2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

CERTIFICATE OF INSURANCE FOR
GROUP SPECIFIED CRITICAL ILLNESS POLICY

THIS IS A SPECIFIED CRITICAL ILLNESS CERTIFICATE THAT ONLY PROVIDES BENEFITS AS A RESULT OF LOSSES SHOWN IN THE CERTIFICATE SCHEDULE.

THIS CERTIFICATE PROVIDES BENEFITS FOR THE SPECIFIED CRITICAL ILLNESSES LISTED. IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.
THIS IS NOT A MEDICARE SUPPLEMENT POLICY. PLEASE READ YOUR CERTIFICATE CAREFULLY
If you are eligible for Medicare, review the Guide to Health Insurance For People with Medicare.

CERTIFICATE INDEX

We certify that you are insured under the Specified Critical Illnesses Policy (herein called the Plan) issued to the policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from Specified Critical Illnesses.

Certain provisions of the Plan are summarized in this certificate. All provisions of the Plan, whether contained in your certificate or not, apply to the insurance referred to by the certificate.

The Effective Date of your certificate is as shown in the Certificate Schedule if you are on that date actively at work. If not, this certificate will become effective on the next date you are actively at work as an eligible Employee. This certificate will remain in effect for the period for which the premium has been paid. This certificate may be continued for further periods as stated in the Plan, under Portability Privilege.

This certificate is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application.

This certificate, on its Effective Date, automatically replaces any certificate or certificates previously issued to you under the Plan.

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

An Employee is eligible if he is:

1. eligible to participate in the Flexible Benefits Program as follows:

    (a) Regular full-time employees of the State of Georgia or of a state agency who work at least 30 hours a week on a continuing basis and whose employment is expected to last at least nine (9) months;

    (b) Public school teachers who are employed in a professionally certificated capacity, work half-time (50%) or more, and at least seventeen and one-half (17.5) hours per week, and are not considered "temporary" or "emergency" employees;

    (c) Employees of a local school system who hold a non-certificated position, are eligible to participate in the Teachers' Retirement System or its equivalent, and work at least twenty (20) hours per week; or 60% of the time normally required for these positions, if that is more than 20 hours per week;

    (d) Employees who are eligible to participate in the Public School Employees' Retirement System and work at least fifteen (15) hours per week or 60% of the time normally required for these positions, if that is more than 15 hours per week;

    (e) Employees of a county or regional library who works at least seventeen and one-half (17.5) hours per week;

    (f) Employees who are in active employment and a member of the General Assembly, a constitutional officer, or an employee of an appropriate judicial branch;

    (g) Other employees deemed eligible by Federal and State of Georgia law.

2. at least 18 years of age and under age 70 at initial eligibility date; and
3. actively at work.

EFFECTIVE DATE

The Effective Date of the Plan is shown on Page 1 of the Master Policy.

The Effective Date for the certificate is as follows:

1. Your coverage will be effective on the date shown on the Certificate Schedule provided you are then actively at work.

2. If you are not actively at work on the date coverage would otherwise become effective, the Effective Date of your coverage will be the date on which you are first thereafter actively at work.

An eligible employee may enroll for coverage or change multiples of coverage during the Open Enrollment period. An eligible employee may also enroll or increase coverage within thirty-one (31) days of a change in status event.

An employee may decrease or terminate coverage within ninety (90) days of a change in status event.

If an employee enrolls for coverage or increases coverage above the guarantee issue due to a change in status event, proof of medical insurability is required. The employee should ask the Plan Administrator for the effective date for a change in coverage due to a change in status event.

Changes must be consistent with the change in status event.

If the employee ends employment and is rehired within the same plan year, the employee may be insured on his/her eligibility date for the coverage the employee had under the plan when the employee ended employment. The employee cannot change his coverage until the next annual Open Enrollment period or a change in status event.

LEAVE WITHOUT PAY AND PREMIUM PAYMENTS

Coverage is extended on a month-by-month basis. Premiums for coverage must be paid in advance of coverage. Normally, premiums are paid through payroll reduction/deduction in the month prior to coverage. When an employee is not in pay status, the employee must pay the monthly premium amount to the Flexible Benefits Program prior to the first of each coverage month.

If you cease to be Actively at Work due to:

- suspension without pay, or
- approved leave of absence without pay with respect to which you have a scheduled date of return,

your insurance may be continued through the twelfth (12^{th}) calendar month through personal premium payments. The exception to this rule is those employees affected by USERRA, who may continue personal premium payments as long as on active duty.

If you are absent from work without pay for any reason, discuss continuing your insurance with your personnel officer. If you coverage is terminated for failure to pay premium, your re-enrollment will be in accordance with the regulations of the Employee Benefit Plan Council and may include submitting new proof of insurability.

TERMINATION OF THE PLAN

The Plan will cease if the policyholder fails to pay the premium before the end of the Grace Period.

Forty-two months after the Plan Effective Date, Continental American has the right to cancel the Plan on the day prior to the date any premium is due by giving 60 days written notice.

The Plan will terminate when the number of participating Employees is less than the number mutually agreed upon by the policyholder and Continental American in writing.

In these events, the Plan and all certificates issued hereunder will terminate on such date at 12:01 a.m. Standard Time at the policyholder's address. This will be without prejudice to the rights of any Insured as respects any claim arising during the period the Plan is in force.

The policyholder has the sole responsibility to notify an Insured of such termination.

TERMINATION OF AN INSURED'S INSURANCE

Your insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. on the 61st day after the premium due date if the required premium has not been paid;
3. on the date you cease to meet the definition of an Employee as defined in the Plan;
4. on the date you are no longer a member of the class eligible; or
5. on the premium due date following the date you notify the policyholder in writing.

Termination of your insurance shall be without prejudice your rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS
Premiums payable on any premium due date for insurance on an Insured will be calculated in accordance with the Schedule of Premiums. Continental American will give the policyholder written notice 60 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS
The first premiums are due on the Effective Date of the Plan. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for the Plan are to be paid by to the Company our Home Office in Columbia, South Carolina. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD
The Plan has a 60-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 60 days. During the Grace Period, the Plan will stay in force, unless the policyholder has given to the Company written notice of discontinuance of the Plan.

SECTION III – GENERAL DEFINITIONS / BENEFIT DEFINITIONS

When the terms below are used in this certificate, the following definitions will apply:

Actively at Work to be considered actively at work, you must perform for a full normal workday the regular duties of your employment at the regular place of business of your employer or at a location to which you may be required to travel to perform the regular duties of your employment.

Date of Diagnosis is:

For cancer and/or carcinoma in situ: The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.

For heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

For stroke: The date a stroke occurred based on documented neurological deficits and neuroimaging studies.

For end stage renal failure: The date that your doctor recommends that you begin renal dialysis.

Major organ transplant surgery or coronary artery bypass surgery: The date the surgery occurs for covered transplants or covered coronary artery bypass surgery.

Doctor means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include you or a member of your family.

Family Member means your spouse, son, daughter, mother, father, sister, or brother.

Hospital means a place which:

1. is legally licensed and operated as a hospital;
2. provides overnight care of injured and sick people;
3. is supervised by a doctor;
4. has full-time nurses supervised by a registered nurse;
5. has on-site or pre-arranged use of X-ray equipment, laboratory and surgical facilities; and
6. maintains permanent medical history records.

A Hospital is not:

1. a nursing home;
2. an extended care facility;
3. a convalescent home;
4. a rest home or a home for the aged;
5. a place for alcoholics or drug addicts; or
6. a mental institution.

Open Enrollment means a period designated by State Personnel Administration during which employees have the opportunity to enroll or change coverage.

Pathologist means a doctor, other than yourself or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.

Specified Critical Illness means such specified critical illness shown in the Schedule and as defined in this certificate.

Waiting Period-Means the number of days after the Effective Date before we will pay benefits for loss due to a Critical Illness. We won't pay benefits for a Critical Illness that begins during the Waiting Period.

You, Your means the Insured shown on the Certificate Schedule.

Whenever a male pronoun is used, it includes the female unless the context clearly shows otherwise.

BENEFIT DEFINITIONS

Cancer (internal or invasive) means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers that are non-invasive such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ;
3. Any skin cancers except melanomas;
4. Basal cell carcinoma and squamous cell carcinoma of the skin; and
5. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm.

Cancer is also defined as a disease which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Carcinoma in Situ means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is 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 up by the American Board of Pathology.

2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of 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 doctor is treating an Insured for Cancer and/or Carcinoma in Situ.

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include all of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine physphokinase (CPK), a CPK-MB measurement must be used; and
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after an Insured's Effective Date. Stroke does not include Transient Ischemic Attacks and attacks of Verterbrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or magnetic Resonance Imaging (MRI). **Stroke does not mean head injury, transient ischemic attack or chronic cerebrovascular insufficiency.**

Kidney Failure (Renal Failure) means the end stage renal failure presenting as chronic, irreversible failure of both kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

SECTION IV – BENEFITS

We will pay this benefit when an Insured is diagnosed with one of the Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while the his coverage is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Initial Maximum Benefit amount is shown in the Schedule. If the Schedule shows a Maximum Benefit Reduction Date, a Certificate's Maximum Benefit will be reduced to the Reduced Maximum Benefit Amount, also shown in the Schedule, on that date. Benefits will be based on the Maximum Benefit amount in effect on the Critical Illness Date of Diagnosis. Any partial benefits paid will be deducted from the amount payable for the applicable Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Critical Illness in the order the events occur.

2. No benefits are payable for each different Critical Illness after the first unless its date of diagnosis is separated from the prior different Critical Illness by at least 6 months and it is not caused by or contributed to by a Critical Illness for which benefits have been paid.

3. Once benefits have been paid for a Critical Illness, no additional benefits are payable for that same Critical Illness unless the dates of diagnosis are separated by at least 12 months or for cancer 12 months treatment free). Cancer that has spread (metastasized), even though there is a new tumor, will not be considered an additional occurrence unless you have been treatment free for 12 months.

Partial Benefits

Partial Benefits will be paid for Carcinoma in-situ and Coronary Artery Bypass Surgery at the amount shown on the benefit schedule page. Partial benefits will reduce the maximum benefits paid under the certificate by the amount paid as a partial benefit.

We figure partial benefits by multiplying:

1. Your Maximum Benefit Amount (Initial or Reduced, as the case may be); LESS
2. Any benefits previously paid; TIMES
3. The Partial Benefit Percentage shown in the "Benefit Percentages By Certificate Year" table in the Certificate Schedule for the applicable Specified Critical Illness and certificate year.

Portability Privilege

When your coverage would otherwise terminate under the Plan because you end employment with your employer, you may elect to continue your coverage. But you must have been continuously insured for at least six months under the Plan and/or the prior plan just before the date your employment terminated. The coverage you may continue is that which you had on the date your employment terminated, including dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:

    a. the insured failed to pay any required premium;
    b. the insured having attained age 70;
    c. the Group Policy terminates.

2. To keep your insurance in force you must:

    a. make written application to the Company within 31 days after the date your insurance would otherwise terminate;
    b. pay the required premium to the Company no later than 31 days after the date your insurance would otherwise terminate; and

3. Insurance will cease on the earliest of these dates:

    a. the date you failed to pay any required premium;
    b. the date the Group Policy is terminated.

If you qualify for this Portability Privilege as described, then the same benefits, Plan provisions, and premium rate as shown in this certificate as previously issued will apply.

Health Screening Benefit (Calendar Year Limit)

We will pay this benefit for the following health screening tests performed after the Waiting Period and while this Certificate is in force. We will pay the amount shown in the Certificate Schedule for the following health screening tests. This benefit is payable once per calendar year up to the maximum benefit amount shown in the Certificate Schedule. Payment of this benefit will not reduce the face amount of the Certificate.

Health screening test is defined as:

Stress test on a bicycle or treadmill,
Fasting blood glucose test,
Blood test for triglycerides,
Serum cholesterol test to determine level of HDL and LDL,
Bone marrow testing,
Breast ultrasound,
CA 15-3 (blood test for breast cancer),
CA 125 (blood test for ovarian cancer),
CEA (blood test for colon cancer),
Chest X-ray,
Colonoscopy,
Flexible sigmoidoscopy,
Hemocult stool analysis,
Mammography,
Pap smear,
PSA (blood test for prostate cancer),
Serum Protein Electrophoresis (blood test for myeloma),
Thermography.

There is no limit to the number of years you can receive benefits for health screening tests, as long as this certificate is in force.

We will pay this benefit regardless of the results of the test.

SECTION V - LIMITATIONS AND EXCLUSIONS

This Plan contains a 30-day Waiting Period. This means no benefits are payable for any Insured who has been diagnosed before their coverage has been in force 30 days from their Effective Date. If an Insured is first diagnosed during the Waiting Period, benefits for the treatment of that Critical Illness will apply only to loss commencing after 12 months from their coverage Effective Date; or at the Employee's option, they may elect to void the Certificate from the beginning and receive a full refund of premium.

Diagnosis must be made in the United States.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within twenty (20) days after a covered loss or as soon as reasonably possible. The notice can be given to the Company at P.O. Box 427, Columbia, South Carolina 29202. Notice should include your name and the Certificate number.

Claim Forms: When we receive a notice of claim, we will send the claimant forms for filing proof of loss. If the forms are not given to you within 10 working days, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written proof of loss must be furnished to the Company at P.O. Box 427, Columbia, South Carolina 29202 within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Time of Payment of Claims: Benefits payable under this certificate will be paid immediately upon receipt of written proof of loss. Should Continental American fail to pay any benefits payable upon receipt of written proof of loss, we shall have 15 working days thereafter in which to notify the insured person in writing of the reasons why the claim has not been paid. The notice shall itemize the information needed to process the claim. When all information needed to process the claim is received, we then have 15 working days in which to either deny or pay the claim. If we fail to notify the insured person or pay the claim in the required time, we will pay interest equal to 18 percent per annum on the benefit due under this policy.

Payment of Claims: All benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefit unpaid at your death may be paid to your estate.

Conformity with State Statutes: Any provision of the Plan that, on its "Effective Date", is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from you. If you have any questions about this policy, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this policy. Thank you for your loyal patronage.

Entire Contract, Changes: The Plan together with the application, endorsements, benefit agreements, certificate and riders, if any, is the entire contract of insurance. No change in the policy shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change the policy or waive any of its provisions. Any rider, endorsement or application that modifies, limits or excludes coverage under this certificate must be signed by you, the insured, to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have you examined as often as reasonably necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this certificate within 60 days after written proof of loss has been given as required by this certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from the effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for a covered specified critical illness commencing after the expiration of such two-year period. (2) No claim for loss incurred after two years from the effective date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such effective date.

Clerical Error: Clerical error by the policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

Individual Certificate: Continental American will give the policyholder a certificate for each Employee. The certificate will set forth:

1. the coverage;
2. to whom benefits will be paid; and
3. the rights and privileges under the Plan.

Data Required: The policyholder will furnish all information and proofs that Continental American may reasonably require with regard to the Plan.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

CONTINENTAL AMERICAN INSURANCE COMPANY
2801 Devine Street, Columbia, South Carolina 29205
800-433-3036

ADDITIONAL BENEFITS RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

This Rider is a part of the certificate to which it is attached. We have issued this Rider to you because (1) you paid the additional premium for this Rider; and/or (2) we relied on the application you made. Unless amended by this Rider, Certificate Definitions, other Provisions and terms apply to this Rider.

Effective Date - If issued at the same time as the certificate, this Rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this Rider will have a later Effective Date, which will be shown in the Rider Schedule issued with this Rider.

DEFINITIONS

Specified Critical Illness means such illness shown in the Rider Schedule and as defined in this Rider.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to Specified Critical Illness. We won't pay benefits for a Specified Critical Illness which begins during the Waiting Period.

Diagnosed/Diagnosis means a definitive and unequivocal diagnosis made by a Physician: (1) based upon the use of clinical and/or laboratory investigations as supported by the Insured's medical records; and (2) meeting any Diagnostic Requirements set forth in this Rider for the particular Specified Critical Illness being diagnosed.

Actively At Work Requirement
If you are not Actively at Work on the last scheduled work day coincident with or preceding the date your insurance would otherwise become effective, insurance will not be effective until the date you return to and remain Actively at Work.

If an eligible Spouse or Dependent Child is unable to engage in the normal activities of a person in good health of like age and sex on the date this Rider would otherwise become effective, coverage will not be effective until the date such person is able to engage in the normal activities of a person in good health of like age and sex. This will not apply to an eligible Dependant Child who is incapable of self-sustaining employment by reason of mental or physical incapacity, and who is primarily dependent on the Insured for support and maintenance.

BENEFIT DEFINITIONS

Coma means a state of unconsciousness for 30 consecutive days with:

1. no reaction to external stimuli;
2. no reaction to internal needs; and

3. the use of life support systems.

Paralysis/Paralyzed means the permanent, total, and irreversible loss of muscle function or sensation to the whole of at least two limbs as a result of injury or disease and supported by neurological evidence.

Severe Burn/Severely Burned means cosmetic disfigurement of the surface of a body area not less than 35 square inches due to fire, heat, caustics, electricity or radiation that is a full-thickness or third-degree burn, as determined by a Physician. (A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

Loss of Sight, Speech or Hearing means:

1. Loss of Speech means the total and permanent loss of the ability to speak as the result of physical injury.
2. Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device shall not be considered an irrevocable loss.
3. Loss of Sight means the total and irreversible loss of all sight in both eyes

BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured diagnosed with one of the Specified Critical Illnesses shown on the Rider Schedule if:

1. The Date of Diagnosis is after the Waiting Period;
2. The Date of Diagnosis is while this Rider is in force; and
3. It is not excluded by name or specific description in this Rider.

This Rider pays the indicated percentages of the applicable Maximum Benefit Amount shown in the Certificate Schedule that occurs while this Rider is in force. Benefits are not payable under this Rider for Loss if these conditions result from another Specified Critical Illness. The Dates of Loss for Specified Critical Illnesses must be separated by at least 12 months for benefits to be payable for multiple Specified Critical Illnesses.

Coma

If an Insured is Diagnosed as being Comatose after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Coma shown in the Schedule of Benefits.

The Diagnosis of Coma must indicate that permanent neurological deficit is present.

Paralysis

If an Insured is first Diagnosed as being Paralyzed after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Paralysis shown in the Schedule of Benefits.

The Diagnosis of Paralysis must include documented evidence of the illness or injury that caused the Paralysis.

Severe Burn

If an Insured is first Diagnosed as having suffered a Severe Burn after his Effective Date and any applicable

Waiting Period, the Company will pay the Benefit Amount for Severe Burn shown in the Schedule of Benefits.

Loss of Sight, Speech or Hearing
If an Insured is first Diagnosed as having suffered Loss of Sight, Speech, or Hearing after his Effective Date and any applicable Waiting Period, the Company will pay the Benefit Amount for Loss of Sight, Speech or Hearing shown in the Schedule of Benefits.

LIMITATIONS AND EXCLUSIONS

This Rider contains a 30-day Waiting Period. This means no benefits are payable for any Insured who has been diagnosed before coverage has been in force 30 days from the Insured's Effective Date shown in the Rider Schedule. If an Insured is first diagnosed during the Waiting Period, benefits for treatment of that Specified Critical Illness will apply only to loss commencing after twelve months from the Insured's Effective Date; or, at your option, you may elect to void this rider from the beginning and receive a full refund of premium.

EXCLUSIONS

1. No benefits will be paid if the Specified Critical Illness is a result of:

    a. Intentionally self inflicted injury or action;
    b. Suicide or attempted suicide while sane or insane;
    c. Illegal activities or participation in an illegal occupation;
    d. War, declared or undeclared, or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence; or
    e. Substance abuse.
2. No benefits will be paid for loss which occurred prior to the effective date of this Rider.
3. No benefits will be paid for diagnosis made outside the United States.

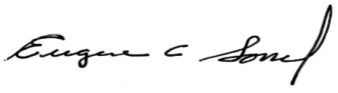
GENERAL PROVISIONS

This Rider is part of the Critical Illness Certificate and will terminate when that Certificate terminates, or when premiums are no longer paid for this Rider.

The premium for this Rider is shown in the Rider Schedule. Premiums for this Rider are payable for the number of years shown in the Rider Schedule or until the Rider terminates.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless any such items are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office.



President

RIDER SCHEDULE

Insured -
Effective Date -
***Initial Premium -**

Group Policy Number -
Certificate Number -
First Renewal Date -

BENEFITS

Coma, Paralysis, Burns	
Coma	100% of applicable Maximum Benefit
Paralysis	**100**% of applicable Maximum Benefit
Severe Burn	100% of applicable Maximum Benefit
Loss of Sight, Speech or Hearing	
Loss of Speech	100% of applicable Maximum Benefit
Loss of Hearing	100% of applicable Maximum Benefit
Loss of Sight	100% of applicable Maximum Benefit