covered person is diagnosed for a second time with a cancer critical illness for which a benefit was previously paid under the Cancer Critical Illness Benefits provision if:

1. the second date of diagnosis is more than 6 months after the first date of diagnosis for the cancer critical illness;
2. the covered person did not receive treatment during that 6-month period; and
3. the second date of diagnosis is while the covered person is insured under this policy.

All other requirements of the policy not specifically stated within this amendment still apply.

This amendment will be attached to and form a part of the group policy, and will not be held to alter or affect any of the terms of such policy other than as specifically stated, but not unless the company has executed this amendment.



Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

ENDORSEMENT

This endorsement is made a part of the policy or certificate to which it is attached. All definitions, exclusions, limitations, terms, conditions, and provisions of the policy or certificate apply to this endorsement. If there is a conflict between this endorsement and the policy or certificate, this endorsement will control.

The policy and certificate are changed to require at least 75 days' advance written notice of any change in premium rates.

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

Signed for American Heritage Life Insurance Company at its home office in Jacksonville, Florida.



Secretary

MS201

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

SUPPLEMENTAL CRITICAL ILLNESS RIDER

Benefits are subject to all of the terms, conditions, and provisions of the policy and any attached riders. All terms defined and used in the policy apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Activities of daily living (ADLs) means the following activities that are performed by independently functioning individuals on a daily basis:

1. Bathing. Means to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
2. Dressing. Means to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
3. Toileting. Means to get on and off the toilet and maintain personal hygiene.
4. Bladder and Bowel Continence. Means to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
5. Transferring. Means to move in and out of a bed, chair, or wheelchair, with or without the use of equipment.
6. Eating. Means to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Advanced Alzheimer's disease means a progressive degenerative disease of the brain that is diagnosed as Alzheimer's Disease by a physician who is a psychiatrist or neurologist. The covered person must:

1. exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
2. be certified by a physician as requiring substantial physical assistance from another adult to perform at least 2 of the activities of daily living.

The date of diagnosis for Advanced Alzheimer's Disease is the date a physician certifies that the covered person is incapacitated due to Alzheimer's Disease and requires substantial physical assistance from another adult to perform at least 2 of the activities of daily living.

We will not pay benefits for Advanced Alzheimer's Disease if the covered person was diagnosed with Alzheimer's Disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Advanced Parkinson's disease means a brain disorder that is diagnosed as Parkinson's Disease by a physician who is a psychiatrist or neurologist. The covered person must:

1. exhibit 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesis (abnormal slowness of movement or sluggishness of physical and mental responses); and
2. be certified by a physician as requiring substantial physical assistance from another adult to perform at least 2 of the activities of daily living.

The date of diagnosis for Advanced Parkinson's Disease is the date a physician certifies that the covered person is incapacitated due to Parkinson's Disease and requires substantial physical assistance from another adult to perform at least 2 of the activities of daily living.

We will not pay benefits for Advanced Parkinson's Disease if the covered person was diagnosed with Parkinson's Disease, regardless of the covered person's symptoms or incapacities, prior to the effective date of coverage.

Benign brain tumor means a non-malignant tumor that is located in the cranial vault and limited to the brain, meninges, cranial nerves, or pituitary gland. The tumor must require surgery or radiation treatment or cause irreversible objective neurological deficits.

The date of diagnosis for Benign Brain Tumor is the date a physician determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Benign brain tumor does not include: tumors of the skull; pituitary adenomas less than 10mm; or germinomas.

Coma means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 7 days and for which period the Glasgow Coma score must be 4 or less. The date of diagnosis is the first day of the period for which a physician confirms a Coma has lasted for 7 or more consecutive days.

Coma does not include:
1. a medically-induced Coma;
2. a Coma which results directly from alcohol or drug use; or
3. a diagnosis of brain death.

Complete loss of hearing means the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The date of diagnosis for Complete Loss of Hearing is the date the physician makes an accurate certification of total and permanent hearing loss.

Complete loss of sight means the total and irreversible loss of vision in both eyes, evidenced by:
1. the corrected visual acuity being 20/200 or less in both eyes; or
2. the field of vision being less than 20 degrees in both eyes.

The date of diagnosis for Complete Loss of Sight is the date a physician makes an accurate certification of total and permanent blindness.

Complete loss of speech means the total and irreversible loss of the ability to speak or communicate verbally without the assistance of a medical device. The diagnosis of Complete Loss of Speech must be made by a specialist.

The date of diagnosis for Complete Loss of Speech is the date a specialist makes accurate certification of total and permanent loss of speech.

Paralysis means the total and permanent loss of muscle function of 2 or more limbs as a result of disease or injury to the nerve supply of those limbs.

This does not include loss of muscle function that is limited to fingers or toes.

The date of diagnosis for Paralysis is the date a physician establishes the diagnosis of Paralysis based on clinical and/or laboratory findings as supported by medical records.

Policy means the policy to which this rider is attached.

Rider date means 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.

BENEFIT INFORMATION

We will pay a benefit when a covered person is diagnosed with a Supplemental Critical Illness by a physician if:
1. the date of diagnosis is after the effective date of this rider;
2. the date of diagnosis is while this rider is in force; and
3. the illness is not excluded by name or specific description in the policy or any attached rider.

The benefit amount for each Supplemental Critical Illness is the percentage shown below for that Supplemental Critical Illness multiplied by the Basic Benefit Amount for the Initial Critical Illness Benefit applicable to the covered person on the Policy Specifications page. This benefit is payable only once per covered person.

Supplemental Critical Illness	Percentage Of Basic Benefit Amount
Advanced Alzheimer's Disease	100%
Advanced Parkinson's Disease	100%
Benign Brain Tumor	100%
Coma	100%
Complete Loss of Hearing	100%
Complete Loss of Sight	100%
Complete Loss of Speech	100%
Paralysis	100%

LIMITATIONS AND EXCLUSIONS

The Pre-existing Condition Limitation and Exclusions provisions in the policy apply to this rider.

TERMINATION

This rider terminates at the earliest of:
1. the date the policy is canceled;
2. the last day of the period for which any required premium payments were made;
3. the last day the primary insured is in active employment with his or her employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision;
4. the date the primary insured is no longer in an eligible class;
5. the date the primary insured's class is no longer eligible; or
6. the date of our discovery of fraud or material misrepresentation in the presentation of a claim under the policy or any attached rider.

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



Secretary



President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

FIXED WELLNESS RIDER

Benefits are subject to all of the terms, conditions, and provisions of the policy and any attached riders. All terms defined and used in the policy apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Policy means the policy to which this rider is attached.

Rider date means 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.

BENEFIT INFORMATION

We pay the amount shown on the Policy Specifications page for one of the eligible wellness services performed for the purposes of preventative care or for the detection of a critical illness covered by the policy or any attached rider. This benefit is payable once per calendar year, per covered person.

Eligible wellness services shall be:

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

EXCLUSIONS

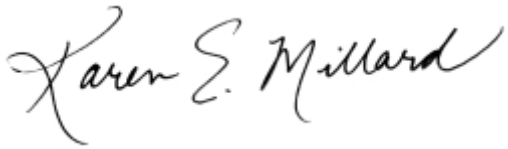
The Exclusions provision in the policy applies to this rider.

TERMINATION

This rider terminates at the earliest of:

1. the date the policy is canceled;
2. the last day of the period for which any required premium payments were made;
3. the last day the primary insured is in active employment with his or her employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision;
4. the date the primary insured is no longer in an eligible class;
5. the date the primary insured’s class is no longer eligible; or
6. the date of our discovery of fraud or material misrepresentation in the presentation of a claim under the policy or any attached rider.

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



Secretary



President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

SKIN CANCER RIDER

Benefits are subject to all of the terms, conditions, and provisions of the policy and any attached riders. All terms defined and used in the policy apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Policy means the policy to which this rider is attached.

Rider date means 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.

BENEFIT INFORMATION

We pay the amount shown on the Policy Specifications page when a covered person is positively diagnosed with skin cancer provided that:

1. the date of diagnosis is after the effective date of this rider;
2. the date of diagnosis is while this rider is in force;
3. it is not excluded by name or specific description in the policy or any attached riders; and
4. we have not paid a prior skin cancer benefit for a covered person for a positive diagnosis of skin cancer made in the prior 365 days.

Skin cancer includes basal cell carcinoma and squamous cell carcinoma of the skin.

Positive diagnosis of skin cancer means 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 microscopic examination of skin biopsy samples.

The date of diagnosis for skin cancer is the earliest date tissue specimen, culture and/or titer(s) are taken upon which the positive diagnosis of Skin Cancer is based.

LIMITATIONS AND EXCLUSIONS

The Pre-existing Condition Limitation and Exclusions provisions in the policy apply to this rider.

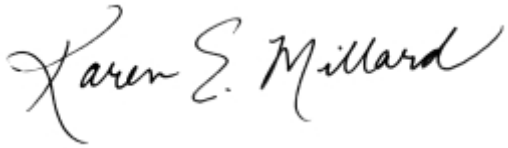
Skin cancer does not include: malignant melanoma. It also does not include any conditions which may be considered pre-cancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; non-malignant melanoma; moles; or similar diseases or lesions.

TERMINATION

This rider terminates at the earliest of:

1. the date the policy is canceled;
2. the last day of the period for which any required premium payments were made;
3. the last day the primary insured is in active employment with his or her employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision;
4. the date the primary insured is no longer in an eligible class;
5. the date the primary insured’s class is no longer eligible; or
6. the date of our discovery of fraud or material misrepresentation in the presentation of a claim under the policy or any attached rider.

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



Secretary



President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

CARDIOPULMONARY ENHANCEMENT RIDER

Benefits are subject to all of the terms, conditions, and provisions of the policy and this rider. All terms defined and used in the policy apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Clinical diagnosis means a clinical identification of a Cardiopulmonary Critical Illness based on history, laboratory study, and symptoms. We will pay benefits for a clinical diagnosis only if there is medical evidence to support the diagnosis.

Pathological diagnosis means identification of a Cardiopulmonary Critical Illness based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis is in keeping with the standards set by the American Board of Pathology.

Policy means the policy to which this rider is attached.

Rider date means 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.

Sudden cardiac arrest means the sudden and unexpected loss of normal heart function due to a malfunction in the electrical system of the heart, resulting in serious irregularity (cardiac arrhythmia) and/or cessation (asystole) of a normal heart rhythm.

BENEFIT INFORMATION

We will pay a benefit when a covered person is diagnosed with a Cardiopulmonary Critical Illness by a physician if:
1. the date of diagnosis is after the effective date of this rider;
2. the date of diagnosis is while this rider is in force; and
3. it is not excluded by name or specific description in the policy or any attached riders.

The date of diagnosis of a Sudden Cardiac Arrest, a Pulmonary Embolism, or a Pulmonary Fibrosis is the earliest of the date of: Clinical Diagnosis by a physician; or the earliest date the tissue specimen, culture and/or titer(s) are taken upon which a Pathological Diagnosis is based.

A benefit for Sudden Cardiac Arrest is only payable if it is a primary diagnosis.

The benefit amount for each Cardiopulmonary Critical Illness is the percentage shown below for that illness multiplied by the Basic Benefit Amount for the Initial Critical Illness Benefit applicable for the covered person shown on the Policy Specifications page. This benefit is payable only once per illness per covered person.

Cardiopulmonary Critical Illness	Percentage of Basic Benefit Amount
Sudden Cardiac Arrest	25%
Pulmonary Embolism	25%
Pulmonary Fibrosis	25%

LIMITATIONS AND EXCLUSIONS

The Pre-existing Condition Limitation and Exclusions provisions in the policy apply to this rider.

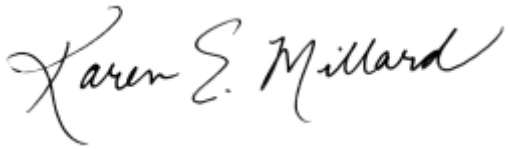
Sudden cardiac arrest does not include a heart attack (Myocardial Infarction).

TERMINATION

This rider terminates at the earliest of:

1. the date the policy is canceled;
2. the last day of the period for which any required premium payments were made;
3. the last day the primary insured is in active employment with his or her employer and/or a member in good standing in the labor union, association or other entity that is the policyholder, except as provided under the “Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence” provision;
4. the date the primary insured is no longer in an eligible class;
5. the date the primary insured’s class is no longer eligible; or
6. the date of our discovery of fraud or material misrepresentation in the presentation of a claim under the policy or any attached rider.

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



Secretary



President



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.

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



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.

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.

NOTICE OF PROTECTION PROVIDED BY MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in net cash surrender and net cash withdrawal values

- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in Miss. Code Ann. § 83-23-209 and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Mississippi law. Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org, or contact:

Mississippi Life & Health Insurance Guaranty Association
330 North Mart Plaza
Jackson, MS 39206-5327
601-981-0755

Mississippi Insurance Department
Woolfolk Building
501 N. West Street, Suite 1001
Jackson, MS 39201
601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

NOTICE OF NON-INSURANCE VALUE-ADDED PRODUCTS OR SERVICES

American Heritage Life Insurance Company ("we," "us," "our") may arrange for third party vendors to offer or provide value-added products or services to eligible covered persons insured with us at no or reduced cost.

The value-added products or services offered or provided are:

- Not specified in the policy or certificate;
- Related to the insurance coverage; and
- Primarily designed to satisfy one or more of the following:
  - Provide loss mitigation or loss control;
  - Reduce claim costs or claim settlement costs;
  - Provide education about liability risks or risk of loss to persons or property;
  - Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;
  - Enhance health;
  - Enhance financial wellness through items such as education or financial planning services;
  - Provide post-loss services;
  - Incent behavioral changes to improve the health or reduce the risk of death or disability of a policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured, or applicant; or
  - Assist in the administration of the employee or retiree benefit insurance coverage.

The cost for the value-added products or services may be either billed directly to you or remitted to us by the policyholder, as agreed to by the policyholder.

Third party vendors are solely liable for providing the value-added products or services. We will not be responsible for third party vendors providing or failing to provide the value-added products or services to eligible covered persons. We will not be liable to eligible covered persons for the negligent provision of the value-added products or services by third party vendors.

The value-added products or services may automatically terminate with the policy or certificate. We reserve the right to terminate, modify, or replace any value-added products or services at any time with 31 days' advance written notice to the policyholder.