APPLICATION KIT

Louisiana

SAVERS ADVANTAGE

HOME HEALTH CARE INSURANCE

Standard Life And Casualty Insurance Company

Protecting American Families Since 1947

Underwritten by **Standard Life And Casualty Insurance Company**

SAVERS ADVANTAGE

Health. Value. Peace of Mind.

If possible, wouldn't you rather recuperate from an injury or chronic illness in the comfort of your own home? A sudden illness, injury, or debilitating chronic condition can happen to any individual at any age.

Standard's **Savers Advantage Home Health Care Insurance** is an affordable solution that provides both the flexibility and the financial support you need to recover at home surrounded by family and those that you love. These plans can also minimize financial stress and allow you to focus your energy and attention on your own personal recovery.

Welcome "Home"

Standard Life And Casualty Insurance Company (Standard) has protected American families since 1947 with innovative products and superior customer service. Standard has sales agents located across the country and our headquarters is located in Salt Lake City, UT.

Standard provides competitive Medical, Life, Cancer, and Supplemental Health insurance with the personal attention you've come to expect from your insurance company.

Standard's core values include competitive products, personal service, and prudent financial management. Our Customer Service team is friendly, knowledgeable, and ready to help you.

Home Health Care Market

- By 2030, 20% of the population (approximately 70 million people) will be 65 years old or older.
- Home health care services are not just utilized by Medicare-eligible individuals.
- Most studies indicate that people prefer to recover at home instead of a nursing home.
- Studies indicate that annual expenditures for home health care are greater than $72 billion.
- Hospital stays are typically shorter in length than in the past.
- Home health care is often a cost-effective service for both those recovering from illness or injury as well as for those unable to care for themselves.

(**Sources**: National Association for Home Care & Hospice, *Basic Statistics About Home Care*, Updated 2010. US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *2000 National Home and Hospice Care Survey*, CD-ROM Series 13, No. 31, July 2002.)

Standard Life And Casualty Insurance Company

Home Office
PO Box 510690
Salt Lake City, UT 84151-0690
Phone: (800) 327-0695
www.slacins.com

Application Fax Cover Sheet Checklist

Total Pages:

FAX TO*: (866) 754-9350 or (801) 538-0392

Full Legal Name of Proposed Insured: _____

Before faxing an application, complete the following checklist to ensure prompt processing and service. Please use a separate fax cover sheet for each application.

Fax the following:

- ☐ Properly signed and completed application.
- ☐ Properly signed and completed *Important Notice to Persons on Medicare*, if applicable.
- ☐ Any additional forms required.

If applicant has provided a check for first premium (Quarterly, Semi-Annual, or Annual):

- ☐ Follow instructions above for faxing in application. Then, either:
  - ◊ Mail the check along with a copy of the first page of the application to; or
  - ◊ Fax a copy of the filled out check, the Authorization To Fax Check form, and all completed application materials to:

Regular USPS Mail:	Overnight Courier Delivery:
Standard Life And Casualty Insurance Company PO Box 510690 Salt Lake City, UT 84151-0690	Standard Life And Casualty Insurance Company 420 East South Temple St. Suite 555 Salt Lake City, UT 84111

Agent Information:

Name	
Producer ID	
E-mail Address	
Phone Number	

* Only use this ***Application Fax Cover Sheet Checklist*** for Standard Life And Casualty Savers Advantage Home Health Care Insurance applications.

Standard Life
And Casualty Insurance Company

Application for Home Health Care Indemnity Insurance

Insurance Benefits Provided by Standard Life And Casualty Insurance Company

APPLICANT(S)

Applicant "A"

Full Legal Name of Proposed Insured _____

Gender: ☐ Male ☐ Female **SSN #**: ___|___|___ - ___|___ - ___|___|___|___ **Date of Birth**: _____/_____/_____

Legal Residence Address: _____
Street *City* *State* *Zip*

Mailing Address: _____
Street *City* *State* *Zip*

Phone No: _____ - _____ - _____ E-mail: _____

Name of Owner if other than Proposed Insured: _____

Applicant "B"

Full Legal Name of Proposed Insured _____

Gender: ☐ Male ☐ Female **SSN #**: ___|___|___ - ___|___ - ___|___|___|___ **Date of Birth**: _____/_____/_____

Legal Residence Address: _____
Street *City* *State* *Zip*

Mailing Address: _____
Street *City* *State* *Zip*

Phone No: _____ - _____ - _____ E-mail: _____

Name of Owner if other than Proposed Insured: _____

HOME HEALTH CARE INDEMNITY POLICY

UNDERWRITING

If you are applying for the Home Health Care Indemnity Policy, please answer the following:

	Applicant A	Applicant B
1. Do you have any health insurance (including home health care, long-term care, or similar coverage) in force at the time of this application?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
2. If the answer to Question 1 is "Yes," do you intend to replace your current health insurance coverage with the policy applied for? (Complete Replacement Notice if "Yes")	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
3. Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
4. Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting or transferring to or from a bed or chair?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
5. Do you acknowledge receipt of an outline of coverage for this policy?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Applicant "A"

Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Automated Bank Account Withdrawal)			
Policy Selected	**Home Health Care Policy**:	☐ Classic ☐ Deluxe	**Initial Premium: $_____**
		☐ Extra Benefits Rider	

Applicant "B"

Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Automated Bank Account Withdrawal)			
Policy Selected	**Home Health Care Policy**:	☐ Classic ☐ Deluxe	**Initial Premium: $_____**
		☐ Extra Benefits Rider	

If selecting Extra Benefits Rider:

	Applicant "A"	**Applicant "B"**
Beneficiary Name:		
Relationship:		

Applicant "A" The sum of $ _____, which is the (select payment mode at right) initial premium for the policy(ies) applied for, has been ☐ **Paid to;** or ☐ **Authorized as a draft on my account by;** Standard Life	☐ **Annual** ☐ **Semi-Annual** ☐ **Quarterly** ☐ **Monthly**
Applicant "B" The sum of $ _____, which is the (select payment mode at right) initial premium for the policy(ies) applied for, has been ☐ **Paid to;** or ☐ **Authorized as a draft on my account by;** Standard Life	☐ **Annual** ☐ **Semi-Annual** ☐ **Quarterly** ☐ **Monthly**
If eligible for Medicare, I/we have received a "Guide to Health Insurance for People With Medicare" and the "Important Notice to Persons on Medicare".	☐ **Yes** ☐ **No**
If accepted by the Company, the applicant(s) request(s) coverage to be effective: ☐ Date of Application ☐ Date of Issue ☐ Other _____/_____/_____	**Policy to be Delivered to**: ☐ Applicant(s) ☐ Agent

AGREEMENTS, AUTHORIZATIONS & SIGNATURES

I understand that Company, its reinsurers, and their authorized representatives, for purposes of insurability and underwriting determinations, may obtain medical and other information in order to evaluate my application for insurance. The purpose of the release of this information is for the Company to evaluate and underwrite an application for insurance coverage, to determine the rates and terms that apply to such coverage, and/or resolve any issues of incomplete, incorrect, or misrepresented information on the application which may arise during the processing of the application. I authorize any Medical Provider, as described below, to disclose or release Protected Health Information, as described below, to Company and/or their authorized representatives.

- **Medical Provider**: Any physician, medical or dental practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, pharmacy related service organization, or other medical or medically-related facility.
- I also authorize the Veterans Administration, insurance company, MIB, Inc. ("MIB"), my employer, consumer reporting agency, or other organization that possesses information, records, or knowledge of me to furnish such information to Company, its reinsurers, and/or their authorized representatives upon presenting this authorization.
- **Protected Health Information (PHI)**: Any and all records and health information within Medical Provider's possession such as medical history, entire medical records, mental, psychiatric and physical condition, prescription drug records, tobacco, drug and alcohol use and any other PHI concerning me. This includes information which may be considered to be a communicable or sexually transmitted disease.

By my signature below, I acknowledge that any agreements I have made to restrict my PHI do not apply to this authorization and I instruct any Medical Provider to release and disclose my entire medical record without restriction. I authorize the Company or its reinsurers to make a brief report of my PHI to MIB. Company or its reinsurers may make a brief report regarding me to other insurance companies to whom I have applied or may apply. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule. I, or my authorized representative, am/is entitled to receive a copy of this authorization upon request. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at PO Box 510690; Salt Lake City, UT 84151-0690. If this application was taken over the telephone, I state that my answers were correctly recorded and I have signed this application after the telephone call.

(AUTHORIZATIONS CONTINUED ON FOLLOWING PAGE)

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE. IT IS REPRESENTED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND CORRECTLY RECORDED AND THAT:

1. This application and any supplements thereto will be the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief.
2. The insurance applied for in this application will not be considered in force until issued by Standard Life And Casualty Insurance Company (Company) and the first premium paid during the insured's lifetime.
3. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN ADDITIONAL PAYMENT WITH YOUR TAXES.

I hereby attest that I am purchasing this policy as a supplement or addition to other major medical health insurance coverage, also known as minimum essential coverage.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant "A"

Signed at: _____ _____
City *State*

_____ _____
Signature of Proposed Insured *Date*

_____ _____
Signature of Owner/Trustee (If other than Proposed Insured) *Date*

Owner/Trustee Residence Address: _____
Street *City* *State* *Zip*

Applicant "B"

Signed at: _____ _____
City *State*

_____ _____
Signature of Proposed Insured *Date*

_____ _____
Signature of Owner/Trustee (If other than Proposed Insured) *Date*

Owner/Trustee Residence Address: _____
Street *City* *State* *Zip*

Agent(s): I certify that I asked each question of the applicant(s) personally and the answers have been truly and accurately recorded hereon.

_____ _____ _____ _____
Signature of Producer/Agent *Producer ID* *Date* *Split %*

_____ _____ _____ _____
Signature of Producer/Agent *Producer ID* *Date* *Split %*

_____ _____
Print Producer Name *Agency Name*

BANK DRAFT AUTHORIZATION

Sign the authorization below and provide a voided check or provide the info below from the account you would like to use for bank draft. Your premium will be paid by your bank and will be reflected in your bank statement.

As a convenience to me, I hereby request and authorize Company to pay and charge to my account checks or credits on my account by and payable to Standard Life And Casualty Insurance Company, Salt Lake City, UT provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that Company's rights in respect to each such check or credit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until Company actually receives such notice I agree that Company shall be fully protected in honoring any such check or credit. I further agree that if any such check or credit be dishonored, whether with or without cause and whether intentionally or inadvertently, Company shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ ___|___|___|___|___|___|___|___|___ ___|___|___|___|___|___|___|___|___|___|___

Bank Name *Bank Routing/ABA #* *Bank Account #* ☐ Checking ☐ Savings

_____ _____ ☐ Monthly

Signature EXACTLY as it appears on bank records *Date*

Standard Life And Casualty Insurance Company
PO Box 510690
Salt Lake City, UT 84151-0690

Name – Applicant "A" (please print): _____ **Policy Form Applied For:** _____

Name – Applicant "B" (please print): _____ **Policy Form Applied For:** _____

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

- Check the coverage in **all** health insurance policies you already have.
- For more information about long-term care insurance, review the *Shopper's Guide to Long Term Care Insurance,* available from the insurance company.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

_____ (Agent's Signature)

_____ (Agent's Signature)

_____
(Signature – Applicant "A")

Standard Life And Casualty Insurance Company
Home Office:
420 E. South Temple St.; Suite 555
Salt Lake City, UT 84111

_____
(Signature – Applicant "B")

_____
(Date)

For use when an applicant is eligible for Medicare
Insurance Benefits Provided by **Standard Life And Casualty Insurance Company**

Standard Life
And Casualty Insurance Company
P.O. Box 510690 ● Salt Lake City, UT 84151-0690 ● 800-327-0695

HOME HEALTH CARE INDEMNITY POLICY FORM SLAC-HHC-2015-LA
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

The Company is hereinafter referred to as "we." The individual(s) covered under the policy are referred to as "you" or "your."

NOTE: This policy IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

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 your insurance company. It is therefore important that you READ YOUR POLICY CAREFULLY!

2. **Limited Benefit Health Coverage** is designed to provide, to persons insured, limited or supplemental coverage. This policy provides coverage in the form of a daily indemnity benefit for Home Health Care and Home Health Care Aide services, **and the optional benefits shown below if selected by you**.

3. **BENEFITS:**

   A. **HOME HEALTH CARE BENEFIT:** We will pay a daily benefit each day you require Home Health Care provided by an Approved Home Health Care Practitioner, subject to the eligibility conditions below. The amount of the daily benefit for all Home Health Care Services for any one day will be the lesser of: (i) the Daily Maximum Aggregate Benefit shown below; or (ii) the amount set forth opposite the Home Health Care Services listed below.

Home Health Care Benefit (Daily Maximum Aggregate)	$150.00 or $300.00
Home Health Care Services	**Daily Benefit**
Skilled Nursing Care – provided by a licensed graduate nurse (RN)	$75.00 or $150.00
General Nursing Care – provided by a licensed practical nurse (LPN), licensed vocational nurse (LVN) or licensed visiting nurse	$60.00 or $120.00
Physical Therapy	$75.00 or $150.00
Speech Pathology	$75.00 or $150.00
Occupational Therapy	$75.00 or $150.00
Chemotherapy Specialist Services	$60.00 or $120.00
Enterostomal Therapy	$50.00 or $100.00
Respiration Therapy	$50.00 or $100.00
Medical Social Services	$100.00 or $200.00

B. **HOME HEALTH CARE AIDE BENEFIT:** Immediately following a Hospital confinement of not less than three days, we will pay a daily benefit of $40.00 or $80.00 for each day you require the services of a Home Health Care Aide in Your Home.

C. **PRESCRIPTION DRUG BENEFIT:** If, while this Policy is in force, an Insured/Covered Person incurs expenses for Prescription Drugs for the treatment of an Injury or Sickness, we will pay $10.00 per Generic Drug prescription, or $25.00 per Brand Name Drug prescription, limited to a maximum benefit of $300.00 or $600.00 per Policy Year. The maximum benefit shall apply to each Insured/Covered Person separately per Policy Year. The Pre-Existing Conditions Limitation does not apply to the Prescription Drug Benefit. For purposes of this benefit:

i "**Prescription Drugs**" means drugs which: (a) require a prescription written by a Physician; and (b) are dispensed by a licensed pharmacist.
ii **"Generic Drugs"** means a Prescription Drug that has the same active ingredients as an equivalent Brand Name Drug, does not carry any drug manufacturer's brand name on the label, and is not protected by a patent. It must be listed as a generic drug by the United States national drug data bank.
iii **"Brand Name Drugs"** means a Prescription Drug for which a pharmaceutical company has received a patent or trade name, and is under patent protection.
iv **"Policy Year"** means each successive 12-month period extending from the Effective Date of the Policy, so that each successive 12-month period will constitute a single Policy Year.

Maximum Benefit Periods: The Maximum Benefit Period for the Home Health Care Benefit is 360 days, and the Maximum Benefit Period for the Home Health Care Aide Benefit is 60 days. The Maximum Benefit Period is the maximum number of days we will pay benefits during your lifetime, unless benefits are restored as provided in the Restoration of Benefits provision.

Restoration of Benefits: The original Maximum Benefit Periods for the Home Health Care Benefit and the Home Health Care Aide Benefit will be restored if benefits have not been paid or required for 180 consecutive days.

Conditions on Eligibility for the Home Health Care Benefit and the Home Health Care Aide Benefit: Payment of the Home Health Care Benefit and the Home Health Care Aide Benefit is subject to the following:

- Your loss must be incurred after the policy's effective date and while the policy is in force;
- For the Home Health Care Benefit, care must be provided in Your Home by an Approved Home Health Care Practitioner, as defined in the policy; and for the Home Health Care Aide Benefit, care must be provided in Your Home by a Home Health Care Aide, as defined in the policy; and
- You must be unable to perform, without the assistance of another person, two or more Activities of Daily Living (ADLs); or you must require continuous supervision and assistance due to a Cognitive Impairment. To meet this requirement, your Physician must perform such tests as are in accordance with accepted standards of medical practice and, based on such tests, certify in writing that you are unable to perform two or more ADLs or that you have a Cognitive Impairment. ADLs are bathing, dressing, eating, toileting and transferring to or from a bed or a chair.

4. OPTIONAL BENEFITS: The following are optional benefit riders which may be available in your state. Your application reflects that you have applied for the additional benefits checked.

A. _____ **(Applicant "A" initials to select): EXTRA BENEFIT RIDER (form #HHC-2015-EBR-LA):**

B. _____ **(Applicant "B" initials to select): EXTRA BENEFIT RIDER (form #HHC-2015-EBR-LA):**

(1) **ANNUAL PHYSICAL EXAMINATION BENEFIT:** If you have not used any other benefit under the rider or the policy (except the Prescription Drug Benefit) and have a physical examination performed by a Physician more than 12 months after the rider's effective date, we will pay a benefit of $150.00. After your first physical examination for which this benefit is payable, we will pay a benefit of $150.00 each time you have a physical examination performed by a Physician in each succeeding 12-month period, provided you have not used any other benefit under the rider or the policy (except the Prescription Drug Benefit) during such 12-month period, limited to one physical examination in any 12-month period.

(2) **ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT:** If, while this Rider is in force, a Covered Person (a) suffers an accidental death; or (b) suffers an accidental bodily injury that results in the loss of finger, toe, hand, arm, foot, leg, or sight, we will pay benefits in an amount equal to the benefit shown in the Insured Schedule. We will pay benefits in an amount equal to the Accidental Death Benefit shown below if Your death is due to any injury. To be covered, death must occur within 90 days after the date the injury was sustained and while this policy is in force. Benefits will be paid to Your beneficiary in the event of Your death. If an Accidental Bodily Injury results in Loss of finger, toe, hand, arm, foot, leg or sight of You within 90 days of the accident causing such Injury, the Company will pay the Accidental Dismemberment Benefit shown below. The total amount payable for all Losses resulting from the same accident will not exceed the Maximum Dismemberment Benefit per Accident shown below. We do not pay benefits for both Accidental Death and Accidental Dismemberment if caused by the same accident. If both an Accidental Death Benefit and Accidental Dismemberment Benefits would otherwise be payable, benefits will be paid under the provision that would pay the most.

Accidental Death	$10,000.00
Maximum Dismemberment Benefit, for losses shown below:	
Sight, both eyes	$5,000.00
Sight, one eye	$2,500.00
Hand, arm, foot or leg (multiple)	$5,000.00
Hand, arm, foot or leg (single)	$2,500.00
Finger or toe (multiple)	$500.00
Finger or toe (single)	$250.00

(3) **HOME MEDICAL EQUIPMENT BENEFIT:** If, while this Rider is in force, a Covered Person requires Home Medical Equipment specifically related to the Sickness or Injury for which Home Health Care Benefits are paid, we will pay scheduled benefits, as shown in the Insured Schedule, of up to $500 per Maximum Benefit Period.

When the term **Home Medical Equipment** is used in this Rider, it means items which:

- are reasonable and necessary to sustain a minimum threshold of independent daily living;
- are primarily and customarily used to serve a medical purpose;
- are not useful to a person in the absence of illness or injury;
- are ordered or prescribed by a physician;
- are reusable;
- can stand repeated use; and
- are appropriate for use in the home.

Covered Home Medical Equipment is limited to the following:

Mobility Assistance: Wheelchairs; walkers, rollators, canes, crutches or similar walking aids.

Transfer Aids: Gait/transfer belts; transfer benches; transfer boards; transfer mats.

Bathroom Safety: Shower chairs; elevated toilet seats; commode chairs.

Home Accommodations: hospital beds; patient lifts; trapezes.

Personal Medical Equipment: braces (arm, leg, back and neck).

Home Medical Equipment must be the most appropriate model that adequately meets a member's medical need in the performance of Activities of Daily Living, as measured by Medicare guidelines. Some items ordered by a physician, even if medically necessary, may not be covered. Total benefits for rented equipment may not exceed the benefit for purchase of that same equipment.

Exclusions & Limitations Specific to the Home Medical Equipment Benefit:

We will not pay benefits under this policy for services or expenses or any such Loss resulting from or in connection with: (a) charges in excess of usual and customary amounts for like items; (b) equipment with features in excess of the model required to adequately meet a Covered Person's medical need in the performance of Activities of Daily Living; (c) disposable equipment or supplies; (d) medical supplies, ostomy or urological supplies; (e) oxygen and respiratory care equipment; (f) rehabilitative and assistive technology not listed above; repairs, maintenance or replacement of Home Medical Equipment.

5. **PRE-EXISTING CONDITIONS LIMITATION:** This Policy is not considered to be in force or effective for any Pre-Existing Condition, as defined in the Policy, until six months after the Policy's Effective Date.

6. **EXCLUSIONS:** The Policy does not cover any Loss caused or contributed to by: (a) mental or emotional disorders (Note: **This exclusion does not apply to Alzheimer's Disease, senility or other organic brain syndrome**. These diseases are covered by the Policy like any other Sickness subject to the Pre-Existing Conditions Limitation); (b) the insured's being intoxicated or under the influence of narcotics unless administered on the advice of a physician; (c) pregnancy, except that complications of pregnancy shall be covered as any other Sickness; (d) war or act of war (whether declared or not); (e) participation in a felony riot or insurrection; (f) service in the armed forces or units auxiliary to it; (g) attempted suicide, while sane, or intentionally self-inflicted Injury; (h) Injury or Sickness to the extent benefits are paid therefor under a state or federal worker's compensation law, employers liability or occupational diseases law, or motor vehicle no-fault law; (i) services performed by a member of your Immediate Family; (j) services for which no charge is normally made in the absence of insurance; (k) dental care or treatment; (l) rest cures, custodial care or transportation.

7. **GUARANTEED RENEWABILITY:** The policy is guaranteed renewable for your lifetime. We cannot cancel, refuse to renew, or change the Policy as long as you pay the premiums as they become due or with the 31-day grace period. The Policy will continue in force during the grace period.

8. **PREMIUMS SUBJECT TO CHANGE:** Premiums for the Policy are based on the attained age of each Covered Person, and each Covered Person's premium maybe increase following his/her birthday. Premiums may also increase at any time due to the Company changing its table of rates applicable on a class basis in your state. No change in premiums will be effective before the Policy's first anniversary and not more than once in any six month period following the initial 12-month period. Any change will apply to future premiums for all policies with the same form number issued to us to persons in your state of residence. We will give you 45 days written notice before any premium change.

THIS IS A LIMITED BENEFIT POLICY. READ THE POLICY CAREFULLY WITH THIS OUTLINE OF COVERAGE.

THIS IS NOT A LONG-TERM CARE POLICY.

RECEIPT FOR ADVANCED PREMIUM

Valid only if signed by an agent of Standard Life And Casualty Insurance Company (Standard)

Standard Life And Casualty Insurance Company
PO Box 510690 • Salt Lake City, UT 84151-0690 • (800) 327-0695

MAKE YOUR PREMIUM CHECK PAYABLE TO: "**Standard Life**"
DO **NOT** MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from _____ on (date) _____ the sum of $ _____, being payment of an advanced premium on an application for Savers Advantage Home Health Care Insurance to Standard, which application bears the same date as this receipt.

Proposed Insured: _____

The insurance applied for will not take effect until a policy issued on the basis of this application has been delivered to the proposed insured, and the full first premium paid. This must be all during the lifetime and before any change in the insurability of the proposed insured as stated in the application. Otherwise, there shall be no liability on the part of the Company except to refund this payment upon surrender of this receipt.

The Company shall have 60 days within which to consider and act upon the said application. If within such period a policy has not been issued to the applicant as applied for or if notice of approval or rejection has not been given, then the application shall be deemed to have been declined by the Company. If you do not receive a policy or refund of the amount paid within 60 days from this date, please notify the Company, in writing, at the address above. Please provide your name, date and the amount of payment, and the name of the agent.

_____	_____	_____
Agent Name (Printed)	*Signature of Agent*	*Date*

P.O. Box 510690 ● Salt Lake City, UT 84151-0690 ● 800-327-0695

HOME HEALTH CARE INSURANCE