[redacted]

Insured: [redacted]

Policy: **896**[redacted]

KTRICE

Print Date: **02/28/2023**

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Standard Life
AND CASUALTY INSURANCE COMPANY
A ManhattanLife Company

Date February 28, 2023

[redacted]

Insured: [redacted]
Policy Number: 040-[redacted]

Scan QR Code to access your Customer Portal

Dear [redacted]

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 upmost 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 Assurance Company of America, 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 Assurance Company of America 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.

ManhattanLife.

NOTICE CONCERNING COVERAGE UNDER THE

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

SHORT-TERM FACILITY CARE INSURANCE POLICY
LIMITED BENEFITS

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide, available from Us.

PLEASE READ YOUR POLICY CAREFULLY AND BECOME FAMILIAR WITH ITS TERMS, LIMITS, EXCLUSIONS, AND BENEFIT PROVISIONS.

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

NOTICE: This is not a major medical insurance policy. This Policy provides limited fixed indemnity benefits for short-term care. Fixed indemnity 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 the health care provider's statement.

THIS IS A LIMITED POLICY – PLEASE READ IT CAREFULLY! This is a legal contract between You and Standard Life and Casualty Insurance Company. Standard Life and Casualty Insurance Company agrees to pay the benefits to You 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, as 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.

GUARANTEED RENEWABLE: You have the right to renew this Policy if You pay the correct premium when due or within the Grace Period.

WE RETAIN THE RIGHT TO CHANGE THE PREMIUM ON THIS POLICY: If We do change the premium, We will do so only if: (1) We change the premiums for all policies of this same form and rate class in Your state of issue; (2) such change is in accordance with the laws and regulations of Your state of issue; and (3) We give You at least 30-days advance written notice prior to any premium change.

NOTICE OF INSURED'S RIGHT TO EXAMINE POLICY FOR THIRTY DAYS

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.

John McGettigan,
Secretary

Todd R. Tippets,
President

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

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.

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POLICY SCHEDULE

Insured: [redacted] Issue Age: 65, years Policy Number: 040-[redacted] Effective Date: 02/11/2023

Spousal Discount: No First Policy Anniversary Date: 02/11/2024

Payment Option: Monthly Modal Premium: $ 69.93

DESCRIPTION OF COVERAGE

SHORT-TERM FACILITY CARE INSURANCE POLICY — **Annual Premium** $ 505.08

Facility Care Benefit — **Benefit Amount on Effective Date:** $50.00

Policy Anniversary	Per Day Benefit	Policy Anniversary	Per Day Benefit
1	$60.00	4	$90.00
2	$70.00	5, and thereafter	$100.00
3	$80.00		

Elimination Period	0 days
Benefit Period	360 days
Lifetime Maximum	720 days
Bed Reservation Benefit Policy Yearly Maximum	10 days
Bed Reservation Lifetime Maximum	20 days

Prescription Rx Drug Benefit

Rx Generic Drug	$10 per prescription
Rx Name Brand Drug	$25 per prescription
Policy Year Maximum	$300

OPTIONAL RIDER(S) (available for an additional premium)

Home Health Care Benefit Rider — **Benefit Amount on Effective Date:** $50.00 — **Annual Premium** $206.28

Policy Anniversary	Per Day Benefit	Policy Anniversary	Per Day Benefit
1	$60.00	4	$90.00
2	$70.00	5, and thereafter	$100.00
3	$80.00		

Elimination Period	0 days
Benefit Period	360 days
Lifetime Maximum	720 days

Hospital Indemnity Benefit Rider — **Annual Premium** $127.80

Benefit Amount	$100.00
Maximum Period of Confinement	20 days
Lifetime Maximum	180 days

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DEFINITIONS

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.

Assisted Living Facility: A facility which is either separate from or a distinct part of a health care facility that:

1. is licensed, certified, or accredited by the appropriate state agency and operates pursuant to law;
2. provides assistance with ADLs to ambulatory residents who require protected living arrangements, or coordinated supportive personal and health care services to semi-independent residents;
3. provides at least one (1) trained staff member who is actively on duty 24-hours-a-day to provide care and services;
4. provides three (3) meals per day and accommodates special dietary needs;
5. has formal arrangements for the services of a Physician or registered nurse to furnish emergency medical care; and
6. has appropriate methods and procedures for handling and administering drugs and biologicals.

An Assisted Living Facility known as a residential care facility, personal care, domiciliary care, or any other name, will be considered eligible for benefits only when the facility meets all items indicated above. An independent living unit, an apartment, retirement community, or congregate housing will not meet these terms. If the facility is licensed or accredited for multiple purposes, only the confinement in the wing, ward, unit, or section as an Assisted Living Facility will be eligible for benefits.

Benefit Period: The maximum amount of days for which benefits will be paid under this Policy during one Period of Care. The Benefit Period is shown on the Policy Schedule corresponding to the applicable benefit provision.

Cognitive Impairment: Deficiency in short-term or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness, that requires Substantial Supervision. Such impairment can result from the following covered conditions that is measured and confirmed by clinical and standardized tests that reliably measure such impairment: demonstrable organic brain disease, such as Alzheimer's Disease, Parkinson's Disease, senile dementia or other nervous or mental disorders of organic origin.

Durable Medical Equipment: Equipment, such as a hospital bed, wheelchair, or crutches, which is customarily used to serve a medical purpose and is designed for repeated use and is intended for use by successive patients.

Elimination Period: The specified number of days for which benefits are not payable. The Elimination Period must be satisfied before the benefit is payable, unless it is waived by a Fast-50 benefit. The Elimination Period, if any, is shown on the Policy Schedule corresponding to the applicable benefit provision.

Hospice Facility: A place which operates and is licensed or certified pursuant to law and provides a formal program of care:

1. for Terminally Ill patients;
2. that is provided on an Inpatient basis; and
3. that is directed by a duly licensed Physician.

A Hospice Facility does not include, nor provide, care for patients that are not Terminally Ill.

Hospice Care: A program that:

1. provides support and care for the Terminally Ill;
2. is prescribed by and under the direction of a Physician; and
3. is provided by an organization that meets applicable federal or state requirements for certification or licensing as a hospice care organization and provider**.**

Hospital: An institution operated pursuant to law that:

1. is accredited by the Joint Commission on Accreditation of Hospitals;
2. is primarily engaged in providing or operating either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians, medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an Inpatient basis for which a charge is made; and
3. provides access to laboratory and imaging services at appropriate in-house facilities or offsite facilities on a prearranged contractual basis.

A hospital does not include convalescent homes, or convalescent, rest, or nursing facilities; facilities primarily affording custodial, educational or rehabilitative care; facilities for the aged, drug addicts or alcoholics; or any military or veteran's or soldier's home or any hospital contracted or operated by any national government or agency thereof for the treatment of members or former members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

Immediate Family: A family member who is:

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

Inpatient: Admitted to a Hospital for a stay of at least 24 hours for Medically Necessary room and board.

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.

Lifetime Maximum: The total number of days for which benefits are payable for the life of this Policy is shown on the Policy Schedule corresponding to the applicable benefit provision.

Loss of Functional Capacity: Is when You require care to assist in meeting at least two (2) ADLs.

Medically Necessary: The treatment, services, or supplies necessary and appropriate for the diagnosis or treatment of sickness or injury based upon generally accepted medical practice. The fact that a Physician may prescribe, authorize, or direct a service does not guarantee that it is Medically Necessary.

Mental or Nervous Disorders: Neuroses, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind. It does not mean a demonstrable organic brain disease, such as Parkinson's Disease, Alzheimer's Disease, or senile dementia or other nervous or mental disorders of organic origin.

Nursing Home/Facility: A separate facility or distinct part of a health care facility that is:

1. licensed and legally operated to provide nursing care (skilled, intermediate, custodial) for sick and injured persons at their own expense;
2. primarily engaged in providing, in addition to room and board accommodations, nursing care (skilled, intermediate, custodial) by or under the supervision of a licensed Physician;
3. provides continuous 24-hour-a-day nursing services by or under the supervision of a registered professional nurse (RN); and
4. maintains a daily medical record of each patient.

Outpatient: Treatments, services and/or supplies rendered on anything other than an Inpatient basis.

Period of Care: The period that begins on the first day of Assisted Living Facility, Hospice Facility, or Nursing Home/Facility ("Facility Care") confinement. It ends at the end of one hundred eighty (180) consecutive days, thereafter, during which:

1. You were able to perform, without Substantial Assistance, all ADLs; and
2. You did not need Substantial Supervision due to Cognitive Impairment; and
3. You have not been confined to an Assisted Living, Hospice or Nursing Home/Facility.

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 licensed by the state in which he or she practices, who is acting within the scope of his or her license. As used herein, Physician includes a duly licensed health care practitioner, acting within the scope of his or her license. A Physician does not include You or Your Immediate Family.

Plan of Care: A written individualized program of care developed and approved in writing by Your Physician. The Plan of Care must include, but not be 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 Anniversary: This is the annual date that coincides with the Policy's original Effective Date.

Policy Year: The year beginning on the Effective Date, then on each following annual anniversary of the Effective Date.

Policy Year Maximum: The total days or dollar amounts for which benefits are payable for the Policy Year. Policy Year Maximum amounts are shown on the Policy Schedule corresponding to the applicable benefit provision.

Pre-Existing Conditions: A condition and related complications for which medical advice or treatment was recommended by or received from a provider of health care services within six (6) months preceding Your Effective Date of coverage.

Prescription Drug: Any medication that:

1. has been fully approved by the FDA for marketing in the United States;
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 received final approval to market it for the particular sickness, injury, or demonstrable organic brain disease, such as Alzheimer's Disease, Parkinson's Disease, senile dementia or other nervous or mental disorders of organic origin. Any approval granted as an interim step in the FDA regulatory process, such as an Investigational Drug, is not sufficient.

Prescription Order: The request 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.

Substantial Assistance: means either standby assistance or hands-on assistance:

1. standby assistance is the physical presence of another person within arm's reach that is necessary to prevent injury to You while You are performing an ADL; and
2. hands-on assistance is the physical assistance of another person without which You would be unable to perform an ADL.

Substantial Supervision: Supervision by another person, which may include cueing by verbal prompting, gestures or other demonstrations, which is necessary to protect You from threats to Your health or safety.

Terminally Ill: A Physician has certified that:

1. there is no reasonable prospect of cure for You; and
2. Your life expectancy is estimated at less than six (6) months.

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

You, Your: The insured named on the Policy Schedule**.**

PREMIUMS AND REINSTATEMENT

Premium Payments: The first premium is due on the Effective Date. Premiums paid after the first premium are renewal premiums.

The date renewal premiums are due is called the due date. Subject to the Grace Period, Your Policy will end if a renewal premium is not paid by the due date. All premiums are payable to Us.

Grace Period: This Policy has a 31-day Grace Period. This means that if a premium (other than the first) is not paid on or before the date it is due, it may be paid during the next 31 days after it is due. During the Grace Period, the Policy will stay in force. If You do not pay the premium by the end of the Grace Period, Your Policy will lapse (end).

Reinstatement: If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us, without requiring an application for reinstatement, shall reinstate the Policy; provided, however that, if We require an application for reinstatement, and issue 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 (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Policy shall cover only loss resulting from injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after that date. In all other respects the Company and You shall have the same rights hereunder as the Company and You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon and attached hereto in connection with the reinstatement.

Refund of Unearned Premium: Upon Our receipt of proof of Your death, We will promptly refund any unearned premium. The unearned premium will be computed pro rata.

Unpaid Premiums: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

BENEFIT PROVISIONS

FACILITY CARE BENEFIT

Eligibility for Facility Care Benefits. Before the per day benefit can be paid under this Policy for short-term care in either an Assisted Living Facility, Nursing Home/Facility, or Hospice Facility ("Facility Care"), Your Physician must certify that You:

1. have Loss of Functional Capacity;
2. have Cognitive Impairment; or
3. are Terminally Ill.

Limitations or Conditions on Eligibility for Facility Care Benefits. You must:

1. be eligible for benefits as described in the Eligibility for Facility Care Benefits provision above;
2. have satisfied Your Elimination Period, if any; and
3. have received care while confined in either an Assisted Living Facility, Nursing Home/Facility, or Hospice Facility, and the care received must be prescribed in Your Plan of Care.

We may periodically review the necessity of care and treatment. 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;
5. Your physical limitations and impairments; and
6. the objectives of Your Physician's Plan of Care.

Subject to the Eligibility for Facility Care Benefits, and Limitations or Conditions on Eligibility for Facility Care Benefits provisions above, Benefit Period, and Facility Care Lifetime Maximum, We will pay the per day benefit amount that is shown on the Policy Schedule for Facility Care.

We will pay only one per day benefit without regard to the amount of Facility Care services You receive in any one day. We will consider Facility Care services as received as of the date of the confinement.

Fast-50 Facility Care Benefit ("Fast-50")

You may elect to receive a Fast-50 Facility Care Benefit in place of the Facility Care Benefit for which You are eligible for under this Policy by notifying Us in writing at Our Administrative Office. If You elect to receive the Fast-50 Facility Care Benefit, We will pay fifty percent (50%) of Your per day Facility Care Benefit amount that is shown on the Policy Schedule.

The Elimination Period for the Facility Care Benefit, if any, is waived if You elect to receive the Fast-50 Facility Care Benefit. If You are eligible for the Facility Care Benefit and elect the Fast-50 Facility Care Benefit, We will pay the Fast-50 Facility Care Benefit amount for each day You meet the coverage requirements. If You switch from the Fast-50 Facility Care Benefit to the Facility Care Benefit, You must still satisfy the Elimination Period, if any.

The Fast-50 Facility Care Benefit will end on the earliest date that one of the following occurs:

1. You are no longer eligible per the Eligibility for Facility Care Benefits provision above;
2. We receive written notice from You at Our Administrative Office that You elect to discontinue receiving the Fast-50 Facility Care Benefit;
3. We receive written notice from You at Our Administrative Office that You wish to switch to another Policy benefit; or
4. You have reached Your Facility Care Lifetime Maximum.

Automatic Restoration of Facility Care Benefit. If Your Period of Care ends, and Your Facility Care benefits have not been paid for the entire Facility Care Benefit Period, We will restore Your Benefit Period, as of the date that Your Period of Care ended, subject to any Elimination Period, if any, and the Lifetime Maximum for Facility Care. Once the Lifetime Maximum for Facility Care has been paid, Facility Care benefits are no longer payable under this Policy.

Bed Reservation Benefit

Subject to the Facility Care Elimination Period, if any, Bed Reservation Policy Year Maximum and Bed Reservation Lifetime Maximum, We will pay the per day Facility Care benefit amount to reserve Your bed in a Nursing Home/Facility or Assisted Living Facility while You are an Inpatient in a Hospital if benefits are payable under this Policy for Nursing Home/Facility or Assisted Living Facility. The Bed Reservation Benefit is not payable unless, after discharge from the Hospital, You immediately return to the Nursing Home/Facility or Assisted Living Facility where You were staying immediately prior to the Inpatient Hospital admission.

PRESCRIPTION ℞ DRUG BENEFIT

Subject to the per prescription and Policy Year Maximum amounts that are shown on the Policy Schedule and Limitations and Exclusions in this Policy, We will pay this benefit for each Prescription Order filled through a 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 Medically Necessary; and
3. Prescription Drugs that are within the quantity, supply, or other limits that are appropriate for a Prescription Drug.

This benefit is not subject to the Pre-Existing Conditions Limitation. This benefit is not subject to Your eligibility for the Facility Care Benefit.

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

1. drugs or medicines obtained from sources outside of the United States or Canada;
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

We will NOT pay benefits for:

1. illness, treatment, or medical condition arising out of:
    a. war or act of war (whether declared or undeclared);
    b. Your participation in a felony, riot, or insurrection; or
    c. Your attempted suicide (while sane or insane), or intentionally self-inflicted injury;
2. confinement due to alcoholism or drug addiction;
3. Durable Medical Equipment;
4. confinement, treatment, or care received outside of the United States except for Prescription Drugs received from Canada;
5. loss that is caused by a Mental or Nervous Disorder; or
6. treatment provided in a government facility (unless otherwise required by law), and services for which no charge is normally made in the absence of insurance.

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.

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 a request in writing to cancel this Policy or on a later date that is requested by You for cancellation.

CLAIM PROVISIONS

Notice of Claim: We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Us at Our Administrative Office.

Claim Forms: When We receive the notice of claim, We will furnish You forms for filing proof of loss. If We do not furnish the forms within fifteen (15) working days after receiving written notice of claim, Your written statement will be accepted if We receive written proof of the event and type and extent of the loss within the time stated below in the proof of loss provision.

Proof of Loss: Written proof of loss must be furnished to Us at Our Administrative Office within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. Proof must be sent as soon as reasonably possible, except in the absence of legal capacity, no later than one (1) year from the time proof is otherwise required. We have the right to request records as may reasonably be necessary to determine if benefits are payable under this Policy.

Time of Payment of Claims: Indemnities payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to Your estate. Any other accrued indemnities

unpaid at Your death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to You.

If any benefit is payable to Your estate, to a minor or to any person not able to give a valid release, We may pay up to $1,000.00 to any relative of Yours by blood or connection by marriage, or any beneficiary that We find equitably entitled to the payment. Any payment We make in good faith will fully discharge Us to the extent of the payment.

Claim Denial: If Your claim is denied, We will make available all information directly relating to such denial within sixty (60) days of Your written request to Our Administrative Office.

Appeal Procedure: If We deny a claim for benefits in whole or in part, You will be notified. The notification will explain the reason(s) for denial. If You disagree with Our denial, You may request a formal review of the claim. The request must be in writing and sent to Us at Our Administrative Office within sixty (60) days after the denial. Such request must include the following information:
1. Your name;
2. Your policy number;
3. other identifying information found on the notice from Us, if any;
4. a concise statement of issues; and
5. any information, documents, or comments that You may want to have considered.

The results of this review will be sent to You within sixty (60) days following Our receipt of Your request.

GENERAL PROVISIONS

Entire Contract; Changes: This Policy, including the endorsements, application, any benefit riders, and any attached documents, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

Time Limit On Certain Defenses: After two years from the date of issue of this Policy, the Policy shall be incontestable, except for nonpayment of premium or fraudulent misstatements made by You in the application for the Policy.

Physical Examinations and Autopsy: We, at Our own expense, shall have the right and opportunity to examine the person of the insured when, and as often as, it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Misstatement of Age: If Your age has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

Legal Action: No action at law or in equity shall be brought to recover on 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 such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Change of Beneficiary: Unless You make an irrevocable designation of 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.

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.

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.

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 may be 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.

Standard Life and Casualty Insurance Company
Administrative Office: 10777 Northwest Freeway Houston, TX 77092
Customer Service: (800) 672-4535

LIMITED BENEFIT INSURANCE POLICY FOR SHORT-TERM FACILITY CARE
GUARANTEED RENEWABLE

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 AL7060TN
SHORT-TERM FACILITY 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, ELIMINATION PERIODS, AND DAILY, POLICY YEAR, AND LIFETIME 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 short-term care Policy is designed to provide limited fixed indemnity benefits for covered short-term care within an eligible facility.

NOTICE: This is not a major medical insurance Policy. The Policy provides limited fixed indemnity benefits for short-term care. Fixed indemnity 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 the provider's statement.

THIS IS NOT A 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

FACILITY CARE BENEFIT

Subject to the Eligibility for Facility Care Benefits, and Limitations or Conditions on Eligibility for Facility Care Benefits, Benefit Period, and Facility Care Lifetime Maximum, We will pay the per day benefit for Facility Care.

We will pay only one per day benefit without regard to the amount of Facility Care services You receive in any one day. We will consider Facility Care services as received as of the date of the confinement.

Eligibility for Facility Care Benefits. Before the per day benefit can be paid under the Policy for short-term care in either an Assisted Living Facility, Nursing Home/Facility, or Hospice Facility ("Facility Care"), Your Physician must certify that You:

1. have Loss of Functional Capacity;
2. have Cognitive Impairment; or
3. are Terminally Ill.

Limitations or Conditions on Eligibility for Facility Care Benefits. You must:

1. be eligible for benefits as described in the Eligibility for Facility Care Benefits provision;
2. have satisfied Your Elimination Period, if any; and
3. have received care while confined in either an Assisted Living Facility, Nursing Home/Facility, or Hospice Facility, and the care received must be prescribed in Your Plan of Care.

Fast-50 Facility Care Benefit ("Fast-50")

You may elect to receive a Fast-50 Facility Care Benefit in place of the Facility Care Benefit for which You are eligible for under the Policy. If You elect to receive the Fast-50 Facility Care Benefit, We will pay fifty percent (50%) of Your per day Facility Care Benefit amount for each day You meet the coverage requirements.

The Elimination Period for the Facility Care Benefit, if any, is waived if You elect to receive the Fast-50 Facility Care Benefit. If You switch from the Fast-50 Facility Care Benefit to the Facility Care Benefit, the Elimination Period, if any, must be satisfied.

The Fast-50 Facility Care Benefit will end on the earliest date that one of the following occurs:

1. You are no longer eligible per the Eligibility for Facility Care Benefits provision;
2. We receive written notice from You that You elect to discontinue receiving the Fast-50 Facility Care Benefit;
3. We receive written notice from You that You wish to switch to another Policy benefit; or
4. You have reached Your Facility Care Lifetime Maximum.

Automatic Restoration of Facility Care Benefit. If Your Period of Care ends, and Your Facility Care benefits have not been paid for the entire Facility Care Benefit Period, We will restore Your Benefit Period, as of the date that Your Period of Care ended, subject to any Elimination Period, if any, and the Lifetime Maximum for Facility Care. Once the Lifetime Maximum for Facility Care has been paid, Facility Care benefits are no longer payable under the Policy.

Bed Reservation Benefit

Subject to the Facility Care Elimination Period, if any, Bed Reservation Policy Year Maximum and Bed Reservation Lifetime Maximum, We will pay the per day Facility Care benefit amount to reserve Your bed in a Nursing Home/Facility or Assisted Living Facility while You are an Inpatient in a Hospital if benefits are payable under the Policy for Nursing Home/Facility or Assisted Living Facility. The Bed Reservation Benefit is not payable unless, after discharge from the Hospital, You immediately return to the Nursing Home/Facility or Assisted Living Facility where You were staying immediately prior to the Inpatient Hospital admission.

PRESCRIPTION ℞ DRUG BENEFIT

Subject to the per prescription and Policy Year Maximum amounts and Limitations and Exclusions in the Policy, We will pay this benefit for each Prescription Order filled through a 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 Medically Necessary; and
3. Prescription Drugs that are within the quantity, supply, or other limits that are appropriate for a Prescription Drug.

This benefit is not subject to the Pre-Existing Conditions Limitation. This benefit is not subject to Your eligibility for the Facility Care Benefit.

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

1. drugs or medicines obtained from sources outside of the United States or Canada;
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: The 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.

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

We will NOT pay benefits for:

1. illness, treatment, or medical condition arising out of:
    a. war or act of war (whether declared or undeclared);
    b. Your participation in a felony, riot, or insurrection; or
    c. Your attempted suicide (while sane or insane), or intentionally self-inflicted injury;
2. confinement due to alcoholism or drug addiction;
3. Durable Medical Equipment;
4. confinement, treatment, or care received outside of the United States except for Prescription Drugs received from Canada;
5. loss that is caused by a Mental or Nervous Disorder; or
6. treatment provided in a government facility (unless otherwise required by law), and services for which no charge is normally made in the absence of insurance.

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

HOME HEALTH CARE BENEFIT RIDER:

Subject to Eligibility for Home Health Care Benefit, and Limitations or Conditions on Eligibility for Home Health Care Benefit, Benefit Period, and Home Health Care Lifetime Maximum, We will pay the per day Benefit amount that is shown on the Policy Schedule for Home Health Care.

We will pay only one per day benefit regardless of the amount of Home Health Care You receive in any one day. We will consider Home Health Care services received as of the date of the Home Health Care.

Eligibility for Home Health Care Benefit. Before the per day benefit can be paid for Home Health Care under the Rider, a Physician must certify that You:

1. have Loss of Functional Capacity;
2. have Cognitive Impairment; or
3. are Terminally Ill.

Limitations or Conditions on Eligibility for Home Health Care Benefit. You must:

1. be eligible for benefits as described in the Eligibility for Home Health Care Benefit provision;
2. have satisfied Your Elimination Period, if any; and
3. have received care while Home, and the Home Health Care received must be prescribed in Your Plan of Care.

Home Health Care does not mean, nor include Home Health Care rendered by Your Immediate Family or friend, unless You elect to receive the Fast-50 Home Care Benefit provided below.

Fast-50 Home Health Care Benefit ("Fast-50")

You may elect to receive a Fast-50 Home Health Care Benefit in place of the Home Health Care Benefit. If You elect to receive the Fast-50 Home Health Care Benefit, We will pay fifty percent (50%) of Your per day Home Health Care Benefit amount.

If You elect to receive the Fast-50 Home Health Care Benefit:

1. the Elimination Period for the Home Health Care Benefit is waived, if any;

2. You can receive medical Home Health Care from an Immediate Family Member or friend who is a Home Health Care Practitioner; and
3. You can receive nonmedical Homemaker Services from an Immediate Family member or friend.

If You switch from the Fast-50 Home Health Care Benefit to the Home Health Care Benefit, You must still satisfy the Elimination Period, if applicable.

The Fast-50 Home Health Care Benefit will end on the earliest date that one of the following occurs:
1. You are no longer eligible per the Eligibility for Home Health Care Benefit provision above;
2. We receive written notice from You that You elect to discontinue receiving the Fast-50 Home Health Care Benefit; or
3. You have reached Your Home Health Care Lifetime Maximum.

Automatic Restoration of Home Health Care Benefit. If Your Period of Home Health Care ends, and Your Home Health Care benefits have not been paid for the entire Home Health Care Benefit Period, We will restore Your Benefit Period, as of the date that Your Period of Home Health Care ended, subject to any Elimination Period, if any, and the Lifetime Maximum for Home Health Care. Once the Lifetime Maximum for Home Health Care has been paid, Home Health Care benefits are no longer payable under the Policy.

HOSPITAL INDEMNITY BENEFIT RIDER:

Inpatient Hospital Confinement Benefit: Subject to the per day, Maximum Period of Confinement, and Lifetime Maximum amounts, We will pay a per day benefit for each day there is a charge for Inpatient room and board during a Confinement Period under the orders of a health care practitioner for care of Sickness or Injury. Room and board may be provided in any appropriate Inpatient setting including in an intensive care setting, such as an Intensive Care Unit (ICU), a Neonatal Intensive Care Unit (NICU), a Coronary Intensive Care Unit (CICU) or a step-down unit. Benefits under that provision are not payable when the confinement is in a rehabilitation unit.

This Rider does not provide benefits for Your loss as a result of:

1. intentionally self-inflicted injury;
2. a contributing cause of Your loss was Your commission of or attempt to commit a felony;
3. war or any act of war, declared or not, or participating in or contracting with the armed forces (including Coast Guard) of any country or international authority;
4. injury received while traveling or operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft including those, which are not motor-driven;
5. suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane;
6. injury resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the injury occurs; or being under the influence of any illegal drugs or narcotic unless administered on the advice and as directed by Your health care provider;
7. injury to the spine, or the cervical, thoracic spinal, dorsal, sacro-iliac, or lumbar regions;
8. repetitive motion injuries, strains, all types of hernia, tendinitis, bursitis and heat exhaustion not related to a specific injury;
9. injury resulting from testing cars/trucks on any racetrack or speedway;
10. injury sustained while taking part in any of the following activities: as a rider in or driving in competitive motor sport, water sport races, stunt show or speed test, or while testing any vehicle on any racecourse or speedway, spelunking (exploring caves), mountaineering, scaling up or down cliffs or mountain walls, practice for or participation in a rodeo, flying in an ultra-light, hang gliding, parachuting, parasailing, parakiting, bungee cord jumping;
11. participating in any sporting event for pay or prize money;
12. injuries incurred and resulting from hazardous occupations such as circus workers, commercial fisherman, crop dusters, farm labors, firefighters, lumberjacks, oil field workers, police, quarry workers, rodeo riders, security guards, underground miners, or window washers;
13. injuries arising out of or in the course of employment and which is payable or covered under any Workers' Compensation or Occupational Disease Act or Law;
14. injuries incurred more than forty (40) miles 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 sixty (60) days; or
15. Hospital Confinement due to giving birth or pregnancy (except for Complications of Pregnancy).

PARAGRAPH 6: RENEWABLITY

Guaranteed Renewable. You have the right to renew this Policy if You pay the correct premium when due or within the Grace Period.

PARAGRAPH 7: PREMIUM

We retain the right to change the premium on the Policy. If We do change the premium, We will do so only if: (1) We change the premiums for all policies of this same form and rate class in Your state of issue; (2) such change is in accordance with the laws and regulations of Your state of issue; and (3) We give You at least 30-days advance written notice prior to any premium change.

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

Policy	$505.08
Home Health Care Benefit Rider	$206.28
Hospital Indemnity Benefit Rider	$127.80
TOTAL:	$ 839.16

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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 BENEFIT RIDER

PLEASE READ THIS RIDER CAREFULLY. This Rider is effective as of the Policy's Effective Date.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first premium. All definitions, provisions, limitations and exclusions, and exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

DEFINITIONS

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.

Home Health Care: Medical or nonmedical services provided to ill, disabled or infirm persons in their Home pursuant to a Plan of Care. Home Health Care includes:

1. Hospice Care;
2. nursing care services under the direction of a registered nurse, including services of a home health aide;
3. physical therapy;
4. speech therapy;
5. occupational therapy;
6. respiratory therapy;
7. enterostomal therapy;
8. medical social services;
9. chemotherapy specialist services;
10. home enteral nutrition therapy; and
11. nonmedical Homemaker Services.

Home Health Care Agency: An agency approved under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.) (Medicare); or an agency certified to provide Home Health Care in this state. The Home Health Care Agency must maintain a complete, written, daily record of Home Health Care services that are provided to You pursuant to a Plan of Care, and the record of Home Health Care shall be made available to Us upon Our written request.

Home Health Care Practitioner: An individual who is qualified to provide Home Health Care. A Home Health Care Practitioner includes the following: a home health aide; a provider of medical or social services; a registered professional nurse (RN); a licensed practical nurse (LPN); a licensed vocational nurse (LVN); a licensed speech therapist or audiologist; a licensed respiratory therapist; a licensed physical therapist; an occupational therapist; a licensed chemotherapy specialist; a certified hospice and palliative nurse (CHPN); or a licensed nutritional therapist. A Home Health Care Practitioner whose specialty is not listed here may be used if included in the Plan of Care. A Home Health Care Practitioner:

1. must be licensed or certified in the state, except for a home health aide, or lawfully recognized as such by the state in which the care is given;
2. cannot be You;
3. shall not reside at Your residence; and
4. must maintain a complete, written, daily record of Home Health Care services provided to You, and the record of Home Health Care shall be made available to Us upon Our written request.

Homemaker Services: include the following services that are incidental to personal care:

1. Home cleaning;
2. laundry;
3. food shopping and errands;
4. meal preparation and cleanup;
5. transportation assistance to and from medical appointments;
6. heavy cleaning that involves thorough cleaning of the Home to remove hazardous debris or dirt; and
7. other Home services determined by Us to be appropriate.

Period of Home Health Care: The Period of Home Health Care begins on the first day You receive Home Health Care. It ends at the end of one hundred eighty (180) consecutive days, thereafter, during which:

1. You were able to perform, without Substantial Assistance, all ADLs; and
2. You did not need Substantial Supervision due to Cognitive Impairment; and
3. You have not been receiving Home Health Care.

BENEFIT PROVISIONS

HOME HEALTH CARE BENEFIT

Eligibility for Home Health Care Benefit. Before the per day benefit can be paid for Home Health Care under this Rider, a Physician must certify that You:

1. have Loss of Functional Capacity;
2. have Cognitive Impairment; or
3. are Terminally Ill.

Limitations or Conditions on Eligibility for Home Health Care Benefit. You must:

1. be eligible for benefits as described in the Eligibility for Home Health Care Benefit provision above;
2. have satisfied Your Elimination Period, if any; and
3. have received care while Home, and the Home Health Care received must be prescribed in Your Plan of Care.

We may periodically review the necessity of care and treatment. 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;
5. Your physical limitations and impairments; and
6. the objectives of Your Physician's Plan of Care.

Subject to Eligibility for Home Health Care Benefit, and Limitations or Conditions on Eligibility for Home Health Care Benefit above, Benefit Period, and Home Health Care Lifetime Maximum, We will pay the per day Benefit amount that is shown on the Policy Schedule for Home Health Care.

We will pay only one per day benefit regardless of the amount of Home Health Care You receive in any one day. We will consider Home Health Care services received as of the date of the Home Health Care.

Home Health Care does not mean, nor include Home Health Care rendered by Your Immediate Family or friend, unless You elect to receive the Fast-50 Home Care Benefit provided below.

Fast-50 Home Health Care Benefit ("Fast-50")

You may elect to receive a Fast-50 Home Health Care Benefit in place of the Home Health Care Benefit by notifying Us in writing at Our Administrative Office. If You elect to receive the Fast-50 Home Health Care Benefit, We will pay fifty percent (50%) of Your per day Home Health Care Benefit amount that is shown on the Policy Schedule.

If You elect to receive the Fast-50 Home Health Care Benefit:

1. the Elimination Period for the Home Health Care Benefit is waived, if any;
2. You can receive medical Home Health Care from an Immediate Family Member or friend who is a Home Health Care Practitioner; and
3. You can receive nonmedical Homemaker Services from an Immediate Family member or friend.

If You switch from the Fast-50 Home Health Care Benefit to the Home Health Care Benefit, You must still satisfy the Elimination Period, if applicable.

The Fast-50 Home Health Care Benefit will end on the earliest date that one of the following occurs:

1. You are no longer eligible per the Eligibility for Home Health Care Benefit provision above;
2. We receive written notice from You at Our Administrative Office that You elect to discontinue receiving the Fast-50 Home Health Care Benefit; or
3. You have reached Your Home Health Care Lifetime Maximum.

Automatic Restoration of Home Health Care Benefit. If Your Period of Home Health Care ends, and Your Home Health Care benefits have not been paid for the entire Home Health Care Benefit Period, We will restore Your Benefit

Period, as of the date that Your Period of Home Health Care ended, subject to any Elimination Period, if any, and the Lifetime Maximum for Home Health Care. Once the Lifetime Maximum for Home Health Care has been paid, Home Health Care benefits are no longer payable under this Policy.

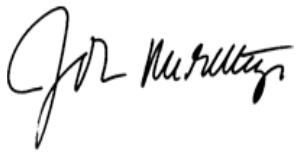
TERMINATION

This Rider terminates when the Policy to which it is attached terminates; or when the Lifetime Maximum benefit amount for this Rider has been paid by Us; or upon Our receipt of Your written request to cancel this Rider or on such later date as may be specified in the notice. In the event You cancel this Rider, 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.

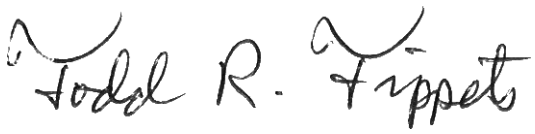
PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium shown on the Policy Schedule includes the additional premium for this Rider. We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We will provide You with at least 30-days advance written notice of any change in the premium.

Other than as stated above, this Rider shall not alter, waive, or extend any other provisions of the Policy to which this Rider is attached.



John McGettigan,
Secretary



Todd R. Tippets,
President

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

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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

HOSPITAL INDEMNITY BENEFIT RIDER

PLEASE READ THIS RIDER CAREFULLY. This Rider is effective as of the Policy's Effective Date.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first premium. All definitions, provisions, limitations and exclusions, and exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

DEFINITIONS

Complications of Pregnancy: Complications of Pregnancy include the following:

1. conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, health care practitioner-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and,
2. non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Confinement Period: A continuous and uninterrupted period of at least 24 hours during which You are admitted to a Hospital to obtain Medically Necessary Inpatient treatment for a Sickness or Injury while under the regular care and attendance of a Physician.

Injury: An accidental bodily injury sustained by the insured which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.

Period of Confinement: Consecutive days of confinement in a Hospital; it shall be deemed to include successive periods of confinement in a Hospital that are due to the same or related cause and are not separated by at least 60 days during which You are not confined in a Hospital.

Sickness: A disease or an illness for which diagnosis or treatment is received or recommended after the Effective Date, and the loss occurs while the Policy is in force; and the Pre-Existing Condition waiting period has been satisfied for such loss if the insured has a Pre-Existing Condition as it is defined in the Policy; and the loss has not been specifically excluded by name or description in this Policy. Sickness includes Complications of Pregnancy, but not the pregnancy itself.

INPATIENT HOSPITAL CONFINEMENT BENEFIT

Inpatient Hospital Confinement Benefit: Subject to the per day, Maximum Period of Confinement, and Lifetime Maximum amounts shown on Your Policy Schedule, We will pay this per day benefit for each day there is a charge for Inpatient room and board during a Confinement Period under the orders of a health care practitioner for care of Sickness or Injury. Room and board may be provided in any appropriate Inpatient setting including in an intensive care setting, such as an Intensive Care Unit (ICU), a Neonatal Intensive Care Unit (NICU), a Coronary Intensive Care Unit (CICU) or a step-down unit. Benefits under this provision are not payable when the confinement is in a rehabilitation unit.

RIDER EXCLUSIONS

This Rider does not provide benefits for Your loss as a result of:

1. intentionally self-inflicted injury;
2. a contributing cause of Your loss was Your commission of or attempt to commit a felony;
3. war or any act of war, declared or not, or participating in or contracting with the armed forces (including Coast Guard) of any country or international authority;

4. injury received while traveling or operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft including those, which are not motor-driven;
5. suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane;
6. injury resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the injury occurs; or being under the influence of any illegal drugs or narcotic unless administered on the advice and as directed by Your health care provider;
7. injury to the spine, or the cervical, thoracic spinal, dorsal, sacro-iliac, or lumbar regions;
8. repetitive motion injuries, strains, all types of hernia, tendinitis, bursitis and heat exhaustion not related to a specific injury;
9. injury resulting from testing cars/trucks on any racetrack or speedway;
10. injury sustained while taking part in any of the following activities: as a rider in or driving in competitive motor sport, water sport races, stunt show or speed test, or while testing any vehicle on any racecourse or speedway, spelunking (exploring caves), mountaineering, scaling up or down cliffs or mountain walls, practice for or participation in a rodeo, flying in an ultra-light, hang gliding, parachuting, parasailing, parakiting, bungee cord jumping;
11. participating in any sporting event for pay or prize money;
12. injuries incurred and resulting from hazardous occupations such as circus workers, commercial fisherman, crop dusters, farm labors, firefighters, lumberjacks, oil field workers, police, quarry workers, rodeo riders, security guards, underground miners, or window washers;
13. injuries arising out of or in the course of employment and which is payable or covered under any Workers' Compensation or Occupational Disease Act or Law;
14. injuries incurred more than forty (40) miles 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 sixty (60) days; or
15. Hospital Confinement due to giving birth or pregnancy (except for Complications of Pregnancy).

TERMINATION

This Rider terminates when the Policy to which it is attached terminates; or when the Lifetime Maximum benefit amount for this Rider has been paid by Us; or upon Our receipt of Your written request to cancel this Rider or on such later date as may be specified in the notice. In the event You cancel this Rider, 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.

PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium shown on the Policy Schedule includes the additional premium for this Rider. We can change the premium for this Rider if We change it for all Riders like Yours in Your state on a class basis. We will provide You with at least 30-days advance written notice of any change in the premium.

Other than as stated above, this Rider shall not alter, waive, or extend any other provisions of the Policy to which this Rider is attached.

John McGettigan,
Secretary

Todd R. Tippets,
President

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

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 77092
Phone: (800) 672-4535

APPLICATION FOR SHORT-TERM CARE INSURANCE

☑ New Application ❑ Reinstatement Policy No._____ Group No. _____

APPLICANT A – PROPOSED INSURED'S INFORMATION

Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
[redacted]	01/30/****	Male

Address (Street, City, State, ZIP Code)
[redacted] ANTIOCH TN 37013

Telephone Numbers (Home, Work, and Cell)	Social Security No.
[redacted]	***** [redacted]

Beneficiary Name	Requested Future Effective Date 02/11/2023
Estate	*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
Self	❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)

Special Requests Section

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.)

Special Requests Section

EXISTING COVERAGE(S)/REPLACEMENT(S)/ELIGIBILITY

	APPLICANT A	APPLICANT B
1. Do you have any similar insurance coverage for which you are applying for currently in force?	○ Yes ◉ No	○ Yes ○ No
a. If "**YES**," provide type of contract or policy number, and the name of company:		
A._____ B._____		
b. If replacement is involved, have you received a replacement form (in states required by law)?	○ Yes ○ No	○ Yes ○ No

SPOUSAL DISCOUNT INFORMATION

To qualify for a spousal discount, you must be married and residing with your spouse. Please indicate the following:

1. Is your spouse applying for coverage? ○ Yes ◉ No

2. Does your spouse have a short-term care policy with Standard Life and Casualty Insurance Company or any of this Company's affiliates? If "**YES,**" provide the following information about your spouse: ○ Yes ◉ No

Spouse's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Social Security No.	Policy No.

APPLICANT A - INSURANCE APPLIED FOR

Short-Term Facility Care Insurance Policy

☒ Maximum Daily Base Benefit Amount $50-400 in $10 increments $ 100.00

Elimination Period
◉0 ○20 ○60 ○90

Benefit Period
○90 ○180 ○270 ◉360

Prescription Drug
◉$300

Home Health Care Benefit Rider

☒ Maximum Daily Base Benefit Amount $50-300 in $10 increments $ 100.00

Elimination Period
◉0 ○20 ○60 ○90

Benefit Period
○90 ○180 ○270 ◉360

Simple Inflation Protection

○Yes ◉No

(If "**Yes**," the simple inflation protection applies to Short-Term Facility Care and Home Health Care, if You choose the Home Health Care Rider)

Hospital Indemnity Benefit Rider

☒ Maximum Daily Base Benefit Amount $50-300 in $10 increments $ 100.00

Benefit Period
○3 ○6 ◉20

In the last 24 months, have you used any tobacco products? ○Yes ◉No

APPLICANT A - TOTAL PREMIUM: $ 69.93

Total Premium does not include Your one-time $25 policy fee

APPLICANT B - INSURANCE APPLIED FOR

Short-Term Facility Care Insurance Policy

☐ Maximum Daily Base Benefit Amount $50-400 in $10 increments $ _____

Elimination Period
○0 ○20 ○60 ○90

Benefit Period
○90 ○180 ○270 ○360

Prescription Drug
○$300

Home Health Care Benefit Rider

☐ Maximum Daily Base Benefit Amount $50-300 in $10 increments $ _____

Elimination Period
○0 ○20 ○60 ○90

Benefit Period
○90 ○180 ○270 ○360

Simple Inflation Protection

○Yes ○No

(If "**Yes**," the simple inflation protection applies to Short-Term Facility Care and Home Health Care, if You choose the Home Health Care Rider)

Hospital Indemnity Benefit Rider

☐ Maximum Daily Base Benefit Amount $50-300 in $10 increments $ _____

Benefit Period
○3 ○6 ○20

In the last 24 months, have you used any tobacco products? ○Yes ○No

APPLICANT B - TOTAL PREMIUM: $ _____

Total Premium does not include Your one-time $25 policy fee

HEALTH QUESTIONS – PART I (If any answer to questions 1-5 below is "YES", you are not eligible for coverage)	APPLICANT A	APPLICANT B
1. Have you been treated or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or tested positive for human immunodeficiency virus (HIV) infection?	○ Yes ◉ No	○ Yes ○ No
2. Is any applicant currently eligible for Medicaid or on early Medicare due to disability (prior to age 65) or disabled?	○ Yes ◉ No	○ Yes ○ No
3. Are you currently:		
a. Receiving assistance or supervision to perform activities of daily living such as bathing, dressing, eating, toileting, getting in or out of bed, or have an inability to control bowel or bladder function?	○ Yes ◉ No	○ Yes ○ No
b. Receiving home health care services, or confined in a rehabilitation facility, nursing facility, or assisted living facility?	○ Yes ◉ No	○ Yes ○ No
c. Being treated, or have you been diagnosed, by a medical professional for Alzheimer's Disease, dementia, Parkinson's Disease (stage 4 or 5), Huntington's Chorea, or cognitive impairment?	○ Yes ◉ No	○ Yes ○ No
d. Receiving treatment by a medical professional for diabetic complications resulting in neuropathy, proliferative retinopathy, kidney disease or failure, renal insufficiency, or kidney dialysis?	○ Yes ◉ No	○ Yes ○ No
e. Receiving treatment by a medical professional for insulin dependent diabetes in conjunction with heart failure?	○ Yes ◉ No	○ Yes ○ No
4. Within the past 12 months, have you been advised to have tests, treatment, or surgery that has not yet been performed or have pending test results?	○ Yes ◉ No	○ Yes ○ No
5. Within the last 24 months, have you been diagnosed with, received treatment for, or been prescribed medication for any of the following conditions by a medical professional: Cancer (other than skin cancer in situ), leukemia, lymphoma, malignant melanoma, or cancer that has spread from its original site?	○ Yes ◉ No	○ Yes ○ No

HEALTH QUESTIONS – PART II (If any answer to question 1 below is "YES", any simple inflation benefit is not available, and the applicant will be limited to a maximum of $100 of daily benefit on the base Policy, Home Health Care Rider, and Hospital Indemnity Rider).	APPLICANT A	APPLICANT B
1. Within the past 24 months, have you been diagnosed with, received treatment for, or been prescribed medication for any of the following conditions by a medical professional:		
a. Stroke, transient ischemic attack (TIA), congestive heart failure (CHF), or organ transplant (other than corneal transplant)?	○ Yes ◉ No	○ Yes ○ No
b. Diabetes that requires more than 50 units of insulin daily or more than 2 oral and 1 injectable medications?	◉ Yes ○ No	○ Yes ○ No
c. Systemic lupus, multiple sclerosis, muscular dystrophy, cerebral palsy, motor neuron disease, Lou Gehrig's disease (ALS), psychotic disorders, alcohol, or substance abuse or any other neurological or neuromuscular disease?	○ Yes ◉ No	○ Yes ○ No
d. Amputation caused by disease?	○ Yes ◉ No	○ Yes ○ No
e. Chronic obstructive lung or pulmonary disease (COPD), chronic bronchitis or emphysema, respiratory disease requiring the use of oxygen, or chronic liver disease?	○ Yes ◉ No	○ Yes ○ No

PRESCRIPTION DRUG QUESTIONS – PART III (You must answer this question)	APPLICANT A	APPLICANT B
Has any applicant taken or been prescribed drugs by a medical professional in the last 24 months? f "**Yes**" complete the chart below.	◉ Yes ○ No	○ Yes ○ No

APPLICANT A	APPLICANT B	Prescribed Medication	Date Prescribed	Frequency and Dosage	Diagnosis/onset Date	
☐	☐	glimepiride	01/01/2017	4mg1xday	Diabetes	01/20/2016
☐	☐	jardiance	01/01/2021	10mg 1 x day	diabetes	01/20/2016
☐	☐	pravastatin	03/21/2011	40 mg 1 x day	cholsetrol	03/01/2017
☐	☐	benazepine	04/23/2016	20/125mg 1 x day	high blood pressure	04/01/2016
☐	☐	amlodipone	04/23/2016	10 mg 1 x day	high blood pressure	04/01/2016
☐	☐	trulicity	02/03/2019	3 mg 1 x day	diabetes	01/20/2016
☐	☐	ezetimibe	02/04/2021	10mg 1 x day	cholostrol	03/01/2017
☐	☐					

APPLICANT A	APPLICANT B	Prescribed Medication	Date Prescribed	Frequency and Dosage	Diagnosis/onset Date
☐	☐				
☐	☐				
☐	☐				
☐	☐				
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☐	☐				
☐	☐				
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☐	☐				

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, Texas 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: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed at ANTIOCH Tennessee, on 02/10/2023 X [redacted]
(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.

X [redacted]	[redacted]	01JU[redacted]	_____ %	_____
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.

Splits 0.00% 0.00% 0.00%

Splits 0.00% 0.00% 0.00%

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: [redacted] Date: 02/10/2023

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.

PAYMENT OPTIONS AUTHORIZATION

❑ **Payroll Deduction (Listbill)**

Assigned list bill number, if known: _____

I hereby authorize my employer to deduct from my salary and pay to Standard Life and Casualty Insurance Company the premium.

☒ **Automatic Bank Draft (Electronic Funds Transfer)**

☒ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

Type of Account: ☒ Checking ❑ Savings

Desired withdrawal date (Between the 1st and the 28th) 15

Bank name: [redacted] BANK

City: ANTIOCH State: TN

Routing number (9 Digits): 064000017

Account number: [redacted]

↑ Routing Number ↑ Account Number

Authorization for Electronic Funds Transfer (EFT)

I (we) hereby authorize Standard Life and Casualty Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder's Signature [redacted] Date 02/10/2023

❑ **Direct Billing** ❑ Quarterly ❑ Semi-Annually ❑ Annually

If your billing address is different than your home address, please enter it below:

Billing Address: _____

(Street) (City) (State) (Zip)

Name of person paying, if different: _____

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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