Insured:

Policy:

OPLOA

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Standard Life
AND CASUALTY INSURANCE COMPANY
A ManhattanLife Company

Scan QR Code to access
your Customer Portal

Insured:

Dear

Thank you for choosing Standard Life and Casualty Insurance Company, a Manhattan Life Group Company, to fulfill your insurance needs.

We are happy to enclose your new insurance policy. Accuracy is of the utmost importance to us, so we ask that you take time to review and verify all documents, to ensure you understand the policy provisions. The information you provided for the application was used to issue the Policy. Please make sure that the personal and health information was completed correctly on the application, as the application is part of the Policy. If there are any changes required, please contact us so that we can make the necessary corrections.

Creating an account is easy! When scanning the QR code above you will be taken to the Client Services Log In page, where you will click on the "First Time User? Register Now" hyperlink. This will take you to the Registration Terms and Conditions, the first of the quick and easy five-step process to register for your Policyholder Portal.

If you are unable to log-in successfully or need any additional information, you may contact your servicing agent or our Customer Service Center at the number listed below.

We look forward to providing you with excellent service for many years to come.

Sincerely,

Yvette Escobar

Yvette Escobar
Director of Operations

10777 Northwest Freeway
Houston, TX 77092

T: 800-672-4535
manhattanlife.com

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PRIVACY POLICY

A Commitment to Protecting, Preserving, and Respecting Your Privacy

Your privacy is important to us. This Privacy Policy ("Policy") describes the standards we follow in handling information about you that is not publicly available, herein called "nonpublic personal information". This Privacy Policy applies to the following: The Manhattan Life Insurance Company, ManhattanLife Insurance and Annuity Company, Western United Life Assurance Company, Family Life Insurance Company, ManhattanLife of America Insurance Company, Standard Life and Casualty Insurance Company, and all coinsurance and assumption reinsurance treaties administered and/or assumed.

This Privacy Policy is provided to you for informational purposes only. You do not need to call or take any action in response to this notice. We recommend that you read and retain this Privacy Policy with your insurance papers.

A Summary of the Guidelines for Family Life Insurance Company The Manhattan Life Insurance Company ManhattanLife Insurance and Annuity Company Standard Life and Casualty Insurance Company ManhattanLife of America Insurance Company and Western United Life Assurance Company ("The Companies" & its Affiliated Entities)

- We collect nonpublic personal information to process and administer our customers' business and to ensure that we are satisfying their financial and insurance needs.
- We do not share any nonpublic personal information about our customers to anyone, except as permitted by law.
- We use our customers' information responsibly to provide them with benefits and improved products and services.
- We have policies and procedures in place to protect our customers' nonpublic personal information.
- We hold our employees to the highest standards of conduct in ensuring this confidentiality.
- We comply with federal and state privacy laws and regulations.
- Our privacy policy applies to customers with a current or former relationship.

Types of Nonpublic Personal Information We Collect and How We Use It

As part of our insurance business, employees, representatives, agents and selected third parties may collect nonpublic personal information about our customers. This includes the following:

- Information we have received from you on applications or other forms.
- Information about transactions with us, our affiliates or third parties.
- Information from others, such as credit reporting agencies, employers, and federal and state agencies.
- Nonpublic personal health information, like medical reports, for certain types of insurance polices in order to underwrite the policy, administer claims or perform other insurance or insurance related functions.
- Examples of nonpublic personal information we may collect are your name, address, social security number, date of birth, gender, medical history, account activity, account balances, income, assets, marital status, payment history, insurance premiums, and information received from a consumer and/or credit reporting agency.
- Please note: There may be instances when the agents and representatives referred to above may not be acting on behalf of "The Company", in which case they may collect nonpublic personal information on their own behalf or on behalf of another. In these instances, "The Companies" Privacy Policy would not apply.

Types of Nonpublic Personal Information We Share and with Whom We Disclose

- We do not share nonpublic personal information about our customers with anyone, except as permitted by law. We may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business to: (1) affiliated companies, employees, agents, representatives and third parties that administer and service customer accounts on our behalf and that market our services; or (2) other insurance and/or financial institutions with which we have joint marketing agreements.
- Examples of the types of companies and individuals with whom we disclose nonpublic personal information are attorneys, trustees, third-party administrators, insurance agents, registered brokers/dealers, insurance companies, insurance support organizations, banks, credit reporting agencies, medical professionals, auditors, federal and state regulators, transfer agents, and reinsurers.
- If medical information is collected in the course of providing insurance services to you, this personally identifiable health information will not be used for any purpose, unless the customer or the applicable law authorizes further sharing.
- We do not sell nonpublic personal information about our customers to other companies so they may solicit you.
- We disclose this nonpublic personal information outside the company only as authorized by you or for a specific business purpose.

Our Safeguards to Protecting Nonpublic Personal Information

- We restrict access to nonpublic personal information to authorized individuals who need to know the information to provide benefits and improved products and services to our customers.
- We have guidelines in place that inform and give direction to our employees, agents, and representatives acting on our behalf on how to protect and use nonpublic personal information.
- We maintain physical, electronic, and procedural safeguards that protect nonpublic personal information.
- We will continue to enhance our security procedures, as new technologies become available.

Additional Privacy Policy Information

- This Policy is provided to you in accordance with the privacy provisions in Title V of the Gramm-Leach-Bliley Act. We may change this policy and/or related procedures at any time, in accordance with applicable federal and state laws. Customers with a continuing relationship will receive appropriate notice if our Policy changes.
- **Our Policy will be available to all interested parties on our web site at www.manhattanlife.com.**

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HIPAA PRIVACY NOTICE

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.

The terms of this Notice of Privacy Practices – Protected Health Information ("Notice") applies to Protected Health Information (defined below) associated with Health Plans (defined below) issued by or coinsured by the following companies: ManhattanLife Insurance and Annuity Company, The Manhattan Life Insurance Company, Family Life Insurance Company, ManhattanLife of America Insurance Company, Standard Life and Casualty Insurance Company, and Western United Life Assurance Company, hereafter referred to as ("the Company"). This Notice describes how the Company may use and disclose Protected Health Information to carry out payment and health care claims and/or operations and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide our policyholders with notice of our legal duties and privacy practices concerning Protected Health Information. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as set forth below; we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, we will mail copies of revised notices to all policyholders then covered by a Health Plan. Copies of our current Notice may be obtained by contacting the Company at the telephone number or address below, or on our Web site at www.manhattanlife.com.

DEFINITIONS

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by the Company and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining insurance, and we have the right, under other law, to contest a claim under the policy or the policy itself.

Uses and Disclosures for Payment – We may make requests, uses and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or another Health Plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include underwriting, premium rating or other activities relating to the creation, renewal, or replacement of a Health Plan, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our Professional judgment to disclose PHI with your spouse concerning the processing of a claim. If you do not wish the Company to share PHI with your spouse or others, you may exercise your right to request a restriction on the Company's disclosures of your PHI (see below).

Business Associates – Certain aspects and components of our services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents and vendors that help us process your claims. At times it may be necessary for us to provide certain aspects of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Health Plan coverage, and about health-related products and services that may add value to your Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, the Company may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaver organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose your PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

RIGHTS THAT YOU HAVE

Access to your PHI – You have the right to copy and/or inspect your PHI that we maintain. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from the Company at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from the Company at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from the Company at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we do not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request, but we will accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. By contacting the Company at the telephone number or address below you may make requests for a restriction (or termination of an existing restriction).

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to the Company at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting the Company at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with the Company in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the Company by writing to or by calling:

10777 Northwest Freeway
Houston, TX 77092
1-800-669-9030

EFFECTIVE DATE - This Notice is effective September 1, 2003.

NOTICE CONCERNING COVERAGE UNDER THE TENNESSEE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Insurance companies and health maintenance organizations (HMOs) licensed in this state to write life insurance, annuities or health insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to provide a safety-net of coverage, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, HMO contract, or an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
2) any policy of reinsurance (unless an assumption certificate was issued);
3) interest rate yields that exceed an average rate;
4) dividends;
5) credits given in connection with the administration of a policy by a group contractholder;
6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010.

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- Life insurance death benefits - $300,000
- Life insurance cash surrender value - $100,000
- Present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000.
- Present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- Health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- Health insurance benefits for companies declared insolvent on or after January 1, 2010:

- $100,000 for limited benefits and supplemental health coverages $300,000 for disability and long term care insurance
- $500,000 for basic hospital, medical and surgical insurance or major medical insurance

NOTE

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association
P.O. Box 190434
Nashville, TN 37219
Website: www.tnlifega.org

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

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Standard Life and Casualty Insurance Company

Home Office: Salt Lake City, UT
Administrative Office: **10777 Northwest Freeway, Houston, TX 77092**
(800) 672-4535

HOME HEALTH CARE INSURANCE POLICY
LIMITED BENEFITS

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from Us.

Notice to Buyer: This Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all expenses. Benefits are paid in the amount stated on the Policy Schedule without regards to the cost of services rendered. This Policy does not provide expense reimbursement for charges based on provider's statement.

THIS POLICY DOES NOT PROVIDE LONG-TERM CARE INSURANCE COVERAGE, AS IT IS NOT A LONG-TERM CARE INSURANCE POLICY.

THIS IS A LIMITED POLICY – READ IT CAREFULLY! This Policy is a legal contract between You and Standard Life and Casualty Insurance Company. It is issued in return for Your application and first premium. Standard Life agrees to pay this Policy's benefits to You if You suffer a covered loss under this Policy while this Policy is in effect, and the Policy's provisions are met.

EFFECTIVE DATE: The date that coverage under this Policy begins for You, which is shown on the Policy Schedule. Your coverage begins at 12:00 a.m. local time at Your residence. The Effective Date of the Policy will be the date recorded by Us at Our Administrative Office. It is not the date the application is signed. The Policy will become effective when all underwriting requirements have been satisfied, and the required premium is paid.

RENEWABILITY

GUARANTEED RENEWABLE: This Policy is renewable as long as You live, provided You continue to pay premiums when due or within the Grace Period. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage.

WE RETAIN THE RIGHT TO CHANGE THE PREMIUM RATES ON THIS POLICY: See the "Premium Provisions" section in this Policy. Premiums are based on Your attained age. The premium will change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. We will give You advance written notice as required by Your state prior to any premium change.

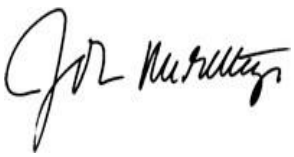
THIRTY-DAY RIGHT TO RETURN

Please read Your Policy. If You are not satisfied for any reason, return the Policy to Standard Life and Casualty Insurance Company's Administrative Office within 30 days after it is delivered to You. As soon as You deliver or mail the Policy to Us, it is treated as if it was never issued. We will return your premium paid, less any claims paid.

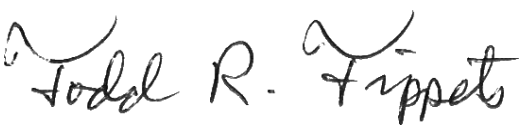
IMPORTANT NOTICE

PLEASE READ THE COPY OF THE APPLICATION ATTACHED TO THIS POLICY. IF ANY INFORMATION ON THE APPLICATION IS NOT TRUE AND COMPLETE, WRITE TO US AT OUR ADMINISTRATIVE OFFICE WITHIN 30 DAYS. THE APPLICATION IS A PART OF THIS POLICY, WHICH WAS ISSUED ON THE BASIS THAT THE ANSWERS TO ALL QUESTIONS AND THE INFORMATION SHOWN ON THE APPLICATION ARE CORRECT AND COMPLETE.

Executed by Standard Life and Casualty Insurance Company on the Effective Date.



John McGettigan,
Secretary



Todd R. Tippets,
President

TABLE OF CONTENTS

DEFINITIONS

The following terms in this Policy are defined as follows:

Activities of Daily Living (ADL): Means bathing, continence, dressing, eating, toileting or transferring:

1. bathing is washing oneself by sponge-bath, or in either a tub or shower, including the task of getting into or out of the tub or shower;
2. continence is the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag);
3. dressing is putting on and taking off all items of clothing, including items such as any necessary braces, fasteners, or artificial limbs;
4. eating is feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously;
5. toileting is getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene; and
6. transferring is moving into or out of a bed, chair, or wheelchair.

Brand Name Drugs: A Prescription Drug for which a pharmaceutical company has received a patent or trade name and is under patent protection.

Chemotherapy: Treatment, prescribed by a Physician, which is a chemical substance (or combined chemical substance) that has a cancericidal effect for the purpose of the destruction of malignant cells during the treatment of cancer.

Cognitive Impairment: A deficiency in a person's short-term or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgement as it relates to safety awareness, which results in the inability to take care of oneself without the ongoing hands-on or standby assistance of another person. Cognitive Impairment must be evaluated and measured through clinical evidence and standardized tests. Cognitive Impairment is demonstrable organic brain disease, such as Alzheimer's Disease, Parkinson's Disease, senile dementia or other nervous or mental disorders of organic origin.

Daily Maximum Aggregate Benefit: The maximum amount We will pay per day for all covered Home Health Care Services and Home Health Care Aide Services that are payable for that day.

Generic Drugs: A Prescription Drug that has the same active ingredients as an equivalent Brand Name Drug, which does not carry any drug manufacturer's brand name on the label, and it is not protected by a patent. It must be listed as a generic drug by the United States national drug data bank.

Home: Your primary place of residence. It includes a private dwelling, a home for the retired or aged, or a place that provides only residential care. It does not include a nursing facility, hospice facility, assisted living facility, hospital, or other institutional setting.

Immediate Family: Immediate Family is Your:

1. spouse;
2. the children, brothers, sisters, and parents of either You or Your spouse;
3. the spouses of the children, brothers, and sisters of You and Your spouse; or
4. anyone with whom You have a relationship based on a legal guardianship.

Insured: Means You, as named on the Policy Schedule.

Investigational Drug: A drug that has successfully completed Phase 1 of a clinical trial but has not yet been approved for general use by the U.S. Food and Drug Administration (FDA) and remains under investigation in a FDA approved clinical trial.

Maximum Benefit Period: Means the maximum number of days We will pay benefits for Home Health Care Services or Home Health Care Aide Services during Your lifetime, unless benefits are restored as provided in the Policy's Restoration of Benefits provision. Maximum Benefit Periods are shown on the Policy Schedule.

Pharmacy: A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

Physician: A person who is duly licensed as a physician, by the state in which he or she practices, to give treatment for which benefits are provided under the Policy and who is acting within the scope of his or her license.

Plan of Care: A written individualized program of care developed and approved in writing by a Physician. The Plan of Care must include, but it is not limited to:

1. the reason for the need for continued care, including diagnosis and symptoms;
2. schedule of treatment, including level of care and providers of services appropriate to meet Your needs; and
3. functional limitations, including deficiencies in ADLs.

Policy Year: Each successive twelve (12) month period extending from the Effective Date of the Policy so that each successive twelve (12) month period will constitute a single Policy Year.

Policy Year Maximum: The maximum amount We will pay per each Policy Year for a benefit. Policy Year Maximums are shown on the Policy Schedule, by the applicable benefit.

Pre-Existing Condition: Means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment within a six (6) month period preceding the Effective Date, or a condition for which medical advice or treatment was recommended by or received from a Physician or duly licensed health care practitioner within the six (6)month period prior to the Effective Date.

Prescription Drugs: Any medication that:

1. has been fully approved by the FDA for marketing in the United States (any approval granted as an interim step in the FDA regulatory process, such as an Investigational Drug, is not sufficient);
2. can be legally dispensed only with the written Prescription Order in accordance with applicable state and federal laws; and
3. is dispensed by a licensed pharmacist.

For any drug, the FDA must have given final approval to market it for the particular sickness, injury, or mental illness.

Prescription Order: The request by Your duly licensed health care practitioner for:

1. each separate Prescription Drug and each authorized refill;
2. insulin or insulin derivatives only by prescription; and
3. any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:
    a. disposable insulin syringes and needles; or
    b. disposable blood/urine/glucose/acetone testing agents or lancets.

We, Us, Our, Standard Life Insurance, or **Company:** Means Standard Life and Casualty Insurance Company.

BENEFIT PROVISIONS

Eligibility for Home Health Care Services and Home Health Care Aide Services Benefits

1. You must not be able to perform, without the assistance of another person, two (2) or more ADLs; and/or, require continuous supervision and assistance due to a Cognitive Impairment;
2. Your Physician must perform such tests as are in accordance with accepted standards of medical practice and, based on such tests, certify in writing that You are unable to perform two (2) or more ADLs and/or that You have Cognitive Impairment that requires continuous supervision and assistance;
3. Your Home Health Care Services or Home Health Care Aide Services, must be prescribed in Your Plan of Care; and
4. benefits are subject to the Pre-Existing Conditions Limitation.

We may periodically review Your eligibility for these benefits. Our review may include:

1. Your diagnosis, symptoms, complaints, and complications of a condition;
2. the reason for the services being rendered to You;
3. Your Physician's orders;
4. Your schedule of treatment; and
5. Your physical limitations and impairments.

Home Health Care Services and Home Health Care Aide Services:

1. cannot be provided by You or Your Immediate Family;
2. the provider if these services shall not reside at Your residence; and
3. the provider must maintain a complete, written, daily record of health care and aide services that were provided to You in Your Home pursuant to the Plan of Care, and the record of those covered services shall be made available to Us upon Our written request.

HOME HEALTH CARE SERVICES BENEFITS

Nursing Care Services: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Nursing Care Services. Nursing Care Services for professional nursing care must be provided to You in Your Home by an individual who is qualified to provide Nursing Care Services, which includes the following: a registered professional nurse (RN); a licensed practical nurse (LPN); a licensed vocational nurse (LVN), and a certified or licensed hospice and palliative nurse (CHPN), who is practicing within the geographic area for which he or she is licensed or certified to practice. This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

Physical Therapy: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Physical Therapy. Physical therapy must be provided to You in Your Home by a duly licensed physical therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The physical therapist uses therapeutic exercise and other services that focus on improving:

1. posture;
2. locomotion;
3. strength;
4. endurance;
5. balance;
6. coordination;
7. joint mobility;
8. flexibility;
9. ADLs; and
10. alleviating pain.

This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

Speech Pathology: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Speech Pathology. Speech pathology therapy must be provided to You in Your Home by a duly licensed speech pathologist

therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The speech pathologist therapist uses rehabilitative techniques to improve:

1. voice;
2. speech;
3. language, and
4. swallowing disorders.

This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

Occupational Therapy: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Occupational Therapy. Occupational therapy must be provided to You in Your Home by a duly licensed occupational therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The occupational therapist uses using purposeful activities or assistive devices that focus on the following:

1. developing daily living skills;
2. strengthening and enhancing function;
3. coordination of fine motor skills; and
4. muscle and sensory stimulation.

This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

Chemotherapy Specialist Services: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Chemotherapy Specialist Services. Chemotherapy must be administered and monitored for treatment of Your cancer while in Your Home, by a duly licensed chemotherapy services specialist nurse, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

Enterostomal Therapy: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Enterostomal Therapy. Enterostomal Therapy must be provided to You in Your Home during the post-operative period following an ostomy (a surgically made opening that connects a portion of the intestine to the exterior (usually through the abdominal wall)) where enterostomal therapy is needed. Wound care that requires an enterostomal therapist is also considered Enterostomal Therapy. Enterostomal Therapy must be provided by a duly licensed enterostomal therapist (CETN), practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

Respiratory Therapy: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Respiratory Therapy. Respiratory therapy must be provided to You in Your Home by a duly licensed respiratory therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice, who:

1. teaches You about Your respiratory condition and how to manage it;
2. instructs You on how to use equipment, such as oxygen concentrators and related equipment, CPAP/BiPAP machines, nebulizers, and other respiratory assist devices;
3. teaches You breathing techniques to help reduce shortness of breath; and
4. participates in the development of a treatment plan.

Respiration Therapy does NOT include watching or protecting a patient (examples include pulse oximetry monitoring, monitoring of respiratory status, seizure monitoring and observation of a person who is stable without cardiorespiratory compromise). This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

Medical Social Worker Services: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Medical Social Worker Services. Medical Social Services must be provided to You in Your Home by a duly licensed medical social worker, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The purpose of the medical social worker's Home visit is to:

1. assist the Physician and other health professionals in understanding the social and emotional factors related to Your health problems;

2. participate in the development of a treatment plan; and
3. assess and ensure use of appropriate community resources.

This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

HOME HEALTH CARE AIDE SERVICES BENEFIT

We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Home Health Care Aide Services. Home Health Care Aide Services must be provided to You in Your Home by an individual, who is qualified by training and experience to provide assistance with ADLs, and who is certified as a Home Health Care Aide, or Certified Nursing Assistant (CNA) by the appropriate regulatory authority in the geographic area for which he or she is certified to practice. Only one (1) benefit is payable per a twenty-four (24) period, regardless of the amount of Home Health Care Aide Services are provided on such day. This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Aide Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in this Policy), as shown on the Policy Schedule.

RESTORATION OF BENEFITS

If You have received the Home Health Care Services Benefit or Home Health Care Aide Services Benefit under this Policy and have used up all of the Maximum Benefit Period of one or both of these benefits, but have recovered sufficiently to no longer require Home Health Care Services or Home Health Care Aide Services, We will restore Your Maximum Benefit Period to its full original Maximum Benefit Period each time the following conditions are met:

1. You have not received these services in Your Home for a period of 180 consecutive days; and
2. Your Physician must certify that You have sufficiently recovered and no longer require any services and that You have not been advised by a Physician to obtain such services.

There is no limit to the number of times Your Maximum Benefit Period may be restored. If the Maximum Benefit Period for the Home Health Care Services benefit is restored, the Maximum Benefit Period for the Home Health Care Aide Services benefit will also be restored and vice versa.

PRESCRIPTION DRUG BENEFITS

Subject to the per-prescription Generic Drug or per-prescription Brand Name Drug and Policy Year Maximum amount, as shown on the Policy Schedule, We will pay this per-prescription benefit for each Prescription Order for a Generic Drug or Brand Name Drug that is filled for You through a retail or mail-order Pharmacy for:

1. Prescription Drugs that are fully approved and prescribed for the specified indications by the FDA for marketing in the United States and can be obtained only with a Prescription Order from Your duly licensed health care practitioner;
2. Prescription Drugs in dosages, dosage forms, dosage regimens, and durations of treatment that are prescribed by Your duly licensed health care practitioner for sickness or injury; and
3. Prescription Drugs that are within the quantity, supply, or other limits that are appropriate for a Prescription Drug.

The Pre-Existing Conditions Limitation does not apply to the Prescription Drug Benefit.

Prescription Drug Limitations and Exclusions: We will not pay benefits for—

1. drugs or medicines obtained from sources outside of the United States;
2. vitamins and/or vitamin combinations even if they are prescribed by a duly licensed health care practitioner;
3. any prescription products, drugs, or medicines in the following categories, whether or not prescribed by a duly licensed health care practitioner:
    a. herbal or homeopathic medicines or products;
    b. minerals;
    c. appetite suppressants;
    d. dietary or nutritional substances or dietary supplements;
    e. nutraceuticals; or
    f. medical foods;
4. drugs or medicines dispensed at or by a hospital, an emergency room, a free-standing facility, an urgent care facility, a health care practitioner's office, or other inpatient or outpatient setting for take home by You;
5. drugs or medicines prescribed for treatment of a condition that is specifically excluded under this Policy;
6. drugs, medicines, or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state;

7. duplicate prescriptions, replacement of lost, stolen, destroyed, spilled, or damaged prescriptions;
8. any administration for drug injections or any other drugs or medicines obtained other than through a Pharmacy with a Prescription Order;
9. Prescription Drug refills more than the number specified on the Prescription Order;
10. Prescription Drugs refilled more frequently than the prescribed dosage indicates; or
11. Prescription Drug that is filled on or after the date this insurance coverage terminates.

LIMITATIONS AND EXCLUSIONS

This Policy does not cover any loss caused or contributed to by:

1. simple rest care, hotel or retirement home expense, or other expense which is related to Your Home;
2. declared or undeclared war or act thereof;
3. charges that You would not legally be obligated to pay in the absence of this insurance; or
4. alcoholism or drug addiction.

PRE-EXISTING CONDITIONS LIMITATION

This Policy and any attached benefit rider(s) do not cover Pre-Existing Conditions whether disclosed in the application or not, for the first six (6) months beginning on the date You become insured under this Policy. This Pre-Existing Conditions Limitation provision does not apply to the Prescription Drug Benefits.

Conditions specifically named or described as excluded in any part of this Policy are never covered.

TERMINATION

This Policy will terminate at 11:59 p.m. local time at Your state of residence on the earlier of:

1. when You fail to pay premiums before the end of the Grace Period;
2. the date You die; or
3. the date We receive Your request in writing to cancel this Policy or on such later date that is specified by You in Your written notice to Us to cancel this Policy.

We will consider any claim that began before the insurance ended.

PREMIUM PROVISIONS

Premium Payment: The initial premium must be paid on or before the due date for this coverage to be in-force. Each renewal premium must be received by Us on its due date, subject to the Grace Period.

Changes in Premiums: We have the right to change premiums. If We change premiums, We will do so only if:

1. We change the premiums for all policies of this form and attained age in Your state of issue;
2. if a new table of rates is applicable to the Policy, the change in the table of rates will apply to all covered persons in the same class on the date of the change (class is defined as attained age);
3. such change is in accordance with the laws and regulations of Your state of issue; and,
4. We give You advance written notice before such change becomes effective, as required by Your state.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES: This Policy and the application with any riders, endorsements or attachments is the entire contract of insurance. A change in this Policy is not valid until the change is approved by one of Our executive officers and unless the approval is endorsed hereon or attached to this Policy. An agent does not have authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two (2) years from the Effective Date of this Policy, no misstatement, except for fraudulent misstatements, made by the applicant in the application, shall be used to void this Policy or deny a claim for loss incurred after the expiration of such two (2) year period.

If a Rider is added after the Policy Effective Date, We cannot cancel or deny benefits because of a misstatement made by You, except for fraudulent misstatements, in the application after the Rider has been in force for two (2) years from the Rider's Effective Date.

After the coverage has been in force beyond the Pre-existing Condition period, We will pay benefits for any Pre-existing Conditions not specifically excluded by name or description in the Policy, Rider or endorsement, if any.

GRACE PERIOD: A period of thirty-one (31) days will be granted for the payment of each premium due after the first premium. During the Grace Period, the Policy continues in force.

REINSTATEMENT: If any renewal premium be not paid within the time granted You for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified the You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects, You and the Company shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Reinstatement in case of Cognitive Impairment or functional incapacity: Within five (5) months after lapsing due to nonpayment of premium, You or any person authorized to act on Your behalf may request reinstatement of this Policy on the basis that the loss of coverage was the result of Your Cognitive Impairment or functional incapacity. We may require a medical demonstration that You suffered from a Cognitive Impairment or loss of functional capacity at the time of lapse. If such medical demonstration substantiates the existence of Cognitive Impairment or functional incapacity at the time of Policy cancellation to Our satisfaction, the Policy will be reinstated. The medical demonstration shall be at Your expense. The reinstated Policy will be issued without evidence of insurability and will cover loss that occurred from the date of the cancellation. Payment shall be made within fifteen (15) days after request from Us. If the premium is not paid as required, the Policy will not be reinstated, and We will not be responsible for claims incurred after the initial date of cancellation.

CLAIM PROVISIONS

NOTICE OF CLAIM: A written notice of claim must be given to Us at Our Administrative Office within twenty (20) days after the date the of the occurrence or beginning of any loss covered by the Policy, or as soon thereafter as reasonably possible. When providing notice of claim, You must include Your name, address, and policy number.

CLAIM FORMS: We, upon Our receipt of the claimant's notice of claim, will provide to the claimant such forms as are usually provided by Us for filing proof of loss. If such forms are not provided within fifteen (15) days after the date of the notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be provided to Us at Our Administrative Office within ninety (90) days after the date of loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one (1) year after the time proof is otherwise required, except in the event of a legal incapacity.

The proof of loss must include all of the following:

1. Your name and Policy number;
2. the name and address of the provider of the services involved with the covered loss; and
3. an itemized statement from the provider of the services involved with the covered loss that includes all of the following as appropriate:
    a. International Classification of Disease (ICD) procedures;
    b. Current Procedural Terminology (CPT) code(s);
    c. Healthcare Common Procedure coding System (HCPCS) level II codes; and
    d. National Drug Codes.

TIME OF PAYMENT OF CLAIMS: We will pay You immediately upon receipt of due written proof of loss for benefits provided under this Policy.

PAYMENT OF CLAIMS: Benefits will be paid to You. Indemnity for loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to Your estate. Any other benefits unpaid at death may be paid, at Our option, either to Your beneficiary or estate.

If any indemnity under this Policy is payable to Your estate or a beneficiary who is a minor or is otherwise not competent to give a valid release, We may pay the indemnity up to $1,000.00 to Your relative by blood or connection by marriage whom We consider to be equitably entitled to the benefits. Any payment made by Us in good faith in accordance with this provision fully discharges Us to the extent of the payment.

PHYSICAL EXAMINATIONS AND AUTOPSY: We, at Our expense, may have You physically examined when and as often as We may reasonably require while a claim is pending. We, at Our expense, may also have an autopsy conducted unless forbidden by law.

LEGAL ACTIONS: No legal action at law or in equity may be brought to recover benefits under this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No legal action may be brought after three (3) years from the time written proof of loss is required to be given.

OTHER PROVISIONS

MISSTATEMENT OF AGE: If Your age has been misstated, all amounts payable under this Policy are the amounts the premium paid would have purchased at the correct age.

OTHER INSURANCE WITH US: You can be insured under only one Policy like this one with Us at any one time. If You are insured under more than one such Policy, You can select the one that is to remain in effect. We will return all premiums paid (less any claims paid) for any Policy that does not remain in effect.

REFUND OF UNEARNED PREMIUM: Upon Our receipt of proof of death or termination of this Policy, We will promptly refund any unearned premium. The unearned premium will be computed pro rata.

UNPAID PREMIUM: At the time of payment of a claim under this Policy, any premium then due and unpaid may be deducted from the claim payment.

ILLEGAL OCCUPATION: We are not liable for any loss to which a contributing cause was Your commission of or attempt to commit a felony or to which a contributing cause was due to You being engaged in an illegal occupation.

INTOXICANTS AND NARCOTICS: The Company will not be liable for any loss resulting from the insured person being drunk, or under the influence of any narcotic unless taken on the advice of their Physician.

CANCELLATION BY INSURED: You may cancel this Policy at any time by written notice delivered or mailed to Us at Our Administrative Office effective upon receipt or on such later date as specified in the notice. In the event of cancellation, We will return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

CONFORMITY WITH STATE STATUTES: Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

CHANGE OF BENEFICIARY: Unless You made an irrevocable beneficiary, the right to change a beneficiary is reserved for You, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

Standard Life and Casualty Insurance Company

Administrative Office: 10777 Northwest Freeway, Houston, TX 77092 Customer Service: (800) 672-4535

HOME HEALTH CARE INSURANCE POLICY

LIMITED BENEFITS

GUARANTEED RENEWABLE. SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS

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Standard Life and Casualty Insurance Company
Home Office: Salt Lake City, UT
***Administrative Office*:10777 Northwest Freeway, Houston, TX 77092**
(800)672-4535

Policy Schedule

Insured: **Effective Date:**
Policy Number: **Issue Age:**
Initial Payment Option Mode: Monthly **Initial Modal Premium:** $40.76

DESCRIPTION OF COVERAGE	BENEFIT AMOUNT	MODAL PREMIUM
HOME HEALTH CARE INSURANCE POLICY		$ 490.20
Home Health Care Services Benefit		
Nursing Care Services	$200 per day	
Physical Therapy	$200 per day	
Speech Pathology	$200 per day	
Occupational Therapy	$200 per day	
Chemotherapy Specialist Services	$200 per day	
Enterostomal Therapy	$200 per day	
Respiratory Therapy	$200 per day	
Medical Social Worker Services	$300 per day	
Home Health Care Services Maximum Benefit Period	365 days	
Home Health Care Aide Services Benefit	$120 per day	
Home Health Care Aide Services Maximum Benefit	60 days	
Home Health Care Services and Home Health Care Aide	$450	
Prescription Drug Benefits		
Generic Drugs	$10 per prescription	
Brand Name Drugs	$25 per prescription	
Prescription Drug Policy Year Maximum	$900	

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Standard Life and Casualty Insurance Company

Home Office: Salt Lake City, UT

Administrative Office: **10777 Northwest Freeway, Houston, TX 77092**

(800) 672-4535

OUTLINE OF COVERAGE
FOR POLICY FORM AM7008
HOME HEALTH CARE INSURANCE POLICY

PARAGRAPH 1: **Read Your Policy Carefully.** This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and the Company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**

THE POLICY HAS LIMITED BENEFITS AND IS SUBJECT TO THE POLICY'S LIMITATIONS AND EXCLUSIONS, PER DAY, POLICY YEAR, AGGREGATE, LIFETIME, AND OTHER MAXIMUM BENEFIT AMOUNTS. READ YOUR POLICY CAREFULLY TO UNDERSTAND POLICY LIMITATIONS.

The capitalized terms used in this Outline of Coverage are defined in Your Policy or Rider.

THE POLICY DOES NOT PROVIDE LONG-TERM CARE INSURANCE COVERAGE.

PARAGRAPH 2: The Policy is designed to provide coverage in the form of a fixed daily benefit limited fixed indemnity benefit for covered home health care, subject to any limitations set forth in the Policy. Coverage is not provided for any benefits other than home health care, and home health care aide, and any additional indemnity benefit described below.

NOTICE: This is not a major medical insurance Policy. The Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all expenses. Benefits are paid in the amount stated on the Policy Schedule without regards to the cost of services rendered. The Policy does not provide expense reimbursement for charges based on provider's statement.

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

PLEASE READ YOUR POLICY CAREFULLY TO UNDERSTAND POLICY LIMITATIONS.

PARAGRAPH 3. BASE POLICY BENEFITS

HOME HEALTH CARE SERVICES BENEFITS

Nursing Care Services: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Nursing Care Services. Nursing Care Services for professional nursing care must be provided to You in Your Home by an individual who is qualified to provide Nursing Care Services, which includes the following: a registered professional nurse (RN); a licensed practical nurse (LPN); a licensed vocational nurse (LVN), and a certified or licensed hospice and palliative nurse (CHPN), who is practicing within the geographic area for which he or she is licensed or certified to practice. This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Physical Therapy: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Physical Therapy. Physical therapy must be provided to You in Your Home by a duly licensed physical therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The physical therapist uses therapeutic exercise and other services that focus on improving:

1. posture;
2. locomotion;
3. strength;
4. endurance;
5. balance;
6. coordination;
7. joint mobility;

8. flexibility;
9. ADLs; and
10. alleviating pain.

This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Speech Pathology: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Speech Pathology. Speech pathology therapy must be provided to You in Your Home by a duly licensed speech pathologist therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The speech pathologist therapist uses rehabilitative techniques to improve:

1. voice;
2. speech;
3. language, and
4. swallowing disorders.

This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Occupational Therapy: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Occupational Therapy. Occupational therapy must be provided to You in Your Home by a duly licensed occupational therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The occupational therapist uses purposeful activities or assistive devices that focus on the following:

1. developing daily living skills;
2. strengthening and enhancing function;
3. coordination of fine motor skills; and
4. muscle and sensory stimulation.

This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Chemotherapy Specialist Services: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Chemotherapy Specialist Services. Chemotherapy must be administered and monitored for treatment of Your cancer while in Your Home, by a duly licensed chemotherapy services specialist nurse, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Enterostomal Therapy: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Enterostomal Therapy. Enterostomal Therapy must be provided to You in Your Home during the post-operative period following an ostomy (a surgically made opening that connects a portion of the intestine to the exterior (usually through the abdominal wall)) where enterostomal therapy is needed. Wound care that requires an enterostomal therapist is also considered Enterostomal Therapy. Enterostomal Therapy must be provided by a duly licensed enterostomal therapist (CETN), practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Respiratory Therapy: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Respiratory Therapy. Respiratory therapy must be provided to You in Your Home by a duly licensed respiratory therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice, who:

1. teaches You about Your respiratory condition and how to manage it;
2. instructs You on how to use equipment, such as oxygen concentrators and related equipment, CPAP/BiPAP machines, nebulizers, and other respiratory assist devices;
3. teaches You breathing techniques to help reduce shortness of breath; and
4. participates in the development of a treatment plan.

Respiration Therapy does NOT include watching or protecting a patient (examples include pulse oximetry monitoring, monitoring of respiratory status, seizure monitoring and observation of a person who is stable without cardiorespiratory compromise). This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily

Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Medical Social Worker Services: We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Medical Social Worker Services. Medical Social Services must be provided to You in Your Home by a duly licensed medical social worker, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The purpose of the medical social worker's Home visit is to:

1. assist the Physician and other health professionals in understanding the social and emotional factors related to Your health problems;
2. participate in the development of a treatment plan; and
3. assess and ensure use of appropriate community resources.

This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

HOME HEALTH CARE AIDE SERVICES BENEFIT

We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Home Health Care Aide Services. Home Health Care Aide Services must be provided to You in Your Home by an individual, who is qualified by training and experience to provide assistance with ADLs, and who is certified as a Home Health Care Aide, or Certified Nursing Assistant (CNA) by the appropriate regulatory authority in the geographic area for which he or she is certified to practice. Only one (1) benefit is payable per a twenty-four (24) period, regardless of the amount of Home Health Care Aide Services are provided on such day. This benefit is subject to the Home Health Care Services and Home Health Care Aide Services Daily Maximum Aggregate Benefit amount, and the Home Health Care Aide Services Maximum Benefit Period (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

RESTORATION OF BENEFITS

If You have received the Home Health Care Services Benefit or Home Health Care Aide Services Benefit under the Policy and have used up all of the Maximum Benefit Period of one or both of these benefits, but have recovered sufficiently to no longer require Home Health Care Services or Home Health Care Aide Services, We will restore Your Maximum Benefit Period to its full original Maximum Benefit Period each time the following conditions are met:

1. You have not received these services in Your Home for a period of 180 consecutive days; and
2. Your Physician must certify that You have sufficiently recovered and no longer require any services and that You have not been advised by a Physician to obtain such services.

There is no limit to the number of times Your Maximum Benefit Period may be restored. If the Maximum Benefit Period for the Home Health Care Services benefit is restored, the Maximum Benefit Period for the Home Health Care Aide Services benefit will also be restored and vice versa.

PRESCRIPTION DRUG BENEFITS

Subject to the per-prescription Generic Drug or per-prescription Brand Name Drug and Policy Year Maximum amount, as shown on the Policy Schedule, We will pay this per-prescription benefit for each Prescription Order for a Generic Drug or Brand Name Drug that is filled for You through a retail or mail-order Pharmacy for:

1. Prescription Drugs that are fully approved and prescribed for the specified indications by the FDA for marketing in the United States and can be obtained only with a Prescription Order from Your duly licensed health care practitioner;
2. Prescription Drugs in dosages, dosage forms, dosage regimens, and durations of treatment that are prescribed by Your duly licensed health care practitioner for sickness or injury; and
3. Prescription Drugs that are within the quantity, supply, or other limits that are appropriate for a Prescription Drug.

The Pre-Existing Conditions Limitation does not apply to the Prescription Drug Benefit.

Prescription Drug Limitations and Exclusions: We will not pay benefits for—

1. drugs or medicines obtained from sources outside of the United States;
2. vitamins and/or vitamin combinations even if they are prescribed by a duly licensed health care practitioner;
3. any prescription products, drugs, or medicines in the following categories, whether or not prescribed by a duly licensed health care practitioner:
    a. herbal or homeopathic medicines or products;
    b. minerals;

c. appetite suppressants;
d. dietary or nutritional substances or dietary supplements;
e. nutraceuticals; or
f. medical foods;

4. drugs or medicines dispensed at or by a hospital, an emergency room, a free-standing facility, an urgent care facility, a health care practitioner's office, or other inpatient or outpatient setting for take home by You;
5. drugs or medicines prescribed for treatment of a condition that is specifically excluded under the Policy;
6. drugs, medicines, or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state;
7. duplicate prescriptions, replacement of lost, stolen, destroyed, spilled, or damaged prescriptions;
8. any administration for drug injections or any other drugs or medicines obtained other than through a Pharmacy with a Prescription Order;
9. Prescription Drug refills more than the number specified on the Prescription Order;
10. Prescription Drugs refilled more frequently than the prescribed dosage indicates; or
11. Prescription Drug that is filled on or after the date this insurance coverage terminates.

PARAGRAPH 4: LIMITATIONS AND EXCLUSIONS

Pre-Existing Conditions Limitation: This Policy and any attached benefit rider(s) do not cover Pre-Existing Conditions whether disclosed in the application or not, for the first six (6) months beginning on the date You become insured under the Policy. This Pre-Existing Conditions Limitation provision does not apply to the Prescription Drug Benefits.

Conditions specifically named or described as excluded in any part of the Policy are never covered.

This Policy does not cover any loss caused or contributed to by:

1. simple rest care, hotel or retirement home expense, or other expense which is related to Your Home;
2. declared or undeclared war or act thereof;
3. charges that You would not legally be obligated to pay in the absence of this insurance; or
4. alcoholism or drug addiction.

PARAGRAPH 5: OPTIONAL BENEFIT RIDER(S) (available for an additional premium):

AMBULANCE BENEFIT RIDER:

We will pay the Ambulance benefit per each one-way trip if a professional Ambulance service provides transportation for Emergency Care. Ambulance services also includes Ambulance transportation from one medical facility to another medical facility when health care services are provided during the duration of such transportation. This benefit is limited to the per-trip, Policy Year, and Lifetime Maximum amounts as shown on the Policy Schedule.

Ambulance transportation is not covered if provided solely for You, or Your family or health care provider's convenience.

EXCLUSIONS

This Rider does not pay benefits:

1. due to not having a charge or legal obligation to pay;
2. if the benefit would not routinely be paid in the absence of insurance;
3. due to You being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a Physician that are misused;
4. due to You engaging in an illegal activity or occupation;
5. due to You intentionally self-inflicting a bodily injury;
6. due to You committing or attempting suicide, while sane or insane;
7. due to You being exposed to war or any act of war, declared or undeclared;
8. due to You actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve; or
9. due to participating in a felony, riot or insurrections.

ACCIDENT EXPENSE BENEFIT RIDER:

Benefits for Covered Accidents are payable if diagnosed and treated by a duly licensed health care practitioner in a Hospital Emergency Room, Urgent Care Facility, or Physician's office. Benefits are subject to the conditions, limitations and exclusions in this Rider, and the Maximum Amount Per Each Covered Accident and Accident Expense Lifetime Maximum amounts as shown on the Policy Schedule.

HIP DISLOCATION
We will pay the Hip Dislocation benefit amount shown on the Policy Schedule if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a hip Dislocation.

KNEE DISLOCATION
We will pay the Knee Dislocation benefit amount shown on the Policy Schedule if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a knee Dislocation.

HIP FRACTURE
We will pay the Hip Fracture benefit amount shown on the Policy Schedule if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a hip Fracture.

SKULL FRACTURE
We will pay the Skull Fracture benefit amount shown on the Policy Schedule if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a skull Fracture.

ALL OTHER FRACTURES
We will pay the All-Other Fracture benefit amount shown on the Policy Schedule if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a Fracture that is not otherwise provided herein.

Limitation: No benefits are payable for any Fractured finger, toe, rib, coccyx, or chipped, Fractured or broken tooth.

KNEE LIGAMENT TEAR
We will pay the Knee Ligament Tear benefit amount shown on the Policy Schedule if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a Knee Ligament Tear.

EXCLUSIONS

This Rider does not provide benefits due to You:

1. operating, learning to operate, or serving as a crew member of any aircraft;
2. officiating, coaching, practicing for, or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received;
3. being exposed to war or any act of war, declared or undeclared;
4. actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
5. participating in a felony, riot or insurrections;
6. being engaged in an illegal occupation;
7. intentionally self-inflicting an injury intentionally;
8. committing or attempting to commit suicide, while sane or insane;
9. being injured which arose out of or in the course of employment and which is payable or covered under any Workers' Compensation or Occupational Disease Act or Law; or
10. receiving injuries incurred outside the territorial limits of the United States or Canada unless such loss is incurred while You are on a trip of not more than 60 days.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT RIDER

ACCIDENTAL DEATH BENEFIT
If You are in a Covered Accident, which results in Your death within ninety (90) days after the date the Covered Accident, We will pay the Accidental Death benefit amount shown on the Policy Schedule. Your death must occur while this Rider is in force. Benefits will be paid to Your designated beneficiary. If You do not have a beneficiary, benefits will be paid to Your estate.

ACCIDENTAL DISMEMBERMENT BENEFIT
If You are in a Covered Accident, and within ninety (90) days of the Covered Accident and suffer a Complete Loss of:

1. Your hand, arm, foot, or leg (multiple);
2. Your hand, arm, foot, or leg (single);
3. Your finger or toe (multiple);
4. Your finger or toe (single);
5. Your sight, both eyes; or

6. Your sight, one eye.

We will pay the Accidental Dismemberment benefit amount shown on the Policy Schedule. Only the highest single benefit will be payable per Covered Accident. Benefits will be paid only once per Covered Accident. If death and loss of finger, toe, hand, foot, or eyesight result from the same Covered Accident, only the Accidental Death Benefit will be paid. This benefit is subject to the Accidental Dismemberment Lifetime Maximum amount as shown on the Policy Schedule.

EXCLUSIONS

This Rider does not provide benefits due to You:

1. operating, learning to operate, or serving as a crew member of any aircraft;
2. officiating, coaching, practicing for, or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received;
3. being exposed to war or any act of war, declared or undeclared;
4. actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
5. participating in a felony, riot or insurrections;
6. being engaged in an illegal occupation;
7. intentionally self-inflicting an injury intentionally;
8. committing or attempting to commit suicide, while sane or insane;
9. being injured which arose out of or in the course of employment and which is payable or covered under any Workers' Compensation or Occupational Disease Act or Law; or
10. receiving injuries incurred outside the territorial limits of the United States or Canada unless such loss is incurred while You are on a trip of not more than 60 days.

HOME MEDICAL EQUIPMENT BENEFIT RIDER

If Your Physician or Your duly licensed health care provider prescribes or orders Home Medical Equipment while You are receiving Home Health Care Services and/or Home Health Care Aide benefits under the Home Health Care Insurance Policy for which this Rider is attached, and You purchase or enter into a rental agreement for such Home Medical Equipment, We will pay the Home Medical Equipment benefit. This benefit is subject to the Home Medical Equipment per item and Lifetime Maximum amounts as shown on the Policy Schedule for this benefit Rider.

Limitations:

1. Home Medical Equipment is limited to the following Durable Medical Equipment:
   Mobility Assistance: Wheelchairs; walkers, rollators, canes, crutches or similar walking aids.
   Transfer Aids: Gait/transfer belts; transfer benches; transfer boards; transfer mats.
   Bathroom Safety: Shower chairs; elevated toilet seats; commode chairs.
   Home Accommodations: hospital beds; patient lifts; trapezes.
   Personal Medical Equipment: braces (arm, leg, back and neck).
2. Home Medical Equipment must be the most appropriate model that adequately meets Your medical need, as measured by Medicare guidelines.
3. Replacement of Home Medical Equipment will only be covered for a material change in clinical status or customary wear and tear; duplicates are never a covered benefit.
4. Total benefits for rented Home Medical Equipment shall not exceed the benefit for purchase of that same equipment.

Unused benefits in one Policy Year are not carried forward to any future Policy Year.

ROUTINE ANNUAL PHYSICAL EXAMINATION BENEFIT RIDER

Subject to a 12-Month Waiting Period

If You undergo a Routine Annual Physical Examination, We will pay an Annual Physical Examination Benefit amount shown on the Policy Schedule. This benefit is limited to one (1) Routine Annual Physical Examination per Policy Year, and payable only after the 12-month Waiting Period is satisfied.

PARAGRAPH 6: RENEWABILITY

Guaranteed Renewable. You have the right to renew the Policy as long as You live if You pay the correct premium when due or within the Grace Period. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage.

PARAGRAPH 7: PREMIUM

We retain the right to change the premium on the Policy. Premiums are based on Your attained age. The premium will change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. We will give You advance written notice as required by Your state prior to any premium change.

The total annual premium for this insurance coverage that You applied for is:

Home Health Care Insurance Policy $ 489.12

TOTAL: $ 489.12

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Standard Life
AND CASUALTY INSURANCE COMPANY
A ManhattanLife Company

Standard Life and Casualty Insurance Company
Home Office: Salt Lake City, UT
Administrative Office: 10777 Northwest Freeway, Houston, TX
(800) 672-4535

APPLICATION FOR HOME HEALTH CARE INSURANCE

❑ Reinstatement ❒ Benefit Increase Policy No._____ Group No. _____

APPLICANT A – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Telephone Numbers (Home, Work, and Cell)	Social Security No.	
Beneficiary Name Estate	Requested Future Effective Date **Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship Self	Mail Policy to: ❑ Agent ☒ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	

APPLICANT A - INSURANCE REQUESTED		PREMIUM
Home Health Care Insurance Policy	❑ Classic - $150 ❑ Premier - $300 ☒ Deluxe - $450	$ 39.09
Routine Annual Examination Rider	❑	$ _____
Accidental Death & Dismemberment Rider	❑	$ _____
Home Health Equipment Rider	❑	$ _____
Accident Expense Benefit Rider	Per Accident - ❑ $1250 ❑ $2500	$ _____
Ambulance Benefit Rider	❑	$ _____
	APPLICANT A - TOTAL PREMIUM	$ _____

APPLICANT A - HEALTH QUESTIONS		
1.	Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	❑ Yes ☒ No
2.	Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting and transferring from bed to chair?	❑ Yes ☒ No

APPLICANT A – EXISTING COVERAGE		
1.	Do you have existing health coverage (including home health care, long-term care, or similar coverage)?	❑ Yes ☒ No
2.	Are any policy(s) intended to replace any other insurance now in force? If "**Yes**," provide the company name, policy number, and type of coverage below.	❑ Yes ☒ No

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone Number: (800) 672-4535 FAX: (713) 583-2738

APPLICANT B – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)	Social Security No.	
Beneficiary Name	Requested Future Effective Date **Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	

APPLICANT B - INSURANCE REQUESTED		PREMIUM
Home Health Care Insurance Policy	❑ Classic - $150 ❑ Premier - $300 ❑ Deluxe - $450	$ _____
Routine Annual Examination Rider	❑	$ _____
Accidental Death & Dismemberment Rider	❑	$ _____
Home Health Equipment Rider	❑	$ _____
Accident Expense Benefit Rider	Per Accident - ❑ $1250 ❑ $2500	$ _____
Ambulance Benefit Rider	❑	$ _____
	APPLICANT B - TOTAL PREMIUM	$ _____

APPLICANT B - HEALTH QUESTIONS		
1.	Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	❑ Yes ❑ No
2.	Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting and transferring from bed to chair?	❑ Yes ❑ No

APPLICANT B – EXISTING COVERAGE		
1.	Do you have existing health coverage (including home health care, long-term care, or similar coverage)?	❑ Yes ❑ No
2.	Are any policy(s) intended to replace any other insurance now in force? If "**Yes**," provide the company name, policy number, and type of coverage below.	❑ Yes ❑ No

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092

Toll Free Telephone Number: (800) 672-4535 FAX: (713) 583-2738

AUTHORIZATION AND SIGNATURE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, LLC (MIB), Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give to the Standard Life and Casualty Insurance Company (the Company) or its reinsurers, any such information. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal law governing privacy and confidentiality. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I authorize Standard Life and Casualty Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB, LLC.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by the Company will remain protected by federal and/or state regulations.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with the Company.

I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to the Company will result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying the Company in writing at their Administrative Office: 10777 Northwest Freeway, Houston, TX 77092. I understand that such revocation will not have any effect on actions the Company took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits, or, for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be as valid as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete, and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, certify that I have read, or had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE ADMINISTRATIVE OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime, punishable under law, and may be subject to civil penalties.

Signed at _____, on _____ X Hensley
(City and State) (Month/Day/Year) Applicant A's signature (or their authorized representative)

Signed at _____, on _____ X _____
(City and State) (Month/Day/Year) Applicant B's signature (or their authorized representative)

AGENT(S) STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ☐ is ☒ is not involved at this time.

Signature of Agent	Printed Agent's Name	Agent No.	% Credit	State ID No.
X			%	
Signature of Agent	Printed Agent's Name	Agent No.	% Credit	State ID No.

NOTICE: All premium checks must be made payable to Standard Life and Casualty Insurance Company. Do not make the check payable to the agent or leave the payee blank.

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone Number: (800) 672-4535 FAX: (713) 583-2738

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APPLICANT A - EMAIL CONSENT AUTHORIZATION

○ I give my written consent to allow Standard Life and Casualty Insurance Company (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(s) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

◉ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below)

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

APPLICANT B - EMAIL CONSENT AUTHORIZATION

○ I give my written consent to allow Standard Life and Casualty Insurance Company (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(s) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

○ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below)

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

Special Request

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone Number: (800) 672-4535 FAX: (713) 583-2738

Notice of Information Practices
Including Fair Credit Reporting Act Notice and MIB, LLC Notice

To obtain further information, contact
Standard Life and Casualty Insurance Company
10777 Northwest Freeway, Houston, TX 77092

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Administrative Office at the above address. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, andyou have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Administrative Office at the address on the front of this Notice.

MIB, LLC Pre-Notice

Information regarding your insurability will be treated as confidential. Standard Life and Casualty Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of insurance companies that are members *of MIB Group, Inc*. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 *or go to its website www.mib.com*. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

Standard Life and Casualty Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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