

**CONTINENTAL LIFE INSURANCE COMPANY OF  
BRENTWOOD, TENNESSEE  
HOME OFFICE**

800 Crescent Centre Dr., Suite 200  
Franklin, Tennessee 37067  
Telephone: [1-800-264-4000](tel:1-800-264-4000)

**THIS IS A LIMITED BENEFIT HOSPITAL INDEMNITY AND SHORT  
TERM RECOVERY CARE FIXED INDEMNITY POLICY - PLEASE READ  
IT CAREFULLY**

**NOTICE:** This is not a major medical insurance policy. This Policy provides a fixed indemnity benefit paid in the amount stated on the Schedule of Benefits page without regard to the cost of services rendered. This Policy does not provide expense reimbursement for charges based on Your health care provider's bill and is not intended to satisfy the requirement of minimum essential benefits under the federal Patient Protection and Affordable Care Act.

READ YOUR POLICY CAREFULLY AND BECOME FAMILIAR WITH ITS TERMS, LIMITS, EXCLUSIONS AND CONDITIONS. This Policy is a legal contract between You and the Company. We agree to insure You in return for Your premium payments. The Company will pay a fixed benefit if You have a Covered Event listed on the Schedule of Benefits page while this Policy is in force and after this Policy's terms have been met.

**RIGHT TO EXAMINE POLICY:** You have 30 Days after receipt of this Policy to examine its provisions. During that 30-Day period, if You are dissatisfied with the Policy, it may be returned to the Company at its Home Office or to the agent from whom it was purchased. Immediately upon such return, this Policy shall be void from the beginning and any premium paid will be promptly refunded.

**GUARANTEED RENEWABLE:** You have the right to renew this Policy for consecutive terms by paying the required premium before the end of the Grace Period. You have the right to renew this Policy subject to the Policy Termination provisions detailed below.

**PREMIUM AGREEMENT:** Premiums for this Policy may be changed. Any change in premium will apply to all

Insured Persons with Your same Policy type based on the issue state of Your Policy. Any change in premium may occur on the next premium due date after We give You at least 30 Days advance notice in writing of such premium change.

**IMPORTANT NOTICE:** Please read the copy of Your application attached to this Policy. Omissions or misrepresentations in Your application could cause a claim to be denied or Your Policy rescinded. If Your Policy is rescinded, it will be voided back to its Effective Date and You will have no insurance Coverage under Your Policy. Carefully check Your application and write to the Home Office within 10 Days of the receipt of Your Policy if any information shown on it is not correct and complete or if any past medical history is left out. Your application is part of Your Policy and Your Policy was issued on the basis that the answers to all questions and information shown on Your application are correct and complete.

**Notice to buyer: THIS IS NOT A MEDICARE SUPPLEMENT POLICY.** If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the Company.

**THIS IS NOT A LONG TERM CARE POLICY – THIS POLICY PROVIDES A LIMITED BENEFIT FOR HOSPITAL CONFINEMENT AND SHORT TERM RECOVERY CARE ONLY.**

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Continental Life Insurance Company of Brentwood, Tennessee

# SCHEDULE OF BENEFITS

POLICY OWNER: [APPLICANT'S NAME]

COVERAGE EFFECTIVE

DATE: [xx/xx/xxxx ]

POLICY NUMBER: [\[123456789\]](#)

ISSUE AGE: [XX]

ADDRESS: [123 ANYSTREET]

PREMIUM MODE: [ ]

[ANYTOWN, USA 12345]

[ADDITIONAL ADDRESS SPACE]

INITIAL PREMIUM: [ ]

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**BENEFIT AMOUNT**

## **A. DAILY HOSPITAL CONFINEMENT INDEMNITY BENEFIT**

Daily Benefit Amount for Hospital  
Confinement [\$10 - \$300] per Day [in  
units of [\$10]]

Maximum Number of Days per Period of  
Care [20-40] Days

Lifetime Maximum Number of Days [180-365]  
Days

## **B. SHORT TERM RECOVERY CARE BENEFITS**

### **1. Daily Nursing Facility, Assisted Living Facility, Fixed Indemnity Benefit**

Daily Benefit Amount for Nursing Facility or  
Assisted

Living Facility Confinement [\$100 - \$300] per  
Day [in units of [\$10]]

Maximum Number of Days per Period of Care [90  
- 360]  
Lifetime Maximum Number of Days [180 – 720]  
Days  
Waiting Period [None] [10-100] Days

## **2. Bed Reservation Fixed Indemnity Benefit**

Daily Benefit Amount for Bed  
Reservation [ \$100  
- \$300] per Day in units  
of [ \$10]  
Maximum Number of Days per Period of  
Care [10 - 30]  
Days  
Lifetime Maximum Number of Days [20 - 60]  
Days

### **[C. Home Care Fixed Indemnity Benefit Rider**

Weekly Benefit Amount for Home Care –  
Minimum  
of 3 Home Care Service visits per Week  
Required [ \$150 - \$1,200] per  
Week  
Maximum Number of Weeks per Period of Care  
[13 - 52] Weeks  
Lifetime Maximum Number of Weeks [26 –  
104] Weeks

THIS PAGE INTENTIONALLY LEFT BLANK **SECTION 1 -  
DEFINITIONS**

Shown below are the defined terms used in Your Policy. These terms will have the first letter of each word capitalized wherever they appear in the Policy.

**Accident** means a sudden and unforeseen event or circumstance that causes bodily injury or injuries resulting in a Loss under this Policy. It does not include an intentional, self-inflicted injury, while sane.

**Activities of Daily Living (ADL)** means Bathing, Contenance, Dressing, Eating, Toileting and Transferring.

“Bathing” means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

“Contenance” means the ability to maintain control of bowel

and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

“Dressing” means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

“Eating” means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

“Toileting” means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

“Transferring” means moving into or out of a bed, chair or wheelchair.

**Advanced Studies** means angiogram; arteriogram; computer tomography scan (CT); electroencephalogram (EEG); magnetic resonance imaging (MRI); myelogram; positron emission tomography scan (PET); or thallium stress test.

**Ambulatory Surgical Center or Outpatient Surgical Facility** means any public or private establishment with (a) an organized medical staff of doctors; (b) permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (c) continuous doctors’ services whenever a patient is in the facility; and which does not provide services or accommodations for patients to stay overnight.

**Assessment** means a comprehensive, written evaluation that includes generally accepted tests and instruments that use objective measures and produce verifiable results performed by an agency, entity or

person designated and approved by Us. A person assigned to perform an Assessment will be a registered professional nurse, licensed social worker or other similarly licensed person.

**Assisted Living Facility means** a place which is a separate facility or distinct part of a health care facility, which is licensed by the state, is operated pursuant to law and meets all the following criteria:

- a. Provides continuous room and board that includes 3 meals a Day;
- b. Provides assistance with Activities of Daily Living to ambulatory residents who require protected living arrangements, or coordinated supportive personal and health care services to semi-independent residents;
- c. Has at least one (1) trained staff member actively on duty in the facility twenty-four (24) hours per Day to provide supervision and care;
- d. Has formal arrangements with a Physician or nurse to furnish medical care in emergencies; and
- e. Has appropriate methods and procedures to assist residents in handling and administering medications.

Services in an Assisted Living Facility known as a residential care facility or any other name will be considered eligible for benefits only if the facility meets all terms of this definition. A retirement community, independent living unit or an apartment will not meet these terms. If the facility is licensed for multiple purposes, only the confinement in the section, wing, ward, or unit that qualifies as an Assisted Living Facility will be eligible for benefits.

**Benefit Amount** means the amount We will pay for a Covered Event shown on the Schedule of Benefits page.

**Calendar Year** means the period from January 1 through December 31 of the same year.

**Cognitive Impairment** means the deterioration or loss of intellectual or mental capacity, as determined by clinical evidence and standardized tests, resulting in the Insured's need for the continual assistance of, or supervision by, another person, including supervision and assistance that is necessary to protect the health and safety of the Insured or others.

**Complications of Pregnancy** means: (a) conditions (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion hyperemesis gravidarum, preeclampsia, and similar medical and surgical conditions of comparable severity; and (b) non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, elective cesarean section, and similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy.

**Confined/Confinement** means the Insured is formally admitted to a Nursing Facility, Assisted Living Facility or a Hospital on an Inpatient basis or receives necessary and continuous observation in a Hospital for at least 24 hours.

**Cosmetic Surgery** means a surgical procedure undergone for the sole purpose of improving appearance or self-esteem and not as treatment for a Covered Illness or Covered Injury.

**Coverage** means the insurance provided for the Insured to cover Losses under the terms of this Policy.

**Coverage Effective Date** means the date Coverage by this Policy begins at 12:01 A.M. where the Insured lives. The Coverage Effective Date is listed on the Schedule of Benefits page.

**Covered Event** means a Hospital Confinement, a Nursing Facility Confinement or an Assisted Living Facility Confinement of the Insured while this Policy is in force.

**Covered Illness** means only sickness or disease or Complications of Pregnancy, which require treatment by a Physician.

**Covered Injury** means bodily injury caused by an Accident resulting directly and independently of all other causes and which requires treatment by a Physician.

**Day** means a period of 24 hours in a row.

**Emergency Room** means a facility located on the premises of, or physically a part of, a Hospital that provides initial treatment to patients with a broad spectrum of illnesses and injuries that require immediate attention and is especially equipped and staffed for Emergency care. An Urgent Care Facility is excluded from this definition.

**Executive Officer** means the President or Senior Vice President of the Company.

**Experimental or Investigational** means the use of any treatment, procedure, facility, equipment, drugs, devices, or supplies not yet recognized as accepted medical practice by the American Medical Association, and any of such items requiring Federal or other government agency approval not granted at the times services were provided.

**Hands-On Assistance** means physical assistance of another person without which the Insured would be unable to perform any two (2) or more of the Activities of Daily

Living (ADLs).

**Hospital** means a legally constituted and operated institution which: (a) primarily engages in providing care and treatment of sick or injured persons on an Inpatient basis; (b) provides such care and treatment under the supervision of one or more Physicians with twenty-four hour nursing service under the supervision of the Physician in charge of the hospital; and (c) has organized facilities for laboratory and diagnostic work and major surgery.

**Hospice Care Facility** means a place which is a separate facility or distinct part of a health care facility, is operated pursuant to law, and provides a program of care for the terminally ill and their families that includes medical, palliative, psychological, spiritual or supportive care and treatment.

**Hospital Confinement** or **Confined** means the Insured is formally admitted to a Hospital on an Inpatient basis or receives necessary and continuous observation in a Hospital for at least 24 hours.

**Immediate Family** means the Insured, the Insured's spouse or Domestic Partner, the Insured's Children, mother, father, grandmother, grandfather, sister, brother, aunt, uncle, or any relation by blood or marriage.

**Inpatient** means the Insured has been formally admitted to a Hospital with a Physician's order.

**Lifetime Maximum** means the maximum number of Days or Weeks for which We will provide benefits during the lifetime of this Policy. The Lifetime Maximums are shown on the Schedule of Benefits page.

**Loss** or **Losses** means the Insured has a Covered Illness or Covered Injury, a Cognitive Impairment or an inability to perform two (2) or more Activities of Daily Livings (ADLs) without Hands-On Assistance that results in a Covered Event that occurs after the Coverage Effective Date.

**Material Information** means a health condition or combination of health conditions You were requested to disclose on the application and which, if disclosed, would have required a different premium or caused Us to deny issuing Your Policy.

**Medically Necessary** means the services, care, or supplies that are required to identify or treat the Insured's condition and are: (a) consistent with the symptom or

diagnosis, and treatment is distinctly aimed at improvement of the Insured's condition; (b) in accordance with standards of good medical practice; (c) not mainly for convenience of the Insured, a Physician or other provider; (d) the most appropriate medical supply or level of care, which can safely be provided; and (e) the Insured's medical symptoms or condition require that the services cannot be safely provided as an Outpatient

**Mental or Nervous Disorder** means any condition classified as neurosis, psychoneurosis, psychopathy, psychosis, or functional disorders of any type or cause.

**Nursing Care Services means** services performed under orders of a Physician for the purpose of meeting either the medical or personal care needs of an Insured residing in a Nursing Home or Assisted Living Facility, and are performed at the direction and under the supervision of a licensed registered or practical nurse.

**Nursing Facility means a** place which is a separate facility or distinct part of a health care facility which is licensed as a nursing home or nursing facility, is operated pursuant to law, provides continuous accommodations to persons who require daily Nursing Care Services, and maintains records of each patient or resident.

**Outpatient** means Emergency Room services, observation services, outpatient surgery, lab tests, X-rays or any other Hospital services for which a Physician has not written an order to admit an Insured to a Hospital as an Inpatient.

**Period of Care** for the Daily Hospital Confinement Indemnity Benefit means the period of time that begins with the first Day of Hospital Confinement because of a

Covered Injury or Covered Illness. It ends when the Insured has been out of the Hospital and does not require Medically Necessary care for sixty (60) continuous Days.

**Period of Care** for the Nursing Facility, Assisted Living Facility Fixed Indemnity Benefit means the period of time that begins with the first Day of Nursing Facility or Assisted Living Facility Confinement. It ends following a period of one hundred eighty (180) consecutive Days, during all of which:

- a. The Insured was not confined to a Nursing Facility or Assisted Living Facility;
- b. The Insured was able to perform five (5) or more Activities of Daily Living (ADLs), as defined in this Policy, without the Hands-On Assistance of another person; and
- c. If the Insured is Cognitively Impaired, the Insured did not require or receive the assistance or supervision of another person.

The end of a Period of Care means that benefits will be restored each time the Insured meets the requirements above, until the total number of Days or Weeks equal the Lifetime Maximum Benefit.

**Physician** means a person who holds a current license to legally practice medicine or surgery, or any other practitioner of the healing arts rendering care within the lawful scope of his or her license. We will not recognize the Insured or a member of the Insured's Immediate Family as a Physician for purposes of this Policy.

**Plan of Care** means a written, individualized plan of services that specifies the Insured's care needs and the type, frequency and providers of services appropriate to meet those needs.

**Policy** means this contract issued by Us to the Policy Owner providing benefits for the Policy Owner.

**Policy Owner** means the person to whom the Policy is issued shown on the Schedule of Benefits page.

**Pre-Existing Condition** means a condition for which the Insured has been medically diagnosed, treated by, or sought advice from, or consulted with, a Physician during

the six (6) months before the Insured's Coverage Effective Date. Pre-Existing Conditions are not covered unless the Loss begins more than six (6) months after the Coverage Effective Date.

**Pregnancy** means pregnancy or childbirth, or elective cesarean section.

**Schedule of Benefits** means the Policy page that lists the fixed Benefit Amounts payable under the terms of this Policy.

**Substance Use Disorder**— means the pathological use or abuse of alcohol or other drugs in a manner and to a degree that produces impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

**Urgent Care Facility** means a free-standing facility, by whatever actual name it may be called, which is engaged primarily in providing minor emergency and episodic, medical care. However, a facility located on the premises of, or physically a part of, a Hospital is excluded from this definition.

**Us, We, Our** and **Company** mean Continental Life Insurance Company of Brentwood, Tennessee.

**Waiting Period** means the number of Days of a Confinement in a Nursing Facility or Assisted Living Facility before benefits are payable. The Waiting Period, if any, is shown on the Schedule of Benefits page and must be satisfied for each Period of Care in a Nursing Facility or Assisted Living Facility.

**You, Your, Insured** mean the person listed on the Schedule of Benefits page as the Policy Owner.

## SECTION 2 - BENEFIT PROVISIONS

We will pay the Benefit Amount shown on the Schedule of Benefits page, in accordance with the provisions and limitations of this Policy, for the following Covered Events:

The following benefits are subject to specific benefit maximums or limitations, as specified on the Schedule of Benefits page. It is important that the Insured reviews the Schedule of Benefits page for the Benefit Amount maximums or limitations.

### **A. Daily Hospital Confinement Indemnity Benefit**

We will pay the Daily Hospital Confinement Indemnity Benefit Amount shown on the Schedule of Benefits page when the Insured is Confined in a Hospital.

The Confinement must be:

- a. Medically Necessary as a result of a Covered Illness or Covered Injury, as defined in this Policy;
- b. Ordered by a licensed Physician; and
- c. Not excluded in Section 3 – Limitations and Exclusions.

The Daily Hospital Confinement Indemnity Benefit will be paid for each Day of such Hospital Confinement.

This Benefit is limited to the Daily Benefit Amount, the Maximum Number of Days per Period of Care and the Lifetime Maximum Number of Days, shown on the Schedule of Benefits page.

### **B. Short Term Recovery Care Benefits**

## **1. Daily Nursing Facility, Assisted Living Facility Fixed Indemnity Benefit**

We will pay the Daily Nursing Facility, Assisted Living Facility Benefit Amount shown on the Schedule of Benefits page when the Insured is Confined in a Nursing Facility or Assisted Living Facility.

The Waiting Period, if any, must be met before benefits are paid for a covered Confinement in a Nursing Facility or Assisted Living Facility. The Insured must satisfy the Waiting Period for each Period of Care.

An Insured is eligible for this Benefit when We receive documentation which establishes that:

- a. The Insured cannot perform, without the Hands-On Assistance of another person, two (2) or more of the Activities of Daily Living (ADLs); or
- b. The Insured has a Cognitive Impairment.

Acceptable documentation may include a Comprehensive Minimum Data Set (MDS) Assessment within the first fourteen (14) Days of a Confinement or other written Assessment if the Nursing Home in which the Insured resides is not a Medicare or Medicaid certified Nursing Home and is not required by state law to use the Comprehensive MDS Assessment; or if the Insured resides in an Assisted Living Facility.

We may have an Insured re-Assessed to determine continued eligibility for the payment of the Nursing Facility, Assisted Living Facility Benefit as reasonably necessary.

In general, a re-Assessment will not take place more than once in any 90 Day period.

This Benefit is payable only when:

- a. The Insured's eligibility for benefits begins

while this Policy is in force;

b. The services received are consistent with the Insured's Plan of Care; and

c. The Confinement is not excluded in Section 3 – Limitations and Exclusions.

This Benefit is limited to the Daily Benefit Amount, the Maximum Number of Days per Period of Care and the Lifetime Maximum Number of Days shown on the Schedule of Benefits page.

## **2. Bed Reservation Benefit**

We will pay the Bed Reservation Benefit shown on the Schedule of Benefits page to reserve an Insured's bed during a covered Nursing Facility or Assisted Living Facility Confinement when the Insured is admitted as an Inpatient to a Hospital.

The Bed Reservation Benefit is not payable unless, upon discharge from the Hospital, the Insured immediately returns to the Nursing Facility or Assisted Living Facility where the Insured resided immediately prior to admission to the Hospital.

This Benefit is limited to the Daily Benefit Amount, the Maximum Number of Days per Period of Care and the Lifetime Maximum Number of Days shown on the Schedule of Benefits page.

SECTION 3 - LIMITATIONS AND EXCLUSIONS

We will not pay any benefits for Losses that are caused by or the result of the insured's:

a.

Confinement for the following treatment, procedures, conditions, disorders or services - including:

1. Allergy testing and allergy injections;
2. Cosmetic surgery, routine foot care, dental services, acne or varicose veins;
3. Diagnostic lab testing, x-rays, Advanced Studies and venipuncture;
4. Experimental or Investigational procedures or participation in clinical trials;
5. Infertility and impregnation procedures, such as but not limited to, artificial insemination, in-vitro fertilization, embryo and fetal implantation and G.I.F.T. (gamete intrafallopian transfer);
6. Mental or Nervous Disorders or Substance Use Disorders;
7. Obesity, extreme obesity, morbid obesity or weight reduction, including, but not limited to, wiring of the teeth and all forms of surgery including, but not limited to, bariatric surgery, intestinal bypass surgery and complications resulting from any such surgery;
8. Pregnancy and related services; except for

- Complications of Pregnancy;
9. Programs, treatment or procedures for tobacco cessation;
  10. Routine newborn care, including routine nursery charges;
  11. Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire;
  12. Therapy or treatment of learning disorders or disabilities, developmental delays or sleep disorders;
  13. Voluntary abortion, except with respect to the Insured: (a) where such Insured's life would be endangered if the fetus were carried to term; or (b) where medical complications have arisen from an abortion; and
  14. Voluntary sterilization or reversal thereof.

b.

Outpatient treatment, services or supplies of any type.

c.

Confinement in a Hospice Care Facility.

d.

Home Health Care unless the Home Care Fixed Indemnity Rider is attached to this Policy and Home Care is shown as covered on the Schedule of Benefits

page.

e. Stay in a community living center or a place that primarily provides domiciliary, retirement or educational care.

f.

Participation in a War or an act of war, riot or international armed conflict.

g. The

commission or attempted commission of a crime or felony or while engaged in an illegal act; or while imprisoned.

h.

Suicide or attempted suicide or intentionally self-inflicted injury, whether while sane or insane.

i.

Participation in skydiving, scuba diving, hand or ultra light gliding, ballooning, bungee jumping, parakiting, riding an all-terrain vehicle such as a dirt bike, snowmobile or

go-cart, racing with a motorcycle, motor vehicle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests.

j. Injury sustained while operating a motor vehicle where the Insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the injury occurred.

k.  
Confinement outside of the United States.

#### SECTION 4 - POLICY TERMINATION

The Policy Owner may cancel this Policy at any time by sending Us a written request to cancel. Upon cancellation, We will return the unearned portion of any premium paid in accordance with the laws in Your state of residence.

Your Policy will terminate at 12:01 a.m. local time at Your state of residence on the earliest of the following dates:

1. The date We receive Your written request to cancel Your Policy or on a later date that is requested by You.
2. The Premium Due Date, if sufficient premium has not been paid before the end of the Grace Period; and
3. The date of death of the Policy Owner.

## **SECTION 5 - OTHER PROVISIONS**

**ENTIRE CONTRACT CHANGES:** This Policy, the application, endorsements, riders and any attached papers constitute the entire contract. No one has the authority to change this Policy or to waive any of its provisions unless the change is approved in writing by a Company Officer. The approval must be written on or attached to this Policy.

**TIME LIMIT ON CERTAIN DEFENSES:** If there has been a misrepresentation in Your application, We may rescind (void) this Policy or deny a claim: (a) while this Policy has been in force for 2 years, if the misrepresentation is Material Information We relied on in Our decision to provide You insurance Coverage under this Policy; or (b) at any time during the term of Coverage if You made a material misrepresentation to procure the Policy.

**MISSTATEMENT OF AGE:** If Your age has been misstated in Your application for this Policy and the premium amount would have been different had the correct age been disclosed, Your premium will be adjusted based on the correct age upon reasonable notice to You. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue Coverage. If based on Your true age this Policy would not have been issued, We will be liable only for the refund of premiums paid for this Policy.

**GRACE PERIOD:** A grace period of thirty-one (31) Days from Your Premium Due Date will be allowed for late payment of premium. During such Grace Period, this Policy will not lapse as long as You pay Your full premium before the end of the Grace Period.

**REINSTATEMENT:** If You do not pay Your premium by the end of the Grace Period, this Policy will lapse. Acceptance of premium by Us or Our duly authorized agent, without requiring an application for reinstatement, will reinstate this Policy. If We or Our agent require an application for reinstatement and issues a conditional receipt for the premium tendered, You must apply for reinstatement within one hundred and eighty (180) Days of the lapse in writing to Our administrative office. If We have not already acted to approve or decline Your application for reinstatement, this Policy will be reinstated without approval forty-five (45) Days after You apply for reinstatement. If the application for reinstatement is disapproved, any premium received will be returned to You. If the application for reinstatement is approved, the reinstated policy will cover only Loss sustained after the Effective Date of reinstatement and Loss due to such sickness as may begin more than 10 Days after such date. In all other respects, You and the Company shall have the same rights under this Policy as were in effect before it lapsed,

subject to the provisions of any rider which may be attached in connection with the reinstatement.

**NOTICE OF CLAIM:** Written notice of claim must be given to the Company within twenty Days after the beginning of any Loss covered by this Policy. If notice cannot be given within that period, it must be given as soon as is reasonably possible. The notice will be considered sufficient if it identifies You and is sent to the Company Claims Department address or given to any authorized agent of the Company.

**CLAIM FORMS:** The Company, after receiving notice of claim, will furnish to the claimant forms for filing proof of Loss. If forms are not furnished within 10 Days after the giving of such notice, the claimant will be considered to have met the requirements of this Policy for proof of Loss if the Company is furnished proof of Loss as stated below.

**TIME OF PAYMENT OF CLAIMS:** Benefits payable under this Policy will be paid within 15 Days after the Company receives written proof of Loss.

**PROOF OF LOSS:** Written proof of Loss must be sent to the Company Claims Department address within 90 Days after the date of Loss. Failure to furnish proof within 90 Days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

When We receive written proof of Loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Claims Information Requirements provision below. We will not pay benefits if the required information or authorization for its release is not furnished to Us. If You have other insurance with Us, We may use information received through such insurance when determining benefits under this Policy.

**CLAIMS INFORMATION REQUIREMENTS:** To determine Our liability, We may request additional information from You, a Health Care Practitioner, facility, or other individual or entity. You must cooperate with Us, and assist Us by obtaining the following information within 30 Days of Our request. Claims will be denied if We are unable to determine Our liability because You, Health Care Practitioner, facility, or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.
2. Provide Us with any medical records requested by Us.
3. Provide Us with

information We  
requested about  
pending claims.

4. Provide Us with information that is accurate and complete.
5. Have any examination completed as requested by Us.
6. Provide reasonable cooperation to any requests made by Us.

**PAYMENT OF CLAIMS:** All Benefit Amounts are payable to You unless We receive proof of an assignment of benefits to pay Your health care provider. Any Benefit Amounts or unearned premium unpaid at Your death will be paid at our option to Your spouse, Your domestic partner or to Your estate. Any amount We pay in good faith will release Us from further liability for that amount.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** We, at our expense, shall have the right and opportunity to have a Physician examine You when and as often as We may reasonably require while a claim is pending under Your Policy, and to request an autopsy in case of death where it is not prohibited by law.

**LEGAL ACTION:** No action at law or in equity can be brought to recover on this Policy until 60 Days after written proof of Loss has been given to the Company. No action can be brought after 3 years from the date written proof of Loss is required.

**CONFORMITY WITH STATE STATUTES:** Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which You reside on such date is automatically changed to meet the minimum requirements of such statutes.

**SEVERABILITY:** If any clause or portion of this Policy is held invalid by a court or otherwise unenforceable, the remainder of the Policy shall not be affected.

**UNPAID PREMIUMS:** When benefits are paid for a claim under this Policy, any premium due and unpaid may be deducted, at Our option, from the benefits payable.

**TERM OF COVERAGE:** Your Policy starts on the Effective Date at 12:01 A.M. where You live. It ends at 12:01 A.M. where You live on the termination date as described in the Policy Termination section.

**IN WITNESS WHEREOF,** Continental Life Insurance Company of Brentwood, Tennessee has caused this Policy to be signed and attested by its authorized Executive Officers.



President

Secretary

**CONTINENTAL LIFE INSURANCE COMPANY OF  
BRENTWOOD, TENNESSEE  
HOME OFFICE**

800 Crescent Centre Dr., Suite 200  
Franklin, Tennessee 37067

Telephone: [1-800-264-4000](tel:1-800-264-4000)

LIMITED BENEFITS POLICY

## **Fixed Indemnity Benefits**

**If You need information or have questions regarding  
Your policy, please contact:**

Continental Life Insurance Company of Brentwood,  
Tennessee

Attention: Policyholder Services

P.O. Box 1188  
Brentwood, TN 37024-9486  
[800 264.4000](tel:8002644000) Phone  
[855 291.0553](tel:8552910553) Fax

**To submit a claim:**

Continental Life Insurance Company of Brentwood,  
Tennessee

Attention: Claims Department  
P.O. Box 5008  
Brentwood, TN 37024  
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