

# APPLICATION KIT

North  
Carolina

**SAVERS  
ADVANTAGE**

**HOME  
HEALTH CARE  
INSURANCE**



*Protecting American Families Since 1947*

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





## SAVERS ADVANTAGE

### 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.

### 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.

### 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](http://www.slacins.com)

### Savers Advantage Home Health Care 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:**

<b>Name</b>	
<b>Producer ID</b>	
<b>E-mail Address</b>	
<b>Phone Number</b>	

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



Application for Home Health Care Indemnity Insurance

**Insurance Benefits Provided by  
Standard Life And Casualty Insurance Company**

APPLICANT(S)	<b>Applicant "A"</b>		
	Full Legal Name of Proposed Insured _____		
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female    SSN #: ____ ____ ____ - ____ ____ - ____ ____ ____ ____    Date of Birth: ____/____/____		
	Legal Residence Address: _____ <span style="display: block; text-align: center;"><i>Street</i> <span style="margin-left: 200px;"><i>City</i></span> <span style="margin-left: 100px;"><i>State</i></span> <span style="margin-left: 50px;"><i>Zip</i></span></span>		
	Mailing Address: _____ <span style="display: block; text-align: center;"><i>Street</i> <span style="margin-left: 200px;"><i>City</i></span> <span style="margin-left: 100px;"><i>State</i></span> <span style="margin-left: 50px;"><i>Zip</i></span></span>		
	Phone No: _____ - _____ - _____    E-mail: _____		
	Name of Owner if other than Proposed Insured: _____		
	<b>Applicant "B"</b>		
	Full Legal Name of Proposed Insured _____		
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female    SSN #: ____ ____ ____ - ____ ____ - ____ ____ ____ ____    Date of Birth: ____/____/____		
Legal Residence Address: _____ <span style="display: block; text-align: center;"><i>Street</i> <span style="margin-left: 200px;"><i>City</i></span> <span style="margin-left: 100px;"><i>State</i></span> <span style="margin-left: 50px;"><i>Zip</i></span></span>			
Mailing Address: _____ <span style="display: block; text-align: center;"><i>Street</i> <span style="margin-left: 200px;"><i>City</i></span> <span style="margin-left: 100px;"><i>State</i></span> <span style="margin-left: 50px;"><i>Zip</i></span></span>			
Phone No: _____ - _____ - _____    E-mail: _____			
Name of Owner if other than Proposed Insured: _____			

**HOME HEALTH CARE INDEMNITY POLICY**

If you are applying for the Home Health Care Indemnity Policy, please answer the following:			
UNDERWRITING		<b>Applicant A</b>	<b>Applicant B</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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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")	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Do you acknowledge receipt of an outline of coverage for this policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Applicant "A"**

<b>Payment Mode:</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (Automated Bank Account Withdrawal)		
<b>Policy Selected</b>	<b>Home Health Care Policy:</b> <input type="checkbox"/> Classic <input type="checkbox"/> Deluxe	<b>Initial Premium: \$</b> _____
	<input type="checkbox"/> Extra Benefits Rider	

**Applicant "B"**

<b>Payment Mode:</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (Automated Bank Account Withdrawal)		
<b>Policy Selected</b>	<b>Home Health Care Policy:</b> <input type="checkbox"/> Classic <input type="checkbox"/> Deluxe	<b>Initial Premium: \$</b> _____
	<input type="checkbox"/> Extra Benefits Rider	

## AGREEMENTS, AUTHORIZATIONS & SIGNATURES

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.

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.

<b>If accepted by the Company, the applicant(s) request(s) coverage to be effective:</b>	<b>Policy to be Delivered to:</b>
<input type="checkbox"/> Date of Application <input type="checkbox"/> Date of Issue <input type="checkbox"/> Other ____/____/____	<input type="checkbox"/> Applicant(s) <input type="checkbox"/> Agent

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 selecting Extra Benefits Rider:**

	<b>Applicant "A"</b>	<b>Applicant "B"</b>
<b>Beneficiary Name:</b>		
<b>Relationship:</b>		

**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

**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.

_____	__ _ _ _ _ _ _ _ _ _ _ _ _ _ _	__ _ _ _ _ _ _ _ _ _ _ _ _ _ _	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
<i>Bank Name</i>	<i>Bank Routing/ABA #</i>	<i>Bank Account #</i>		
_____	_____		<input type="checkbox"/> Monthly	
<i>Signature EXACTLY as it appears on bank records</i>	<i>Date</i>			



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**





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

**HOME HEALTH CARE INDEMNITY POLICY FORM SLAC-HHC-2015-NC  
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.**

**PRE-EXISTING CONDITIONS LIMITATION:** If you are age 65 or younger on the Effective Date of coverage, Pre-existing Conditions will be covered after the policy has been in force for 6 months, unless specifically eliminated by rider. If you are over age 65 on the Effective Date of coverage, Injuries and Sicknesses will be covered on the Effective Date, unless excluded by the Exclusions provision or specifically eliminated by rider.

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
<b><u>Home Health Care Services</u></b>	<b><u>Daily Benefit</u></b>
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 365 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.

D.  **EXTRA BENEFIT RIDER (form #HHC-2014-EBR-NC):**

- (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. EXCLUSIONS:** This Policy does not cover any loss caused or contributed to by: (a) simple rest care, hotel or retirement home expense or other expense which is related to Your Home; (b) services other than those of an Approved Home Health Care Practitioner or a Home Health Care Aide, except as may be provided by rider; (c) declared or undeclared war or act thereof; (d) mental or nervous disorder without demonstrable organic origin (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); (e) charges that a Covered Person would not be legally obligated to pay in the absence of this insurance; (f) attempted suicide or self-inflicted injury; (g) alcoholism or drug addiction; (h) a Covered Person's participation in a felony, riot or insurrection; i) any condition, either pre-existing or otherwise, which is excluded from coverage under this Policy by name or specific description as shown on an elimination Rider effective on the date of the loss; (j) Pre-Existing Conditions, as defined herein, are not covered under this Policy until this Policy has been in force for a period of six months; (k) services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- 6. RENEWABILITY:** Except for non-payment of the required premium when due or within the grace period, we will renew the policy unless we give you sufficient notice in writing of non-renewal. We can decline to renew the policy only if renewal premiums are declined on all policies with the same form number issued by us to persons in your state of residence. We may cancel the policy as of the next premium due date if there was a failure to correctly report matters inquired of in the application.
- 7. PREMIUMS SUBJECT TO CHANGE:** We can change the premiums for the policy at any time and from time to time, and premiums also increase based on your attained age. No change in premiums will be effective before the first policy anniversary. If premiums are increased after the first policy anniversary, premiums will not be increased again for a period of 12 months. Any change will apply to future premiums for all policies with the same form number issued by us to persons in your state of residence. We will give you 45 days notice before any premium change under this provision.

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

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**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**