Critical Illness Insurance

FIELD REFERENCE GUIDE

Underwriting Rules

Introduction

Your importance in the underwriting process cannot be overemphasized. The job you do affects your client's feeling toward you and the Companies, and it can affect the availability of this type of insurance at an affordable price.

Issue Ages

Ages 20 through 59

Individual Critical Illness State Availability

Individual Critical Illness is available in all states except:

- Connecticut
- Maryland
- Massachusetts
- New Hampshire
- New Jersey

Couples

If	Then use policy/certificate form	With the annual policy/certificate fee of
Both husband and wife are issued,	CI1/CCI1 (one policy/certificate per person)	$25 per policy
One spouse is issued	CI/CCI	$50

Client Interview Process

A Client Interview will be completed on each application for benefit amounts of $100,000 or greater. For benefit amounts under $100,000, interviews will be conducted at underwriter discretion.

Underwriting Outcomes

Band 1 Critical Illness insurance uses simplified underwriting and is issued as:

- Class 1 (C1)
- Class 2 (C2)
- Class 3 (C3)
- Declined

Band 2 Critical Illness insurance is fully underwritten and issued as:

- Standard;
- Substandard with rate-up (25%, 50%, 75% or 100%);
- Some elimination riders (i.e. deafness and blindness); or
- Declined

Attending Physician Statement

Generally, Attending Physician's Statements will be ordered more often with critical illness applications. Some conditions which may require an APS are recent doctor visits, circulatory disorders (high blood pressure) and growth removal (polyps and moles).

Attending Physician's Statement (APS) requirements:

- If the proposed insured has not seen a doctor within the last 2 years and:
  (a) Is age 50 or older and/or
  (b) Is applying for a benefit of $250,000 or greater

  then the proposed insured must have a complete physical exam by an M.D. at the proposed insured's expense.

Underwriting Rules, Continued

Benefit Amounts

Benefits are purchased:

- In increments of $1,000
- With a $10,000 minimum benefit

Financial Guidelines

Benefit amounts should generally be within 3 to 5 times annual income plus outstanding mortgage balance.

Financial requirements for benefits of $250,000 and above:

- For self-employed individuals: 2 years proof of income including complete tax returns
- For salaried individuals: the most recent W2 or pay stub showing one full month with year-to-date earnings
- For all individuals: cover letter to justify benefit amount
  - include how the requested benefit amount was derived (example – three times annual salary plus mortgage balance)
- Underwriters may request these additional requirements for amounts less than $250,000 if needed to qualify the risk

Critical Illness coverage may be issued in addition to critical illness coverage with another company as long as the total benefits do not exceed $1,000,000 (in Georgia, $250,000) and follow the Risk Class Guidelines.

For business situations, such as buy-sell, key person or credit protection, please provide a cover letter outlining the basis for determination of the benefit amount.

Risk Class Guidelines

Band 1 – Simplified Issue
($10,000 - $99,000)

Risk Class	Maximum Benefit Amount Available
1	$99,000
2	$99,000
3	$50,000

Band 2 – ($100,000 - $1,000,000)

Risk Class	Maximum Benefit Amount Available
Standard	$1,000,000
+25	$500,000
+50	$250,000
+75	$100,000
+100	$50,000

In Georgia, Critical Illness coverage may be issued in addition to critical illness coverage with another company as long as the total benefits do not exceed $250,000 and follow the Georgia Risk Class Guidelines.

Georgia Risk Class Guidelines

Band 1 – Simplified Issue
($10,000 - $99,000)

Risk Class	Maximum Benefit Amount Available
1	$99,000
2	$99,000
3	$50,000

Band 2 – ($100,000 - $1,000,000)

Risk Class	Maximum Benefit Amount Available
Standard, +25 and +50	$250,000
+75	$100,000
+100	$50,000

Underwriting Rules, Continued

Application
Use the currently approved Critical Illness application in your state.

Modes
The premium modes for Critical Illness insurance are the following:

- Annual
- Semiannual
- Quarterly
- Bank Service Plan (BSP)
- Payroll Deduction (PRD)

Regular monthly mode is NOT available.

Riders
The following riders may be used where approved:

- 0HA5M Disability Benefit Rider
  Not available in: AR, CA, CT, FL, IA, IL, KS, LA, MA, MD, MO, NH, NJ, NY, OR, PA, PR, SC, SD, VA, VI, VT and WA
- 0HA6M Accidental Death and Dismemberment Benefits Rider
  Not available in: CT, ID, MA, MD, NH, NJ, NY and WA
- 0HA2M Association Group Hospital Confinement Benefit Rider
  Not available in: CT, IA, MA, MD, NH, NJ, NY, OR, TN and WA

The premium payor rider may not be used.

DI Benefit Rider (0HA5M)
This rider may be added to both new and inforce CI/CI1/CCI/CCI1 policies/certificates (or state equivalent). An applicant may not use this rider in order to replace an existing disability or income replacement plan. The applicant also must be employed at least 30 hours per week.

The maximum benefit is the lesser of $100,000 or the critical illness benefit.

Issue Exceptions
CI/CI1/CCI/CCI1 may not be issued to persons on Medicare or Medicaid.

Foreign Nationals
CI/CI1/CCI/CCI1 may not be issued to Foreign nationals living in the U.S. for less than 3 years. (To be eligible, these individuals must have 3 years of uninterrupted residency in the U.S. Proof of alien status will be required (i.e., Alien Registration number and inspection of Registration Receipt Card – green card).

Guidelines when Considering Immigrants and Non-Immigrants for Insurance Coverage (M24221)
Acceptable Immigrant Status for Consideration and/or Health Insurance Coverage. An individual with a valid Alien Registration Receipt Card (also known in layman's term as a "Green Card") will be eligible to apply for such coverage. In addition, the individual must meet all four requirements listed below:

1. Reside in the United States for a minimum of 12 consecutive months to apply for life insurance coverage and 36 consecutive months to apply for health insurance coverage.
2. Have a minimum net annual income of $20,000 from U.S. based assets or entitlement benefits (i.e., social security or pension benefits) or U.S. based employment.
3. Show intent to reside permanently in the United States. Some examples of this intent are:
   - Own a home in the United States,
   - Own business in the United States, and/or,
   - Have child or children who are United States citizens and who reside in the United States.

Underwriting Rules, Continued

4. Complete the Foreign National Questionnaire (L5719_1103).

Unacceptable Non-Immigrant Visas. Except as otherwise noted below, individuals who have the following temporary visas WILL NOT be considered for life and/or health insurance coverage:

A-1	D-2	H-1C	L-2*	P-4
A-2	E1	H-2A	M-1	Q-1
A-3	E2	H-2B*	M-2	Q-3
B-1	F1	H-3	N-8	R-1
B-2	F2	H-4	N-9	R-2
C-1	G1	J-1	O-1	S-5
C-1D	G2	J-2	O-2	S-6
C-2	G3	K-1	O-3	
C-3	G4	K-2	P-1	
C-4	G5	L-1A*	P-2	
D-1	H-1B*	L-1B*	P-3	

We will also not consider individuals who reside in the United State because of their receipt of a Political Asylum or Humanitarian Asylum Visa.

***Note:** Some individuals who have a valid H-1B, H-2B, L-1A, L-1B, or L-2 visa may be considered for life and/or health insurance coverage. The producer must contact Life Underwriting and/or Health Underwriting, as applicable, to discuss the case and obtain the applicable underwriting approval before completing an application.

Military

CI/CI1/CCI/CCI1 may be issued to active Military officers and non-commissioned officers (Sergeant E-5 and above) only.

Consideration Guide

The following list of medical conditions can be utilized to help you determine the insurability of your clients. Conditions not listed, multiple medical conditions, or the use of multiple medications will be evaluated by our Underwriting Department to determine insurability.

	Band 1	**Band 2**
Asthma		
Mild	C1	Standard
Moderate	Decline	+75
Severe	Decline	Decline
Atrial Fibrillation		
Paroxymal		
No cause found and no underlying cardiac disease	Decline	+100
If under treatment with anticoagulation	Decline	+75
Chronic or recurrent		
No cause found and no underlying cardiac disease, on anticoagulation therapy and no cardiac impairment	Decline	+75
If not on anticoagulation therapy or cardiac impairment present	Decline	Decline
Benign Breast Disorders		
Fibrocystic disease diagnosed within 2 years and no biopsy performed or pending	C3	+50
Breast disorders that include a biopsy (pathology report required)	Insurability and rating based upon pathology report	Insurability and rating based upon pathology report

Underwriting Rules, Continued

Cholesterol

Ages 0-49 years

Cholesterol/HDL Ratio										
TOTAL CHOLESTEROL	**<5.7**		**5.7-7.1**		**7.2-8.6**		**8.7-10.0**		**>10.0**	
	Band 1	Band 2	Band 1	Band 2	Band 1	Band 2	Band 1	Band 2	Band 1	Band 2
<200	C1	+0	C1	+0	C3	+50	Decline	+75	Decline	+100
200-240	C1	+0	C1	+0	Decline	+75	Decline	+100	Decline	Decline
241-300	C1	+0	C3	+50	Decline	+100	Decline	+100	Decline	Decline
301-350	C2	+25	Decline	+75	Decline	+100	Decline	Decline	Decline	Decline
351-400	C3	+50	Decline	+100	Decline	Decline	Decline	Decline	Decline	Decline
>400	Decline	Decline	Decline	Decline	Decline	Decline	Decline	Decline	Decline	Decline

Ages 50 and over

Cholesterol/HDL Ratio										
TOTAL CHOLESTEROL	**<5.7**		**5.7-7.1**		**7.2-8.6**		**8.7-10.0**		**>10.0**	
	Band 1	Band 2	Band 1	Band 2	Band 1	Band 2	Band 1	Band 2	Band 1	Band 2
<200	C1	+0	C1	+0	C2	+25	C3	+50	Decline	+75
200-240	C1	+0	C1	+0	C3	+50	Decline	+75	Decline	+100
241-300	C1	+0	C1	+0	Decline	+75	Decline	+100	Decline	Decline
301-350	C1	+0	C3	+50	Decline	+100	Decline	Decline	Decline	Decline
351-400	C2	+25	Decline	+75	Decline	+100	Decline	Decline	Decline	Decline
>400	Refer to MD	Refer to MD	Refer to MD	Refer to MD	Decline	Decline	Decline	Decline	Decline	Decline

If cholesterol/HDL ratio is not available, then rate the cholesterol alone as follows:

Ages 0-49 years		Band 1	Band 2
Total Cholesterol	<250	C1	+0
	251-300	C3	+50
	301-350	Decline	+100
	>351	Decline	Decline
Ages 50 and over			
Total Cholesterol	<250	C1	+0
	251-300	C2	+25
	301-350	Decline	+75
	351-400	Decline	+100
TRIGLYCERIDES (12 HOUR FASTING SAMPLE)			
	<400	C1	+0
	401-800	C3	+50
	>800	Refer to MD	Refer to MD

Diabetes Mellitus	**Band 1**	**Band 2**
Type I: Formerly called juvenile onset (JODM) or insulin-dependent diabetes mellitus (IDDM)	Decline	Decline
Type II: Formerly called adult onset (AODM) or non-insulin dependent diabetes mellitus (NIDDM). Consider only those candidates with good blood sugar control, i.e., HBA1C under 8%, no microalbuminuria, no complications (including neuropathy, peripheral vascular disease, renal impairments, or retinopathy or diabetic coma) and no debits for build (over +50%) blood pressure, or lipids.		

Must have current HBA1C and Microalbumin readings.

Underwriting Rules, Continued

Age at diagnosis:	**Band 1**	**Band 2**
Under age 45	Decline	Decline
Age 46-54	Decline	+100
Age 55 and up	C3	+75/+50
Gestational Diabetes: Can consider 3 months post partum.		
Normal blood profile	C1	Standard
Abnormal	Rate for findings	Rate for findings
Papanicolaou (PAP) or Cervical Smears		
Screening Test: Papanicolaou (PAP Smear)		
Class I (normal)	C1	Standard
Class II (atypical)	C1	Standard
Class III (dysplasia)	Postpone*	Postpone*
Class IV (carcinoma in situ)	Decline	Decline
Class V (invasive carcinoma)	Decline	Decline

**With treatment and resolution of abnormality, confirmed with normal (Class I) PAP results, allow Standard.*

Polyps

Certain types of non-malignant colon and small intestine polyps may be standard.

Uninsurable Conditions

Overview

Because of the nature of Critical Illness insurance, certain medical conditions will cause an individual to be ineligible for coverage.

Uninsurable Conditions

If a person has or **ever** has had any of the following medical conditions, he or she is **NOT** eligible for Critical Illness coverage. This list is **NOT** all inclusive, but does include many of the unacceptable health problems you may encounter:

1. AIDS, HIV+*
2. Alcohol or Drug Abuse (treatment within 5 years)
3. Alzheimer's Disease
4. Angina
5. Angioplasty
6. Cancer (does not include skin cancer)
7. Cardiomyopathy
8. Chronic Kidney Disease
9. Congestive Heart Failure
10. Coronary Artery Bypass
11. Cystic Fibrosis
12. Heart Attack
13. Hepatitis C
14. Huntington's Chorea
15. Insulin Dependent or Uncontrolled Diabetes
16. Kidney Failure
17. Major Organ Transplant
18. Multiple Sclerosis
19. Muscular Dystrophy
20. Permanent Paralysis
21. Polycystic Kidney Disease
22. Stroke
23. Systemic Lupus Erythematosis

*See state special guidelines for California.

Family History Guidelines

Overview

Family history can affect an applicant's eligibility or rating for Critical Illness coverage. Use the following information as guidelines in qualifying an applicant with a significant family history.

NOTE: The following examples represent the most frequent family history scenarios. The table is not intended to represent the only situations where underwriting action would be taken due to family history.

Family History

Family history can affect an applicant's eligibility or rating for critical illness coverage and is a more significant risk factor than with respect to life insurance. Family history includes notable health history on any first-degree relative (defined as a natural parent or a natural brother or sister). It doesn't include grandparents, aunts, uncles, stepparents or stepbrothers or stepsisters.

Conditions such as heart disease, stroke, high cholesterol and diabetes demonstrate a genetic disposition. Certain types of cancer have a strong genetic tendency. For example, someone with a family member that has had breast, ovarian and colon cancer has an increased risk of developing those types of cancer. Generally, the younger the family member was diagnosed the more the risk increases.

Asking the family history question – "Have you or any first degree relative been diagnosed with cancer, heart disease or diabetes before age 60?" – is critical while completing the application with your client. Unless two or more first-degree relatives have been diagnosed prior to age 60, family history isn't an issue and there will be no rating. The exception will be breast and colon cancer, when there could be a rating if one first degree relative was diagnosed with colon or breast cancer prior to age 60.

Family history may be taken into consideration with other factors such as obesity, high blood pressure, high cholesterol and smoking.

Cancer – Consider All Malignant Tumors Diagnosed in Any Family Member Prior to Age 60

	Band 1	**Band 2**
Single Family Member with History of Cancer		
Malignant Tumors other than Breast or Colon	C1	Standard
Multiple Family Members with History of Cancer		
Malignant Tumors other than Breast or Colon, diagnosed in different locations:		
Two family members	C3	+50
Three family members	Decline	Decline
Four family members	Decline	Decline
*Credit – 25% if applicant is over age 50		
Malignant Tumors other than Breast or Colon, same location:		
Two family members	Decline	+100
Three or more family members	IC, Usually Decline	IC, Usually Decline
*Credit – 25% if applicant is over age 50		
Malignant Tumors **including** one Breast or Colon, diagnosed in different locations		
Two family members	Decline	+100
Three or more family members	Decline	Decline

Family History Guidelines, Continued

Breast Cancer (in immediate family members before age 60)		
	Band 1	**Band 2**
Note: If genetic test are available	Refer to MD	
Female applicants		
One family member:		
Applicant under age 50		
Onset in family member under age 50	C3	+50
Onset in family member between ages 50-60	C2	+25
Applicant over age 50		
Onset in family member under age 50	C2	+25
Onset in family member between ages 50-60	C1	Standard
Two family members:		
Applicant under age 50		
Onset in both family members under age 50	Decline	Decline
Onset in one family member under age 50 and the other between 50-60	Decline	+100
Onset in both family members between ages 50-60	Decline	+75
Applicant over age 50		
Onset in both family members under age 50	Decline	+100
Onset in one family member under age 50 and the other between 50-60	Decline	+75
Onset in both family members between ages 50-60	C3	+50
Three or more family members	Decline	Decline
Male applicants		
Two or more females with breast cancer in immediate family	C2	+25
Colorectal Cancer (excluding Familial Adenomatous Polyposis and HNPCC)		
Diagnosed in immediate family member before age 60		
One family member	C3	+50
Two family members	Decline	+100
Three or more family members	Decline	Decline
Familial Adenomatous Polyposis (FAP)		
A rare disease inherited autosomal dominantly which can be genetically screened for. It is characterized by a large number of adenomatous tumors arising from the mucouslining of the colon and rectum, which inevitably undergo malignant change. **Congenital hypertrophy of the retinal pigment epithelium (CHRPE)** is present in two-thirds of those suffering with FAP and is useful for screening purposes in your patients.		
Definite diagnosis of immediate family member		
No genetic test performed		
Normal colonoscopy and no history of polyps		
No hypertrophy of retinal pigment epithelium		
Age 40 and under	Decline	Decline
Over age 40	C1	Standard

Family History Guidelines, Continued

Hereditary Nonpolyposis Colorectal Cancer (HNPCC)		
The clinical criteria for hereditary nonpolyposis colorectal cancer (HNPCC) include 3 or more first degree relatives (spanning at least 2 generations) with colon cancer, with one or more cases diagnosed before age 50. The colon cancers associated with this syndrome often occur on the right side of the colon and women with this syndrome also have increased risk of ovarian and endometrial cancers.		
	Band 1	**Band 2**
All applicants	Decline	Decline
Cardiovascular, Cerebrovascular (in immediate family members before age 60)		
Immediate family members are considered to be parents and siblings, both male and female lives.		
One family member:	C1	Standard
Two family members:		
Applicant under age 50		
Onset in both family members under age 50	Decline	Decline
Onset in one family member under age 50 and the other member 50-60	Decline	+100
Onset in both family members between 50-60	Decline	+75
Applicant over age 50*		
Onset in both family members under age 50	Decline	+100
Onset in one family member under age 50 and the other member 50-60	Decline	+75
Onset in both family members between 50-60	C3	+50
Three or more family members:	IC, Usually Decline	
*Consider a credit of 25% in non-smoking applicants over age 50 with normal lipids, blood pressure, no build debits, and normal ECG if available.		
Diabetes		
Diagnosis in immediate family member before age 60		
One immediate family member	C1	Standard
Two or more immediate family members*		
Both NIDDM	C3	+50
Bone NIDDM and one IDDM	Decline	+75
Both IDDM	Decline	+100
*Credit 25% for applicants over age 50 with normal blood profile, build, blood pressure, lipids, and no adverse health history.		

Substandard Ratings

The Critical Illness underwriter will determine any final, substandard rating by using the:

- Application;
- Interview; and
- Other requirements needed

Address any specific questions to the Underwriting Department.

Build Chart

Use the following table in the underwriting process to determine standard and substandard rates or decline for Critical Illness insurance coverage.

Band 1 – Simplified Issue
($10,000 - $99,000)

			Weight Range to be Considered as:			
Height Feet and Inches	**Height Inches**	**Decline Below**	**Class 1**	**Class 2**	**Class 3**	**Decline Over**
4′8″	56″	80	80 - 129	130 - 138	139 - 151	152+
4′9″	57″	83	83 - 134	135 - 143	144 - 157	158+
4′10″	58″	86	86 - 138	139 - 148	149 - 162	163+
4′11″	59″	89	89 - 143	144 - 153	154 - 168	169+
5′0″	60″	92	92 - 148	149 - 158	159 - 174	175+
5′1″	61″	95	95 - 153	154 - 164	165 - 179	180+
5′2″	62″	98	98 - 158	159 - 169	170 - 185	186+
5′3″	63″	102	102 - 163	164 - 175	176 - 191	192+
5′4″	64″	105	105 - 168	169 - 180	181 - 198	199+
5′5″	65″	108	108 - 174	175 - 186	187 - 204	205+
5′6″	66″	112	112 - 179	180 - 192	193 - 210	211+
5′7″	67″	115	115 - 185	186 - 197	198 - 217	218+
5′8″	68″	118	118 - 190	191 - 203	204 - 223	224+
5′9″	69″	122	122 - 196	197 - 209	210 - 230	231+
5′10″	70″	125	125 - 202	203 - 216	217 - 236	237+
5′11″	71″	129	129 - 207	208 - 222	223 - 243	244+
6′0″	72″	133	133 - 213	214 - 228	229 - 250	251+
6′1″	73″	136	136 - 219	220 - 234	235 - 257	258+
6′2″	74″	140	140 - 225	226 - 241	242 - 264	265+
6′3″	75″	144	144 - 232	233 - 248	249 - 272	273+
6′4″	76″	148	148 - 238	239 - 254	255 - 279	280+
6′5″	77″	152	152 - 244	245 - 261	262 - 286	287+
6′6″	78″	156	156 - 250	251 - 268	269 - 294	295+
6′7″	79″	160	160 - 257	258 - 275	276 - 301	302+
6′8″	80″	164	164 - 264	265 - 282	283 - 309	310+
6′9″	81″	168	168 - 270	271 - 289	290 - 317	318+
6′10″	82″	172	172 - 277	278 - 296	297 - 325	326+
6′11″	83″	176	176 - 284	285 - 303	304 - 333	334+

Build rate-ups may be influenced by other health factors such as High Blood Pressure. Applicants with combinations of High Blood Pressure and overweight may be subject to a higher rate-up. However, applicants with well controlled blood pressure that do not have any other impairments may be rated standard.

Build Chart

Use the following table in the underwriting process to determine standard and substandard rates or decline for Critical Illness insurance coverage.

Band 2
($100,000 - $1,000,000)

			Weight Range to be Considered as:					
Height Feet and Inches	**Height Inches**	**Decline Below**	**Standard**	**+25%**	**+50%**	**+75%**	**+100%**	**Decline Over**
4′8″	56″	80	80 - 129	130 - 138	139 - 151	152 - 160	161 - 173	174+
4′9″	57″	83	83 - 134	135 - 143	144 - 157	158 - 166	167 - 180	181+
4′10″	58″	86	86 - 138	139 - 148	149 - 162	163 - 172	173 - 186	187+
4′11″	59″	89	89 - 143	144 - 153	154 - 168	169 - 178	179 - 193	194+
5′0″	60″	92	92 - 148	149 - 158	159 - 174	175 - 184	185 - 199	200+
5′1″	61″	95	95 - 153	154 - 164	165 - 179	180 - 190	191 - 206	207+
5′2″	62″	98	98 - 158	159 - 169	170 - 185	186 - 196	197 - 213	214+
5′3″	63″	102	102 - 163	164 - 175	176 - 191	192 - 203	204 - 220	221+
5′4″	64″	105	105 - 168	169 - 180	181 - 198	199 - 209	210 - 227	228+
5′5″	65″	108	108 - 174	175 - 186	187 - 204	205 - 216	217 - 234	235+
5′6″	66″	112	112 - 179	180 - 192	193 - 210	211 - 223	224 - 241	242+
5′7″	67″	115	115 - 185	186 - 197	198 - 217	218 - 229	230 - 249	250+
5′8″	68″	118	118 - 190	191 - 203	204 - 223	224 - 236	237 - 256	257+
5′9″	69″	122	122 - 196	197 - 209	210 - 230	231 - 243	244 - 264	265+
5′10″	70″	125	125 - 202	203 - 216	217 - 236	237 - 250	251 - 271	272+
5′11″	71″	129	129 - 207	208 - 222	223 - 243	244 - 258	259 - 279	280+
6′0″	72″	133	133 - 213	214 - 228	229 - 250	251 - 265	266 - 287	288+
6′1″	73″	136	136 - 219	220 - 234	235 - 257	258 - 272	273 - 295	296+
6′2″	74″	140	140 - 225	226 - 241	242 - 264	265 - 280	281 - 303	304+
6′3″	75″	144	144 - 232	233 - 248	249 - 272	273 - 288	289 - 312	313+
6′4″	76″	148	148 - 238	239 - 254	255 - 279	280 - 295	296 - 320	321+
6′5″	77″	152	152 - 244	245 - 261	262 - 286	287 - 303	304 - 328	329+
6′6″	78″	156	156 - 250	251 - 268	269 - 294	295 - 311	312 - 337	338+
6′7″	79″	160	160 - 257	258 - 275	276 - 301	302 - 319	320 - 346	347+
6′8″	80″	164	164 - 264	265 - 282	283 - 309	310 - 327	328 - 355	356+
6′9″	81″	168	168 - 270	271 - 289	290 - 317	318 - 335	336 - 363	364+
6′10″	82″	172	172 - 277	278 - 296	297 - 325	326 - 344	345 - 373	374+
6′11″	83″	176	176 - 284	285 - 303	304 - 333	334 - 352	353 - 382	383+

Build rate-ups may be influenced by other health factors such as High Blood Pressure. Applicants with combinations of High Blood Pressure and overweight may be subject to a higher rate-up. However, applicants with well controlled blood pressure that do not have any other impairments may be rated standard.

Occupations

CI/CI1/CCI/CCI1

Most occupations will be considered standard for the Critical Illness product. The following occupations, however, are examples of "risky" occupations and would normally be ineligible for Critical Illness coverage:

- Asbestos Workers
- Underground Miners
- Commercial Divers

AD&D Benefit Rider (0HA6M) (May not be available in all states)

Certain occupational classes, which are usually characterized by the existence of significant injury hazard, extreme physical demands, unfavorable working conditions or unstable employment are usually ineligible for this rider.

The following occupations are examples of such occupations which would be ineligible for the AD&D rider (0HA6M):

- Professional Athletes – Boxers/Jockeys
- Blasters & Explosive Handlers
- Structural Workers – Iron Workers
- Sky Divers
- Mountain Climbers
- Racing Drivers
- Underground Workers
- Underwater Workers

Benefits are purchased:

- In increments of $1,000
- With a $10,000 minimum benefit, and a
- Maximum benefit amount equal to or less than the base amount not to exceed $500,000

Client Interview Requirements

Client Interview Process

Use the client interview process with the individual Critical Illness product. Follow these steps:

- Complete the application,
- Collect the premium amount (at least 2 months BSP),
- Determine and execute the necessary testing procedures (blood & urine, paramed, etc.), and
- Call a Client Interviewer through the PAL line for completion of an interview.

Indicate all the initiated or completed underwriting requirements on the submission checklist located on the application.

Client Interview Requirements

The following table provides the procedures required for applicants according to both age and coverage amount (not applicable in Georgia):

Age	$10,000 to $99,000	$100,000 to $199,000	$200,000 to $499,000	$500,000 to $1,000,000
20-39	Interview H.O. Underwriter Discretion	Interview *Physical Data *Blood & Urine	Interview *Paramed *Blood & Urine	Interview Paramed Blood & Urine MVR
40-49	Interview H.O. Underwriter Discretion	Interview *Physical Data *Blood & Urine	Interview *Paramed *Blood & Urine	Interview Paramed Blood & Urine EKG MVR
50-59	Interview H.O. Underwriter Discretion	Interview *Physical Data *Blood & Urine	Interview *Paramed *Blood & Urine	Interview M.D. Exam Blood & Urine EKG MVR

*This requirement may be waived if medical records are available within 12 months of an M.D. visit which included a blood and urinalysis and physical data. These cases should include a current oral fluid.

Interview – A complete detailed client phone interview
Blood & Urine – A blood and urine collection by an approved paramedical vendor
Physical Data – Hgt/Wgt, blood pressure and pulse recorded on lab ID slip by paramed
Paramed – A long form paramedical exam (form L2-9-88)
M.D. Exam – M.D. completed paramedical exam (specializing in internal medicine) on form L2-9-88
EKG – Electrocardiogram
TEKG – Treadmill Electrocardiogram
2 View X-ray – PA and lateral view chest X-ray (if smoker)
MVR – Motor Vehicle Report

Client Interview Requirements For Georgia

Age	$10,000 to $99,000	$100,000 to $199,000	$200,000 to $250,000
20-59	Interview H.O. Underwriter Discretion	Interview *Physical Data *Blood & Urine	Interview *Paramed *Blood & Urine

*This requirement may be waived if medical records are available within 12 months of an M.D. visit which included a blood and urinalysis and physical data. These cases should include a current oral fluid.

KEY:

Interview – A complete detailed client phone interview

Blood & Urine – A blood and urine collection by an approved paramedical vendor

Physical Data – Hgt/Wgt, blood pressure and pulse recorded on lab ID slip by paramed

Paramed – A long form paramedical exam (form L2-9-88)

Client Interview Process

Band 2 only – ($100,000 - $1,000,000)

Band 1-Client interviews will be conducted from home office at underwriter discretion

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A personalized underwriting process designed to recognize that no two of our clients are the same. The agent thoroughly prepares the client for a one-on-one dialogue with the underwriter, and the pertinent health information is gathered.

For Best Results

1. Complete and sign the application.
2. Review "The Importance of an Accurate Health History" with the client.
3. Orient the client with the client profile interview. Advise the client that the interview will be recorded. Displaying confidence in the process will reduce the client's concerns.
4. Have the client gather his or her doctor and medication information.
5. Make the phone call – greet the client interviewer in a warm, friendly manner.
6. Turn the phone over to the client to begin the client profile interview. Allow the client complete privacy during the interview.

Completing a Client Profile

Call PAL **1-800-775-3000** and choose client profile option (press 1).

Hours: 8:00 a.m. – 8:00 p.m. CST Monday – Thursday

8:00 a.m. – 5:00 p.m. CST Friday

Glossary

Alzheimer's Disease

Policy Definition

Alzheimer's Disease means a progressive degenerative disease of the brain. In order to meet the definition of Alzheimer's Disease, the Diagnosis must be supported by medical evidence that the insured exhibits the loss of intellectual capacity resulting in impairment of memory and judgment. This impairment results in a significant reduction in mental and social functioning, such that the insured requires permanent daily personal supervision and is unable to perform independently three or more of the following activities of daily living: transferring (moving in or out of a bed or chair), dressing, bathing, feeding, toileting, and continence. No other dementing organic brain disorders or psychiatric illnesses shall meet the definition of Alzheimer's Disease, nor will they be considered a Critical Illness Insured Condition. In order for Alzheimer's Disease to be covered under this policy/certificate, the Legally Qualified Physician making the Diagnosis of Alzheimer's Disease must be a board certified neurologist.

Practical Interpretation

Alzheimer's Disease is a progressive degenerative brain disease characterized by memory loss and loss of judgment resulting in a significant reduction in mental and social functions. To receive policy/certificate benefits, the insured must require permanent daily supervision and be unable to perform three or more activities of daily living.

Critical Illness Insurance Plan Pays

for Alzheimer's Disease when a neurologist diagnoses the insured with the advanced stage of Alzheimer's in which he/she:

- requires permanent daily supervision, and
- cannot do three or more of these activities of daily living without help:
    1. move in or out of a bed or chair (transferring)
    2. dress
    3. bathe
    4. feed
    5. use the toilet
    6. control the bladder.

Blindness

Policy Definition

Blindness means the permanent and uncorrectable loss of sight in both eyes. In order for the Diagnosis of Blindness to be covered under this policy/certificate, the insured's corrected visual acuity must be worse than 20/200 in both eyes or the insured's field of vision must be less than 20 degrees in both eyes. The Legally Qualified Physician making the Diagnosis of Blindness must be a board certified ophthalmologist.

Practical Interpretation

To receive benefits, an ophthalmologist must diagnose Blindness as permanent in both eyes and despite corrective lenses, the vision cannot be improved beyond 20/200. Diabetes, an accident, or a disease can cause Blindness, which can be of sudden or gradual onset.

Critical Illness Insurance Plan Pays

for Blindness when an ophthalmologist confirms the insured's:

- vision cannot be corrected to better than 20/200 in both eyes, or
- field of vision must be less than 20 degrees in both eyes.

Cancer

First Carcinoma in Situ

Policy Definition

First Carcinoma in Situ means the first Diagnosis of cancer wherein the tumor cells still lie within the tissue of the site of origin without having invaded neighboring tissue. This does not include skin cancer. First Carcinoma in Situ must be Diagnosed pursuant to a Pathological Diagnosis or Clinical Diagnosis.

Practical Interpretation

First Carcinoma in Situ is a condition in which malignant cells have the potential to invade and metastasize, but have not done so yet.

Exception:

- skin cancer

Limitation:

First Carcinoma in Situ is not covered if, within 30 days following (may vary by state) the policy/certificate issue date or the last reinstatement date, the insured:

- is first Diagnosed with First Carcinoma in Situ, or
- has symptoms or medical problems which result in a First Carcinoma in Situ Diagnosis.

Critical Illness Insurance Plan Pays

for First Carcinoma in Situ when the insured's cancer tumor is:

- malignant,
- located only in its original part of the body (has not spread), and
- pathologically or clinically diagnosed (see Diagnosis).

Cancer, Continued

Life-Threatening Cancer

Policy Definition

Life-Threatening Cancer means a malignant neoplasm (including hematologic malignancy), which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically hereafter excluded. The following types of cancer are not considered a Life-Threatening Cancer: early prostate cancer diagnosed as T1N0M0 or equivalent staging; First Carcinoma in Situ; pre-malignant lesions (such as intraepithelial neoplasia), benign tumors or polyps; any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become Life-Threatening Cancers. Life-Threatening Cancer must be diagnosed pursuant to a Pathological Diagnosis or a Clinical Diagnosis.

Practical Interpretation

Life-Threatening Cancer is an uncontrolled growth of abnormal cells that invade healthy tissue. These growths are called malignant tumors and if untreated, can interfere with normal body functions and ultimately cause death.

Life-Threatening Cancer includes but is not limited to these cancers:

- lung,
- breast,
- colon,
- leukemia, lymphoma,
- prostate (except as described below),
- bone,
- kidney,
- bladder,
- invasive malignant skin cancer (melanoma in the dermis or deeper), and
- skin malignancies that have become life threatening.

Exceptions:

- early prostate cancer diagnosed as a tumor (T1N0M0) or equivalent staging,
- First Carcinoma in Situ,
- pre-malignant lesions, benign or pre-malignant tumors, or polyps, and
- any skin cancer other than invasive malignant melanoma in the dermis or deeper, or skin malignancies that have become Life-Threatening Cancers.

Limitation:

Life-Threatening Cancer is not covered if, within 30 days following (may vary by state) the policy/certificate issue date or the last reinstatement date, the insured:

- is first Diagnosed with Life-Threatening Cancer, or
- has shown symptoms or medical problems which result in a Life-Threatening Cancer Diagnosis.

Critical Illness Insurance Plan Pays

for Life-Threatening Cancer when the insured's cancer is:

- malignant,
- growing uncontrollably outside its original area, and
- pathologically or clinically diagnosed (see Diagnosis).

Deafness

Policy Definition

Deafness means a permanent loss of hearing in both ears with an auditory threshold of more than 90 decibels in each ear. For Deafness to be covered under this policy/certificate, the Legally Qualified Physician making the Diagnosis of Deafness must be a board certified otolaryngologist.

Practical Interpretation

Hearing tests confirm that hearing loss is permanent in both ears.

Critical Illness Insurance Plan Pays

for Deafness when a doctor confirms:

- the insured's hearing loss is permanent in both ears.

Diagnosis

Policy Definition

Diagnosis means the definitive establishment of the Critical Illness Insured Condition through the use of clinical and/or laboratory findings. The Diagnosis must be made by a Legally Qualified Physician who is also a board certified specialist where required under this policy/certificate.

In the case of a First Coronary Angioplasty or First Coronary Artery Bypass Surgery, the Diagnosis includes the performance of the surgical treatment as defined in this policy/certificate.

In the case of a Major Organ Transplant, the Diagnosis includes Mutual of Omaha verification that the insured has been registered by the United Network of Organ Sharing (UNOS).

Practical Interpretation

A Legally Qualified Physician (and board-certified specialist where required) uses clinical and/or laboratory tests to conclude that the insured has a Critical Illness condition.

For	diagnosis includes
■ First Coronary Angioplasty ■ First Coronary Artery Bypass Surgery	surgery as defined in policy/certificate.
Major Organ Transplant	verification that the insured is registered with the United Network of Organ Sharing (UNOS).

Date of Diagnosis

Policy Definition

Date of Diagnosis means the date the Diagnosis is established by a Legally Qualified Physician, who is also a board certified specialist where required under this policy/certificate through the use of clinical and/or laboratory findings as supported by the insured's medical records.

In the case of a First Coronary Angioplasty or First Coronary Artery Bypass Surgery, the Date of Diagnosis is the date of the performance of the surgical treatment as defined in this policy/certificate.

In the case of a Major Organ Transplant, the Date of Diagnosis is the date that the Insured has been registered by the United Network of Organ Sharing (UNOS).

Practical Interpretation

The date a Legally Qualified Physician (and board-certified specialist where required) confirms through clinical and/or laboratory tests that the insured has a Critical Illness condition.

For	the Date of Diagnosis is the date
■ First Coronary Angioplasty ■ First Coronary Artery Bypass Surgery	of surgery as defined in the policy/certificate.
Major Organ Transplant	the insured is registered with the United Network of Organ Sharing (UNOS).

Clinical Diagnosis

Policy Definition

Clinical Diagnosis means a Diagnosis of Life-Threatening Cancer or First Carcinoma in Situ based on the study of symptoms and diagnostic test results. Mutual of Omaha will accept a Clinical Diagnosis of Life-Threatening Cancer or First Carcinoma in Situ only if the following conditions are met:

(a) a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;

(b) there is medical evidence to support the Diagnosis; and

(c) a Legally Qualified Physician is treating the insured for Life-Threatening Cancer and/or First Carcinoma in Situ.

Practical Interpretation

Type of Diagnosis	Conditions
Clinical	■ a physician who is treating the insured for cancer studies symptoms and diagnostic test results, ■ a Pathological Diagnosis is medically inappropriate or life threatening, and ■ medical evidence supports the diagnosis.

Pathological Diagnosis

Policy Definition

Pathological Diagnosis means a Diagnosis of Life-Threatening Cancer or First Carcinoma in Situ based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Legally Qualified Physician who is also a board certified pathologist and whose Diagnosis of malignancy conforms with the standards set by the American College of Pathology.

Practical Interpretation

Type of Diagnosis	Conditions
Pathological	■ a pathologist studies fixed tissue or blood under a microscope, and ■ the diagnosis meets American College of Pathology standards.

Heart Disease

Angioplasty

Policy Definition

First Coronary Angioplasty (surgical treatment) means the first-ever balloon angioplasty or other forms of catheter based percutaneous transluminal coronary artery therapy to correct narrowing or blockage of one or more coronary arteries, performed by a Legally Qualified Physician who is also a board certified cardiologist.

Practical Interpretation

Coronary Angioplasty is a procedure to open blocked arteries on the heart's surface that supply blood to the heart muscle. A balloon or other device reduces the blockage within the artery and restores more normal blood flow. A cardiologist (heart specialist) performs this procedure.

Critical Illness Insurance Plan Pays

for First-Ever Coronary Angioplasty when a cardiologist:

- opens the insured's blocked or narrowing artery(ies) with a balloon or other device to restore normal blood flow.

Bypass Surgery

Policy Definition

First Coronary Artery Bypass Surgery (surgical treatment) means the first-ever coronary artery revascularization surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, performed by a Legally Qualified Physician who is a board certified cardiothoracic surgeon.

Practical Interpretation

First Coronary Artery Bypass Surgery is a surgical operation to restore more normal blood flow to the heart muscle. A cardiothoracic surgeon bypasses blocked arteries using a portion of an artery from the chest wall or a segment of vein from the leg. This requires opening the chest and connecting the patient to a heart-lung machine during the operation.

Critical Illness Insurance Plan Pays

for First-Ever Coronary Artery Bypass Surgery (surgical treatment) when a cardiothoracic surgeon:

- places a healthy artery and/or vein segment(s) around the insured's blocked artery(ies).

Heart Disease, Continued

Heart Attack

Policy Definition

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle, resulting from blockage of one or more coronary arteries. In order to be covered under this policy/certificate, the Diagnosis of Heart Attack (Myocardial Infarction) must be based upon both:

1. new electrocardiographic changes consistent with and supporting a Diagnosis of Heart Attack (Myocardial Infarction), and
2. a concurrent diagnostic elevation of cardiac enzymes.

Practical Interpretation

A heart attack occurs when the blood supply to a portion of the heart's muscle is blocked resulting in permanent tissue death and scarring. The Diagnosis is based upon new changes on the electrocardiographic (ECG or EKG) and affirmative blood tests.

Critical Illness Insurance Plan Pays

for a Heart Attack when the insured's:

- heart's blood supply is blocked,
- heart has permanent tissue death and scarring, and
- diagnosis is based on new changes on the electrocardiogram (ECG or EKG) and blood tests.

Legally Qualified Physician

Policy Definition

Legally Qualified Physician means a person, other than the insured or the Owner, a member of the insured's or the Owner's immediate family, or a business associate of the insured or Owner, who is duly licensed and practicing medicine in the United States, and who is legally qualified to diagnose and treat sickness and injuries. He or she must be providing services within the scope of his or her license, and must be a board certified specialist where required under this policy/certificate.

Practical Interpretation

A Legally Qualified Physician:

is	■ licensed and practicing medicine in the United States, ■ legally qualified to diagnose and treat sickness and injuries, ■ providing services within the scope of his or her license, and ■ a board certified specialist where required under this policy/certificate.
is not	■ the insured or the person or entity the insured assigns as owner, ■ a member of the insured's or owner's immediate family, or ■ the insured's or owner's business associate.

Major Organ Transplant

Policy Definition

Major Organ Transplant means clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the insured to be replaced with the organ(s) or tissue from a suitable donor under generally accepted medical procedures. Those organs or tissues covered by this definition are limited to: liver, kidney, lung, entire heart, small intestine, pancreas, pancreas-kidney or bone marrow. In order for the insured's Major Organ Transplant to be covered under this policy/certificate, the insured must also be registered by the United Network of Organ Sharing (UNOS).

Practical Interpretation

A Major Organ Transplant is a surgical procedure to replace the recipient's malfunctioning organ or tissue with an organ or tissue from a suitable donor. The insured must be registered by the United Network of Organ Sharing.

The following organs or tissues are covered:

- liver
- kidney
- lung
- entire heart
- small intestine
- pancreas
- pancreas-kidney
- bone marrow

Critical Illness Insurance Plan Pays

for a Major Organ Transplant when:

- there is clinical evidence a major organ has failed,
- the insured's malfunctioning organ(s) or tissue must be replaced with a suitable donor's organ(s) or tissue, and
- the insured is registered with the United Network of Organ Sharing.

Multiple Sclerosis*

Policy Definition

Multiple Sclerosis (MS) means the occurrence of at least two episodes of well-defined neurological abnormalities, with objective evidence of lesions at more than one site within the central nervous system. In order for Multiple Sclerosis to be covered under this policy/certificate, a Legally Qualified Physician who is a board certified neurologist must make a definitive Diagnosis of Multiple Sclerosis, supported by modern imaging and/or investigative techniques.

Practical Interpretation

MS is a condition of the nervous system that is commonly progressive and results in multiple and varied nervous symptoms. These may be intermittent and follow a course that alternates from very active to non-existent. A neurologist's diagnosis is based upon abnormal symptoms and physical exam findings. Modern X-ray imaging may also be used to confirm the diagnostic impression.

Neurological symptoms include:

- numbness and tingling in the hand or arm,
- loss of vision in one eye,
- weakness in the leg with difficulty walking, and
- double vision.

Critical Illness Insurance Plan Pays

for Multiple Sclerosis when the insured has:

- at least two episodes of abnormal neurological symptoms, and
- lesions in more than one place in the central nervous system.

*Not a covered condition in Louisiana

Paralysis

Policy Definition

Paralysis means the complete and permanent loss of the use of two or more limbs through neurological injury confirmed to have been present for a continuous period of at least 180 days by a Legally Qualified Physician who is a board certified neurologist. A limb means an arm or leg of the insured.

Practical Interpretation

Paralysis is the complete and permanent loss of the use of two or more limbs from an injury to the nervous system. Accidents and strokes are the most common causes. To clarify the extent of permanent paralysis, a longer waiting period is necessary before benefits are paid.

Critical Illness Insurance Plan Pays

for Paralysis when the insured cannot use two or more limbs:

- completely and permanently
- from an injury to the nervous system, and
- for at least 180 days in a row.

Renal Failure

Policy Definition

Renal Failure means the chronic irreversible failure of both of the kidneys (end-stage renal disease), which requires treatment with regular dialysis. In order for Renal Failure to be covered under this policy/certificate, the Diagnosis of Renal Failure must be made by a Legally Qualified Physician who is a board certified nephrologist.

Practical Interpretation

Renal Failure requires regular dialysis to cleanse the body of naturally-produced waste products.

Critical Illness Insurance Plan Pays

for Renal Failure when:

- the insured's kidneys permanently fail, and
- the insured requires regular dialysis.

Stroke

Policy Definition

Stroke means a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least 30 days following the occurrence of the Stroke. Stroke does not include Transient Ischemic Attack (TIA) or other cerebral vascular events.

In Arkansas: Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery that is diagnosed or treated after the effective date of the policy. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The Stroke must be positively diagnosed by a Legally Qualified Physician based upon documented neurological deficits and confirmatory neuroimaging studies. Stroke does not mean head injury, transient ischemic attack (TIA) or cerebrovascular insufficiency.

Practical Interpretation

Stroke affects the blood vessels supplying blood to the brain. It is also sometimes called "brain attack." A stroke occurs when a blood vessel bringing oxygen and nutrients to the brain bursts or is clogged by a blood clot or some other particle. Because of this rupture or blockage, part of the brain doesn't get the flow of blood it needs. A warning sign of a potential stroke, TIA is not covered by Critical Illness insurance.

Exceptions:

- Transient Ischemic Attack (TIA), and
- other cerebral vascular events.

In Arkansas:

- head injury,
- Transient Ischemic Attack (TIA), and
- cerebrovascular insufficiency.

Critical Illness Insurance Plan Pays

for a Stroke when:

- a blood vessel ruptures in the brain, or
- a blood clot blocks blood flow through the brain, and
- the neurological injury lasts for at least 30 days.
- **In Arkansas:** the neurological injury lasts for at least 24 hours.