Washington National®

AGENT GUIDE

WASHINGTON NATIONAL

ACTIVE care®

THE SUPPLEMENTAL SOLUTION

Life is worth living well.

AC-BOOK-AGT

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SECTION 1: PRODUCT INTRODUCTION

Washington National Active Care® is an exciting addition to our supplemental health insurance portfolio. For your individual and group clients, this product offers multiple coverages and key supplemental benefits in one simple solution.

Active Care conveniently combines the best features of our cancer, heart and stroke, hospital and accident policies, with additional benefits for other critical illnesses. Coverage can easily be customized to fit the needs and budget of your clients, whether they are 18, 85 or any age in between. With this product, you can present worksite clients much-needed benefits with just one brochure, one application and one rate book in just one payroll slot.

Now more than ever, companies of all sizes are implementing wellness initiatives that motivate employees to adopt and maintain healthier lifestyles. As studies show, employer-sponsored wellness programs contribute to a healthier, more productive workforce. Healthier groups are then able to access life and health insurance options at much lower rates. Active Care offers a whole range of benefits that help protect employees and their families from the many medical and nonmedical costs associated with illnesses and injuries. Plus, the product goes a step further by offering a benefit for a doctor office wellness visit, which provides an additional incentive for employees to make healthful choices and seek preventive care. This wellness-promoting option makes Active Care even more attractive and appealing to today's employers and their employees.

SELECTING BENEFITS IS EASY!

STEP 1: CHOOSE WHO IS COVERED

☐Individual ☐Individual and child ☐Individual and spouse ☐Family

STEP 2: CHOOSE YOUR LUMP-SUM BENEFIT AMOUNT FOR CANCER, HEART & STROKE AND CRITICAL CONDITIONS

☐$5k ☐$10k ☐$20k ☐$30k ☐$40k ☐$50k ☐$60k ☐$70k ☐$100k

The lump-sum benefit for child(ren) is a maximum of $10,000.

STEP 3: CHOOSE YOUR COVERAGE

☐Cancer
☐Radiation and chemotherapy upgrade
☐Heart and stroke
☐Critical conditions
☐Hospital
☐Accident
☐Return of Premium or Cash Value

The information in this agent guide is based on standard policy language. For state variations, refer to the state-specific brochure and sample policy book for your state, available to order or download at WNbizlink.com.

Note: The policy language takes precedence over all other references and sales materials.

SECTION 2: COVERAGE DESCRIPTION AND OPTIONS

POLICY STRUCTURE

Active Care offers a variety of coverage types in one simple product. Your clients can choose from a menu of options, including one or more types of base coverage and a variety of additional benefits. This flexible structure enables you to tailor coverage to suit specific groups and individuals.

One client, for example, could select all coverage types for protection against the costs of illnesses and injuries. Another client could choose one coverage type—for example, cancer coverage—to protect against that illness alone. Yet another client may have sufficient coverage for cancer care, but want additional benefits for heart-related illnesses and hospital stays. Active Care offers a high level of flexibility to serve more of your clients' supplemental health insurance needs.

Base coverages–availability may vary by state

MARKETING NAME	COVERAGE TYPE	BENEFIT FORM*
Cancer	Cancer critical illness coverage	WNIC1068CN
Heart & stroke	Heart & stroke critical illness coverage	WNIC1068HS
Cancer and heart & stroke	Combined critical illness coverage	WNIC1068CH

**May vary by state.*

Riders–availability may vary by state

MARKETING NAME	COVERAGE TYPE	RIDER FORM*
Radiation and chemotherapy upgrade	Radiation and chemotherapy benefit rider	R1072
Critical conditions	Critical conditions rider	R1073
Hospital	Hospital indemnity rider	R1070
Accident	Accidental and death dismemberment rider	R1069
Return of Premium	Return of Premium rider	R1077ROP
Cash Value	Cash Value rider	R1077CV

**May vary by state.*

BASE POLICY

The coverage for cancer and/or heart & stroke serves as the client's base policy, and all other selected options are structured as riders. The base policy must have a minimum lump-sum benefit of $5,000 for cancer and/or heart & stroke coverage. Due to this plan design, every policy is considered "critical illness" coverage—even though benefits in addition to cancer and heart & stroke coverage may be selected.

LUMP-SUM BENEFITS

At the time of application, the client will choose a lump-sum benefit amount ranging from $5,000 to $100,000 (see page 1 for specific increments). The selected amount applies to the policyowner and the spouse, when covered. This amount will apply to all chosen coverages that pay a lump-sum benefit: cancer, heart & stroke and critical conditions. (Note: For clients who prefer varying lump-sum benefit amounts for different coverages, multiple supplemental policies may be written.) Child coverage is limited to $5,000 when the policyowner selects the lowest lump-sum amount and $10,000 for all other coverage levels selected.

For each selected coverage option, the lump-sum benefit amount is payable. When all three coverage options with lump-sum benefits—cancer, heart & stroke and critical conditions—are chosen, 100% of the lump-sum benefit is payable for a diagnosis in each coverage option.

Example: *A client selects the $100,000 lump-sum benefit amount and all three coverage types. The policyholder would receive a total of $300,000 in lump-sum benefits if he or she were diagnosed with:*

- *Cancer —100% lump-sum benefit*
- *Stroke —100% lump-sum benefit*
- *Major organ transplant—100% lump-sum benefit*

The lump-sum amount is payable in one full benefit or multiple partial benefits until 100% has been paid out to the insured. After the full lump-sum amount is paid, the policy's many indemnity benefits and recurrence benefits for cancer and heart & stroke remain available for ongoing health care needs.

INDEMNITY BENEFITS

Active Care base policy and riders also provide a number of indemnity benefits. These indemnity benefits are paid in addition to any applicable lump-sum benefit and do not reduce that amount. Benefits are not coordinated, which allows policyholders to receive indemnity benefits in more than one coverage type. For example, inpatient hospital indemnity benefits could be paid in two types—hospital and cancer—during one period of confinement, if hospitalized due to cancer.

COVERAGE OPTIONS

Cancer critical illness coverage (WNIC1068CN or state-specific variation)—availability may vary by state. The cancer critical illness coverage includes a lump-sum benefit for cancer and additional indemnity benefits for routine care and treatment.

LUMP-SUM BENEFITS	AMOUNT	BENEFIT DETAILS
Cancer	100%	Cancer means a disease that expresses itself as a malignant tumor characterized by the uncontrolled growth and spread of malignant cells; the invasion of body tissue by such malignant cells; leukemia; or Hodgkin's disease. Cancer is classified as one of three types: melanoma, nonmelanoma or internal cancer. Cancer does not include premalignant conditions, conditions with malignant potential or preleukemic conditions. Pays a lump-sum benefit for a diagnosis of cancer. The lump-sum benefit is not payable for skin cancer or any specified cancer diagnosed or treated before the effective date of the policy or during the waiting period.
Carcinoma-in-situ	25%	Carcinoma-in-situ is the earliest form of cancer, involves only the tissue where it is found and has not invaded the surrounding tissue or organs in the body. Pays a reduced lump-sum benefit for a diagnosis of carcinoma-in-situ. The lump-sum benefit is not payable for carcinoma-in-situ diagnosed or treated before the effective date of the policy or during the waiting period.
Skin cancer	$300	Skin cancer means melanoma and nonmelanoma skin cancer. Pays a one-time benefit when an insured is diagnosed with melanoma or nonmelonoma skin cancer and does not reduce the lump-sum benefits above.

INDEMNITY BENEFITS	AMOUNT	BENEFIT DETAILS
Inpatient hospital benefit	$300 per day	Benefits are paid for each day an insured is confined as an inpatient to a hospital due to cancer. The benefit is limited to three days per confinement and three confinements per calendar year. Confinements separated by fewer than 30 days are considered the same period of confinement. The benefit has a lifetime maximum of $15,000. For the inpatient hospital benefit to be paid, an insured must be confined as an inpatient for 24 hours and must be charged for room and board. Charges for observation units are not considered hospital confinements.
Annual care benefit	$75 per year	This benefit covers those expenses that are often incurred years after a cancer diagnosis. When an insured is under the continued care of a physician for a cancer diagnosis, the benefit pays beginning with the first anniversary after the payment of the lump-sum benefit and is payable each year on the date of the payment of the lump-sum benefit and will not exceed a total of five consecutive annual payments per insured.
Recurrence benefit	Builds to 50% of the lump-sum benefit	The benefit pays for a subsequent diagnosis of cancer excluding carcinoma-in-situ and skin cancer. The benefit builds by 10% of the lump-sum benefit per year. The benefit becomes available for payment when the covered condition is diagnosed more than 12 months after any previous diagnosis and no treatment has been required or received during the 12 months between the diagnoses. Treatment does not include maintenance medications and follow-up visits to a physician. After five years, the benefit reaches its maximum of 50% of the lump-sum benefit.

<13 months	**13–24 months**	**25–36 months**	**37–48 months**	**49–60 months**	**61+ months**
0	10%	20%	30%	40%	50%

Radiation and chemotherapy benefit rider (R1072 or state-specific variation)—availability may vary by state. This rider provides radiation and chemotherapy benefits when an insured has been diagnosed and is receiving treatment for cancer. At the time of administration, the treatments must be fully or investigationally approved for the treatment of cancer by the U.S. Food and Drug Administration or the National Cancer Institute. Inpatient and outpatient treatments are covered. This rider can be added to a Active Care policy any time a lump-sum of $5,000 or more in cancer coverage is selected.

INDEMNITY BENEFITS	AMOUNT	BENEFIT DETAILS
Radiation therapy benefit	$200 per day	Up to $5,000 per calendar year. No lifetime maximum on this benefit.
Injected chemotherapy benefit	$200 per day	Up to $5,000 per calendar year. No lifetime maximum on this benefit.
Oral chemotherapy benefit	$300 per month	Lifetime maximum of 36 months.

Heart and stroke critical illness coverage (WNIC1068HS or state-spec. variation)—availability may vary by state. The heart and stroke critical illness coverage includes a lump-sum benefit for a heart attack, stroke, coronary artery bypass, angioplasty, stent and transient ischemic attack (TIA), with additional indemnity benefits for routine care and treatment.

LUMP-SUM BENEFITS	AMOUNT	BENEFIT DETAILS
Heart attack	100%	Heart attack means a myocardial infarction. A myocardial infarction occurs when the blood supply to the heart is severely reduced, commonly due to blockage in one of the coronary arteries, resulting in damage to the heart muscle. Pays a lump-sum benefit for a diagnosis of a heart attack. The lump-sum benefit is not payable for a heart attack diagnosed or treated before the effective date of the

LUMP-SUM BENEFITS	AMOUNT	BENEFIT DETAILS
		policy or during the waiting period.
Stroke	100%	Stroke means a cerebrovascular accident lasting more than 24 hours that causes neurological deficiency. A cerebrovascular accident means a sudden, unexpected interference in brain function resulting from an insufficient supply of blood to part of the brain. Stroke does not mean a head injury, transient ischemic attack or chronic cerebrovascular insufficiency. Pays a lump-sum benefit for a diagnosis of a stroke. The lump-sum benefit is not payable for a stroke diagnosed or treated before the effective date of the policy or during the waiting period.
Coronary artery bypass	50%	Coronary artery bypass surgery means undergoing a surgical procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, but excluding procedures such as, but not limited to, laser relief or noninvasive procedures. Pays a reduced lump-sum benefit for a coronary artery bypass. The lump-sum benefit is not payable for a coronary artery bypass treated before the effective date of the policy or during the waiting period.
Angioplasty	25%	Angioplasty is the technique of mechanically widening a narrowed or obstructed blood vessel with a balloon-tipped catheter. Pays a reduced lump-sum benefit for an angioplasty. The lump-sum benefit is not payable for an angioplasty treated before the effective date of the policy or during the waiting period.
Stent	25%	Stent means a small mesh tube that is used to treat narrow or weak arteries. Pays a reduced lump-sum benefit for a stent. The lump-sum benefit is not payable for a stent treated before the effective date of the policy or during the waiting period.
TIA	25%	Transient ischemic attack (TIA or sometimes referred to as mini stroke) means, as medically diagnosed by a physician, a transient episode of neurologic dysfunction caused by loss of blood flow (either focal brain, spinal cord or retinal) without acute tissue death and occurring within 72 hours of the onset of the symptoms. Pays a reduced lump-sum benefit for a diagnosis of a TIA. The lump-sum benefit is not payable for a TIA diagnosed or treated before the effective date of the policy or during the waiting period.

INDEMNITY BENEFITS	AMOUNT	BENEFIT DETAILS
Inpatient hospital benefit	$300 per day	Benefits are paid for each day an insured is confined as an inpatient to a hospital due to a heart attack or stroke. The benefit is limited to three days per confinement and three confinements per calendar year. Confinements separated by fewer than 30 days are considered the same period of confinement. The benefit has a lifetime maximum of $15,000. For the inpatient hospital benefit to be paid, an insured must be confined as an inpatient for 24 hours and must be charged for room and board. Charges for observation units are not considered hospital confinements.
Annual care benefit	$75 per year	This benefit covers those expenses that are often incurred years after a heart attack or stroke. When an insured is under the continued care of a physician for a heart attack or stroke, this benefit pays beginning with the first anniversary after the payment of the lump-sum benefit and is payable each year on the date of the payment of the lump-sum benefit and will not exceed a total of five consecutive annual payments per insured.

<table>
<tr><th>INDEMNITY BENEFITS</th><th>AMOUNT</th><th>BENEFIT DETAILS</th></tr>
<tr><td>Recurrence benefit</td><td>Builds to 50% of the lump-sum benefit</td><td>The benefit pays for a subsequent diagnosis of heart attack or stroke. The benefit builds by 10% of the lump-sum benefit per year. The benefit becomes available for payment when the covered condition is diagnosed more than 12 months after any previous diagnosis and no treatment has been required or received during the 12 months between the diagnoses. Treatment does not include maintenance medications and follow-up visits to a physician. After five years, the benefit reaches its maximum of 50% of the lump-sum benefit.
<table>
<tr><th><13 months</th><th>13–24 months</th><th>25–36 months</th><th>37–48 months</th><th>49–60 months</th><th>61+ months</th></tr>
<tr><td>0</td><td>10%</td><td>20%</td><td>30%</td><td>40%</td><td>50%</td></tr>
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Critical conditions rider (R1073 or state-specific variation)—availability may vary by state.
This rider expands critical illness coverage for medical conditions beyond heart disease, stroke and cancer. The rider can be added to a Active Care policy any time a lump-sum benefit of $5,000 or more in cancer and/or heart and stroke coverage is selected. This rider's lump-sum benefit will be equal to the base coverage's lump-sum amount.

LUMP-SUM BENEFITS	AMOUNT	BENEFIT DETAILS
Major organ transplant	100%	Major organ transplant means undergoing surgery to receive a transplant of a human heart, human lung, human liver, human kidney or human bone marrow as a result of failure of that organ of the insured. Pays a lump-sum benefit for a major organ transplant surgery. The lump-sum benefit is not payable for a major organ transplant treated before the effective date of the policy or during the waiting period. If the transplant list lump-sum benefit has already been paid, the major organ transplant lump-sum benefit will be reduced to 50%. **Transplant list** Pays a 50% lump-sum benefit when an insured is registered on the active waiting list for organ transplant surgery maintained by Organ Procurement and Transplantation Network (OPTN). The lump-sum benefit is not payable if an insured is registered before the effective date of the policy or during the waiting period.
Coma	100%	Coma means, as diagnosed by a physician, a state of extreme unresponsiveness, in which an individual exhibits no voluntary movement or behavior. Furthermore, in a deep coma, even painful stimuli (actions which, when performed on a healthy individual, result in reactions) are unable to elicit any response, and normal reflexes are lost. The insured must be in a coma for a period of 14 consecutive days. Coma does not include one that is medically induced. Pays a lump-sum benefit for a diagnosis of a coma. The lump-sum benefit is not payable for a coma diagnosed or treated before the effective date of the policy or during the waiting period.
Permanent blindness	100%	Blindness means clinically proven irreversible reduction of sight in both eyes that has persisted for a period of at least 180 consecutive days. Sight must be reduced to a corrected visual acuity of less than 20/200 or visual field restriction to 20° or less in both eyes. The physician making the diagnosis of blindness must be a board-certified ophthalmologist. Pays a lump-sum benefit for a diagnosis of permanent blindness. The lump-sum benefit is not payable for blindness diagnosed or treated before the effective date of the policy or during the waiting period.

LUMP-SUM BENEFITS	AMOUNT	BENEFIT DETAILS
Permanent paralysis	100%	Paralysis means, as diagnosed by a physician, loss or impairment of the ability to move a body part as a result of damage to its nerve supply. The paralysis must be an impairment of two or more limbs and last 90 days or more. Pays a lump-sum benefit for a diagnosis of permanent paralysis. The lump-sum benefit is not payable for paralysis diagnosed or treated before the effective date of the policy or during the waiting period.
Alzheimer's disease	50%	Alzheimer's disease means a progressive, degenerative disorder that attacks the brain's nerve cells, or neurons, resulting in loss of memory, thinking and language skills and behavioral changes. Alzheimer's disease must be diagnosed by a physician. Pays a reduced lump-sum benefit for a diagnosis of Alzheimer's disease. The lump-sum benefit is not payable for Alzheimer's disease diagnosed or treated before the effective date of the policy or during the waiting period.
Diabetic amputation	50%	Diabetic amputation means surgical amputation above the ankle due to diabetes mellitus. Pays a reduced lump-sum benefit for a diabetic amputation. The lump-sum benefit is not payable for a diabetic amputation diagnosed or treated before the effective date of the policy or during the waiting period.
Permanent deafness	25%	Deafness means, as diagnosed by a physician a permanent condition wherein the ability to detect any sound is completely impaired. Pays a reduced lump-sum benefit for permanent deafness. The lump-sum benefit is not payable for deafness diagnosed or treated before the effective date of the policy or during the waiting period.
End-stage renal failure	25%	Renal failure means the end-stage renal failure presenting as chronic, irreversible failure of an insured's kidney function. The kidney failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly) or result in kidney transplant. For a renal failure benefit to be payable, renal failure must be positively diagnosed by a physician through clinical findings with corroboration from urine and blood tests, ultrasound, CT scan, MRI or kidney biopsy. Pays a reduced lump-sum benefit for end-stage renal failure. The lump-sum benefit is not payable for renal failure diagnosed or treated before the effective date of the policy or during the waiting period.

INDEMNITY BENEFIT	AMOUNT	BENEFIT DETAILS
Inpatient hospital benefit	$300 per day	Benefits are paid for each day an insured is confined as an inpatient to a hospital due to a specified critical illness. The benefit is limited to three days per confinement and three confinements per calendar year. Confinements separated by fewer than 30 days are considered the same period of confinement. The benefit has a lifetime maximum of $15,000. For the inpatient hospital benefit to be paid, an insured must be confined as an inpatient for 24 hours and must be charged for room and board. Charges for observation units are not considered hospital confinements.

Hospital indemnity rider (R1070 or state-specific variation)—availability may vary by state.
This rider provides additional benefits for covered accidents or covered sicknesses. An inpatient hospitalization due to a specified critical illness covered under the base policy will also be considered for inpatient hospitalization under this rider. The rider can be added to an Active Care policy any time a lump-sum benefit of $5,000 or more in cancer and/or heart & stroke coverage is selected.

Example: A person is hospitalized due to a heart attack.

If an insured has heart base coverage and the hospital indemnity rider, the insured could claim against the inpatient hospital benefit under the base **and** the hospital indemnity rider.

INDEMNITY BENEFITS	AMOUNT	BENEFIT DETAILS
Inpatient hospital benefit	$200 per day $400 per day for ICU	Benefits are paid for each day an insured is confined as an inpatient to a hospital due to a covered accident or covered sickness. The benefit is limited to three days per confinement and three confinements per calendar year. Confinements separated by fewer than 30 days are considered the same period of confinement. The benefit has a lifetime maximum of $15,000. For the inpatient hospital benefit to be paid, an insured must be confined as an inpatient for 24 hours and must be charged for room and board. Charges for observation units are not considered hospital confinements.
Outpatient surgeries benefit	$200 per calendar year	Benefit is paid when insured has an outpatient surgery for a covered accident or covered sickness.
Physician's office visit benefit (Doctor office wellness visit benefit)	$75 one-time per calendar year	This one-time-per-calendar year benefit pays for an annual physical exam, as well as the following wellness tests per insured: • Annual physical (ICD-9 CM Code: V70.0) • Biopsy • Blood test for triglycerides • Breast ultrasound • Cancer antigen 125 (CA-125) • Carcino-embryonic antigen (CEA) • Carotid doppler • Chest X-ray • Colonoscopy • Echocardiogram • Electrocardiogram • Fasting blood glucose test • Flexible sigmoidoscopy • Hemoccult stool specimen • Lipid panel • Mammogram • Pap smear • Prostate-specific antigen (PSA) • Serum cholesterol test • Stress test on a bicycle or treadmill • Thermography • ThinPrep • Virtual colonoscopy
Skilled-care facility benefit	$200 per day	This benefit pays for confinement in a skilled nursing facility following a hospital confinement. The benefit has a seven-day elimination period and will pay for up to 14 days. Limited to one confinement per calendar year. To be eligible for the benefit, the insured must be unable to perform two or more of the following activities of daily living: bathing, dressing, eating, toileting, transferring and continence.

Accidental death and dismemberment rider (R1069 or state-specific variation)—availability may vary by state. This rider gives policyholders protection against the costs of accidental injuries as well as accidental death and dismemberment. The rider can be added to an Active Care policy any time a lump-sum benefit of $5,000 or more in cancer and/or heart & stroke coverage is selected.

What is an accidental injury?

An accidental injury is a bodily injury solely caused by and resulting from a sudden, unexpected and unforeseen event.

The best way to understand this definition is by asking these qualifying event questions:

- Was the act that caused the injury a sudden, unexpected and unforeseen event?
  –AND–
- Is the injury related to the act?

For an injury to be considered accidental, the answer to both questions must be "yes."

Example 1: A person is moving some furniture and strains his back. Would this claim be paid?

NO. The act of moving the furniture was not sudden, unexpected and unforeseen. The person intended or planned to move the furniture.

Example 2: A person is moving furniture, drops the sofa on his foot and injures his toe. Would this claim be paid?

YES. The act of dropping the sofa was sudden, unexpected and unforeseen, and the resulting injured toe was related to the act of dropping the sofa.

An accidental injury does not include an injury that is the result of a bodily or mental infirmity, disease or medical treatment. An example of bodily infirmity is an allergic reaction, such as a bee sting. An allergic reaction is not accidental. It is the result of a weakness in an individual's body. Not everyone is allergic to bee stings. The same logic applies to other allergic reactions, such as bites from small insects, like spiders, mosquitoes, etc.

INDEMNITY BENEFITS	POLICYOWNER/SPOUSE	CHILD(REN)
Accidental death benefit	If an accidental injury causes death within 90 days of a covered accident, the rider pays a lump-sum accidental death benefit related to the following: accidental death, motorized vehicle accident, pedestrian accident or common carrier.	
	$50,000	$25,000
Dismemberment benefit	If a covered accident causes the dismemberment of a finger, hand, toe, foot, arm, leg or eye within one year after the covered accident, the rider pays a benefit.	
One finger or toe	$1,000	$500
More than one finger or toe	$1,500	$1,000
One eye, hand, foot, arm or leg	$7,500	$2,000
More than one eye, hand, foot, arm or leg	$25,000	$5,000
Joint replacement	The rider pays a benefit if, as part of a covered accident, an insured is required to have a hip, knee or shoulder replacement within one year after the covered accident.	
	$5,000	$1,250
Fracture	If a covered accident causes a bone fracture and it is diagnosed and treated by a physician within 90 days after the covered accident, the rider pays a benefit. When a fracture requires a surgical incision, we will pay an extra 50% of the amount below.	
Hip or thigh	$1,200	$1,200
Vertebrae	$1,100	$1,100
Pelvis	$1,000	$1,000
Skull (depressed)	$900	$900
Leg	$800	$800
Foot, ankle or kneecap	$600	$600
Forearm or hand	$600	$600
Lower jaw	$500	$500
Shoulder blade, collar bone or sternum	$500	$500
Skull (simple)	$400	$400
Upper arm or upper jaw	$400	$400
Facial bones	$400	$400
Vertebral process	$200	$200
Coccyx, rib, finger, toe or nose	$200	$200

INDEMNITY BENEFITS	POLICYOWNER/SPOUSE	CHILD(REN)
Dislocation	If an insured dislocates a joint due to a covered accident and it is diagnosed and treated by a physician within 90 days after the covered accident, or the dislocation requires surgical incision to relocate the joint, the rider pays a benefit.	
Hip	$1,000	$1,000
Knee (not kneecap)	$800	$800
Shoulder	$600	$600
Foot or ankle	$500	$500
Hand	$400	$400
Lower jaw	$300	$300
Wrist	$200	$200
Elbow	$200	$200
Finger or toe	$200	$200
Laceration	If, as part of a covered accident, an insured is lacerated and the laceration is repaired with sutures by a physician within 72 hours after the covered accident, the rider pays a benefit.	
Combined length over 2"	$100	$100
Injuries requiring surgery		
Eye injury	If, as part of a covered accident, an insured injures an eye and eye surgery is performed due to the covered accident by a physician within 90 days after the covered accident, the rider pays a benefit.	
	$100	$100
Tendon or ligament	If, as part of a covered accident, an insured tears, severs or ruptures a tendon or ligament and has the injured tendon or ligament repaired through surgical incision by a physician within 90 days after the covered accident, the rider pays a benefit. If the dislocation or fracture benefit is payable due to the same covered accident this benefit is not payable.	
	$300	$300
Ruptured disc	If, as part of a covered accident, an insured ruptures a disc in the spine and receives treatment for the rupture from a physician within 60 days after the covered accident, and has the rupture repaired through surgical incision by a physician within one year after the covered accident, the rider pays a benefit.	
Covered accident occurs during first year insured	$100	$100
Covered accident occurs after first year insured	$300	$300
Torn cartilage	If, as part of a covered accident, an insured tears cartilage and receives treatment for the torn cartilage from a physician within 60 days after the covered accident and has the torn cartilage repaired through surgical incision by a physician within one year after the covered accident, the rider pays a benefit.	
Covered accident occurs during first year insured	$100	$100
Covered accident occurs after first year insured	$300	$300
Hernia	If, as part of a covered accident, an insured suffers a hernia and receives treatment for the hernia from a physician within 60 days after the covered accident, and has the hernia repaired through a surgical incision by a physician within one year after the covered accident, the rider pays a benefit. If an insured's hernia is a herniated disc, the ruptured disc benefit will be paid in lieu of the hernia benefit.	
Covered accident occurs during first year insured	$100	$100
Covered accident occurs after first year insured	$300	$300

INDEMNITY BENEFITS	POLICYOWNER/SPOUSE	CHILD(REN)
Burn	If, as part of a covered accident, an insured is burned and the burns are treated by a physician within 72 hours after the covered accident, the rider pays a benefit. Benefits are not payable for first-degree burns.	
	$500	$500
Emergency care services	This rider provides for emergency care services when an insured, due to a covered accident is admitted to an emergency room or seeks care at an urgent care facility within 24 hours of the covered accident. This benefit is payable once within a 24-hour period and once per covered accident per insured.	
	$250 per covered accident per insured	$250 per covered accident per insured
Physician's office visit benefit	This rider provides for a physician's office visit when, within 72 hours of a covered accident, an insured seeks care at physician's office. This benefit is limited to two visits per covered accident per insured	
	$30 limit, 2 per covered accident per insured	$30 limit, 2 per covered accident per insured

PREMIUM-RETURN RIDERS

Active Care offers multiple premium-return riders. In most states, policyholders have a choice between the Cash Value or Return of Premium rider, so they can choose which premium-return option works best for them. (**Note:** Both premium-return options are not available in all states. Check your state availability grid for details.)

Note: One policy can't have both premium-return riders added.
If a premium-return rider is dropped from a policy another cannot be added.

RETURN OF PREMIUM (ROP) RIDER (R1077ROP)

Our most popular cash-return option is the Return of Premium rider. The rider provides a benefit that policyowners can receive a check for all premiums paid—minus claims incurred—every 20 years or on the rider anniversary after his or her 75th birthday, if that comes sooner.

The ROP period broken down by issue age is as follows:

- **Age 55 or under:** 20 years.
- **Age 56-65:** The number of years from the beginning of the ROP period to the first anniversary date after an insured reaches age 75.
- **Age 66 or over:** 10 years.

The premium returned for an insured 65 or under is the premium paid minus claims incurred.

If the policyowner is 66 or older when the ROP period begins, and the policy and rider are kept in force, he or she will receive one-half of all premiums paid—minus claims incurred—every 10 years.

The maturity date is either 20 years or 10 years, based on the policyowner issue age. At the maturity date, a new ROP period begins. If the policy is canceled or surrendered before the maturity date, no premiums are returned.

CASH VALUE (CV) RIDER (R1077CV)

The Cash Value rider works differently with Active Care than for many of our other products. Most notably, the CV period is 25 years, regardless of the policyholder's age at the time of purchase. In other ways, it is similar to the CV rider available with our other products.

Policyholders who choose the CV rider can receive a check for all premiums paid—minus claims incurred—every 25 years. To collect, the policyowner is required only to keep the policy and rider in force until the maturity date. When premiums are returned, the policyowner can continue coverage and collect again.

Beginning with the sixth year, the policyowner will receive a percentage of premiums paid—minus claims incurred—if the policy is surrendered. This percentage increases over time to 100%.

If a policyowner surrenders their policy and receives the CV, the policy has ended and cannot be reinstated.

TABLE OF CASH VALUE PERCENTAGES*	
COMPLETED YEAR(S)	CASH VALUE PERCENTAGE
1-5	0%
6	5%
7	9%
8	12%
9	15%
10	18%
11	21%
12	24%
13	27%
14	30%
15	34%
16	38%
17	42%
18	47%
19	52%
20	58%
21	64%
22	72%
23	80%
24	90%
25	100%

**This may vary by state, see state-specific policy language.*

It is the responsibility of the agent that ROP or CV benefits are accurately explained to every policyholder. ROP and CV explanatory aids are available for order on WNbizlink.com.

PRE-EXISTING CONDITIONS

Pre-existing conditions vary by state; please refer to the state-specific sample policy language. A pre-existing condition is defined as the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 12-month period preceding the effective date of the coverage of the insured or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 12-month period preceding the effective date of coverage. A pre-existing condition can exist even though a diagnosis has not yet been made.

WAITING PERIOD

The waiting period varies by state; please refer to the state-specific sample policy language.

This policy contains a 30-day waiting period. If an insured is diagnosed with or treated for any specified critical illness during the first 30 days of coverage under this policy, no benefits will be provided for loss resulting from that diagnosed specified critical illness until 12 months after the insured's effective date of coverage.

LIMITATIONS AND EXCLUSIONS

Limitations and exclusions vary by state; please refer to the state-specific sample policy language.

Cancer and/or heart policy:

The inpatient hospital benefit is limited to three periods of confinement per calendar year and has a lifetime maximum of $15,000. The annual care benefit is payable beginning with the first anniversary after the payment of the lump-sum benefit and is payable each year up to a total of five consecutive annual payments. Recurrence benefit pays a percentage of the lump-sum benefit for a subsequent diagnosis of cancer, heart attack or stroke (based upon coverage selected) when the subsequent diagnosis is more than 12 months after the previous diagnosis and there has been no treatment received during the 12-month period.

The **critical illness policy** will not pay benefits for loss contributed to, caused by or resulting from the insured:

- Having or being diagnosed with any other disease, sickness or incapacity, even if the disease or condition was caused, complicated or aggravated by the specified critical illness.
- Diagnosis of a specified critical illness during the waiting period which is the first 30 days after the coverage effective date.
- Participating or attempting to participate in an illegal act, or working at an illegal job.
- Being legally intoxicated or so intoxicated that mental or physical abilities are seriously impaired, being under the influence of any illegal drugs, or being under the influence of any narcotic, unless such narcotic is taken under the direction of, and as directed by a physician.
- Injuring or attempting to injure yourself intentionally, regardless of mental capacity. Committing or attempting to commit suicide, regardless of mental capacity.
- Participating in any sporting event for pay or prize money.
- Being exposed to war or any act of war, declared or not, or participating in or contracting with the armed forces (including Coast Guard) of any country or international authority.
- Alcoholism, drug abuse, or chemical dependency.

No benefits are payable for a pre-existing condition during the first 12 months after the effective date of coverage.

The following limitations and exclusions are in addition to the policy's and apply to the **Critical Conditions** rider: The inpatient hospital benefit is limited to three periods of confinement per calendar year and has a lifetime maximum of $15,000. We will not pay benefits for loss contributed to, caused by, or resulting from:

- Renal failure caused by a traumatic event, including surgical traumas.
- A heart transplant that is not a human heart; a bone marrow transplant that is not human bone marrow.
- If the insured's paralysis is related to a stroke and the policy paid a lump-sum benefit, the lump-sum benefit will not be payable under the rider.
- No benefit is payable for diabetic amputations below the ankle. Amputation of a single toe or toes, or any partial foot amputations are not payable.
- No benefits are available for an organ donor under the rider.
- Coma does not include one that is medically induced.

The following limitations and exclusions are in addition to the policy's and apply to the **Hospital Indemnity** rider: The inpatient hospital benefit is limited to three periods of confinement per calendar year and has a lifetime maximum of $15,000. The skilled-care facility benefit is payable when the insured is considered disabled as defined under the policy and has an elimination period of seven days after which the benefit provides for up to 14 days of confinement and is limited to 1 confinement per calendar year.
We will not pay benefits for loss contributed to, caused by, or resulting from:

- Cosmetic or elective surgery that is not for the diagnosis or treatment of covered sickness or covered accident based upon generally accepted medical practice and is not medically necessary.
- Complications from any cosmetic or elective surgery.
- Treatment for dental care or dental procedures, unless treatment is the result of a covered accident.
- Flying including operating, learning to operate, and serving as a crew member on or jumping or falling from any aircraft including those which are not motor-driven.
- Having a mental, behavioral or psychological disorder, disease or syndrome, without demonstrable organic origin.
- No benefits are payable for a separate charge made for the newborn's stay in a nursery as a result of a normal delivery. No benefits are payable for any services provided or charges made in an observation unit. No benefits are payable for a normal pregnancy that occurs within the first 24 months after the effective date of coverage. Loss due to complications of pregnancy will be paid the same as for any other sickness. A cesarean section is not considered a complication of pregnancy. A pregnancy of a dependent child will not be covered.
- Racing including riding in or driving any motor-driven vehicle in a race, stunt show or speed test, or while testing any vehicle on any race course or speedway.
- Travel/Location while being more than 40 miles outside the territorial limits of the United States or Canada. Vision exams or vision procedures, unless treatment is the result of a covered accident or a covered sickness.

The following limitations and exclusions are in addition to the policy's and apply to the **Radiation and Chemotherapy Benefit** rider: There is a calendar year maximum of $5,000 for the radiation and injected chemotherapy benefits. No benefits are payable for preventive treatments prescribed without a diagnosis of cancer. The rider does not pay for continued maintenance medication for the purposes of keeping cancer from recurring.

The following limitations and exclusions are in addition to the policy's and apply to the **Accidental Death and Dismemberment** rider: We will not pay benefits for loss contributed to, caused by, or resulting from:

- Flying including operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft including those which are not motor-driven.
- Hazardous activities which are hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or mountaineering.
- Racing including as a rider in or driving any motor-driven vehicle in a race, stunt show or speed test, or while testing any vehicle on any racecourse or speedway.
- Having any disease, bodily or mental illness or degenerative process.
- We also will not pay benefits for any related medical treatments or diagnostic procedures due to an accident, while traveling which occurs more than 40 miles outside the territorial limits of the United States or Canada, except under the accidental death benefit.

SECTION 3: ELIGIBILITY AND UNDERWRITING GUIDELINES

WHO IS COVERED?

There are four coverage options offered in this policy:

- **Individual**
- **Individual + children**—covers one adult and all dependent children (all children must be listed on the policy to be covered.)
- **Individual + spouse**—covers main insured and spouse as defined under policy
- **Family**—covers main insured, spouse and all dependent children. (all children must be listed on the policy to be covered.)

"Spouse" means the insurable person named as spouse on the application and legally married to the insured on the effective date of the policy.

"Child(ren)" means the insured's and spouse's natural child, stepchild, legally adopted child, child placed with the insured for adoption, foster child or the court-appointed guardianship, order or administrative order of a child (including a grandchild), who is:

- Insurable and named on the application;
- Unmarried;
- Chiefly dependent on the insured or spouse for support; and
- Younger than the limiting age of 26

"Child(ren)" also includes dependent children, regardless of age, who:

- Are mentally or physically handicapped;
- Became or become handicapped prior to the limiting age; and
- Cannot support themselves because of their handicap.

Newborn, adopted, foster or court-appointed children must be added to the policy within 31 days of their date of birth or date of placement without having to answer the health questions. To add a child, written notice including name, date of birth or date of placement as well as any additional premium is required.

ISSUE AGES FOR THE PRIMARY INSURED AND SPOUSE

- 18–75—with ROP or CV rider
- 18–85—without ROP or CV rider

Issue-age limits apply to the primary insured and the spouse. For example, if the primary insured is 75 or younger and the spouse is between 76 and 85, a policy with a ROP or CV rider cannot be issued if the spouse is on the policy. However, separate individual policies can be issued based on each individual's age.

SUITABILITY GUIDELINES

To determine whether the sale or solicitation of Washington National Insurance Company products is reasonable, prudent or in the prospective insured's best interest, you should take into account their personal circumstances. You should examine the totality of the prospective insured's circumstances, including the following:

- Financial condition, i.e. is the person on a fixed income, premium cost;
- Need for insurance at the time of sale, i.e., existing policies, insured's finances; and
- The values, benefits, and costs of the prospective insured's existing insurance program, if any, when compared to the values, benefits, and costs recommended policy or policies.

PURCHASING REQUIREMENTS

Active Care is presented as a menu of benefits. This is an accurate depiction of how the product works, but it is important to understand how the policy is structured and how that affects how the product must be sold.

- The product was filed as a critical illness policy with additional coverage being riders.
- All Active Care policies must have at least a $5,000 lump-sum benefit of either heart or cancer. A policy could not contain accident and hospital without a cancer or heart base.
- The insured's policy will be titled "critical illness policy."

UNDERWRITING QUESTIONS

The underwriting for Active Care consists of simple yes/no knockout questions.

The section II A health question must be answered when an insured is applying for all coverage.

Section II B–E health questions are only required for the coverage types being applied for.

Note: If an insured is applying through a guaranteed conversion, ONLY answer questions 1 and 2.
When applying for the Hospital Indemnity rider, all sections must be answered (Section II A–E).
No additional questions are required when applying for the Accident Death and Dismemberment rider or the Radiation and Chemotherapy rider.

OPTION RESTRICTIONS

Remember these guidelines when selling Active Care:

- A person can own more than one Active Care product as long as lump-sum limits and hospital stays limits are not exceeded.
- All insureds must select the same coverage, riders and benefit levels. If differing levels are wanted, separate policies would be needed.
- If multiple policies are owned, then riders cannot be duplicated. The only exception would be the premium-return riders.
- Child coverage is limited to $5,000 when the policyowner selects the lowest lump-sum amount and $10,000 for all other coverage levels selected. The maximum allowable lump-sum coverage a dependent child could have among all Washington National products is $25,000.
- If individuals want to change their benefits or add benefits, they need to upgrade or downgrade their policy.
- The accidental death and dismemberment rider **can** be purchased by a person who owns an existing Washington National accident policy.

ISSUE LIMITS

Hospital confinement benefits are limited to $1,000 per person per day for policies sold through payroll deduction or direct sales. These limits include coverage from all carriers combined.
An applicant must list all insurance policies owned that pay an indemnity benefit for hospital confinement.

- Policies that should be listed include accident, sickness and hospital indemnity.
- Policies that should not be listed include major medical and specified disease, like cancer, heart/stroke and critical illness.
- When comparing a "per confinement" benefit to a "per day" benefit, divide the per confinement benefit by a factor of 5.

For example:

- $1,000 per confinement benefit = $200 per day benefit
- $1,500 per confinement benefit = $300 per day benefit
- $2,000 per confinement benefit = $400 per day benefit
- $2,500 per confinement benefit = $500 per day benefit

The issue limits:

- Hospital confinement for one diagnosis type—$1,000 per day
- ICU confinement—$1,500 per day
- Lump-sum payment for one diagnosis type—$110,000

    - **Example:** *A policyowner who has a Washington National policy with $600 of cancer hospital confinement benefit could still purchase Active Care, because the $300 benefit would only put the hospital coverage at $900 for a cancer confinement.*
        - They could **not** purchase the additional hospital indemnity rider because the $200 confinement benefit would increase the total amount paid to $1,100, which is $100 over the $1,000 limit for that confinement.
        - A heart and stroke hospital confinement benefit would not be an issue in the example above because it is for a different covered condition.

- A person cannot own more than $110,000 in lump-sum benefits on any one covered illness.
    - **Example:** *A policyowner could have a $10,000 lump-sum cancer benefit on an existing Washington National policy and still purchase cancer coverage at the full $100,000 lump-sum benefit for Active Care.*

TOBACCO STATUS

Active Care's rates are different for tobacco users and nontobacco users. If anyone on the policy uses tobacco, then the tobacco rates should be used. Once a policy has tobacco rates, those rates cannot be changed to nontobacco rates, even if the benefits are upgraded or downgraded.

CONTINUITY OF COVERAGE

Active Care does not offer continuity of coverage. If replacing an existing policy, Active Care will be treated as a new policy.

HEIGHT AND WEIGHT REQUIREMENTS

The proposed primary insured and spouse must fall within the following height and weight guidelines when applying for heart and stroke or hospital indemnity coverage.

GENDER-SPECIFIC HEIGHT AND WEIGHT REQUIREMENTS				
MALE MIN	MALE MAX	HEIGHT	FEMALE MIN	FEMALE MAX
N/A	N/A	4' 6"	N/A	N/A
N/A	N/A	4 ' 7"	N/A	N/A
N/A	N/A	4' 8"	N/A	N/A
N/A	194	4" 9"	N/A	183
N/A	197	4' 10"	N/A	186
N/A	201	4' 11"	N/A	190
N/A	205	5' 0"	N/A	193
N/A	210	5' 1"	N/A	198
N/A	214	5' 2"	N/A	202
N/A	219	5' 3"	N/A	205
N/A	226	5' 4"	N/A	214
N/A	232	5' 5"	N/A	217
N/A	239	5' 6"	N/A	223
N/A	246	5' 7"	N/A	228
N/A	251	5' 8"	N/A	233
N/A	258	5' 9"	N/A	240
N/A	267	5' 10"	N/A	249
N/A	271	5' 11"	N/A	254
N/A	280	6' 0"	N/A	263
N/A	286	6' 1"	N/A	267
N/A	294	6' 2"	N/A	274
N/A	301	6' 3"	N/A	279
N/A	311	6' 4"	N/A	288
N/A	319	6' 5"	N/A	294
N/A	330	6' 6"	N/A	302
N/A	339	6' 7"	N/A	309
N/A	349	6' 8"	N/A	316
N/A	357	6' 9"	N/A	320
N/A	369	6' 10"	N/A	329
N/A	N/A	6' 11"	N/A	N/A

HIGHER-RISK UNDERWRITING

For those individuals who apply for coverage at age 65 and up and/or request lump-sum benefit amounts of $60,000-$100,000, a prescription drug check will be required during the application screening process.

Note: We reserve the right to perform random prescriptions checks on applications for younger ages.

The following are a list of medical conditions that will assist you in evaluating your applicant. This list is not all inclusive.

Contact the underwriting department at IndividualUnderwriting@WashingtonNational.com or (800) 525-7662 ext. 77733 should you have any additional questions.

MAIN INSURED AND SPOUSAL EXCLUSIONS

There are no main insured or spousal exclusions on this product.

CHILD(REN) EXCLUSIONS

The only exclusions that exist are the exclusion of children from an optional rider. If a child has a medical condition that excludes them from the base coverage, they cannot be covered by Active Care. If a child has one of the medical conditions that only excludes them from an optional rider, they can be excluded from the rider's coverage by adding their name to that question on the application.

PRECANCEROUS CONDITIONS EXPLAINED

Multiple conditions are considered to be preleukemic, premalignant or having malignant potential by pathological definition. Some of these conditions represent a significant risk of progressing to a full diagnosis of cancer. If an applicant has been diagnosed with a condition that is preleukemic, premalignant or having malignant potential within the last five years (this time limit is based on the question on the application and varies by state), we use the same underwriting guidelines that apply to a previous diagnosis of cancer. If an applicant is unsure whether a diagnosed or treated condition is considered preleukemic, premalignant or having malignant potential, the writing agent should ask about the condition and compare the diagnosis to the list below. If the condition is on the list, the applicant cannot be covered at this time.

PRECANCEOUS CONDITIONS LIST

- Achlorhydria—gastric
- Bowen's disease
- Metaplasia
- Neoplastic polyps
- Polycythemia vera
- Refractory anemia (RA)
- Refractory cytopenia (RC)
- Erythroplasia
- Esophageal web
- Barrett's esophagus
- Carcinoma in situ (CIS)
- Cervical dysplasia (diagnosed in stage 2 or higher)
- Dysplasia
- Endometrial hyperplasia
- Leukoplakia
- Myelofibrosis with myeloid
- Essential thrombocytopenia
- Familial adenomatous polyposis
- Gastric adenomatous polyps
- Keratocanthoma
- Lentigo maligna

Note: This list is a sample list and is not all inclusive.

HEART CONDITIONS EXPLAINED

Heart conditions (including heart disease)

Rhythm and conduction disorders (Arrhythmia)

A person is not eligible for coverage if treatment is recommended or prescribed for:

- Bradycardia
- Tachycardia
- Heart block
- Rhythm or conduction disorders

Treatment for these conditions may include not only medication, but also prescribed bed rest or surgery, such as the implantation of a pacemaker. Some specific conditions are:

- Atrial flutter
- Bundle branch blocks
- Sick sinus syndrome
- Atrioventricular blocks

- Wolff-Parkinson-White Syndrome
- Atrial fibrillation
- Ventricular fibrillation

Exceptions

Rhythm and conduction disorders for which treatment has not been prescribed or recommended are not excluded from coverage. If no other condition exists, the health question should be answered no.

Myocardial, endocardial and pericardial diseases

A person is not eligible for coverage if they have any form of:

- Cardiomyopathy
- Myocarditi
- Endocarditis
- Pericarditi

Congenital heart defects

A person is not eligible for coverage if they have a congenital heart defect that has not been corrected. Some congenital heart defects are not correctable.

Some specific conditions are:

- Anomalous pulmonary venous connection
- Coarctation of the aorta
- Eisenmenger syndrome
- Transposition of the great vessels
- Atrial septal defect
- Congenital complete heart block
- Patent Ductus Arteriosu
- Truncus Arteriosus
- Cardiac malpositio
- Ebstein's Anomaly
- Tetralogy of Fallots
- Ventricular Septal defect

Valvular heart disease

A person is not eligible for coverage if they have:

- Aortic valve
- Mitral valve
- Pulmonic valve
- Tricuspid valve

Some specific conditions are:

- Aortic insufficiency
- Mitral insufficiency
- Mitral stenosis
- Pulmonic stenosis
- Tricuspid regurgitation
- Aortic regurgitation
- Syphilitic disease
- Pulmonic insufficiency
- Rheumatic heart disease
- Tricuspid stenosis
- Aortic stenosis
- Mitral regurgitation
- Pulmonic regurgitation
- Tricuspid insufficiency

Exceptions

When no other condition is present, mitral valve prolapse will not cause a person to be excluded from coverage. In this case, the health question should be answered no. If mitral valve prolapse is present along with another condition, such as tachycardia for which treatment has been prescribed, an insured will be ineligible for coverage. We will accept a person with a heart murmur only when no other condition is present. In this case, the health question should be answered no. However, if a heart murmur is the result of valvular damage caused by heart disease, an insured will be ineligible for coverage

Angina and heart attack

A person is not eligible for coverage if they have:

- Angina pectoris (chest pain) (see exceptions below)
- Any myocardial infarction (heart attack)

Some specific conditions are:

- Coronary arterial spasm •
- Left ventricular aneurysm and pseudoaneurysm
- Dressler's Syndrome
- Silent myocardial infarction

Exceptions

When no other condition exists, chest pain that is not caused by heart disease will not cause a person to be excluded from coverage. In this case, the health question should be answered no.

Disease or abnormality of the coronary arteries

A person is not eligible for coverage if they have:

- Any coronary artery abnormality
- Any coronary artery disease

Some specific conditions are:

- Atheromatous deposits of the coronary arteries
- Coronary artery occlusion
- Coronary artery stenosis
- Thrombosis formation in the coronary arteries

Arteriosclerosis

A person is not eligible for coverage if they have Arteriosclerosis of the coronary arteries (otherwise known as hardening of the arteries).

Chronic disease of the pericardium

Any person who has chronic pericarditis (chronic means frequent recurrence) is not eligible for coverage

Transient ischemic attack and stroke

A person is not eligible for coverage if they have:

- Any transient ischemic attack (TIA or ministroke)
- Any stroke

Some specific conditions are:

- Cerebral aneurysm
- Cerebrovascular accident
- Cerebral thrombosis
- Cerebral hemorrhage
- Cerebral embolism
- Subarachnoid hemorrhage

High blood pressure

High blood pressure for which medication has been prescribed is not an exclusion.

SALES TO PERSONS ELIGIBLE FOR MEDICARE OR MEDICAID[1]

Federal statute makes it illegal to issue a health insurance policy that duplicates Medicare benefits to anyone who is eligible for Medicare, unless the policy pays without regard to other insurance and the applicant at the time of application is shown a disclosure statement prescribed in the regulation for that type of insurance. Persons may qualify for Medicare if they are 65 or older, have permanent kidney failure or are disabled regardless of age. Because our policies pay without regard to other insurance, Washington National may sell them to people who qualify for Medicare, as long as the applicant signs the appropriate disclosure statement and submits it with the application. The application will not be processed if the statement is not signed or not attached.

The disclosure form number is CIC-1010. This guideline applies only if the policyowner is eligible for Medicare; therefore, Washington National does not need a disclosure statement if only a spouse or dependent child is eligible for Medicare. The disclosure statements and the pamphlet "Guide to Health Insurance for People with Medicare" (form MEDICARE-GUIDE) are available to order from WNbizlink.com. These guidelines apply to new business and conversions, but not reinstatements.

Persons eligible for Medicaid MUST understand that participating in Medicaid will likely reduce or eliminate their Washington National benefits. Even though each state's Medicaid regulations vary, the use of taxpayer dollars to pay these medical expenses mandates that Washington National reimburse the public program first, based on those regulations.

PRIVACY OVERVIEW

Washington National Insurance Company ("the company") must adhere to various legal and regulatory requirements. The company, and its agents, each have a responsibility to be in compliance with state insurance laws and regulations. It is the obligation of each licensed insurance agent to be aware of all laws, regulations and requirements for their state so that they conduct all sales activities in a manner that complies with these laws and regulations.

Additionally, we have set high standards in connection with the sale and servicing of our insurance products. Agents are expected to conduct business with honesty and integrity, as outlined in the Washington National sales representative agreement.

This agreement provides an overview of ethical and compliance expectations as they relate to advertising, field conduct, disclosure, suitability, replacement and unfair trade practices. This agreement is not intended to be a complete listing of all compliance requirements.

[1]The comments regarding Medicare and Medicaid simply reflect our current interpretation of the programs. It is not our intent to give advice on Medicare or Medicaid. Please consult a qualified adviser.

SUITABILITY GUIDELINES

To determine whether the sale or solicitation of Washington National Insurance Company products is reasonable, prudent or in the prospective insured's best interest, you should take into account their personal circumstances.
You should examine the totality of the prospective insured's circumstances, including the following:

- Financial condition, i.e. is the person on a fixed income, premium cost;
- Need for insurance at the time of sale, i.e., existing policies, insured's finances; and
- The values, benefits, and costs of the prospective insured's existing insurance program, if any, when compared to the values, benefits, and costs recommended policy or policies.

Personally Identifiable Information (PII) is information that clearly identifies a distinct individual (a consumer, customer, associate or agent). Examples of PII are name, address, Social Security number, information about health and finances and other information that is not generally available to the public.

A copy of the consumer privacy notice is available at WNbizlink.com under the "Materials" link. Agents should review this form to familiarize themselves with how we handle PII and what consumers can do to change or access it.

Agents are required by law to take an active role in preventing PII from being disclosed to unauthorized parties. If you suspect PII is lost, stolen or disclosed to an unauthorized party, it is critical that you immediately report the situation to the home office by submitting a DATA ALERT form. This form and instructions for submitting it are located on WNbizlink.com. It may be completed online and submitted by email to privacy@cnoinc.com.

Since independent agents are legally responsible for consumers' personal information while under an agents' control, completing and submitting a DATA ALERT should be approached with a sense of urgency and priority.

Questions about privacy regulations should be directed to privacy@cnoinc.com.

ETHICS HOTLINE

At Washington National, we value ethics, fairness and personal responsibility. It's up to each of us to report actions that are illegal, unethical or inconsistent with the CNO Code of Business Conduct and Ethics.

Our door is always open to raise concerns when you don't feel comfortable reaching out resources within your organization, which is why we have the Ethics Hotline (previously referred to as In Touch).

- The Ethics Hotline is confidential, secure and anonymous.
- The Ethics Hotline is available 24/7 365 days a year.
- You can report an issue by calling (855) TELL-CNO or by emailing TellCNO@GetInTouch.com.

The Ethics Hotline phone number and email address are operated by In Touch, an independent third party. Your identity and contact information will not be disclosed to CNO—unless you clearly state in your report that you wish to be identified.

SECTION 4: EFFECTIVE DATES

INDIVIDUAL BUSINESS

The effective date is the date the application is received in the home office, unless otherwise requested. It cannot be earlier than the date the application is received in the home office.

WORKSITE BUSINESS

The effective date of worksite payroll deduction business can be no earlier than the date the application is received in the home office.

- All payroll business is given an effective date of the **1st of the month**.
- If the application is received **on or before the 15th of the month**, the effective date will be the 1st of the month following the date the application is received in the home office.
- If the application is received **after the 15th of the month**, the effective date will be the 1st of the next month following the date the application is received in the home office.
- Payroll check deductions should begin on the policy effective date so that funds are available to remit when the first bill is due.

CREDIT UNIONS

If applications are received on the **1st through the 15th day of the month**, the effective date is 60 days from the first day of the month the application is received.

For applications received on the **16th through the 31st of the month**, the effective date is 90 days from the first day of the month that the application is dated.

The new business department must approve any exceptions to the guidelines stated above.

WAITING PERIOD

In most states, Active Care has a 30-day waiting period. The waiting period does not begin until the effective date of coverage, which is assigned according to the guidelines stated above.

COMMON ERRORS

The following errors require investigation by the underwriting department. The incorrect or incomplete application will be returned to the agent for correction or completion. Additionally, the policy will not be issued until the application is received back in the home office and processed. An application may be returned for correction or completion for any of the following reasons:

- Incorrect application
- Incorrect premium shown on application
- No date shown on application
- Missing/incorrect signature on application
- Missing applicant's age and/or birth date or Social Security number
- Health questions not answered
- Replacement question not answered when required
- Representative not licensed in the state where application is written
- Appropriate boxes not checked on the application
- Missing spouse's age and/or birth date or Social Security number missing (if electing spouse coverage)
- Application altered but not initialed by client
- Information missing on electronic funds transfer form (CI-747)
- Any other required information or forms not provided

SECTION 5: PREMIUM PAYMENT

MINIMUM PREMIUM

There is a minimum premium payment of $15 per month on this policy. Any applications received at a lower premium amount will be rejected. State variations may apply. Please check the state-required forms grid.

INDIVIDUAL AND WORKSITE

Active Care may be sold to applicants who are:

- Aged 18 to 85 without the ROP or CV rider.
- Aged 18 to 75 with the ROP or CV rider.

These age guidelines apply to the primary insured and spouse. Individual and worksite sales use the same rates.

On all new worksite groups, a worksite case profile form (WIS-GRPPRO) must be completed and signed by an officer of the group. This form is required for all worksite sales.

Note: A worksite group must have at least three applicants to qualify for coverage.

BANK DRAFT (PAC/ACH)

When submitting automatic check business, the following items should be attached:

- Electronic funds transfer form (CI-747) for initial and future deductions
- Applicant's check, payable to Washington National Insurance Company, for one month's premium
- A voided check with bank routing transit numbers and account number printed on the slip for the account from which deductions will be made. (Experience shows that far fewer bank processing errors occur when a voided check is provided.) Deductions can be made from checking or savings accounts. Please indicate the type of account on the authorization form.

The automatic check deduction day is the day each month that a policyholder's premium is automatically deducted from his or her checking or savings account. Policyholders should select their preferred day of the month (between the 1st and the 28th) on the electronic funds transfer form (CI-747). If no day is specified, the default deduction day is the date the application is received in the home office. (Applications received on the 29th, 30th or 31st are assigned deduction days of the 1st, 2nd and 3rd, respectively.)

TAXABILITY OF BENEFITS

To avoid the policy being a tax-reportable product, the employee must pay 100% of premiums. The standard policy can be sold under a Section 125 (cafeteria) plan, but the cash return riders are not available under a Section 125 plan. If sold under Section 125, a tax form 1099 will be generated when benefits are paid to employees per Internal Revenue code guidelines. If an employer pays or is treated as paying all or part of the premium, the benefit may be considered taxable income unless excluded under one or more provisions of the Internal Revenue Code. Generally, if benefits paid are less than actual costs incurred, then benefits will be received income tax-free. Policyholders should contact a tax adviser for specific information.

SECTION 6: CHANGES TO POLICIES

It is important that you do not confuse a conversion with an upgrade or downgrade.

- An **upgrade** is defined as increasing the benefits within the current coverage or adding a rider.
- A **downgrade** reduces benefits.
- A **replacement** is when a new policy is taken out and the current policy is canceled.
- A **conversion** is defined as changing of coverage from one product to another.

On upgrades and downgrades, the current policy number is retained.

Note: Conversions are not allowed on this policy.

ADMINISTRATIVE REQUIREMENTS

- For an upgrade, a new application (AP-1067 or state variation) must be completed and will be underwritten. If approved, the increased benefits become effective on the next monthly anniversary date of the existing policy. The original policy number is retained.
- All applications for upgrades must include the policy number on the application.
- The total premium for the policy that will be effective after the upgrade should be listed in the column labeled "premium total."
- Enter the amount of money being submitted with the upgrade application in the blank labeled "amount collected."
- Downgrades may be requested in writing from the policyholder or on an application. Either must include his or her signature to be processed.
- If a multiple-insured policy (individual + child, individual + spouse or family) is being upgraded or downgraded, all members must upgrade or downgrade to the same coverage type and the same option amount.

UPGRADES

The following upgrades are allowed:

- Increasing the lump-sum benefit amount
- Adding additional coverages/riders
- Adding a ROP or CV rider
- Adding a spouse and/or child(ren)
    - A new application (AP-1067 or appropriate state variation) is required. Please check the appropriate box on the application in Section 1. Newborn, adopted, foster or court-appointed children must be added to the policy within 31 days of their date of birth or date of placement without having to answer the health questions. To add a child, written notice including name, date of birth or date of placement as well as any additional premium is required. They will not be covered if not added to the policy.

The effective date of coverage will be the next monthly anniversary date upon receipt of the application by the home office. Rates are based on the effective date of coverage and use the insured's attained age.

Note: Policyholders cannot apply for upgrades until at least 30 days after the policy effective date.

DOWNGRADES

The following downgrades are allowed:

- Decreasing the lump-sum benefit amount
- Removing a family member
- Removing coverages or riders
- Removing the ROP or CV rider

Downgrades can be requested by the policyholder in a letter containing his or her signature or by completion of an application.

Please note that the applicant or spouse cannot improve his or her tobacco class at upgrade or downgrade.

INTERNAL REPLACEMENTS

An internal replacement occurs when a policyholder cancels or lapses their current Washington National policy in order to purchase an Active Care policy. Occasionally internal replacements are in the policyholder's best interest so Washington National does allow it. However, all internal replacements need to be marked as such on the application for the new policy. Commission on an internal replacement policy is paid at half the regular commission rate.

If a new Active Care policy is written and a critical illness, accident or hospital indemnity policy is subsequently canceled or allowed to lapse, and we are **not notified** on the application of an internal replacement, commissions will not be paid for the new policy. Any advances and earned commission already paid will be recouped by the company.

Active Care does not offer continuity of coverage. The client will be subject to the policy's 30-day wait and underwriting of the new policy. For this reason, it is important that you educate a client before implementing an internal replacement on a client's behalf.

REINSTATEMENTS

Washington National will reinstate a policy up to 90 days after the lapse with commission going to the original writing agent. A new application is required for reinstatement.

Washington National will reinstate a policy between 90 and 180 days after the lapse only if the policy was active less than five years. The commission on these transactions goes to the reinstating agent.

GENERAL RULES FOR REINSTATEMENTS

- Once approved, the policy will be reinstated with the same policy number, the lapse in coverage will be shown and the new effective date will indicate when coverage resumed.
- Resumption of a canceled policy (if not canceled at issue) is considered a reinstatement.
- All reinstatements must be done by signed application.
- Premiums will not be accepted for the inactive coverage period.
- Claims incurred during the inactive coverage period will not be paid.
- The ROP maturity date will be extended by the number of days the coverage lapsed.
- For any upgrades executed upon reinstatement, first-year commissions are credited to the reinstating agent based on the incremental premium increase.
- There is a 10-day waiting period after reinstatement.

If a policy lapses or has terminated for more than 180 days, it cannot be reinstated.

SECTION 7: SUBMITTING BUSINESS

APPLICATION REQUIREMENTS AND DETAILS

These items must be left with the policyholder at application:

- Outline of coverage (OC1068 or state variation)
- Signed medical record auth form–point of sale form (MEDAUTH-FORM-PRE)

In the state of South Dakota, it is required that a copy of the appropriate outline of coverage for any product sold is left with every customer at point of sale. All outlines of coverage are available on WNbizlink.com.

The following forms are required to be sent with the application in certain situations:

- New business transmittal form (C-NBT), for all business
- Electronic funds transfer form (CI-747), if an applicant chooses to pay premium by bank draft
- Payroll deduction authorization form (WS-PREM-AUTH), if the applicant is having premium payroll deducted
- Replacement insurance form (REPLACESPECDIS), if the applicant intends to terminate or allow existing coverage to lapse and be replaced
- Conditional receipt (CONDITIONALRECPT), if the applicant pays the initial premium by check
- Medicare disclosure notice (CIC-1010), if the applicant is eligible for Medicare

For any additional state-required forms, please visit WNbizlink.com.

NEW AND UPGRADE APPLICATIONS

New and upgrade applications should be mailed to:

INDIVDUAL SALES	WORKSITE SALES
Attn: New Business Department Washington National Insurance Company 11825 N. Pennsylvania Street Carmel, IN 46032 **OR** P.O. Box 1908 Carmel, IN 46082-1908 **OR** Fax: (800) 906-3926	Attn: Worksite New Business Washington National Insurance Company 11825 N. Pennsylvania Street Carmel, IN 46032 **OR** P.O. Box 2036 Carmel, IN 46082-2036 **OR** Fax: (800) 981-8413 **OR** Email: WIS@WashingtonNational.com

No paper check is required when you fax business to us. To help avoid confusion and delays when faxing business, do not send the original copy of the application to the home office. The application can also be submitted electronically using Washington National One Source®. Please check WNbizlink.com for state availability.

REINSTATEMENT APPLICATIONS

Reinstatement applications and downgrade requests should be mailed to:

INDIVDUAL SALES	WORKSITE SALES
Attn: Policy Change Department Washington National Insurance Company 11825 N. Pennsylvania Street Carmel, IN 46032 **OR** P.O. Box 2022 Carmel, IN 46082-2022 **OR** Fax: (800) 906-3926	Attn: Worksite New Business Washington National Insurance Company 11825 N. Pennsylvania Street Carmel, IN 46032 **OR** P.O. Box 2036 Carmel, IN 46082-2036 **OR** Fax: (800) 981-8413 **OR** Email: WIS@WashingtonNational.com

DELIVERY RECEIPT

Agents may hand-deliver an Active Care policy packet to a policyholder.

- For the agent to receive the policy packet, the "mail to agent" box on the application must be marked. Otherwise, the policy will be mailed directly to the policyholder.
- If the "mail to agent" option is selected on the application, the agent must have the policyholder sign the delivery receipt included in the policy packet. If this form is not returned to the above address when this option is selected, the policyholder will receive a follow-up letter from us requesting the delivery receipt be returned.

If the policy is mailed directly to the policyholder, the delivery receipt will be included in the policy packet. A follow-up letter will be mailed to the policyholder asking for the policy receipt, if it is not returned. No adverse action will be taken if the receipt is not returned.

WNEZQUOTE®

Washington National has a quote-generating tool available for you to use on WNbizlink.com. WNezQuote is quick and easy to use to create custom quotes.

On WNezQuote, you can select the table, individual or census tabs to run a quote. Each tab has two sections: general options and optional riders. Under general options, you can enter basic group information, including premium modes and base coverage selections. In the optional riders section, you can choose which riders to build into the coverage or make available as optional.
For table and individual quotes, you can enter information to generate rate sheets for your group.
The census quote option has an additional category, called "census," where you can upload the group census to generate rates. Worksite case management offers a standard census template you may use.

WASHINGTON NATIONAL ONE SOURCE®

One Source is our state-of-the-art enrollment platform that lets you complete both worksite and individual applications with one convenient tool. You can use the online version of One Source or the offline One Source software on most Windows devices.

For individual sales:

- Reduce pending applications.
- Shorten application processing times.
- Take applications with or without an internet connection.

For worksite sales:

- Enroll core and voluntary benefits on one convenient platform.
- Ensure efficient, accurate enrollments.
- Reduce enrollment time to mere minutes.
- Eliminate manual data entry.

Run a product quote on the spot with WNezQuote® and let the One Source enrollment platform guide you through the application from beginning to end. It doesn't just make submitting new business easier, One Source makes it easy to see any missing or incorrect information, virtually eliminating common errors that lead to pending applications. Business is processed more quickly and you get paid faster.

Visit the One Source support page on WNbizlink.com to learn more, or to download the software.

SECTION 8: COMPENSATION

NEW SALES

First-year and renewal commissions are paid on the base policy and riders from the date the application is signed, according to the percentages shown on the schedule of commissions in effect with your marketing agreement.

UPGRADES

When upgrading coverage within the Active Care product, new commissions are calculated on the incremental increase in premium between the original coverage and the new coverage. Commissions on the incremental increase in premium are calculated according to the same schedule in effect for new sales.

DOWNGRADES

When downgrading coverage within the Active Care (e.g., decreasing lump-sum amount), the original writing agent will continue to receive commission on any premium not exceeding the original premium amount.

REINSTATEMENTS

When the coverage lapse or termination is 90 days or less, the policy can be reinstated, subject to new underwriting with the following guideline: The original writing agent will continue to receive commissions due on the reinstated policy.

When a policy lapses or has been terminated between 90 and 180 days, the policy will be reinstated, subject to new underwriting. In addition:

- The original writing agent will not continue to receive commissions on the reinstated policy; rather, the reinstating agent will receive commissions based on the original effective date.
- If the policy is upgraded at the time of reinstatement, first-year commissions will be paid on the incremental increase in premium. Production credit will be given to the reinstating agent.

If a policy lapses or has terminated for more than 180 days, it cannot be reinstated.

South Dakota mandate SDCL 58-17-11 requires that "every individual health insurance policy or contract, except single premium nonrenewable policies or contracts, issued for delivery in South Dakota on or after December 31, 1966, by an insurance company, nonprofit hospital service plan, or medical service corporation, shall have printed thereon or attached thereto a notice stating in substance that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within ten days of its delivery to said purchaser and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason. If a policyholder or purchaser pursuant to such notice, returns the policy or contract to the company or association at its home or branch office or to the insurance producer through whom it was purchased, it is void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

INTERNAL REPLACEMENTS

Internal replacements are paid at half the regular commission rate. If we are notified of an internal replacement then no commission is paid.

ADVANCES/CHARGEBACKS

Advances are the prepayment of commission based on annualized premium. Advances are calculated by agent setup on all newly issued business, including upgrades. (Not all agents are on advances.)

Annual premium x commission rate x advance rate = advance amount

Example: $420 x 35% x 60% = $88.20

Advance balances are recovered as premium is received on a policy-by-policy basis. The advance balance of any policy that is terminated before the advance is fully recovered will be recouped (charged back) immediately and transferred to the secondary balance. The agent's 1099 earnings include advances paid and are reduced by advances recouped.

COMMISSION EARNINGS

The following formula is used to calculate commission earnings:

Commissionable premium collected x commission rate = commission earned

Earned commissions and advance activity are applied first to pay off any outstanding primary account debt. Earned commission and advance activity in excess of debt in primary and minus secondary paybacks are paid to the agent via electronic funds transfer.

ELECTRONIC FUNDS TRANSFER (EFT)

Advances and commissions are paid via EFT, which helps expedite the payment of advances and commissions and eliminates the wait for a check.

COMMISSION PAYMENTS

The minimum payment is $25. Primary balances that do not meet the minimum payout accumulate until the minimum is met. At that time, an EFT is issued for the accumulated net balance. The file transmission is sent to our bank on Monday of each week, excluding holidays.

COMMISSION STATEMENTS

A statement with detail by policy of premium processed and commission activity is generated weekly for all activity during that week's pay period for every active agent and manager.

All business processed Monday through Friday is reflected on the weekly commission statements.

Commission statements are available at WNbizlink.com, posted by 8 A.M. ET each Monday.

SECTION 9: MARKETING MATERIALS

MARKETING MATERIALS AND FORMS USAGE

The insurance industry is state-regulated. For that reason, Washington National product availability and forms required to sell policies vary by state.

If you have questions regarding product availability or form requirements, please consult the home office. Please don't assume that policies available in one state are available in another state, or that the required forms are the same.

WNBIZLINK.COM

Our online portal, WNbizlink.com, provides easy-to-find product information, news and field updates. You can access forms and marketing materials on WNbizlink.com or by contacting agent care. Registration is required for first-time users. You can view materials on your screen, send them to your printer or download them for later use.

On-hand supplies are normally mailed within 48 hours after an order is received. All supplies are sent by FedEx® ground delivery. There is no charge for most materials and no charge for ground delivery. Expedited shipping can be requested for an additional charge. If you need help, please call agent care at (888) 754-3406. A representative can help you place an order or determine the status of your order.

Need help accessing WNbizlink.com? Contact the help desk, (800) 888-4918, ext. 72269.

CREATING ADVERTISING AND MARKETING MATERIALS

Advertising is anything intended to generate interest in a specific insurance product, company or agent. This includes, but is not limited to, website information and other online services; product brochures; newsletters; agent recruiting materials; prospecting letters; print, radio, television and all other forms of media advertising; illustration and presentation materials; and business cards and stationery.

You may not publish, advertise, use or promote any material concerning our policies/certificates without written approval from the home office. For example, you're authorized to use a comparison statement between a competitor's product and a Washington National product only if that statement is approved in writing by the home office prior to use. Failure to submit advertising may result in termination of the agent contract. Please allow sufficient time for the review and approval process.

Please email all requests for approval to: WNmaterialsreview@WashingtonNational.com.

SECTION 10: CLAIM INFORMATION

Active Care uses multiple claim forms. The claim forms will correspond with the type of diagnosis being claimed. All applicable forms can be ordered at WNbizlink.com or downloaded from WashingtonNational.com.

The policyholder and the attending physician must complete all required sections of the claim form. All necessary documentation—such as hospital bills, doctor bills, etc.—should be attached to the completed form. Claim forms should be mailed to:

Washington National Insurance Company
Attn: Claims Office
Specified Disease Products
P.O. Box 2024
Carmel, IN 46082-2024

Policyholders: (866) 481-9266
Agents: (888) 754-3406

Information concerning a policyholder who has been paid benefits on his or her Washington National policy may be used only if written permission is first obtained from the policyholder and has not reached its expiration date.

CONTESTABLE REVIEW

Knowing the ins and outs of contestable review will help you support a client who files a claim during the contestable period of his or her policy.

What is contestable review?

Insurance companies have a limited amount of time to challenge or contest the validity of a policy based on the policyholder's answers to application questions. In most circumstances, the "contestable period" is the first two years of a new policy, conversion, reinstatement or upgrade. Claims incurred during this time frame trigger a contestable investigation where the claims department collects information to verify the accuracy of the information provided by the policyholder.

Which policies are subject to a contestable review?

All Washington National policies are subject to a contestable review except guarantee-issue (GI) policies. The extent of the review depends on the type of policy. For example, the base plan of an accident policy wouldn't be reviewed. However, the optional disability coverage on an accident policy, which requires health questions on the application, is reviewed for contestability.

Note: Coverage amounts over the GI limit are also subject to a contestable review.

How many claims undergo a contestable review?

Approximately 3% of Washington National's claims in a year undergo a contestable review.

How long does the contestable review process take?

Length of the contestable review depends on how quickly the policyholder and their medical provider(s) return the required information. Some reviews take 90 days or longer to complete, while others are completed more quickly.

Washington National will expedite the processing time once the claim has been approved to be processed following the contestable review.

What are common reasons for delays during the contestable review?

The following circumstances can delay the contestable review investigation:

- Incomplete sections within the claim packet, such as, authorization dates and primary care physician information
- Policyholder failure to complete forms sent by our claims department when a provider requires a different authorization to receive medical records
- Delays in receiving a doctor's response, a valid medical record authorization form, medical records and the employer response if required

What documentation is needed to complete a contestable review?

To complete a review, our claims department requires the following information from the policyholder:

- A fully completed claim form for the appropriate benefits being claimed. All sections should be completed, including the following:
    - A list of primary care physicians, with complete contact information, visited during the look-back years (The look-back period varies by product and is specified on the application.)
    - A signed authorization to obtain medical information
    - A physician's statement, and
    - An employer's statement

Once all necessary information referenced above is received, our claims department may request the following additional information from outside agencies or resources:

- Prescription history
- Physician questionnaire and applicable medical records
- Employer questionnaire

What happens if the contestable review shows misstatements?

If, during the contestable investigation, potential misstatements are identified, our claims department will request an agent statement from the original writing agent. The statement will ask questions related to the medical questions answered by the policyholder within the application and relied upon to issue coverage.

Note: If it's decided that any portion of the policy shouldn't have been issued due to misstatements on the application, correspondence will be sent to the policyholder explaining the results of the investigation.

IF…	THEN…
A misstatement is found in the base policy	A letter will be mailed to the policyholder, the policy will be canceled and all premiums will be refunded.
A misstatement is found about a secondary insured	An option letter will be mailed to the policyholder giving him or her 30 days to either cancel and receive refund of all premiums or remove the secondary insured and return any prorated premiums.
A misstatement is found in secondary coverage, but the base coverage isn't affected	An option letter will be mailed to the policyholder giving him or her 30 days to cancel and receive refund of all premiums or keep the base policy in place and remove optional coverages and return any prorated premiums

How can you help your client expedite the contestable review process?

If your client contacts you for assistance, you can help him or her prepare for the review by:

- Helping your client understand the contestable review process and requirements.
- Reminding him or her to fully complete the claim form, including all sections, authorization dates and physician information.
- Helping your client understand what can create processing delays, including:
    - Incomplete forms.
    - Provider delays in responding to Washington National's requests for information.
    - Provider requests for payment of records.

- Helping your client understand **what not** to do:
    - They should not pay for anything Washington National has requested. Washington National will pay the provider for records requested on the policyholder's behalf.
    - They **should not** collect any medical information on behalf of Washington National.

SECTION 11: FORMS

State-specific forms and marketing materials are available at WNbizlink.com.

FORM NAME	FORM NUMBER	DESCRIPTION
New business application	AP-1067R or state variation	The application should be used to apply for a new, reinstating, upgrading, or adding a family member to a Active Care policy.
Outline of coverage	OC1068 or state variation	The Outline of coverage form should be left with every applicant.
Privacy notice	WNPRIV-FORM-APP	A privacy notice must be left with each application at the time of sale. This form does not require any signatures.
Medical authorization form	MEDAUTH-FORM-PRE	A medical authorization form must be completed with every application. One copy must be submitted with the new business application and one must be left with applicant.
New business transmittal form	C-NBT	This form must accompany applications being sent to the home office for new business, conversions and upgrades. One form is required for every 10 applications submitted.
Worksite new group case profile form	WIS-GRPPRO	A group profile must be completed and submitted with applications for each new group.
Payroll deduction authorization form	WS-PREM-AUTH	This form authorizes the employer to deduct premiums from the employee's payroll check. It should be completed for payroll sales and left with the group's payroll administrator.
Conditional receipt form	CONDITIONALRECPT	This form must be completed and left with the customer whenever premium is collected at the point of sale.
Electronic funds transfer form	CI-747	This form is required whenever an applicant wishes to have either his or her first or subsequent monthly premiums deducted from a checking or savings account. For details, refer to page 25 of this agent guide.
Replacement notice	REPLACESPECDIS	The replacement notice must be given to and signed by the applicant (and spouse, if applicable) whenever the application intends to terminate or allow existing coverage to lapse and be replaced by an Active Care policy. The application book includes two copies of this form. The applicant copy must be left with the applicant and the home office copy must be submitted to the home office with the application.
Medicare supplement notice	CIC-1010	This form must be submitted for any applicant who is eligible for Medicare.

In the state of South Dakota, it is required that a copy of the appropriate outline of coverage for any product sold is left with every customer at point of sale. All outlines of coverage are available on WNbizlink.com.

South Dakota mandate SDCL 58-17-11 requires that "every individual health insurance policy or contract, except single premium nonrenewable policies or contracts, issued for delivery in South Dakota on or after December 31, 1966, by an insurance company, nonprofit hospital service plan, or medical service corporation, shall have printed thereon or attached thereto a notice stating in substance that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within ten days of its delivery to said purchaser and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason. If a policyholder or purchaser pursuant to such notice, returns the policy or contract to the company or association at its home or branch office or to the insurance producer through whom it was purchased, it is void from the beginning and the parties shall be in the same position as if no policy or contract had been issued."

It is the responsibility of the agent that ROP or CV benefits are accurately explained to every policyholder. ROP and CV explanatory aids are available for order on WNbizlink.com.

Insurers and their representatives are not permitted by law to offer tax or legal advice. The general and educational information here supports the sales, marketing and service of insurance policies. Based upon individuals' particular circumstances and objectives, they should seek specific advice from their own qualified and duly-licensed independent tax or legal advisers.

Washington National Insurance Company
Home Office
11825 N. Pennsylvania Street
Carmel, IN 46032

WashingtonNational.com

(09/18) 171362
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