AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

GROUP CRITICAL ILLNESS INSURANCE POLICY
NON-PARTICIPATING

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

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

1. all policy provisions and any amendments and/or attachments issued; and
2. the policyholder's signed application.

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

Signed for American Heritage Life Insurance Company at its Home Office in Jacksonville, Florida on the policy effective date.

Secretary

President

This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract or major medical expense insurance.

THIS IS A SPECIFIED ILLNESS POLICY WHICH ONLY PROVIDES STATED BENEFITS FOR SPECIFIED ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.

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GROUP CRITICAL ILLNESS POLICY SPECIFICATIONS

POLICYHOLDER:	XYZ COMPANY, INC. XYZ LOCAL UNION NO. XXX
POLICY NUMBER:	GROUP106
POLICY EFFECTIVE DATE:	April 1, 2006
POLICY ANNIVERSARY DATE:	April 1, 2007 and the first day of April each calendar year thereafter.
GOVERNING JURISDICTION:	the state of California and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): All full-time or part-time active employees or members age 18 or older who are working at least 17 hours per week, excluding those who are insured under any individual critical illness policy issued by American Heritage Life Insurance Company.

ELIGIBILITY WAITING PERIOD: Three Months

BASIC BENEFIT AMOUNT:
$50,000 for Insured
$25,000 for Insured Spouse or Domestic Partner
$25,000 for Insured Child(ren)

GUARANTEED ISSUE LIMIT: $15,000

ADDITIONAL BENEFITS:
Wellness Benefit –$100 per test per insured
Mammography Benefit – $100

OPTIONAL BENEFITS:
Critical Illness Cancer Benefit – Same amount as Basic Benefit
Recurrence Benefit

INITIAL RATE:
Monthly rate of $XX.XX per insured for Individual Coverage; or
$XX.XX per insured for Individual and Spouse or Domestic Partner coverage; or
$XX.XX per insured for Individual and Children coverage; or
$XX.XX per insured for Family Coverage

RATE GUARANTEE DATE: 04/01/2007

PREMIUM DUE: 04/01/2006 and the first day of each calendar month thereafter.
The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

COST OF COVERAGE:
The policyholder pays the cost of the insured's coverage.
The insured pays the cost of the dependent's coverage.
The insured and the policyholder share the cost of coverage.
The insured pays the cost of coverage.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES:

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

Name	Location (City and State)
None	

POLICYHOLDER PROVISIONS

RATE GUARANTEE

A change in premium rate will not take effect before the Rate Guarantee Date shown on page 3 except for reasons which affect the risk assumed, including those reasons shown below:

1. a change occurs in this plan design; or
2. a division, subsidiary, or affiliated company is added or deleted; or
3. the number of insureds changes by 25% or more; or
4. a new law or a change in any existing law is enacted which applies to this policy; or
5. less than 50% of those eligible for coverage are participating.

We will notify the policyholder, in writing, at least 30 days before a premium rate is changed. We will also notify the producer and administrator, if any, in writing, at least 45 days prior to any rate change. Such change may take effect on an earlier date when both we and the policyholder agree in writing.

PREMIUM INCREASES OR DECREASES

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

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

INFORMATION REQUIRED FROM THE POLICYHOLDER

The policyholder must provide us with the following on a regular basis:

1. information about employees or members:
   a. who are eligible to become insured; and
   b. whose coverage changes; and/or
   c. whose coverage ends; and
2. any information that may be required to manage a claim; and
3. any other information that may be reasonably required.

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

CANCELING POLICY

This policy can be canceled:

1. by us; or
2. by the policyholder.

We may cancel or offer to modify this policy, with at least 30 days written notice to the policyholder and at least 45 days written notice to the producer or administrator, if any, if:

1. less than 15% of those eligible for coverage are participating; or
2. this policy has been in effect more than 12 months; or
3. the policyholder does not promptly provide us with information that is reasonably required; or
4. the policyholder fails to perform any of its obligations that relate to this policy; or
5. fewer than 5 employees or members are insured; or
6. the policyholder fails to pay any premium within the 31 day grace period.

If this policy is canceled or modified and there are non-employee certificate holders or certificate holders of more than one employer covered, written notice will also be mailed to each affected certificate holder or affected employer, at least 30 days prior to the effective date of the action.

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

The policyholder may cancel this policy by written notice delivered to us at least 31 days prior to the cancellation date. When both the policyholder and we agree, this policy can be canceled on an earlier date. If canceled, coverage will end at 12:00 midnight on the last day of coverage.

If the policy is canceled, the cancellation will not affect a payable claim incurred prior to cancellation.

GENERAL PROVISIONS

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. the employee's or member's legal spouse or domestic partner; and
2. unmarried children of the employee or member including adopted children from the moment of placement in the residence, stepchildren, children of a domestic partner, or legal ward who are under 22 years of age, or under 26 years of age and full-time students at an educational institution of higher learning beyond high school. The employee's or member's children must be dependent on the employee or member for support or reside with the employee or member over 50% of the time in a regular parent-child relationship and be named on the enrollment or evidence of insurability form.

After the effective date, any person (except newborns) who becomes an eligible dependent can be added to the policy if we are notified within 31 days after they become eligible.

If the insured has Individual Coverage, then marries or files a Declaration of Domestic Partnership and desires coverage for his or her spouse or domestic partner, we must be notified within 31 days of the marriage or declaration of domestic partnership. We will change the coverage to Individual and Spouse or Domestic Partner Coverage and provide notification of the additional premium due. If we are not notified within 31 days of the marriage or declaration of domestic partnership, then evidence of insurability will be required for the spouse or domestic partner.

A child born to the insured or spouse or domestic partner, while Individual and Children Coverage or Family Coverage is in force, will be eligible for coverage. This coverage begins at the moment of birth of such child and benefits will be the same as provided for any other person insured under the policy. No additional premium will be required for newborns added if Individual and Children Coverage or Family Coverage is in force at the time the newborn is added.

An adopted child or child pending adoption will be covered as follows, as long as Individual and Children Coverage or Family Coverage is in force:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by the insured has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by the insured within 31 days after the date of birth and the insured has temporary custody, coverage is provided from the moment of birth.
3. For children other than newborns, if adoption proceedings have been completed, and a decree of adoption was entered within 1 year from the institution of the proceedings, coverage will begin upon temporary custody for 1 year, unless extended by the order of the court by reasons of the special needs of the child.

Coverage must be provided as long as the insured has custody of the child pursuant to decree of the court and required premiums are paid.

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

1. The employee or member may apply for coverage during:
   a. his or her initial enrollment period; or
   b. any other time, subject to evidence of insurability.
2. The insured may increase coverage at any time, subject to evidence of insurability.
3. The insured may discontinue coverage at any time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of insurability is required at the time of enrollment.

Evidence of insurability is also required if:

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

Evidence of insurability is required if:

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

EFFECTIVE DATE OF COVERAGE

Coverage for each eligible employee or member is effective at 12:01 a.m. on the effective date shown on the certificate of insurance issued to that person.

For any change in an insured's coverage that is subject to evidence of insurability, the change in coverage is effective on the date we approve such change.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change.

WHEN AN EMPLOYEE IS ABSENT FROM WORK OR A MEMBER IS NOT ENGAGED IN ACTIVE EMPLOYMENT ON THE EFFECTIVE DATE OF COVERAGE

If an employee or member is absent from work due to disability, injury, sickness, temporary layoff or leave of absence, coverage for that person begins on the date they meet the definition of Active Employment. This applies to such person's initial coverage, as well as any increase or addition to coverage that occurs after such person's initial coverage is effective.

CERTIFICATES OF INSURANCE

We will issue certificates of insurance to each insured. The certificate will provide a description of the insurance provided by this policy and will state:

1. the benefits provided; and
2. to whom benefits are payable; and
3. the exclusions, limitations and requirements that apply to coverage under the policy.

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

TERMINATION OF COVERAGE

The insured's coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day such insured is in active employment or membership, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or
4. the date such insured is no longer in an eligible class; or
5. the date such insured's class is no longer eligible; or
6. the date each insured has received the maximum total percentage of the basic benefit amount for each critical illness category, including the Optional Recurrence Benefit, if applicable.

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

If the insured has Individual and Spouse or Domestic Partner Coverage or Family Coverage, the spouse or domestic partner's coverage ends upon valid decree of divorce, termination of domestic partnership or death of the insured.

Coverage for a dependent child ends on the certificate anniversary next following the date the child is no longer eligible. This is the earlier of when the child: (a) marries or files a Declaration of Domestic Partnership; or (b) reaches age 22 (26 if a full-time student attending an educational institution of higher learning beyond high school); or (c) otherwise does not meet the requirements of an eligible dependent. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon the insured for support and maintenance.

The child's coverage continues as long as the insured's coverage remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to an insured, such premium will be refunded, coverage will terminate and claims will not be paid. There may be no refund due if the insured has Individual and Children Coverage or Family Coverage and there are other eligible dependents insured under the policy.

AGENCY

For purposes of the policy, the policyholder acts on its own behalf or as the employee's and member's agent. Under no circumstances will the policyholder be deemed our agent.

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

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

If the insured's coverage ends while on a family and medical leave of absence, his or her coverage will be reinstated when he or she returns to active status.

We will not:

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

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the application and other written statements of the policyholder; and
4. any individual applications, enrollment forms, evidences of insurability or other written statements of insureds.

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

INCONTESTABILITY

After 2 years from the effective date of this policy, no misstatement of the policyholder, made in any applications, can be used to void the policy. After 2 years from the effective date of coverage, no misstatement of an insured, made in writing, can be used to void coverage or deny a claim.

DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

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

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

LEGAL ACTION

No legal action may be brought to obtain benefits under the policy:

1. for at least 60 days after proof of loss has been furnished; or
2. after the expiration of 3 years from the time written proof of loss is required to have been furnished.

CLERICAL ERROR

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

EFFECT OF PRIOR COVERAGE ON LOSSES FOR PRE-EXISTING CONDITIONS

We may pay benefits if an insured's claim results from a pre-existing condition if the insured was:

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior group policy when it terminated.

The prior group policy's coverage must be substantially similar to this plan and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits the insured must satisfy the pre-existing condition provision under:

1. the American Heritage Life plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If item 1 or 2 above is not satisfied, we will not pay any benefits resulting from a pre-existing condition.

If item 1 is satisfied, we will determine our payment according to our policy provisions.

CONTINUATION OF INSURANCE (COBRA)

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

This section provides for continuation as mandated by federal law for all benefits. It applies if a person's insurance would otherwise end due to one of the following events, called a qualifying event.

1. Termination of employment (other than by reason of gross misconduct), or of an insured's eligibility due to reduction in his or her hours. Insurance may be continued for any insured.
2. The death of an insured. Insurance may be continued for any insured.
3. Divorce, termination of domestic partnership or legal separation. Insurance may be continued for any insured whose insurance would otherwise end.
4. The insured becoming eligible for Medicare. Insurance may be continued for any insured's dependents who are not entitled to Medicare.
5. A child ceasing to be an eligible dependent as defined in the policy. Insurance may be continued for that child.
6. The policyholder files a Chapter 11 Bankruptcy petition. Insurance may be continued for any insured retiree and his or her covered dependents. But this only applies if the insurance ends or is substantially reduced within 1 year before or after the filing for bankruptcy.

To choose this continuation of critical illness insurance, a person must be insured under the policy on the day before the qualifying event. In the case of bankruptcy, the person must also be: (a) an employee or member who retired on or before the date insurance ends or is substantially reduced; or (b) a dependent of the retiree on the day before the bankruptcy.

A person will not be denied continuation solely because he or she is covered under another group critical illness plan or eligible for Medicare on the date the qualifying event occurs.

COVERAGE CONTINUED

The insurance being continued is subject to all terms and provisions of this policy that do not conflict with this section. The insurance will be the same as that provided under the policy for other persons in the same insurance class in which such person would have been if the qualifying event had not occurred. The continued insurance will be subject to any changes to this policy affecting the benefits of such class following the qualifying event.

NOTIFICATION AND PAYMENT REQUIREMENTS

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

The policyholder has the responsibility of notifying the plan administrator of: (a) an insured's death, termination of employment, or reduction in hours; or (b) the policyholder's bankruptcy. This notice must be made within 30 days of the qualifying event.

The plan administrator will notify the qualifying person of the right to continue within 14 days of the notice described above. The person will then have 60 days to elect to continue his or her insurance. Failure to elect to continue insurance within 60 days after a person is notified by the plan administrator will result in loss of the right to continue such insurance.

The qualifying person will be required to pay a premium for the continued insurance to the policyholder. He or she will have 45 days from the date of election to pay the initial premium due. All further premiums will be due on a monthly basis with a 31 day grace period.

CONTINUATION OF INSURANCE (COBRA) – (Continued)

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES OR MEMBERS)

TERMINATION

Insurance being continued will terminate on the first of the following dates that apply:

1. The date the policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverage has been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date the person becomes covered under any other group critical illness policy, whether as an insured or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date the person becomes entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees or members of policyholders under Chapter 11 Bankruptcy and his or her dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
   (a) If a person is totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, the insured must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
      (1) within 60 days of the Social Security determination of total disability; and
      (2) within the initial 18 months of continuation coverage.
   (b) If an insured has a qualifying event (termination or reduction in hours worked) and he or she had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse or domestic partner and/or children) will be entitled to a period of continuation that is the greater of:
      (1) 36 months from the date the insured first became entitled to Medicare; or
      (2) 18 months from the insured's termination or reduction in hours.
   (c) For a qualifying event involving retired employees or members of policyholders under Chapter 11 Bankruptcy and his or her dependents, the maximum period of continuation coverage is:
      (1) the lifetime of the retiree; or
      (2) the lifetime of the surviving spouse or domestic partner of a retiree who dies before the bankruptcy; or
      (3) 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.

PORTABILITY PRIVILEGE

We will provide critical illness insurance portability coverage, subject to these provisions.

Such coverage will not be available for an insured, unless:

1. coverage under the policy terminates under the General Provision entitled “Termination of Coverage”;
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made on a form we furnish or approve for that purpose.

No portability coverage will be provided for any person, if his or her critical illness insurance under the policy terminated due to his or her failure to make required premium payments.

COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy for critical illness when the insurance terminated. Portability coverage may include any eligible family members who were covered under the policy. Any change made to the policy after a person is insured under the portability privilege will not apply to that insured unless it is required by law.

Portability coverage will be effective on the day after critical illness insurance under the policy terminates.

PREMIUMS

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rates are based on the table of rates in effect on any premium due date. We have the right to change the rate table on any premium due date. Written notice will be given at least 31 days before the change is to take effect.

GRACE PERIOD

The grace period, as defined in the policy, will apply to each certificate holder of portability coverage as if such insured is the policyholder.

TERMINATION OF INSURANCE

Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. The date the person again becomes eligible for critical illness insurance under the policy.
2. The last day for which premiums have been paid, if the insured fails to pay premiums when due, subject to the grace period.
3. With respect to insurance for family members:
   a. the date the insured’s insurance terminates; or
   b. the date the family member ceases to be an eligible family member under the policy.

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

TERMINATION OF THE POLICY

If the policy terminates, insureds and family members will be eligible to exercise the portability privilege on the termination date. Portability coverage may continue beyond the termination date, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.

EXCLUSIONS AND LIMITATIONS

This policy does not pay benefits for an illness due to or resulting from (directly or indirectly):

1. any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or
2. intentionally self-inflicted injuries; or
3. injury incurred while engaging in an illegal occupation or committing or attempting to commit a felony; or
4. attempted suicide, while sane or insane; or
5. any injury sustained or contracted in consequence of the insured being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician; or
6. participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
7. alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

PRE-EXISTING CONDITION LIMITATION

We do not pay any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became insured.

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BENEFIT INFORMATION

SPECIFIED CRITICAL ILLNESS BENEFIT

We pay this benefit if the insured is diagnosed with one of the illnesses shown below if:

1. the date of diagnosis is after the effective date of coverage; and
2. the date of diagnosis is while insured; and
3. the illness is not excluded by name or specific description.

The illnesses covered under this policy are shown in the following chart. The amount payable for each illness is the percentage shown below for each illness multiplied by the basic benefit amount shown on page 3. The maximum total percentage of the basic benefit amount payable per category of illnesses is shown in the last column of the chart below.

Category	Specified Critical Illness	Percentage of the Basic Benefit Amount Shown on Page 3	Maximum Total Percentage of Basic Benefit Amount for Category
1	Heart Attack	100%	100%
1	Stroke	100%	
1	Heart Transplant	100%	
1	Coronary Artery By-Pass Surgery	25%	
2	Major Organ Transplant (excluding heart transplant)	100%	100%
2	End Stage Renal Failure	100%	
2	Paralysis (not as a result of stroke)	100%	
2	Alzheimer's Disease	25%	

The insured's coverage remains in force until 100% of the basic benefit amount shown on page 3 has been paid within category 1 or category 2, individually. Once that occurs, no additional benefits for any illness associated with that category are payable for that insured.

If the insured receives a percentage of the basic benefit amount for one illness within a category, and then becomes eligible for benefits for another illness within the same category, the percentage of the basic benefit amount the insured will receive for the subsequent illness is the lesser of:

1. the percentage of the basic benefit amount shown in the table above for that illness; or
2. 100% minus the percentage of basic benefit amount the insured received for the previous illness(es).

This benefit provides coverage only for the illnesses shown in the chart shown above. It does not cover any other disease, sickness or incapacity, unless specifically stated.

The insured can only receive benefits for an illness shown in the chart above one time, unless the Optional Recurrence Benefit is included.

Claims for benefits under this policy not satisfying all the criteria for diagnosis are subject to review by an independent physician consultant.

All covered illnesses must be diagnosed by a physician. Emergency situations that occur while the insured is outside the United States will be reviewed and considered for approval by a United States physician on foreign soil or when the insured returns to the United States.

As used in this section, date of diagnosis means the date the following diagnoses are made by either symptoms or the study of test results, including clinical diagnosis when consistent with professional medical standards:

1. **For Heart Attack:** The date of death (infarction) of a portion of the heart muscle.
2. **For Stroke:** The date a stroke occurred based on documented neurological deficits and neuroimaging studies.
3. **For End-Stage Renal Failure:** The date that the insured begins renal dialysis.
4. **For Major Organ Transplantation or Coronary Artery By-Pass Surgery:** The date the actual surgery occurs for covered transplants or by-pass surgery.
5. **For Paralysis:** The date the diagnosis is established by the physician based on clinical and/or laboratory findings as supported by the insured's medical records.
6. **For Alzheimer's Disease:** The date the diagnosis is established by the psychiatrist or neurologist based on clinical and/or diagnostic findings as supported by the insured's medical records.

ADDITIONAL BENEFITS

WELLNESS BENEFIT

We pay the benefit amount stated on page 3 when the insured has a preventive test performed while not hospital confined.

This benefit is limited to 1 test per calendar year, per person. The benefit amount shown on page 3 is for each calendar year.

Eligible tests are as follows:

1. Bone Marrow Testing; and
2. CA15-3 (cancer antigen 15-3-blood test for breast cancer); and
3. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
4. CEA (carcinoembryonic antigen – blood test for colon cancer); and
5. Chest X-ray; and
6. Colonoscopy; and
7. Flexible sigmoidoscopy; and
8. Hemocult stool analysis; and
9. Pap Smear, including ThinPrep Pap Test; and
10. PSA (prostate specific antigen – blood test for prostate cancer); and
11. Serum Protein Electrophoresis (test for myeloma); and
12. Biopsy for skin cancer; and
13. Stress test on bike or treadmill; and
14. Electrocardiogram (EKG); and
15. Carotid Doppler; and
16. Echocardiogram; and
17. Lipid panel (total cholesterol count); and
18. Blood test for triglycerides.

DEFINITION

As used in this section:

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

MAMMOGRAPHY BENEFIT

We pay the actual charges up to the benefit amount stated on page 3 for an insured as follows:

1. a baseline mammogram for women age 35 to 39, inclusive; and
2. a mammogram for women age 40 to 49, inclusive, every two years or more frequently based upon the women's physician's recommendation; and
3. a mammogram every year for women age 50 and older.

OPTIONAL BENEFIT

CRITICAL ILLNESS CANCER BENEFIT

We pay this benefit if the insured is diagnosed with a new form or type of cancer that has spread to surrounding tissues or cancer which is contained and has not spread to surrounding tissue, subject to all of the following:

1. clear and definitive diagnosis by either a pathological or clinical method; and
2. the date of diagnosis is after the effective date of coverage; and
3. the date of diagnosis is while this optional benefit is in force; and
4. the illness is not excluded by name or specific description in this policy.

The illnesses covered by this benefit are shown in the following chart. The amount payable for each illness is the percentage shown below for each illness multiplied by the basic benefit amount shown on page 3. The maximum total percentage of the basic benefit amount payable for category 3 of illnesses is shown in the last column of the chart below.

Category	Specified Critical Illness	Percentage of the Basic Benefit Amount Shown on Page 3	Maximum Total Percentage of Basic Benefit Amount for Category
3	Invasive Cancer	100%	100%
3	Carcinoma in Situ	25%	

The insured's coverage remains in force until 100% of the basic benefit amount shown on page 3 has been paid within category 3. Once that occurs, no additional benefits for any illness associated with category 3 are payable for that insured.

If the insured receives a percentage of the basic benefit amount for one illness within category 3, and then becomes eligible for benefits for another illness within the same category, the percentage of the basic benefit amount the insured receives for the subsequent illness is the lesser of:

1. the percentage of the basic benefit amount shown in the table above for that illness; or
2. 100% minus the percentage of basic benefit amount the insured received for the previous illness(es).

This benefit provides coverage only for the illnesses shown in the chart shown above. It does not cover any other disease, sickness or incapacity.

The insured can only receive benefits one time for an illness shown in the chart above once.

Claims for benefits under this optional benefit not satisfying all the criteria for diagnosis are subject to review by an independent physician consultant.

All covered illnesses must be diagnosed by a physician. Emergency situations that occur while the insured is outside the United States will be reviewed and considered for approval by a United States physician on foreign soil or when the insured returns to the United States.

DEFINITIONS

As used in this section, the terms listed below have the following meanings.

Carcinoma in Situ. Means a diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having spread to neighboring tissue. Carcinoma in Situ does cover:

1. early prostate cancer diagnosed as stage A or equivalent staging; and
2. melanoma which has not spread to adjacent tissue.

Conditions not covered:

1. other skin malignancies; or
2. pre-malignant lesions (such as intraepithelial neoplasia); or
3. benign tumors or polyps.

All carcinomas must be identified by a pathological or clinical finding.

CRITICAL ILLNESS CANCER BENEFIT (Continued)

Clinical Diagnosis. Means a clinical identification of cancer based on history, laboratory study and symptoms. We will pay benefits for a clinical diagnosis if:

1. a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening; and
2. there is medical evidence to support the diagnosis; and
3. a physician is treating the insured for cancer.

Date of Diagnosis. Means the earliest of the date of: tentative diagnosis, clinical diagnosis or the day the tissue specimen, culture and/or titer(s) are taken, upon which the positive or tentative diagnosis of cancer is made.

Invasive Cancer. Means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes Leukemia and Lymphoma.

The following are not considered invasive cancer for purposes of this benefit: cancer that has not spread to adjacent tissue; tumors in the presence of any human immuno-deficiency virus; skin cancer other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic; and early prostate (stage A) cancer.

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

Tentative Diagnosis. A tentative diagnosis is established based upon dated medical records which indicate a diagnosis of a probable or possible cancer or specified disease.

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OPTIONAL BENEFIT(S)

RECURRENCE BENEFIT

We will pay this benefit if any insured is diagnosed more than once with the same specified critical illness listed in category 1 or 2 for which a benefit was previously paid if:

1. there is more than 18 months between each diagnosis; and
2. the insured did not receive treatment during that 18 month period. For purposes of the preceding sentence, treatment does not include medications and follow-up visits to the insured's physician; and
3. the subsequent date of diagnosis is while coverage is in force; and
4. the specified critical illness is not excluded by name or specific description in this policy.

We will pay an amount equal to 25% of the specified critical illness basic benefit amount previously paid for that specified critical illness. We will pay no more than one recurrence benefit per previously paid specified critical illness under category 1 and 2.

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CLAIM INFORMATION

NOTICE OF CLAIM

We encourage the insured to notify us of a claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any illness covered by this policy, or as soon as reasonably possible. Notice given to us by, or on behalf of, the insured or the beneficiary at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6687, or to any authorized agent of ours, with the insured's name and certificate number, is notice to us.

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

FILING A CLAIM

The insured must complete his or her own sections of the claim form and then give it to the attending physician. The physician should complete his or her section of the form and send it directly to us.

PROOF OF CLAIM

Written proof must be given to us within 90 days of each illness. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless the insured is legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any insured examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of incontestability, where it is not forbidden by law.

PAYMENT OF CLAIMS

After receiving written proof of claim, we will pay all benefits then due under this policy and will make payment to the insured. Any amounts unpaid at the insured's death may, at our option, be paid either to the named beneficiary or to the insured's estate.

If benefits are payable to the insured's estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000, to someone related to the insured or beneficiary by blood, marriage or domestic partnership that we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

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

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

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. the right to ask for a review of the claim; and
4. the right to submit any additional information that might allow us to change our decision.

The insured may, upon written request, have any reports that are not confidential. For a fee, we will make copies of those reports.

APPEALS PROCEDURE

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

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GLOSSARY

Active Employment. Means that the employee or member is working for an employer for earnings that are paid regularly and is performing the material and substantial duties of his or her regular occupation. The employee or member must be working at least the minimum number of hours as described under Eligible Class(es). The employee or member will be deemed to be in active employment on a day which is not one of the employer's scheduled work days only if actively employed on the preceding scheduled work day.

The employee's or member's work site must be:

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

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

Alzheimer's Disease. Means a clinically established diagnosis of the disease by a psychiatrist or neurologist, resulting in the inability to perform, independently, 3 or more of the following activities of daily living:

1. bathing; or
2. dressing; or
3. toileting; or
4. eating; or
5. taking medication.

Coronary Artery By-Pass Surgery. Means the undergoing of a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist registered in the United States.

Angiographic evidence to support the necessity for this surgery will be required.

The following procedures are not considered coronary artery by-pass surgery: balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

Domestic Partner. Means the insured's same-sex or opposite-sex partner who is eligible for coverage providing the requirements listed below have been met:

Both must:

1. file a Declaration of Domestic Partnership with the Secretary of State; and
2. have a common residence; and
3. not be legally married to, or the legal domestic partner of, someone else that has not been terminated, dissolved, or adjudged a nullity; and
4. not be related by blood in a way that would prohibit them from being married to each other in this state; and
5. be at least 18 years of age; and
6. be capable of consenting to the domestic partnership; and
7. be either members of the same sex or one or both of them meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Not withstanding any other provision listed in this definition, opposite-sex persons may not constitute a domestic partnership unless one or both of the persons are over the age of 62.

"Common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

Eligibility Waiting Period. Means the continuous period of time that the employee or member must be in active employment in an eligible class before he or she is eligible for coverage.

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

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

End Stage Renal Failure. Means failure of both kidneys to perform their essential functions, with the insured undergoing peritoneal dialysis or hemodialysis or a renal transplant.

Evidence of Insurability. Means a statement of the employee's or member's or a dependent's medical history which we will use to determine if he or she is approved for coverage. Evidence of insurability will be provided at such person's expense.

Family Coverage. Means coverage that includes the insured as defined, the insured's spouse or domestic partner and eligible children.

Grace Period. Means a period of 31 days following the premium due date during which premium payment may be made.

Heart Attack. The death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be based on both:

1. new electrocardiographic changes; and
2. elevation of cardiac enzymes or biochemical markers showing a pattern and to a level consistent with a diagnosis of heart attack.

Heart attack does not include an established (old) myocardial infarction.

Heart Transplant. Means the transplantation of the heart from a patient who died and whose heart was intact and capable of functioning in the recipient. The transplanted organ must come from a human donor.

Illness. One of the specified critical illnesses listed in the chart on page 13.

Individual Coverage. Means coverage that includes only the insured, as defined.

Individual and Children Coverage. Means coverage that includes only the insured, as defined, and eligible children.

Individual and Spouse or Domestic Partner Coverage. Means coverage that includes only the insured, as defined, and his or her eligible spouse or domestic partner.

Initial Enrollment Period. Means one of the following periods during which the employee or member may first apply in writing for coverage under this policy:

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

Injury. Means accidental bodily injury sustained by an insured while coverage under this policy is in force.

Insured. Means an employee or member who is age 18 or older and has: (1) fulfilled all eligibility requirements set forth in the policy; and (2) properly completed and signed the enrollment form, provided that the form has been received by us and any required evidence of insurability has been approved by us.

Major Organ Transplantation. Means the surgical transplantation of a lung, liver, pancreas, or kidney. The transplanted organ must come from a human donor.

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

Paralysis. Complete and permanent loss of function of two or more limbs. Paralysis as a result of stroke is excluded. (Note: Stroke is a separate benefit.)

Payable Claim. Means a claim for which we are liable under the terms of this policy.

Physician. Means:

1. a person performing tasks that are within the limits of his or her medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the state he or she practices in.

We will not recognize the insured, the insured's spouse or domestic partner, insured's children, insured's parents, or insured's siblings as a physician for a claim.

Policyholder. Means the legal entity to whom the policy is issued.

Pre-Existing Condition. Means a disease or physical condition for which:

1. symptoms existed within the 12 month period prior to the effective date of coverage; or
2. medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage.

A pre-existing condition can exist even though a diagnosis has not yet been made.

Sickness. Means an illness or disease that must begin while a person is insured under this policy.

Stroke. Death of a portion of the brain producing neurological sequelae including infarction of brain tissue, hemorrhage and embolization from an extra-cranial source. There must be evidence of permanent neurological deficit. Transient ischemic attacks (TIA's), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded.

Temporary Layoff or Leave of Absence or Family and Medical Leave of Absence. Means the insured is absent from active employment for a period of time that has been agreed to in advance in writing by the current employer.

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

Under the Influence. A condition as determined by the laws of the state in which the loss occurred.

We, Us and **Our.** Means American Heritage Life Insurance Company.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

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

A Stock Company

THIS IS A SPECIFIED ILLNESS POLICY WHICH ONLY PROVIDES STATED BENEFITS FOR SPECIFIED ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.