AMERICAN HERITAGE LIFE INSURANCE COMPANY

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A Stock Company

(called "we", "our" or "us")

GROUP CRITICAL ILLNESS CERTIFICATE OF INSURANCE

FIRST OCCURRENCE SPECIFIED ILLNESS INSURANCE
WHICH MAY INCLUDE A CANCER CRITICAL ILLNESS BENEFIT, IF SELECTED BY THE POLICYHOLDER

This certificate explains the policy of insurance underwritten by us. It is not the contract of insurance. The policy (called the "policy"), as issued to the policyholder by us, alone makes up the agreement under which insurance coverage is provided and benefits are determined. The policy is delivered in and is governed by the laws of the governing jurisdiction and, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The policy may be inspected at the office of the policyholder during normal business hours.

CONSIDERATION

Your coverage under the policy is issued to you in consideration of your enrollment form or other form of application and the payment of the first premium. Your coverage under the policy is effective from 12:01 a.m. Standard Time on your effective date.

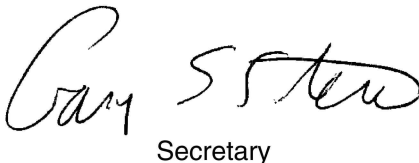
INSURING CLAUSE

We certify that coverage under the policy is in effect for persons who have satisfied all eligibility requirements and for whom the required premium has been paid when due. All such coverage is subject to the terms of the policy.

In this certificate the insured certificate holder will be referred to as "you", "your" or "yours".

This certificate supersedes and replaces any certificate previously issued to you under the policy.

THIS COVERAGE IS NOT MEDICARE SUPPLEMENT COVERAGE.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.


Secretary

President

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

Read Your Certificate Carefully.

This coverage contains a pre-existing condition limitation.
See the “Pre-existing Condition Limitation” on page 11.

Important Cancellation Information – Please Read The Provision Entitled,
“Termination of Coverage” Found On Page 6.

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GENERAL PROVISIONS

COVERAGE SUBJECT TO POLICY

The coverage described in this certificate is subject in every way to the terms of the policy that is issued to the policyholder. It alone makes up the agreement by which the insurance is provided. The policy may at any time be amended or discontinued by agreement between us and the policyholder. Your consent is not required for this. Neither are we required to give you prior notice.

ELIGIBILITY DATE

The date you are eligible for coverage is the later of:

1. the policy effective date; or
2. the date you become a member of the eligible class.

ELIGIBILITY OF DEPENDENTS

Eligible dependents are:

1. your legal spouse or domestic partner; and
2. your unmarried children including adopted children or foster children from the moment of placement in the residence, stepchildren, children of a domestic partner, or legal ward who are under 22 years of age, or under 26 years of age and full-time students at an educational institution of higher learning beyond high school. Your children must be dependent on you for support and be named on the enrollment or evidence of insurability form.

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

If you have Individual Coverage and get married and desire coverage for your spouse, you must notify us within 31 days of the marriage. We will change the coverage to Individual and Spouse Coverage and provide notification of the additional premium due. If you notify us after 31 days of the marriage, then evidence of insurability is required for your spouse.

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

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

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 31 days after the date of birth of the newborn.
2. If adoption proceedings have been instituted by you within 31 days after the date of birth and you have temporary custody, coverage is provided from the moment of birth of the newborn.
3. For children other than newborns, coverage will begin from the moment of placement.

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

COVERAGE FOR CHILDREN OF NONCUSTODIAL PARENTS

If you are a noncustodial parent and provide coverage for a child under the policy, we shall:

1. provide such information to you as may be necessary for the child to obtain benefits;
2. permit you or provider, with your approval, to submit claims for losses without your approval; and
3. make payments on claims submitted in accordance with paragraph 2 of this section directly to you, the provider or the state Medicaid agency.

COVERAGE FOR CHILDREN OF NONCUSTODIAL PARENTS (Continued)

When you are required by a court or administrative order to provide critical illness coverage for a child and you are eligible for Individual and Children Coverage or Family Coverage we will:

1. permit you to enroll under Individual and Children Coverage or Family Coverage a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;
2. enroll the child under Individual and Children Coverage or Family Coverage, upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program, even if you are enrolled but fail to make application for coverage for the child; and
3. not terminate or eliminate coverage of the child unless we are provided satisfactory written evidence that:
   a. the court or administrative order is no longer in effect; or
   b. the child is or will be enrolled in comparable coverage through another insurer that will take effect not later than the effective date of the termination of coverage under the policy.

We shall not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the Medicaid program, and covered for health benefits from us, that are different from requirements applicable to an agent or assignee of any other individual so covered.

WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE YOUR COVERAGE

1. You may apply for coverage during:
   a. your initial enrollment period; or
   b. any other time, subject to evidence of insurability.
2. You may increase coverage at any time, subject to evidence of insurability.
3. You may discontinue coverage at any time.

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Once your initial enrollment period is over, evidence of insurability is required if:

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

CERTIFICATE OF INSURANCE

Once you have been approved for coverage, a certificate of insurance is issued describing the insurance provided by the policy stating:

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

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

EFFECTIVE DATE OF COVERAGE

Your coverage will be effective on the date shown on page 3 of your certificate.

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

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

WHEN YOU ARE ABSENT FROM WORK ON THE EFFECTIVE DATE OF COVERAGE

If you are absent from work due to disability, injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you meet the definition of Active Employment. This applies to your initial coverage, as well as any increase or addition to coverage that occurs after your initial coverage is effective.

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

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

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

If you have Individual and Spouse or Family Coverage, your spouse's coverage ends upon valid decree of divorce or your death.

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

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

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

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

AGENCY

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

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

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

If your coverage ends while on a family and medical leave of absence, your coverage will be reinstated when you return to active status.

We will not:

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

DISCRETIONARY AUTHORITY, IF GOVERNED BY ERISA

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

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

INCONTESTABILITY

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

LEGAL ACTION

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

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

CLERICAL ERROR

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

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CONTINUATION OF INSURANCE (COBRA)

(APPLIES TO GROUPS WITH 20 OR MORE EMPLOYEES)

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

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

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

You will not be denied continuation solely because you are covered under another group critical illness plan or eligible for Medicare on the date the qualifying event occurs.

COVERAGE CONTINUED

The insurance being continued by this section is subject to all terms and provisions of the policy that do not conflict with this section. The insurance will be the same as if the qualifying event had not occurred. The continued insurance will be subject to any changes to the policy affecting the benefits of your class following the qualifying event.

NOTIFICATION AND PAYMENT REQUIREMENTS

You have the responsibility to inform the employer of (a) divorce; (b) legal separation; or (c) a child losing eligibility under the policy. This notice must be made within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of the right to continue the insurance.

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

The plan administrator will notify you of the right to continue within 14 days of the notice described above. You will then have 60 days to elect to continue your insurance. Failure to elect to continue insurance within 60 days after you are notified by the plan administrator will result in loss of the right to continue such insurance.

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

TERMINATION

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

1. The date the policy terminates or is amended to terminate the type of insurance being continued.
2. The end of the last period for which premiums for such coverages have been made. This applies if any required premium is not made to the policyholder within 31 days of the due date.
3. The date you become covered under any other group critical illness policy, whether as an insured or otherwise. (This will not apply if such other policy contains any exclusion or limitation with respect to any pre-existing condition the person may have.)
4. The date you become entitled to benefits under Medicare. (This will not apply if the qualifying event involves retired employees of employers under Chapter 11 Bankruptcy and their dependents.)
5. The date ending 18 months from the date of the qualifying event for persons who qualify due to termination of employment or reduction in hours worked. However, if a second qualifying event occurs within this 18 month period, the period of coverage for any affected dependent may be extended up to 36 months from the date of the first qualifying event. For all other qualifying events, insurance will terminate on the date ending 36 months from the date of the qualifying event, except as provided below:
   (a) If you are totally disabled for Social Security purposes any time during the first 60 days of continuation coverage, the 18 month period may be extended to 29 months. In order for this additional 11 months of insurance to be effective, you must provide the policyholder or plan administrator with a copy of the notice of the determination. The notice must be provided:
      (1) within 60 days of the Social Security determination of total disability; and
      (2) within the initial 18 months of continuation coverage.

   (b) If you have a qualifying event (termination or reduction in hours worked) and you had become entitled to Medicare before the date of this qualifying event, then any other qualified beneficiary (the spouse and/or children) will be entitled to a period of continuation that is the greater of:
      (1) 36 months from the date you first became entitled to Medicare; or
      (2) 18 months from your termination or reduction in hours.

   (c) For a qualifying event involving retired employees of employers under Chapter 11 Bankruptcy and their dependents, the maximum period of continuation coverage is:
      (1) the lifetime of the retiree; or
      (2) the lifetime of the surviving spouse of a retiree who dies before the bankruptcy; or
      (3) 36 months after the date of death of the retiree, when such date is after the bankruptcy.
6. With respect to a person entitled to a 29 month period of continuation coverage due to disability of a qualified beneficiary, the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, insurance will not terminate until the last day of the month that next follows the completion of a 30 day period beginning on the date of such final determination.

PORTABILITY PRIVILEGE

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

Such coverage will not be available for you, unless:

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

No portability coverage will be provided for you, if your critical illness insurance under the policy terminated due to your failure to make required premium payments.

COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy for critical illness when the insurance terminated, including credit for any limitations applied toward a pre-existing condition. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after you are insured under the portability privilege will not apply to that insured unless it is required by law.

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

PREMIUMS

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. Initial premium rates under portability coverage will remain the same as those charged under the policy for critical illness when the insurance was terminated. The premium rates are based on the table of rates in effect on any premium due date. A change in premium rate will not take effect during the first 12 months of coverage. After the first 12 months of coverage we have the right to change the rate table on any premium due date.

Written notice will be given at least 45 days before the change is to take effect.

GRACE PERIOD

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

TERMINATION OF INSURANCE

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

1. The date you again become eligible for critical illness insurance under the policy.
2. The last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
   a. the date your insurance terminates; or
   b. the date the dependents ceases to be eligible under the policy.

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

TERMINATION OF THE POLICY

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

EXCLUSIONS AND LIMITATIONS

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

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

PRE-EXISTING CONDITION LIMITATION

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

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BENEFIT INFORMATION

SPECIFIED CRITICAL ILLNESS BENEFIT

We pay this benefit if you are diagnosed with one of the illnesses shown below if:

1. the date of diagnosis is after the effective date of coverage; and
2. the date of diagnosis is while insured; and
3. the illness is not excluded by name or specific description; or
4. it is determined, as the result of an autopsy, that the insured died as the result of one of the specified critical illnesses listed below.

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

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

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

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

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

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

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

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

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

As used in this section, date of diagnosis means the date the following diagnoses are made:

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

OPTIONAL BENEFIT

CRITICAL ILLNESS CANCER BENEFIT

We pay this benefit if the insured is diagnosed with invasive cancer or carcinoma in situ, as defined below, subject to all of the following:

1. clear and definitive diagnosis by either a pathological or clinical method; and
2. the date of diagnosis is after the effective date of coverage; and
3. the date of diagnosis is while this optional benefit is in force; and
4. the illness is not excluded by name or specific description in the certificate; or
5. it is determined, as the result of an autopsy, that the insured died as the result of one of the specified critical illnesses listed below.

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

Carcinoma in Situ. Means a diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Carcinoma in Situ includes:

1. early prostate cancer diagnosed as stage A or equivalent staging; and
2. melanoma not invading the dermis.

Carcinoma in Situ does not include:

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

Carcinoma in Situ must be identified pursuant to a pathological or clinical diagnosis as defined in the clinical or pathological diagnosis.

CRITICAL ILLNESS CANCER BENEFIT (Continued)

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

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

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

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

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

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

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

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OPTIONAL BENEFIT(S)

WELLNESS BENEFIT

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

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

Eligible tests are as follows:

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

DEFINITIONS

As used in this section:

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

OPTIONAL BENEFIT(S)

RECURRENCE BENEFIT

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

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

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

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CLAIM INFORMATION

NOTICE OF CLAIM

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

FILING A CLAIM

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

You must complete all applicable sections of the claim form and then give it to your attending physician. The physician should complete his or her section statement of the form and send it directly to us.

PROOF OF YOUR CLAIM

Written proof must be furnished to us within 180 days of each illness. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless you are legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

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

TIME OF PAYMENT OF CLAIMS

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

PAYMENT OF CLAIMS

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

CHANGE OF BENEFICIARY

The right to change of beneficiary is reserved for you. Consent of the beneficiary or beneficiaries shall not be required to assign benefits or to change a beneficiary or beneficiaries, or to make any other changes in this certificate.

OVERPAID CLAIM

We have the right to recover any overpayments due to:

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

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

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

CLAIM REVIEW

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

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

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

APPEALS PROCEDURE

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

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GLOSSARY

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

Your work site must be:

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

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

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

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

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

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

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

Domestic Partner. Means your same-sex or opposite-sex partner who is eligible for coverage providing the requirements listed below have been met for the last 12 months.

Both must:

1. have resided together in the same permanent residence; and
2. be at least 18 years of age; and
3. intend to remain each other's sole domestic partner indefinitely; and
4. be emotionally committed to one another and share joint responsibilities for the common welfare and financial obligations of each other; or the domestic partner must be chiefly dependent on you for care and financial assistance; and
5. not be legally married to or the legal domestic partner of anyone else; and
6. not be related by blood closer than would prohibit marriage under applicable state law.

If requested by us, satisfactory proof must be submitted that supports the domestic partner's eligibility for coverage.

Eligibility Waiting Period. Means the continuous period of time that you must be in active employment in an eligible class before you are eligible for coverage.

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

Employer. Means the individual, company or corporation where you are in active employment, and includes any division, subsidiary, or affiliated company named in the policy.

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

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

Family Coverage. Means coverage that includes you, your spouse and eligible children.

Foster Child. Means a minor (a) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (b) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction. The term "placement" when used with reference to a foster child means the child is physically residing with the insured, and the insured has been appointed as guardian or custodian of the foster child. The insured has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the insured on more than a temporary or short-term basis.

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

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

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

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

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

Illness. One of the specified critical illnesses listed in the chart on page 11.

Individual Coverage. Means coverage that includes only you, as defined.

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

Individual and Spouse Coverage. Means coverage that includes only you, as defined, and your eligible spouse.

Initial Enrollment Period. Means one of the following periods during which you may first apply, in writing, for coverage under the policy:

1. a period before the policy effective date as set by us and the policyholder if you are eligible for coverage on the policy effective date; or
2. the period ending 31 days after the date you are first eligible to apply for coverage if you become eligible for coverage after the policy effective date.

Injury. Means accidental bodily injury sustained by you while coverage under the policy is in force.

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

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

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

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

Physician. Means:

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

We will not recognize you, or your spouse, children, parents, or siblings as a physician for a claim.

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

Pre-Existing Condition. Means a disease or physical condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage.

Sickness. Means an illness or disease that must begin while you are insured under the policy.

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

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

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

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

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

You, Your or Yours. Means the insured who meets the eligibility requirements.

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Allstate

Workplace Division

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

A Stock Company

Endorsement

This Endorsement is made part of the Policy and/or Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Policy, not inconsistent with this Endorsement.

All references to the eligibility and termination of dependents are revised to the following:

Eligible dependents are:
1. your legal spouse or domestic partner; and
2. your children and your domestic partner's children.

A child is a person under age 26 who is:
1. your or your domestic partner's natural or adopted son or daughter, stepson or stepdaughter; or
2. a foster child who is placed with you or your domestic partner by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

If your domestic partner is a covered person, your domestic partner's coverage ends upon termination of the domestic partnership or your death.

Coverage for your child will end on the issue day of the month that follows when the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent child who:
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the policy/certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the child's attainment of the limiting age for eligibility.

Domestic Partner means your same-sex or opposite-sex partner who is eligible for coverage provided that:
1. both you and your same-sex or opposite-sex partner must be considered as domestic partners according to the law of your state of residence; or
2. if your state of residence has no domestic partnership laws, you must satisfy the definition of domestic partner as defined by the policyholder.

Issue day means the same day of the month as the effective date of coverage.

All other requirements of the policy and/or certificate not specifically stated within this endorsement still apply.

Secretary

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
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A Stock Company

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