

CriticalCare Elite

Protect your finances from the impact of a critical illness



An authorized agency of

US^{ABLE} Life
Live life. You're covered.™

Why CriticalCare Elite?

Your chances of surviving a critical illness are higher today than ever before. That's good news. But the cost of care and treatment coupled with the potential for loss of income could take a toll on your finances. CriticalCare Elite can help you be prepared for an unexpected critical illness or condition.

You can choose from three coverage amounts: \$10,000, \$20,000 or \$30,000

Lump sum payments are **paid directly to you** at first diagnosis of one of the covered critical illnesses or conditions below:

Covered Illnesses/Conditions	WITH CANCER COVERAGE	WITHOUT CANCER COVERAGE
	Percentage of coverage amount paid	
Cancer	100%	N/A
Heart Attack	100%	100%
Stroke	100%	100%
End Stage Renal (Kidney) Disease	100%	100%
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	100%	100%
Quadriplegia	100%	100%
Major Organ Transplant Surgery	100%	100%
Coronary Artery Bypass Surgery*	25%	25%
Balloon Angioplasty, Stent or Laser Relief Procedure*	10%	10%
Carcinoma in situ*	10%	N/A

Definitions of each covered illness or condition can be found on the last page of this brochure.

**These benefits are each payable only once per covered person. If one or more of these benefits are paid, the remaining amount payable will be the original face amount reduced by all prior benefit payments.*

On the policy anniversary following attainment of age 75, the face amount of all benefits will be restated as 50% of the remaining amount payable.

The covered person's coverage terminates when 100% of the face amount has been paid.

Waiting Period

No benefits will be paid for a specified critical illness diagnosed during the first 30 days following any covered person's effective date of coverage. The waiting period will not apply to any specified critical illness caused by an accident.

If the date of diagnosis of any covered person's specified critical illness occurs during the waiting period, the insured may either return this policy and receive a full return of all the premiums or continue the coverage to provide payment of benefits for the other covered specified critical illnesses for the first two years. After two years from the effective date of coverage, a condition diagnosed during the waiting period will again be covered.

Wellness Benefit Included

The plan pays \$75 per calendar year for a covered person to have one of these preventive tests or routine exams:

- Mammography
- Colonoscopy
- Thermography
- Flexible Sigmoidoscopy
- PSA (Blood Test for Prostate Cancer)
- Bone Marrow Testing
- Chest X-Ray
- Serum Protein Electrophoresis
- EKG
- Breast Ultrasound
- Fasting Blood Glucose Test
- Pap Smear
- CA 15-3 for Breast Cancer
- Hemocult Stool Analysis
- Cholesterol & Diabetes Screening
- CA 125 for Ovarian Cancer
- Blood Test for Triglycerides
- CEA Blood Test for Colon Cancer

This benefit is payable once per covered person per calendar year and two times per family per calendar year.

Limited Benefit—Outline of Coverage

READ YOUR POLICY CAREFULLY. This outline of coverage provides a brief description of some of the important features of your policy. THIS IS NOT THE INSURANCE CONTRACT, AND ONLY THE ACTUAL POLICY PROVISIONS WILL CONTROL. The policy sets forth, in detail, the rights and obligations of any covered person and USAbLe Life. It is, therefore, important that you READ YOUR POLICY CAREFULLY. This is a limited benefit policy and is designed to provide coverage ONLY when certain losses occur as a result of the specified critical illnesses as defined below and more fully in the policy. This policy does not provide for basic hospital, basic medical-surgical or major medical expenses. This policy provides benefits only if the date of diagnosis of specified critical illness is while the policy is in force for the covered person so diagnosed AND after the waiting period has been satisfied by that covered person. Important: Benefits received under this policy may be taxable. You should consult your personal tax advisor to determine whether or not payments received are subject to taxation.

Exceptions and Limitations

EXCEPTIONS — WHAT WE WILL NOT PAY FOR:

This policy pays only for loss resulting from specified critical illnesses or surgeries as defined in the policy. We will not pay benefits for a specified critical illness or surgery that occurs as a result of the following:

1. Conditions other than the specified critical illnesses or surgeries defined in the policy.
2. The covered person being diagnosed with a specified critical illness during the waiting period, unless the specified critical illness is caused by an accident.
3. The covered person voluntarily participating or attempting to participate in an illegal activity.
4. The covered person intentionally causing a self-inflicted injury.
5. The covered person committing or attempting to commit suicide, whether sane or insane.
6. The covered person's voluntary involvement in any period of armed conflict, even if it is not declared.
7. Surgeries performed outside of the United States or its Territories.
8. **Other Exclusions:** We will not pay the Specified Critical Illness Benefit for the following:
 - (a) Cerebral symptoms due to transient ischemic attack (TIA), migraine, cerebral injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions.
 - (b) All skin cancers, unless there is evidence of metastasis or the tumor is a malignant melanoma of greater than 1.5 mm maximum thickness as determined by histological examination using the Breslow method.
 - (c) All tumors which are histologically described as pre-malignant or non-invasive (including cervical dysplasia CIN-1, CIN-2 and CIN-3), except carcinoma in situ.

Pre-Existing Conditions Limitations for Certain Conditions

The benefits of the policy will not be payable for any loss caused by a pre-existing condition during the first 24 months the policy is in force. After this 24-month period, however, loss due to such conditions will be payable unless specifically excluded from coverage. This 24-month period is measured from the effective date of coverage for each covered person. A pre-existing condition means a specified critical illness which is diagnosed or treated within 24 months prior to the effective date of coverage for each covered person. Conditions which are: (a) fully disclosed to us on the application; and (b) not excluded or limited by us are not considered pre-existing conditions.

Definitions

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) – a progressive wasting of motor neurons of the brain and spinal column.

Balloon Angioplasty, Stent or Laser Relief Obstruction Procedures – therapeutic procedures used to correct narrowing or blockage of one or more coronary arteries.

Cancer – disease characterized by the spread of malignant cells. Cancer must be positively diagnosed with histopathological confirmation by a medical practitioner. (See Exceptions and Limitations)

Carcinoma in situ – disease characterized by malignant neoplasm of epithelial origin that is confined to the area in which it was discovered. (See Exceptions and Limitations)

Coronary Artery Bypass Surgery – a major surgical procedure requiring median sternotomy to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

End stage Renal Disease (ESRD) – chronic irreversible failure of both kidneys to function which requires at least weekly hemodialysis or peritoneal dialysis or kidney transplantation.

Heart Attack – characterized by diagnosis of the death of a portion of the heart muscle resulting from inadequate blood supply.

Major Organ Transplant – human to human organ transplant of the liver, heart, lung, pancreas or bone marrow from a donor to the covered person.

Renewability and Continuation

This policy is guaranteed renewable during the covered person's lifetime. USABLE Life may change the premium rate, but only if the rate is changed for all policies and purchased riders in the covered person's state.

This policy will not be issued to anyone 65 years of age or over on the initial effective date. If the covered person purchases the policy prior to his or her 65th birthday, he or she may continue coverage after age 65 as long as he or she continues to timely pay the premium by the due date or during the 31 days that follow.

Coverage for a covered person's spouse will terminate at the time of divorce. However, coverage for a covered person's spouse can be converted upon divorce or the covered person's death.

Quadriplegia – the complete, irreversible paralysis and loss of use of both upper and lower limbs without severance.

Stroke - the result of a cerebrovascular event. Stroke must result in permanent neurologic deficit measured three months or more after the event and result in a score of 3 or higher on the Modified Rankin Scale for stroke outcome. There must also be clear evidence on a CT, MRI, or similar appropriate imaging technique that a stroke has occurred, and either: (a) infarction of brain tissue; or (b) intracranial or subarachnoid hemorrhage. These definitions provide a brief description of the specified critical illnesses covered by your policy. Only the actually policy definitions will control.



Group Insurance Services, Inc.
One Cameron Hill Circle
Chattanooga, Tennessee 37402
www.GISbenefits.com



Personal Critical Illness & Accident Application Submission Checklist

Personal Accident & Critical Illness Checklist

1. Application Submission

- a. Applications should be submitted to **Group Insurance Services** of BlueCross BlueShield of Tennessee via mail, fax or email.

Address:

Group Insurance Services
1 Cameron Hill Circle
Building 2.5
Chattanooga, TN 37402

Fax:

1-877-258-3005

Email:

GISProposalRequests@GISBenefits.com

2. Things to remember when submitting applications:

- a. Applications must be signed by the applicant
- b. All requested information should be completed and questions answered in full
- c. Broker signature must be included
- d. No binder check or payment is needed (first month's bill will be sent to insured along with a copy of their policy and forms to set up auto debit)
- e. Submit to **Group Insurance Services** via one of the above methods

3. Questions

- a. **Sales and product questions should be routed to Individual Sales at BlueCross BlueShield of Tennessee:**

Email:

individual_sales@bcbst.com

Phone:

888-744-9584

b. All new business submission questions should be routed to Group Insurance Services:

Email:

GISProposalRequests@GISBenefits.com

Phone:

888-350-4474; Ext. 2

c. All customer service requests, claims inquiries and application status questions should be routed to USable Life:

Email:

custserv@usablelife.com

Phone:

800-370-5856

Personal Critical Illness Insurance Plan

Rates Per Covered Person

Critical Illness With Cancer– Monthly premiums per \$10,000 unit.

Monthly Premiums (same for both applicant and spouse)						
Issue Age	\$10,000		\$20,000		\$30,000	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
18 - 29	\$ 4.88	\$ 10.08	\$ 9.76	\$ 20.16	\$ 14.64	\$ 30.24
30 - 39	\$ 7.96	\$ 18.44	\$ 15.92	\$ 36.88	\$ 23.88	\$ 55.32
40 - 49	\$ 12.52	\$ 32.56	\$ 25.04	\$ 65.12	\$ 37.56	\$ 97.68
50 - 59	\$ 19.24	\$ 52.12	\$ 38.48	\$ 104.24	\$ 57.72	\$ 156.36
60 - 64	\$ 25.84	\$ 65.44	\$ 51.68	\$ 130.88	\$ 77.52	\$ 196.32

Rates Per Covered Person

Critical Illness Without Cancer– Monthly premiums per \$10,000 unit.

Monthly Premiums (same for both applicant and spouse)						
Issue Age	\$10,000		\$20,000		\$30,000	
	Non-Tobacco*	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
18 - 29	\$ 3.28	\$ 5.56	\$ 6.56	\$ 11.12	\$ 9.84	\$ 16.68
30 - 39	\$ 5.08	\$ 10.32	\$ 10.16	\$ 20.64	\$ 15.24	\$ 30.96
40 - 49	\$ 7.72	\$ 18.00	\$ 15.44	\$ 36.00	\$ 23.16	\$ 54.00
50 - 59	\$ 11.44	\$ 28.20	\$ 22.88	\$ 56.40	\$ 34.32	\$ 84.60
60 - 64	\$ 15.16	\$ 35.56	\$ 30.32	\$ 71.12	\$ 45.48	\$ 106.68

Commission Disclosure: The rates presented in this proposal include commissions, and may include additional compensation. If you have questions, please contact your broker or BCBST representative.

Personal Critical Illness

Personal Critical Illness:

List of Ineligible Occupations

Applications should not be submitted for individual working in the below occupations. These occupations are considered high risk and are automatically declined.

- Asbestos removal worker
- Crop duster
- Seasonal farm worker
- Toxic waste handler
- Work for the Federal or State government
- Work with radioactive materials
- Work in the field extracting coal, metals, oil, petroleum, or natural gas
- Work at manufacturing facility for:
 - 1) Acids
 - 2) Ammunitions
 - 3) Chemicals
 - 4) Explosives
 - 5) Nuclear Power



P.O. Box 1650
Little Rock, Arkansas 72203

Please Print Using Dark Ink

CRITICAL ILLNESS APPLICATION

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc	

New Application Change Form Replaces Policy No. _____

SECTION 1 - APPLICANT INFORMATION

Name (First, MI, Last)					Social Security No.						
Home Address			City		State		Zip		County		
Occupation (Be Exact)		Date of Birth		Age	Birth State or Country		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Height (ft-in.)		Weight (lbs.)
Employer		Date Employed full-time		Work Phone ()		Home Phone ()		Have you used any tobacco products within the past 36 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION 2 - SPOUSE & INFORMATION

Full Name	Occupation	Sex	Date of Birth			Birth State or Country	Height ft /in	Weight lbs
			mo	day	yr			
(spouse)								

Has your spouse used any tobacco products within the past 36 months? Yes No

SECTION 3 - PLAN SELECTION

New Applicant Application for Change

I hereby apply for the following coverage:		Face Amount Applying For (Increments of \$5,000)	Number of Units (\$5,000 per Unit)	Rate	Monthly Premium
<input type="checkbox"/> Applicant Only					
<input type="checkbox"/> Applicant & Spouse		Applicant	X	= \$	
		Spouse*	X	= \$	
* Spouse's signature required if amount exceeds \$25,000.				TOTAL PREMIUM AMOUNT	\$

Monthly Premiums Per \$5,000 Unit

Issue Age	Critical Illness With Cancer Non-Tobacco	Critical Illness With Cancer Tobacco	Critical Illness Without Cancer Non-Tobacco	Critical Illness Without Cancer Tobacco
18-29	\$2.44	\$5.04	\$1.64	\$2.78
30-39	\$3.98	\$9.22	\$2.54	\$5.16
40-49	\$6.26	\$16.28	\$3.86	\$9.00
50-59	\$9.62	\$26.06	\$5.72	\$14.10
60-64	\$12.92	\$32.72	\$7.58	\$17.78

SECTION 4 - BENEFICIARY

Name Beneficiary Change of Beneficiary

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Relationship	Date of Birth	Primary or Secondary	Indicate % Distribution
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	

Employee's Name (Last, First, M.I.)	Social Security #	Employer
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SECTION 5 – MEDICAL INFORMATION
NOTE: If Spouse [or Children] coverage IS NOT being requested answer questions only as applies to applicant.

1. Has any person to be insured ever been diagnosed with or advised to take a diagnostic test, been treated by a member of the medical profession, or taken medication for:

	Yes	No		Yes	No
(a) Any form of internal cancer, carcinoma in-situ, malignant melanoma, or other precancerous findings?	<input type="checkbox"/>	<input type="checkbox"/>	(e) Heart Attack or heart disease, stroke or transient ischemic attack (TIA), or been advised to have coronary bypass surgery, stent insertion, or laser treatment to coronary arteries?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Any chronic or progressive disease or disorder of the heart, kidneys, liver, lungs, pancreas, or bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>	(f) Diabetes (except during a pregnancy), or any blood pressure reading recorded in the last three months exceeding 149/94?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Quadriplegia, amyotrophic lateral sclerosis (Lou Gehrig's disease), or other motor neuron disease?	<input type="checkbox"/>	<input type="checkbox"/>	(g) Acquired Immunodeficiency syndrome ("AIDS"), AIDS related complex, or Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Alcohol or substance abuse (in the last 5 years)?	<input type="checkbox"/>	<input type="checkbox"/>			

2. Has any person to be insured ever been diagnosed by a member of the medical profession with, or does anyone currently have:

	Yes	No		Yes	No
(a) Any abnormal cancer screening tests currently being followed by your doctor?	<input type="checkbox"/>	<input type="checkbox"/>	(c) Carotid artery stenosis, peripheral vascular disease, chronic atrial fibrillation, or chest pain not evaluated by a medical doctor and determined to be non-cardiac?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Any cysts, growths, lumps, or any mole or freckle that has bled, become painful, changed color, increased in size, required medical attention or evaluation for which you have not yet sought medical advice?	<input type="checkbox"/>	<input type="checkbox"/>	(d) Multiple sclerosis, memory loss, schizophrenia, systemic lupus erythematosus, pulmonary or cystic fibrosis?	<input type="checkbox"/>	<input type="checkbox"/>

3. Has any person to be insured had any two or more natural parents, brothers, or sisters diagnosed with coronary artery disease, diabetes, or the same cancer (other than skin cancer) prior to age 55? Or, has any person to be insured had one or more natural parents, brothers, or sisters diagnosed with coronary artery disease or colorectal cancer prior to age 45? Yes No

4. Is any person to be insured currently taking any prescription medicine(s) or have they taken prescription medicine(s) in the last three (3) years? Yes No

5. Has any person to be insured had any abnormal tests (including blood test, urinalysis, X-ray, MRI, ultrasound, stress test, echocardiogram) not found to be normal or benign on further testing, or requiring follow-up by a physician? Yes No

6. Does any person to be insured have any consultation, surgery, or test scheduled or anticipated? Yes No

7. Has any person to be insured ever been diagnosed by a member of the medical profession with a benign tumor, disorder of blood or autoimmune disorder, digestive disorder, urinary system or reproduction organs disorder, heart or circulatory disorder, hypertension (list last two blood pressure readings and dates), mental or nervous disorder, neurological disorder, or respiratory disorder? Yes No

8. Has any person to be insured had any application for critical illness, disability, health, or life insurance modified, rated, or declined in the last 5 years? Yes No

9. Give details to any "Yes" answers, including name of person, prescription medicine(s), diagnosis, and dates of treatment: _____

10. Name, address, and phone number of the personal physician(s) of all applicants with date last seen, reason for visit, and results: _____

Employee's Name (Last, First, M.I.)	Social Security #	Employer
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SECTION 6 – AUTHORIZATION

1. Does any person applying for coverage currently have a Critical Illness or Cancer Policy with us or any other insurance company? Yes No
If yes, give name of company, list type of policy and amount of coverage. _____
2. REPLACEMENT: Is this insurance to replace or Change other insurance? Yes No If "Yes", give details including name of company. _____
3. OUTLINE: Have you received the Outline of Coverage? Yes No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" on page 2 of this application; (c) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to US Able Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (d) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (e) agree that this authorization shall be valid for two (2) years from the application date; (f) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (g) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; and (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application. I understand that my policy will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

Insurance Fraud Warning – It is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

X _____ Signed at: _____
Applicant's Signature (City and State)

X _____ Date of Application: _____
Spouse's Signature (if required) (Month, Day, Year)

X _____ X _____
Agent's Signature Agent's Printed Name and ID Number

Date Received Home Office