Standard Life and Accident Insurance Company

RecoveryCare II

A Short Term Nursing Facility Insurance Solution

AMERICAN NATIONAL

Standard Life
AND ACCIDENT INSURANCE COMPANY
AN AMERICAN NATIONAL COMPANY

888.290.1085

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ST-2551

RCB10IND

Standard Life and Accident Insurance Company

RecoveryCare II

A Short Term Nursing Facility Insurance Solution

RecoveryCare II, from Standard Life and Accident Insurance Company ("Standard Life", "the Company") offers these features and benefits:

- Coverage for Nursing Facility Care
- Coverage for Assisted Living Facility Care
- Bed Reservation Benefit
- Choice of Lifetime Maximum Benefits
- Choice of Lifetime Elimination Periods
- Restoration of Benefits
- Waiver of Premium
- Spousal Discount
- Optional Inflation Protection
- Optional Home Health Care Rider

Recovery Care Solutions

As America continues to age, more people are becoming aware of key health care issues such as the cost of short term nursing care. Even though many of us may avoid catastrophic long term care expenses, we are all exposed to the immediate financial impact of paying for short term care needs such as confinement to a Nursing Facility for recuperation or rehabilitation.

> **"Providing personal assistance in a congregate setting such as a nursing home or assisted living facility may satisfy more of an individual's needs, be more efficient, and involve more direct supervision to ensure better quality than when caregivers travel to individual's homes to serve them one on one."**[1]

Since both Medicare and Medicare Supplement insurance cover only skilled nursing care, you may be responsible for the cost of all services for lesser levels of care.

When will you be able to receive benefits?

Understanding when you will qualify to receive benefits is important! With Standard Life's **Recovery*Care* II**, once you have met the Elimination Period applied for, you will be eligible to receive payments for expenses incurred for all covered services if:

- You are unable to perform, without Hands-on-Assistance, at least two Activities of Daily Living (bathing, dressing, eating, continence, toileting and transferring); or
- You have suffered a Cognitive Impairment and require substantial supervision; or
- You require Nursing Facility Care, Assisted Living Facility Care or Home Health Care (if optional Rider applied for) due to medical necessity, as defined in the policy; and
- The services are in your Plan of Care, approved by your physician and the Company.

RecoveryCare II
Features and Benefits

Coverage for Nursing Facility Care
You can now have peace of mind knowing your selected Daily Benefit will help pay for expenses incurred, up to the Lifetime Maximum Benefit elected (180, 270 or 360 days), if you are in need of Skilled, Intermediate or Custodial Care in a Nursing Facility.

Coverage for Assisted Living Facility Care
If you need assistance that does not require 24 hour care, but you are still in need of services provided in an institutional setting, 75% of the Daily Benefit you selected can help pay for expenses in an Assisted Living Facility for the Lifetime Maximum Benefit selected (180, 270 or 360 days).

Lifetime Elimination Period
You have the option to select either a 0 or 20 day Elimination Period. The Elimination Period is the number of days you must receive services which would qualify for reimbursement under your policy before benefits begin. During the Elimination Period you are responsible for all expenses incurred.

Once your Elimination Period has been satisfied, benefits will be paid in accordance with the policy provisions and you never have to satisfy it again during the time your policy is in force.

Lifetime Maximum Benefit
A Lifetime Maximum Benefit is available for 180, 270 or 360 days. After the Elimination Period, you will receive benefits for each day of care up to your Lifetime Maximum Benefit as shown in the Schedule of Benefits. Once your Lifetime Maximum Benefit is fully exhausted your coverage will be terminated.

Restoration of Benefits
Should your stay require less than your Lifetime Maximum Benefit and you qualify for a Restoration of Benefits as defined in the policy, full benefits will be restored up to the maximum benefit shown in your policy.

Bed Reservation Benefit
If you are hospitalized while receiving benefits in a Nursing Facility or Assisted Living Facility, the Company will continue to pay a benefit for a charge made to reserve your accommodations in the facility for up to 21 days per calendar year.

Waiver of Premium
No additional premium payments will be required once benefits become payable for all covered services, as long as you are still receiving benefits.

Spousal Discount
You can receive a 10% discount when you and your spouse apply for coverage and are both approved.

Coverage for Pre-existing Conditions
Pre-existing conditions disclosed on the application will be covered immediately.

Optional Inflation Protection
Either Simple or Compound inflation can be added at an additional cost.

Optional Home Health Care Rider
At an additional cost, this optional rider will pay 75% of the Daily Benefit of the base policy for medically necessary Home Health Care services for a maximum of 90 days with no Elimination Period.

Footnotes:

1 U. S. Senate, Committee on Aging, *Long Term Care, Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets,* March 2002.

This policy is not available in all states. It contains exclusions and limitations. For costs and complete details, call or write your insurance agent or the Company. Benefits, limitations and exclusions may vary depending on the state of issue and the plan you selected. Policy Form Series 2090, Riders RCCIR-0805-1, RCSIR-0805-1 and SL-HHCR-0912-1.

This is not a Medicare Supplement policy nor a Long Term Care insurance policy. This is a limited benefit Nursing Facility insurance policy.

RecoveryCare II

Home Health Care Rider Benefit
at 75% of Nursing Home Maximum Daily Benefit

ANNUAL PREMIUM RATES PER $10 OF NURSING HOME MAXIMUM DAILY BENEFIT

ISSUE AGE	HHC RIDER	HHC COMPOUND INFLATION BENEFIT	HHC SIMPLE INFLATION BENEFIT
50 - 51	$ 5.95	$ 5.73	$3.39
52	6.07	5.90	3.42
53	6.18	6.14	3.68
54	6.47	6.61	4.08
55	6.92	7.13	4.49
56	7.47	7.67	4.83
57	8.12	8.25	5.14
58	8.86	8.87	5.58
59	9.46	9.36	6.01
60	9.87	9.64	6.35
61	10.32	9.97	6.58
62	11.31	10.70	6.76
63	13.14	11.95	7.07
64	13.92	12.31	7.37
65	14.30	12.34	7.62
66	14.64	12.39	7.87
67	15.08	12.42	8.12
68	15.92	12.44	8.36
69	16.82	12.46	8.60
70	17.72	12.47	8.80
71	18.66	12.49	8.93
72	19.58	12.53	9.01
73	20.53	12.55	9.15
74	21.64	12.57	9.26
75	22.84	12.59	9.32
76	24.13	12.63	9.34
77	25.47	12.67	9.40
78	26.70	12.84	9.64
79	27.99	13.46	9.91

RATES ARE SUBJECT TO CHANGE

If Inflation Protection Rider included in Base Plan, it must be included in Home Health Care Rider.

RecoveryCare II

Annual Rates Per $10 Unit Daily Nursing Home Benefit

	BASE POLICY 20 DAY ELIMINATION			COMPOUND INFLATION RIDER			SIMPLE INFLATION RIDER		
ISSUE AGE	360 days	270 days	180 days	360 days	270 days	180 days	360 days	270 days	180 days
50 - 52	$ 11.00	$ 10.00	$ 8.00	$16.00	$14.00	$12.00	$ 7.00	$ 7.00	$ 6.00
53	11.97	10.85	8.86	18.38	15.88	13.50	7.97	7.84	6.77
54	13.38	12.10	10.01	21.51	18.44	15.55	9.42	9.00	7.78
55	15.22	13.74	11.43	25.25	21.56	18.05	11.30	10.44	9.02
56	17.43	15.71	13.10	29.46	25.12	20.90	13.51	12.12	10.43
57	20.00	18.00	15.00	34.00	29.00	24.00	16.00	14.00	12.00
58	22.88	20.56	17.09	38.74	33.07	27.26	18.68	16.04	13.69
59	26.03	23.35	19.34	43.50	37.19	30.55	21.47	18.19	15.45
60	29.38	26.31	21.70	48.10	41.20	33.76	24.27	20.39	17.26
61	32.88	29.39	24.13	52.36	44.94	36.76	26.98	22.61	19.07
62	36.47	32.53	26.58	56.11	48.25	39.42	29.50	24.78	20.83
63	40.13	35.71	29.05	59.23	51.04	41.66	31.78	26.87	22.53
64	44.00	39.04	31.63	61.86	53.41	43.56	33.90	28.92	24.18
65	48.23	42.67	34.46	64.19	55.52	45.25	35.99	30.97	25.82
66	53.01	46.75	37.69	66.42	57.55	46.85	38.17	33.06	27.47
67	58.50	51.42	41.44	68.75	59.64	48.47	40.56	35.25	29.17
68	64.82	56.79	45.83	71.32	61.92	50.22	43.23	37.56	30.93
69	71.93	62.81	50.77	74.04	64.29	52.02	46.11	39.95	32.75
70	79.72	69.39	56.18	76.74	66.64	53.79	49.04	42.36	34.57
71	88.09	76.45	61.94	79.26	68.82	55.44	51.89	44.73	36.37
72	96.94	83.89	67.94	81.44	70.69	56.86	54.53	47.00	38.11
73	106.27	91.71	74.19	83.18	72.16	57.98	56.85	49.11	39.75
74	116.40	100.31	81.02	84.54	73.18	58.73	58.91	50.97	41.17
75	127.73	110.14	88.85	85.63	73.74	59.06	60.79	52.50	42.28
76	140.67	121.70	98.14	86.56	73.83	58.92	62.59	53.61	42.94
77	155.64	135.44	109.31	87.44	73.44	58.25	64.39	54.22	43.06
78	172.93	151.69	122.63	88.36	72.60	57.05	66.26	54.30	42.56
79	192.38	170.09	137.76	89.26	71.44	55.49	68.13	54.00	41.66

RATES ARE SUBJECT TO CHANGE
FOR 0 DAY ELIMINATION MULTIPLY BY 1.10

Issue Ages: 50 - 79

Daily Benefit: $50 - $300

Lifetime Maximum Benefit:
180, 270, 360 days

Elimination Period:
0 or 20 days

Available Riders:
5% Compound Inflation
5% Simple Inflation
Home Health Care

Available Discounts:
Preferred Underwriting 20%
Spousal Discount 10%
List Bill 5%

Daily Benefit: $_____ Lifetime Maximum Benefit: _____ Days

PREMIUM CALCULATION WORKSHEET

Base Policy Rate: $_____

Number of Units: (×)_____

= $_____

Inflation Rider: $_____

Number of Units: (×)_____

= $_____

Subtotal: = $_____

0 Day Elimination Option: (×) 1.10

= $_____

Home Health Care Rider: $_____

Number of Units: (×)_____

= $_____

Home Health Care Inflation Benefit*: $_____

Number of Units: (×)_____

(*If included in Base Plan, must be included in Rider.)

= $_____

Subtotal: = $_____

Preferred Underwriting: (×) .80
(if applicable)

= $_____

Spousal Discount: (×) .90
(if applicable)

= $_____

Modal Factor: _____

Total Modal Premium: = $_____

MODAL FACTORS

Annual	Semi-Annual	Quarterly	PAC
1.000	0.520	0.270	0.0875

Standard Life and Accident Insurance Company

Standard Life and Accident Insurance Company
Short Term Nursing Care Application
Mailing Address: P.O. Box 10627, Springfield, MO 65808
888.350.1488

* A P P *

SHORT TERM NURSING CARE APPLICATION *(Please Print - Black Ink)*

SECTION A

1. Applicant _____ Date of Birth _____ Age _____
   (First Name / Middle Initial / Last Name)
   Home Address _____ City _____ State _____ Zip _____
   Phone (____) _____ Best Time to Call _____ Email _____
2. Billing Address (if different) _____ City _____ State _____ Zip _____
3. Height _____ Weight _____

SECTION B

❑ New Policy ❑ Reinstatement

4. ❑ Male ❑ Female
5. **I AM APPLYING FOR:**
   a) Daily Benefit $_____ b) Lifetime Maximum Benefit Period (days): ❑ 180 ❑ 270 ❑ 360
   c) Elimination Period (days): ❑ 0 ❑ 20 d) Inflation Protection Rider: ❑ Compound ❑ Simple
   e) ❑ Home Health Care Rider (if Inflation Protection Rider included in Base Plan, it must be included in Home Health Care Rider)
6. **Payment Mode:** ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly PAC
7. **Requested Effective Date:** _____

SECTION C

If the answer to any question in Section C (8-11h) is Yes, the application should not be submitted.

8. Are you now bedridden, confined to a nursing home, assisted living facility or hospital, or receiving the services of a home health care agency? ..... ❑ **Yes** ❑ **No**
9. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection? ... ❑ **Yes** ❑ **No**
10. Within the past **2 years**, have you:
    a) had or been recommended to have medical tests or treatment or surgery which have not been done or for which results have not been given? ..... ❑ **Yes** ❑ **No**
    b) been hospitalized 2 or more times or confined to a nursing home or required assistance or supervision by another person for dressing, eating, personal hygiene (bathing or toileting), walking or transferring to or from a bed or chair or suffered a fracture of the spine or hip? ..... ❑ **Yes** ❑ **No**
    c) required the use of a wheelchair, walker or cane? ..... ❑ **Yes** ❑ **No**
    d) been advised to have cataract surgery or other eye surgery that has not been performed? ..... ❑ **Yes** ❑ **No**

11. Are you currently being treated or recently been diagnosed or within the past **2 years** have you had or been advised to have treatment, surgery or to take prescription medication for:

a) cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission? ..... ❑ **Yes** ❑ **No**

b) congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement? ..... ❑ **Yes** ❑ **No**

c) uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene? ..... ❑ **Yes** ❑ **No**

d) emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen? ..... ❑ **Yes** ❑ **No**

e) ulcerative colitis, Crohn's disease, cirrhosis of the liver, hepatitis or any disease of the pancreas or prostate not cured by surgery or treatment? ..... ❑ **Yes** ❑ **No**

f) Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder? ..... ❑ **Yes** ❑ **No**

g) mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse? ..... ❑ **Yes** ❑ **No**

h) incontinence, any ostomy present due to disease, an organ transplant other than corneal? ..... ❑ **Yes** ❑ **No**

12. Within the past **2 years**, have you consulted a physician, been diagnosed or received treatment for any condition not listed above, including dizziness, vertigo, tremors, seizures, depression, anxiety, amputation, arthritis, asthma, osteoporosis, urinary incontinence, heart rhythm disorders, heart bypass or heart attack? ..... ❑ **Yes** ❑ **No**

If Yes, give information regarding diagnosis or condition. (use additional sheet if necessary) _____

SECTION D

Will any health, recovery short term, long term, or home health care insurance be replaced with this policy? ..... ❑ **Yes** ❑ **No**

If Yes, which company? _____ Policy Number _____

If Yes, read and complete the Notice to Applicant Regarding Replacement.

SECTION E

AGREEMENT — I have read or had read to me my completed application. My answers are true and complete to the best of my knowledge and belief. I understand my coverage, if issued, will begin on the date of issue shown in my policy. I realize that if any of my answers on this application are incorrect or untrue, Standard Life and Accident Insurance Company has the right to deny benefits or rescind my Policy. If application taken over the phone, I agree that my electronic signature serves as my original signature.

FRAUD WARNING — Any person who knowingly and with intent to injure, defraud or deceive any insurer, submits an application for insurance or makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.

ACKNOWLEDGMENT — If Medicare eligible, I have received the *Guide to Health Insurance for People with Medicare* and a Duplication of Medicare Coverage form from the Agent.

The policy provides limited benefits. Review your policy carefully.

Applicant's Signature _____ Date _____

City _____ State _____ Zip _____

A TELEPHONE INTERVIEW WILL BE CONDUCTED.

What will be the best time to contact the Applicant for the telephone interview? _____

* A T H *

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit manager, government agency, group policyholder, employer, benefit plan administrator, MIB, Inc., the Department of Motor Vehicle Registration and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY's or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant(s). It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage;
3. a picture copy or photocopy of this authorization shall be as valid as the original; and
4. I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* If application taken over the phone, I agree that my electronic signature serves as my original signature.

Date

Applicant's Signature

Witness

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____.

* A G S *

AGENT'S STATEMENT

I certify that: 1) I asked the Applicant the questions in the application and truthfully and accurately recorded the answers; 2) the answers did not conflict with my observations and knowledge of the Applicant; and 3) If applicable, I gave the *Guide to Health Insurance for People with Medicare* and a copy of the appropriate form(s) and/or disclosure(s) to the Applicant.

I also certify that: 1) the Applicant has read, or had read to him or her, the completed application; and 2) the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant and which are currently in force are (if none, write "NONE"):

_____

The company names, policy/certificate numbers and types of coverages of any other health insurance policies that I sold to the Applicant during the last 5 years and which are not currently in force are (if none, write "NONE"): _____

As the Agent, do you have any knowledge or reason to believe that replacement of existing insurance may be involved?.....❑ Yes ❑ No

AGENT INFORMATION

Name (printed) _____

Signature _____

Agent Code _____

Date Signed _____

Phone _____ Fax _____

Email _____

❑ Preferred Underwriting ❑ Spousal Discount

Premium Quoted $ _____ Premium Collected $ _____

❑ No money collected. Initial premium is to be drafted.

❑ Receipt Given Mail Policy to: ❑ Insured ❑ Agent

Special Requests: _____

RECEIPT

IF PREMIUM IS COLLECTED, CHECK OR MONEY ORDER FOR INITIAL PREMIUM MUST ACCOMPANY APPLICATION. ALL CHECKS AND MONEY ORDERS MUST BE PAYABLE TO STANDARD LIFE AND ACCIDENT INSURANCE COMPANY. If coverage is not issued, the initial premium will be refunded to the Applicant. If coverage is issued, it will begin on the date of issue shown in the policy.

Received from _____

on _____
Date

an application for Recovery Care II

and a Check ❑ Money Order ❑

for $_____

_____
Applicant's Signature

_____
Agent's Signature

Standard Life
and Accident Insurance Company

Standard Life and Accident Insurance Company
Mailing Address: P.O. Box 10627, Springfield, MO 65808
888.350.1488

* P A C *

AUTHORIZATION TO MY BANK
PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

Bank Information: ❑ Checking ❑ Savings

_____
Name

_____
City State Zip

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If application taken over the phone, I agree that my electronic signature serves as my original signature.

_____
Date Signed

✓ _____
Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number _____

Routing Number _____

DISCLOSURE NOTICE

Fair Credit Reporting Act Pre-notification – Federal and state laws require notification that, with your application, we may request an investigative consumer report. In addition, such a report may be requested subsequently to update our records or if you apply for additional coverage. Upon written request, we will inform you whether or not an investigative consumer report was requested and, if such report was requested, the address and telephone number of the investigative agency to which the request was made. By contacting the local office and providing the proper identification, you may inspect, or for the appropriate fee, receive a copy of such report. Typically, the report will contain information as to character, general reputation, personal characteristics, and mode of living, which information is obtained through an interview with you or an adult member of your family, employers or business associates, financial sources, friends, neighbors, or others with whom you are acquainted. The information will consist, when applicable, of a confirmation of your identity, age, residence, marital status, and past and present employment including occupational duties, financial information, driving record, sports and recreational activities, health history, use of alcohol or drugs if any, living conditions and type of community.

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