



Did you know about **1,479,350** new **Cancer** cases are expected to be diagnosed in 2009<sup>1</sup> and an estimated **80,000,000** American adults have one or more types of **Cardiovascular Disease**<sup>2</sup>?

Help protect your clients with products from... *United Teacher Associates Insurance Company (UTA)*

## First Diagnosis Cancer Benefit Policy<sup>3</sup>

### Benefits

The UTA First Diagnosis Cancer Benefit Policy (FDC) pays a maximum benefit amount paid directly to your client between \$10,000 – \$50,000 on First Diagnosis of Internal Cancer or Malignant Melanoma.

- The money comes directly to your client, all in one lump sum payment!
- Guaranteed renewable for life!
- Your client receives the total benefit whether or not they are hospitalized or receive treatment!

### Riders<sup>3</sup>

**First Diagnosis Heart Attack & First Major Heart Surgery Rider** - **\$10,000-\$50,000** on first diagnosis of heart attack and first major heart surgery.

**Return of Premium Rider** - After your policy has been in force for 20 years, you receive a check for 100% of your premiums paid, less any claims paid to you.

**Intensive Care Unit Benefit Rider** - UTA will pay the ICU charges not to exceed the maximum daily benefit amount you select: **\$600 per day or \$300** per day for confinement in Hospital Intensive Care Unit or Cardiac Intensive Care Unit.

## First Diagnosis Heart Attack & First Major Heart Surgery Policy<sup>3</sup>

### Benefits

The UTA First Diagnosis Heart Attack & First Major Heart Surgery Policy (FDH) provides a lump sum benefit of \$10,000 – \$50,000 upon the first diagnosis of a heart attack or first major heart surgery.

- UTA pays in addition to any other insurance your client may have!
- Premiums do not increase just because your client moves into a higher age bracket!
- Benefits do not reduce at age 65!

### Riders<sup>3</sup>

**Intensive Care Unit Benefit Rider** - UTA will pay the ICU charges not to exceed the maximum daily benefit amount You select: **\$ 600.00 per day or \$ 300.00** per day for confinement in Hospital Intensive Care Unit or Cardiac Intensive Care Unit.

**Return of Premium Rider** - After your policy has been in force for 20 years, you receive a check for 100% of your premiums paid, less any claims paid to you.

**First Diagnosis Stroke Benefit Rider** - The First Diagnosis Stroke Benefit Rider pays the benefit amount selected upon First Diagnosis of Stroke. Select a lump sum of \$5,000, \$10,000, \$15,000, \$20,000 or \$25,000.

**Check the applicable product material, application packet and rate charts on AgentView for complete information, availability and details regarding each policy.**

<sup>1</sup> This estimate does not include carcinoma in situ (noninvasive cancer) of any site except urinary bladder, and does not include basal and squamous cell skin cancers. American Cancer Society. Cancer Facts & Figures 2009. Atlanta: American Cancer Society; 2009. <sup>2</sup> Total Cardiovascular Disease include High blood pressure, Coronary heart disease, Heart failure, Stroke & Congenital cardiovascular defects. NCHS. Compressed mortality file: underlying cause of death, 1979 to 2005; <http://wonder.cdc.gov/mortSQL.html>. <sup>3</sup> Not all products and riders are available in all states.

# CANCER FIRST DIAGNOSIS BENEFIT INSURANCE

Policy Form Number CF-940101-UTA-FL  
MONTHLY BANK DRAFT PREMIUMS

## FLORIDA

### INDIVIDUAL

Issue Age	\$10,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
20-24	\$3.25	\$6.50	\$8.13	\$9.75	\$13.00	\$16.25
25-29	\$3.75	\$7.50	\$9.38	\$11.25	\$15.00	\$18.75
30-34	\$4.50	\$9.00	\$11.25	\$13.50	\$18.00	\$22.50
35-39	\$5.50	\$11.00	\$13.75	\$16.50	\$22.00	\$27.50
40-44	\$7.00	\$14.00	\$17.50	\$21.00	\$28.00	\$35.00
45-49	\$9.00	\$18.00	\$22.50	\$27.00	\$36.00	\$45.00
50-54	\$11.50	\$23.00	\$28.75	\$34.50	\$46.00	\$57.50
55-59	\$13.50	\$27.00	\$33.75	\$40.50	\$54.00	\$67.50
60-65*	\$13.75	\$27.50	\$34.38	\$41.25	\$55.00	\$68.75

### SINGLE PARENT

Issue Age	\$10,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
20-24	\$4.00	\$8.00	\$10.00	\$12.00	\$16.00	\$20.00
25-29	\$4.50	\$9.00	\$11.25	\$13.50	\$18.00	\$22.50
30-34	\$5.25	\$10.50	\$13.13	\$15.75	\$21.00	\$26.25
35-39	\$6.00	\$12.00	\$15.00	\$18.00	\$24.00	\$30.00
40-44	\$7.75	\$15.50	\$19.38	\$23.25	\$31.00	\$38.75
45-49	\$9.75	\$19.50	\$24.38	\$29.25	\$39.00	\$48.75
50-54	\$12.00	\$24.00	\$30.00	\$36.00	\$48.00	\$60.00
55-59	\$14.00	\$28.00	\$35.00	\$42.00	\$56.00	\$70.00
60-65*	\$14.00	\$28.00	\$35.00	\$42.00	\$56.00	\$70.00

### FAMILY

Issue Age	\$10,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000
20-24	\$5.00	\$10.00	\$12.50	\$15.00	\$20.00	\$25.00
25-29	\$6.00	\$12.00	\$15.00	\$18.00	\$24.00	\$30.00
30-34	\$7.26	\$14.52	\$18.15	\$21.78	\$29.04	\$36.30
35-39	\$9.25	\$18.50	\$23.13	\$27.75	\$37.00	\$46.25
40-44	\$12.00	\$24.00	\$30.00	\$36.00	\$48.00	\$60.00
45-49	\$16.00	\$32.00	\$40.00	\$48.00	\$64.00	\$80.00
50-54	\$20.25	\$40.50	\$50.63	\$60.75	\$81.00	\$101.25
55-59	\$24.25	\$48.50	\$60.63	\$72.75	\$97.00	\$121.25
60-65*	\$24.50	\$49.00	\$61.25	\$73.50	\$98.00	\$122.50

\* Benefits reduce 50% for insureds ages 65 and over and for dependent children.

Modal Factors:           Annual = Bank draft x 12  
                                  Semi Annual = Bank draft x 6.24  
                                  Quarterly = Bank draft x 3.18

Minimum Monthly Bank Draft is \$15.00.

Direct Billing is available Quarterly, Semi-Annually or Annually for any amount.

# UNITED TEACHER ASSOCIATES INSURANCE COMPANY

P.O. BOX 559015 • AUSTIN, TEXAS 78755-9015

## APPLICATION FOR CANCER FIRST DIAGNOSIS BENEFIT POLICY

County Name:		County Number:		Date of Birth	Sex	Height	Weight
				Month    Day    Year			
Applicant:							
Spouse:						<b>X</b>	<b>X</b>
Child #1:						Full Time Student	<input type="checkbox"/> Yes <input type="checkbox"/> NO
Child #2:						Full Time Student	<input type="checkbox"/> Yes <input type="checkbox"/> NO
Child #3:						Full Time Student	<input type="checkbox"/> Yes <input type="checkbox"/> NO
Applicant's Address:				City:	State:	Zip Code:	
Payer's Name:		Relationship:		Payer's Address:			
Applicant's Social Security #:				Occupation:			
Beneficiary (full name):		Relationship:		Job Duties:			
Employer's Name				Employer's Address:			
Home telephone #:	(    )	Work telephone #:	(    )	Best time to call			

<input type="checkbox"/> Individual	<input type="checkbox"/> Single Parent	<input type="checkbox"/> Family	Premium Payment Mode:	
<b>Cancer First Diagnosis Benefit Policy</b>		Benefit Amount: \$ _____	Modal Premium	\$
<input type="checkbox"/> Dread Disease Benefit Rider	Benefit Amount: \$N/A		Rider Premium	\$N/A
<input type="checkbox"/> Intensive Care Unit Benefit Rider	Benefit Amount: \$ _____ per day	Rider Premium	\$	
<b>FOR PAYROLL DEDUCTION:</b>				
Group Name:			Enrollment Fee	\$
Group Number:	Is this Section #125?	<input type="checkbox"/> Yes <input type="checkbox"/> No	TOTAL PREMIUM	\$

1. Is the insurance applied for here intended to replace any existing insurance? If yes, list name of Company and policy number: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**MEDICAL INFORMATION. Answer all questions and circle the applicable conditions.**

2. Have you or any person to be insured under this policy ever been treated for or had symptoms of Internal Cancer, Melanoma, Malignant Growth, Sarcoma, or any type of Cancer, except non-melanoma skin cancer? If Yes, who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you or any person to be insured under this policy ever been treated for or had symptoms of Skin Cancer, excluding Melanoma? If Yes, who? _____ <b>Please describe the condition and treatment period.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you or any person to be insured under this policy ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) caused by the (Human Immunodeficiency Virus "HIV") infection, or tested positive for exposure to the AIDS-related (Human Immunodeficiency Virus "HIV") infection? If "Yes", who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage under this policy.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PLEASE ANSWER QUESTIONS #5 &amp; #6 IF YOU ARE APPLYING FOR THE INTENSIVE CARE UNIT BENEFIT RIDER:</b>	
5. Have you or any person to be insured under the Intensive Care Unit Benefit Rider ever been treated for or had symptoms of stroke, heart disease, heart attack or diabetes; or had any other disorder or abnormality of the brain, heart, or circulatory system, including the arteries, veins, lymphatic nodes and vessels (but not including blood pressure, unless uncontrolled)? If Yes, who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage under this rider.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are you or any person to be insured under the Intensive Care Unit Benefit Rider currently pregnant? If Yes, who? _____ <b>If the answer is Yes, any individual named will be excluded from coverage under this rider.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE ANSWER THE FOLLOWING QUESTION IF YOU ARE APPLYING FOR THE DREAD DISEASE BENEFIT RIDER:**

7. Have you or any person to be insured under the Dread Disease Benefit Rider ever been treated for or had symptoms of one of the following dread diseases: Addison's Disease, Amyotrophic Lateral Sclerosis, Diphtheria, Encephalitis, Epilepsy, Legionnaire's Disease, Lupus Erythematosus or any connective tissue disorder, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Smallpox, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Toxic Shock Syndrome, Tuberculosis, Tularemia, Typhoid Fever or Whipple's Disease?  Yes  No

If Yes, who? N/A

For which condition? N/A **If the answer is Yes, any individual named will be Excluded from this condition under this rider.**

I hereby represent that the foregoing answers are recorded as given by me and that the same are true. I represent that all questions on this application were asked and that the answers were properly recorded. I further agree that this insurance applied for shall be subject to the conditions and provisions of the policy and shall not be in force until the application is accepted and the policy issued by the Company. I acknowledge receipt of the Outline of Coverage. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or The Medical Information Bureau to release any records concerning me or my health to United Teacher Associates Insurance Company and its reinsurers. This authorization will be valid for 24 months from the date the authorization is signed. No agent has the right to waive the answer to any question in this application, to pass on insurability, to waive any of the Company's rights or requirements, or to make or alter any contract. I agree that this application shall form a part of any policy issued. The undersigned applicant and agent represent that the applicant has read or had read to him the completed application and he realizes any false statement or misrepresentation therein which is material to the risk or hazard assumed may result in a loss of coverage under the policy subject to the Time Limit on Certain Defenses and legal proceedings. A photographic copy of this authorization shall be as valid as the original.

*I understand that the "Effective Date" of this policy will be the date recorded on the policy schedule by our office. It is not the date the application was signed. The policy has a 30-day "waiting period" which begins on the "Effective Date" of the policy.*

*This policy has a pre-existing condition limitation and if a physician has provided treatment or recommended treatment for an injury or illness or other condition during the twenty-four (24) months prior to the issuance of the policy for which I am applying, no coverage will be provided for this illness or injury or other condition until twenty-four (24) months after the policy has been issued.*

**I KNOW THAT ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE AN INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.**

Note to Agent: Is replacement of insurance involved?  Yes  No

Signed at \_\_\_\_\_ Date: \_\_\_\_\_  
(City and state)

Agent's Signature \_\_\_\_\_ Writing Number \_\_\_\_\_ Read and Signed (✓) \_\_\_\_\_  
(Applicant's Signature)

Agent's Printed Name \_\_\_\_\_ Agent's License Number: \_\_\_\_\_ Check Block if Agent Family Business

***AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED TEACHER ASSOCIATES INSURANCE COMPANY***

Name of Bank: \_\_\_\_\_ Routing Number: \_\_\_\_\_

As a convenience to me, I hereby request and authorize you to initiate debit entries, whether by electronic or paper means, with said debits drawn on my account by and payable to the order of the UNITED TEACHER ASSOCIATES INSURANCE COMPANY, Austin, Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on my account and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring such debit. I further agree that if any such debit is not paid by me for any reason, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such non-payment results in the forfeiture of insurance.

\_\_\_\_\_ ✓) \_\_\_\_\_  
Date (Your signature EXACTLY as it appears on Bank Records) (Account Number)

**IMPORTANT: FOR BANK ACCOUNT IDENTIFICATION, ENCLOSE A VOIDED BLANK PERSONAL CHECK.**

***AUTHORIZATION FOR PAYROLL DEDUCTION***

Employee: \_\_\_\_\_ I hereby authorize my employer: \_\_\_\_\_

To deduct from my salary and pay to United Teacher Associates Insurance Company, Austin, Texas, the monthly deposits as set forth below. Beginning with the month of \_\_\_\_\_, \$ \_\_\_\_\_ each month.

\_\_\_\_\_ ✓) \_\_\_\_\_  
Date Signature of Employee

# **UNITED TEACHER ASSOCIATES INSURANCE COMPANY**

## **CANCER FIRST DIAGNOSIS BENEFIT INSURANCE Outline of Coverage for policy form CF-940101-UTA-FL**

Caution: The issuance of the **Cancer First Diagnosis Benefit Insurance** is based upon Your responses to the questions on Your application. A copy of Your application is attached to Your policy when it is issued. If Your answers are incorrect or untrue, the Company may deny benefits or rescind Your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at: **UNITED TEACHER ASSOCIATES INSURANCE COMPANY**, P.O. Box 26580, Austin, Texas 78755-0580.

**NOTICE TO BUYER:** The policy may not cover all of the costs associated with the **First Diagnosis of Cancer** incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

**PURPOSE OF OUTLINE OF COVERAGE:** This Outline of Coverage provides a very brief description of the important features of Your coverage. This is not the insurance contract and only the actual contract provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth in detail those rights and obligations applicable to both You and **UNITED TEACHER ASSOCIATES INSURANCE COMPANY**. **It is very important therefore, that YOU READ YOUR POLICY CAREFULLY.**

**TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND THE PREMIUM REFUNDED:** **Thirty (30) Day Free Look.** After You receive Your policy, take up to thirty (30) days to examine Your policy. If You are not completely satisfied, You may return it to Us within thirty (30) days and receive a full refund of the premium You paid.

### **AMOUNT OF BENEFITS**

If a Covered Person receives a First Diagnosis of internal Cancer or malignant melanoma (this excludes all other skin Cancer), We will pay the Cancer First Diagnosis Benefit amount shown on the policy schedule page provided the First Diagnosis of internal Cancer or malignant melanoma is after the Waiting Period and while this policy is in force with respect to the Covered Person. If a Covered Person receives a First Diagnosis of skin Cancer (this excludes malignant melanoma), We will pay the Skin Cancer First Diagnosis Benefit amount shown on the policy schedule page provided the First Diagnosis of skin Cancer is after the Waiting Period and while this policy is in force with respect to the Covered Person. Each Covered Person is limited to one First Diagnosis benefit under the terms of this policy for both internal Cancer or malignant melanoma and for skin Cancer.

Coverage for an Insured Child will be equal to one-half of the Cancer First Diagnosis Benefit amount shown on the policy schedule page.

At age sixty-five (65), coverage for each Covered Person will reduce to one-half of the listed Cancer First Diagnosis Benefit amount shown on the policy schedule page.

### **LIMITATIONS AND EXCLUSIONS**

This policy provides benefits only for First Diagnosis of Cancer as defined in the policy. This policy does not cover any other disease, sickness, or incapacity.

### **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**

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#### **RENEWAL CONDITIONS**

Subject to the payment of the Cancer First Diagnosis Benefit amount, You may renew the policy for life by paying each renewal premium as it becomes due. We do not have the right to cancel the policy except for non-payment of premium, the conditions as stated in the Time Limit On Certain Defenses provision, and/or the payment of the Cancer First Diagnosis Benefit amount for the First Diagnosis of internal Cancer or malignant melanoma (this excludes all other skin Cancer).

**PREMIUM CHANGES**

We reserve the right to change premium rates. A change in the rates will apply to all policies of this form in Your state. The change will be effective on the next premium due date of Your policy. If We change the rates, Your premium will be determined by Your age on the Effective Date of the policy. We will write to You at the address shown in Our records, at least forty-five (45) days before We change Your premium rate.

**GRACE PERIOD**

The policy has a thirty-one (31) day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, the policy will stay in force.

**OPTIONAL RIDERS - ADDITIONAL PREMIUM REQUIRED**

**DREAD DISEASE BENEFIT RIDER (Form Number CF-940101-UTA-R01-FL)**

If an Insured Person receives a First Diagnosis of a covered Dread Disease, We will pay the Dread Disease Benefit amount. The First Diagnosis must be after the Waiting Period and while this Rider is in force with respect to the Insured Person. Each Insured Person is limited to one Dread Disease Benefit amount under the terms of this Rider. The benefit amounts are shown on the policy schedule page.

Coverage for an Insured Child will be equal to one-half of the Dread Disease Benefit amount.

At age sixty-five (65), coverage for each Insured Person will reduce to one-half of the listed Dread Disease Benefit amount.

The Dread Diseases are any of the diseases listed below which are first manifested after the Effective Date and after the Waiting Period shown on the schedule page. The disease must be diagnosed by a Doctor based on generally accepted diagnostic criteria. The covered diseases are:

Muscular Dystrophy	Tetanus	Diphtheria	Tularemia
Legionnaire's Disease	Tuberculosis	Sickle Cell Anemia	Typhoid Fever
Toxic Epidermal Necrolysis	Osteomyelitis	Scarlet Fever	Multiple Sclerosis
Amyotrophic Lateral Sclerosis	Meningitis	Smallpox	Epilepsy
Tay-Sachs Disease	Myasthenia Gravis	Rheumatic Fever	Whipple's Disease
Addison's Disease	Reye's Syndrome	Toxic Shock Syndrome	Niemann-Pick Disease
Encephalitis	Lupus Erythematosus	Rabies	Poliomyelitis
Rocky Mountain Spotted Fever			

Not Available

**INTENSIVE CARE UNIT BENEFIT RIDER (Form Number CF-940101-UTA-R02-FL)**

This Rider provides the following benefits:

**ICU Confinement Benefit:** For each calendar day an Insured is necessarily confined to an Intensive Care Unit ("ICU") for treatment of an accidental injury or sickness, We will pay the actual ICU charge for each calendar day up to the maximum ICU Benefit amount. Benefits are payable from the first day of confinement for up to thirty (30) days for the lifetime of each Insured Person. The benefit amounts are shown on the policy schedule page.

At age sixty-five (65), coverage for each Insured Person will reduce to one-half of the listed ICU Benefit amount.

**Government Hospital Benefit:** If an Insured is required to pay the charge of a Government Hospital for an ICU confinement, We will pay the actual charge for each calendar day made by the hospital. The charge must not exceed the daily limit set forth above for any given calendar day.

***Your Total Premium (At time of application):***

\$ \_\_\_\_\_

The additional premium amount for the Rider(s) you selected is \$ \_\_\_\_\_.

# **UNITED TEACHER ASSOCIATES INSURANCE COMPANY**

## **CANCER FIRST DIAGNOSIS BENEFIT INSURANCE** **Outline of Coverage for policy form CF-940101-UTA-FL**

Caution: The issuance of the **Cancer First Diagnosis Benefit Insurance** is based upon Your responses to the questions on Your application. A copy of Your application is attached to Your policy when it is issued. If Your answers are incorrect or untrue, the Company may deny benefits or rescind Your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at: **UNITED TEACHER ASSOCIATES INSURANCE COMPANY**, 5508 Parkcrest Drive P.O. Box 26580, Austin, Texas 78755-0580.

**NOTICE TO BUYER:** The policy may not cover all of the costs associated with the **First Diagnosis of Cancer** incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

**PURPOSE OF OUTLINE OF COVERAGE:** This Outline of Coverage provides a very brief description of the important features of Your coverage. This is not the insurance contract and only the actual contract provisions of the policy will control the rights and obligations of the parties to it. The policy itself sets forth in detail those rights and obligations applicable to both You and **UNITED TEACHER ASSOCIATES INSURANCE COMPANY**. **It is very important therefore, that YOU READ YOUR POLICY CAREFULLY.**

**TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND THE PREMIUM REFUNDED: Thirty (30) Day Free Look.** After You receive Your policy, take up to thirty (30) days to examine Your policy. If You are not completely satisfied, You may return it to Us within thirty (30) days and receive a full refund of the premium You paid.

### **AMOUNT OF BENEFITS**

If a Covered Person receives a First Diagnosis of internal Cancer or malignant melanoma (this excludes all other skin Cancer), We will pay the Cancer First Diagnosis Benefit amount shown on the policy schedule page provided the First Diagnosis of internal Cancer or malignant melanoma is after the Waiting Period and while this policy is in force with respect to the Covered Person. If a Covered Person receives a First Diagnosis of skin Cancer (this excludes malignant melanoma), We will pay the Skin Cancer First Diagnosis Benefit amount shown on the policy schedule page provided the First Diagnosis of skin Cancer is after the Waiting Period and while this policy is in force with respect to the Covered Person. Each Covered Person is limited to one First Diagnosis benefit under the terms of this policy for both internal Cancer or malignant melanoma and for skin Cancer.

Coverage for an Insured Child will be equal to one-half of the Cancer First Diagnosis Benefit amount shown on the policy schedule page.

At age sixty-five (65), coverage for each Covered Person will reduce to one-half of the listed Cancer First Diagnosis Benefit amount shown on the policy schedule page.

### **LIMITATIONS AND EXCLUSIONS**

This policy provides benefits only for First Diagnosis of Cancer as defined in the policy. This policy does not cover any other disease, sickness, or incapacity.

### **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**

#### **RENEWAL CONDITIONS**

Subject to the payment of the Cancer First Diagnosis Benefit amount, You may renew the policy for life by paying each renewal premium as it becomes due. We do not have the right to cancel the policy except for non-payment of premium, the conditions as stated in the Time Limit On Certain Defenses provision, and/or the payment of the Cancer First Diagnosis Benefit amount for the First Diagnosis of internal Cancer or malignant melanoma (this excludes all other skin Cancer).

**PREMIUM CHANGES**

We reserve the right to change premium rates. A change in the rates will apply to all policies of this form in Your state. The change will be effective on the next premium due date of Your policy. If We change the rates, Your premium will be determined by Your age on the Effective Date of the policy. We will write to You at the address shown in Our records, at least forty-five (45) days before We change Your premium rate.

**GRACE PERIOD**

The policy has a thirty-one (31) day Grace Period. This means if a renewal premium is not paid on or before the date it is due, it may be paid during the following thirty-one (31) days. During the Grace Period, the policy will stay in force.

**OPTIONAL RIDERS - ADDITIONAL PREMIUM REQUIRED**

**DREAD DISEASE BENEFIT RIDER (Form Number CF-940101-UTA-R01-FL)**

If an Insured Person receives a First Diagnosis of a covered Dread Disease, We will pay the Dread Disease Benefit amount. The First Diagnosis must be after the Waiting Period and while this Rider is in force with respect to the Insured Person. Each Insured Person is limited to one Dread Disease Benefit amount under the terms of this Rider. The benefit amounts are shown on the policy schedule page.

Coverage for an Insured Child will be equal to one-half of the Dread Disease Benefit amount.

At age sixty-five (65), coverage for each Insured Person will reduce to one-half of the listed Dread Disease Benefit amount.

The Dread Diseases are any of the diseases listed below which are first manifested after the Effective Date and after the Waiting Period shown on the schedule page. The disease must be diagnosed by a Doctor based on generally accepted diagnostic criteria. The covered diseases are:

- |                               |                     |                      |                      |
|-------------------------------|---------------------|----------------------|----------------------|
| Muscular Dystrophy            | Tetanus             | Diphtheria           | Tularemia            |
| Legionnaire's Disease         | Tuberculosis        | Sickle Cell Anemia   | Typhoid Fever        |
| Toxic Epidermal Necrolysis    | Osteomyelitis       | Scarlet Fever        | Multiple Sclerosis   |
| Amyotrophic Lateral Sclerosis | Meningitis          | Smallpox             | Epilepsy             |
| Tay-Sachs Disease             | Myasthenia Gravis   | Rheumatic Fever      | Whipple's Disease    |
| Addison's Disease             | Reye's Syndrome     | Toxic Shock Syndrome | Niemann-Pick Disease |
| Encephalitis                  | Lupus Erythematosus | Rabies               | Poliomyelitis        |
| Rocky Mountain Spotted Fever  |                     |                      |                      |

Not Available

**INTENSIVE CARE UNIT BENEFIT RIDER (Form Number CF-940101-UTA-R02-FL)**

This Rider provides the following benefits:

**ICU Confinement Benefit:** For each calendar day an Insured is necessarily confined to an Intensive Care Unit ("ICU") for treatment of an accidental injury or sickness, We will pay the actual ICU charge for each calendar day up to the maximum ICU Benefit amount. Benefits are payable from the first day of confinement for up to thirty (30) days for the lifetime of each Insured Person. The benefit amounts are shown on the policy schedule page.

At age sixty-five (65), coverage for each Insured Person will reduce to one-half of the listed ICU Benefit amount.

**Government Hospital Benefit:** If an Insured is required to pay the charge of a Government Hospital for an ICU confinement, We will pay the actual charge for each calendar day made by the hospital. The charge must not exceed the daily limit set forth above for any given calendar day.

***Your Total Premium (At time of application):***

\$ \_\_\_\_\_

The additional premium amount for the Rider(s) you selected is \$ \_\_\_\_\_.