

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, IL 60025
(800) 338-7452

**SHORT-TERM HOME HEALTH CARE INSURANCE POLICY
OUTLINE OF COVERAGE**

For Policy Form Series G2370-MI
With Optional Rider Forms RG15CA-MI, RG16ASH-MI, RG16ASB-MI, RG12DV, RG15RPDL, RG23CG

CAUTION: The issuance of the Policy is based on your answers to the questions on your application. A copy of your application will be attached to the Policy. Any omission or wrong statements in your application may result in your loss of coverage. If, for any reason, any of your answers are incorrect, contact us within 30 days at the address shown above.

If you have any questions concerning this coverage, or if we can be of any assistance, please call us at 1-800-338-7452.

NOTICE TO BUYER

THE POLICY MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH SHORT-TERM HOME HEALTH CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THIS IS A LIMITED POLICY. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY LIMITATIONS AND EXCEPTIONS.

POLICY DESIGNATION

The policy is an individual policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of some of the important features of the Policy. This is not the insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail those rights and obligations applicable to both you and Guarantee Trust Life Insurance Company. It is very important, therefore, that you **READ YOUR POLICY CAREFULLY**.

GUARANTEED RENEWABLE

This means you have the right, subject to the terms of the Policy, to continue the Policy as long as you pay your premium on time. We cannot change any of the terms of the Policy on our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY. We may change your premium by giving you advance written notice, as required by state law. We can only do this when we change the premiums for all policies like yours in the state where you live.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither Guarantee Trust Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

SHORT-TERM HOME HEALTH CARE INSURANCE

Policies of this category are designed to provide persons insured with limited or supplemental coverage.

The Policy provides coverage on an indemnity basis for Covered Home Health Care Services. All benefits are subject to the definitions, limitations and exclusions described in the Policy.

BENEFITS PROVIDED BY THE POLICY

Benefit Eligibility: To qualify for benefits, a Licensed Health Care Practitioner must provide us with written certification that: (i) you have a Cognitive Impairment or Functional Impairment, and (ii) Covered Home Health Care Services is/are needed pursuant to a Plan of Care.

BENEFIT ELIGIBILITY TERMS DEFINED:

Cognitive Impairment means a deterioration or loss in intellectual capacity resulting from Alzheimer's disease, dementia or other similar forms of permanent progressive disease that destroy memory and/or other important mental functions of a person such as thinking, sensing or reasoning and which requires Substantial Supervision to protect You from threats or actual harm to Your health and safety. Cognitive Impairment is evaluated and measured by clinical evidence and/or standardized tests that reliably measure impairment in one's: (1) short or long-term memory; (2) orientation as to people, places, or time; and/or (3) deductive or abstract reasoning.

Functional Impairment mean the inability to perform at least two (2) of the six (6) Activities of Daily Living, listed below, without Substantial Assistance.

Activities of Daily Living means the following six (6) basic activities of daily living:

1. **Continence:** The ability to maintain control of bowel or bladder function; or, if unable to maintain control of bowel or bladder function, the ability to perform associated care for a catheter or colostomy bag.
2. **Dressing:** The ability to put on or take off all items of clothing and, if applicable any necessary braces, fasteners or artificial limbs.
3. **Eating:** The ability to feed oneself by getting food into the body from a receptacle (e.g., plate, cup, table) or if fed by a feeding tube or intravenously, Your ability to properly use and maintain such feeding tube.
4. **Personal Hygiene:** The ability to clean oneself and perform grooming activities on oneself like shaving and brushing teeth.
5. **Toileting:** The ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring:** The ability to move into or out of a bed, chair or wheelchair, or generally move from place to place, without assistance.

POLICY BENEFITS BY PLAN SELECTION: Listed below are the benefits provided by the Policy. Benefit payment for each Covered Home Health Care Service is based upon the plan you select.

COVERED HOME HEALTH CARE SERVICES <i>(Check applicant's selection)</i>	PLAN SELECTION		
	<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan B	<input type="checkbox"/> Plan C
NURSING CARE SERVICES			
Skilled Nursing Care /Daily Benefit	\$75	\$150	\$200
General Nursing Care / Daily Benefit	\$60	\$120	\$200
THERAPY AND MEDICAL SOCIAL SERVICES			
Physical / Daily Benefit	\$75	\$150	\$200
Speech / Daily Benefit	\$75	\$150	\$200
Occupational / Daily Benefit	\$75	\$150	\$200
Enterostomal / Daily Benefit	\$50	\$100	\$200
Respirational / Daily Benefit	\$50	\$100	\$200
Chemotherapy Specialist / Daily Benefit	\$60	\$120	\$200
Medical Social Services / Daily Benefit	\$100	\$200	\$300
HOME HEALTH AIDE SERVICES			
Home Health Aide/Daily Benefit	\$50	\$100	\$150
COMBINED MAXIMUM DAILY BENEFIT AMOUNT FOR COVERED HOME HEALTH CARE SERVICES			
Combined Maximum Daily Benefit Amount for <u>ALL</u> above Covered Home Health Care Services, not to exceed:	\$150	\$300	\$450
PRESCRIPTION DRUG BENEFIT*			
Generic/per Prescription Drug	\$10	\$10	\$10
Brand / per Prescription Drug	\$25	\$25	\$25
Prescription Drug Policy Year Maximum	\$300	\$600	\$900

*The Prescription Drug benefit is not subject to the Pre-Existing Condition Limitation and is payable without regard to eligibility for Covered Home Health Care Services.

MAXIMUM BENEFIT PERIODS: The Maximum Benefit Period for all Covered Home Health Care Covered Services is 360 days.

PRE-EXISTING CONDITIONS LIMITATION:

The Policy is subject to a 6 month Pre-Existing Condition limitation. Pre-Existing Condition means a Sickness or Injury, disclosed or not disclosed on the Application, for which medical care, treatment, diagnosis or advice was received or recommended within the 6 month period immediately prior to the Policy's Effective Date OR a condition that, within the 6 months prior to the Policy's Effective Date, manifests itself in such a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. Treatment includes, but is not limited to, being prescribed drugs or taking Prescription Drugs. Any Loss due to a Pre-Existing Condition is not covered unless the Loss begins more than 6 months after the Policy's Effective Date.

LIMITATION ON BENEFITS:

- 1.) Benefits paid for Covered Home Health Care Services are subject to: (a) the Combined Daily Maximum Benefit Amount; and (b) the Maximum Benefit Period.
- 2.) We will not pay more than the Maximum Benefit Period, unless benefits are restored according to the Policy’s Restoration of Benefits provision.
- 3.) The Daily Benefit Amount for each Covered Home Health Care Service is only payable for the date the specific service is provided.
- 4.) For benefits to be payable, Covered Home Health Care Services must occur while the Policy is in force.
- 5.) When multiple Covered Home Health Care Services are received on a single Day, We will count only one Day toward the Maximum Benefit Period.

RESTORATION OF BENEFITS:

The Maximum Benefit Period for Covered Home Health Care Services will be fully restored when:

- 1.) Covered Home Health Care Services are not received for a period of 180 consecutive days; and
- 2.) A Licensed Health Care Practitioner has provided written certification that you have sufficiently recovered enough to no longer qualify as having either (i) a Functional Impairment or (ii) Cognitive Impairment **and** have been advised that (i) you no longer require Covered Home Health Care or (ii) other nursing or home care services, whether or not such services are covered under the terms of the Policy.

POLICY EXCLUSIONS:

The Policy will not pay benefits for Loss under the following circumstances:

- 1.) For the provision of services due to Injury or Sickness arising out of war or any act of war, declared or undeclared while serving in the military services or any auxiliary unit attached thereto;
- 2.) For the commission of or attempt to commit a felony or to which a contributing cause was being engaged in an illegal occupation or other willful criminal activity;
- 3.) For the provision of services due to Injury or Sickness arising out of or in the course of employment or which is compensable under any workers’ compensation or occupational disease act or law; or motor vehicle no-fault law;
- 4.) For the provision of services by a member of Your Immediate Family unless: (a) he or she is employed by the Home Health Care Agency; (b) the Home Health Care Agency receives payment for the services; and (c) he or she receives no compensation other than the normal compensation for employees of the Home Health Care Agency;
- 5.) For the provision of services not included in Your Plan of Care;
- 6.) For the provision of services which would not routinely be paid in the absence of insurance;
- 7.) For the provision of services received outside the United States or its possessions;
- 8.) For the provision of services incurred prior to the Policy Effective Date, or on or subsequent to its termination or expiration date.

OPTIONAL RIDERS

CRITICAL ACCIDENT BENEFIT RIDER – FORM RG15CA-MI

Maximum Benefit Amount per Accident: \$5,000 \$10,000

Waiting Period: 30 days

This Rider pays limited benefits for the following types of Injuries: hip and knee dislocation; fractures; and knee ligament and meniscus tears. To be eligible for benefits, you must receive Medically Necessary services in an Emergency Room or Urgent Care Facility to treat such Injuries within 48 hours of a covered Accident. Benefit payment is subject to a 30 day Waiting Period. Benefits are a paid as a percentage of the Maximum Benefit Amount per Accident:

Covered Injury	Percentage of Maximum Benefit Amount Per Accident That Will be Payable
Dislocation, hip	20%
Dislocation, knee	10%
Fracture, hip or skull	25%
Fracture, all other	5%
Tear, knee ligament or meniscus	10%

If more than one Fracture, Dislocation and / or Knee Ligament / Meniscus Tear is sustained as a result of a covered Injury, only one benefit is payable. The benefit payable will be that of the highest benefit amount associated with the sustained Fracture, Dislocation, or Knee Ligament/Meniscus Tear.

A Loss of Life Benefit is payable in the event of death as a result of Injuries sustained in a covered Accident. The Loss of Life Benefit is equal to the Maximum Benefit Amount Per Accident.

CRITICAL ACCIDENT BENEFIT RIDER EXCLUSIONS: This rider does not provide benefits for:

- 1.) Treatment, services or supplies which:
 - a.) Are not prescribed by a doctor to treat an injury.
 - b.) Are determined to be experimental / investigational in nature.
 - c.) Are received without charge or legal obligation to pay.
 - d.) Are received from persons employed or retained by any family member.
 - e.) Are provided outside of an emergency room or urgent care facility.
- 2.) Fracture of fingers, toes, ribs or coccyx.
- 3.) Injury 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.
- 4.) Injury received while traveling or operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft including those, which are not motor-driven.
- 5.) Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
- 6.) Dental treatment.
- 7.) Treatment of sickness, disease or degenerative process, including degenerative joint disease and/or non-traumatic arthritis. We also will not pay benefits for any related medical treatments or diagnostic procedures.
- 8.) Treatment of vegetation or ptomaine poisoning or bacterial infections, except pyogenic infections due to accidental open cuts; or accidental ingestion of contaminated substances.
- 9.) Any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.
- 10.) Injury resulting from testing cars/trucks on any racetrack or speedway.
- 11.) Injury resulting from participation in intercollegiate sports.
- 12.) Injury sustained while taking part in any of the following activities: as a rider in or driving in competitive motor sports, water sport races, stunt show or speed test, or while testing any vehicle on any racecourse or speedway; spelunking (exploring caves); mountaineering, scaling up or down cliffs or mountain walls; practice for or participation in a rodeo; flying in an ultralight, hang gliding, parachuting, parasailing, para kiting, or bungee cord jumping.
- 13.) Participating in any sporting event for pay or prize money.
- 14.) Injuries incurred and resulting from hazardous occupations such as circus workers, commercial fishermen, crop dusters, farm laborers, firefighters, lumberjacks, oil field workers, police, quarry workers, rodeo riders, security guards, underground miners, or window washers.
- 15.) Injuries arising out of or in the course of employment and which is payable or covered under any workers' compensation or occupational disease act or law.
- 16.) Injuries incurred more than 40 miles outside the territorial limits of the United States or Canada, unless such loss is incurred while you are on a trip of not more than 60 days.

DENTAL AND VISION BENEFIT RIDER - FORM RG12DV

Rider Maximum Amount Selected: \$400 \$800 \$1,200

This rider pays benefits for: (a) non-preventative dental services; and (b) preventative dental and vision services. Preventative dental services are covered with a Calendar Year maximum benefit of \$75. An annual eye examination or eye refraction is covered with a Calendar Year maximum benefit of \$50. Coverage for prescription eyeglasses is provided up to an annual maximum of \$200 per Calendar Year.

Dental and Visions benefits are subject to the:

- Annual Rider Deductible Amount of \$100;
- Insured Percent of covered expenses; and
- The selected Calendar Year Rider Maximum Amount.

The Rider Deductible Amount and Insured Percent of covered expenses do not apply to preventative dental or eye examination / eye refraction services.

This rider provides limited benefits during the first 12 months after the rider effective date. Please read the rider carefully.

DENTAL AND VISION RIDER EXCLUSIONS

Benefits will not be paid for dental expenses arising from or in connection with:

- 1.) A service not furnished by a Dentist, except:
 - a.) That performed by a Dental Hygienist under the supervision of a Dentist.
 - b.) X-rays ordered by a Dentist.
- 2.) Treatment, services or supplies which are:
 - a.) Not Necessary Dental Treatment, except as provided herein.
 - b.) Experimental/Investigational in nature.
 - c.) Conditions covered by Workers’ Compensation Services.
- 3.) Treatment by a Family Member.
- 4.) Services or supplies for which there would be no charge in the absence of insurance.
- 5.) A service furnished to You for:
 - a.) Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic.
 - b.) Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule.)
- 6.) Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouth guards, precision or semi-precision attachments; denture duplication; or sealants.
- 7.) Oral hygiene instructions; plaque control; acid etch; or prescription for take-home fluoride.
- 8.) Over dentures and associated procedures.
- 9.) Services not completed by the end of the month in which insurance terminates.
- 10.) Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:

- 11.) Treatment, services or supplies which:
 - a.) Are Experimental/Investigational in nature.
 - b.) Are received without charge or legal obligation to pay.
 - c.) Treatment by any Family Member.
- 12.) Conditions covered by Workers’ Compensation Services.
- 13.) Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids.
- 14.) Non-prescription (plano) eyewear.
- 15.) Medical or surgical treatments of the eyes, unless to correct refraction of the eyes.
- 16.) Eye examinations required by an employer as a condition of employment.

RETURN OF PREMIUM UPON DEATH BENEFIT RIDER – Form RG15RPDL

This rider pays a return of premium benefit in the event of your death. The actual amount of premium that will be returned, if any, will equal:

- 1. The sum of all premiums paid for the policy, including premiums paid for this rider and any other benefits riders attached to the policy (unless expressly excluded), while this rider is in force (except for any application and annual policy fees.) The sum of all premiums is without interest accumulation. MINUS
- 2. The sum of all benefit paid or then payable under the policy, including benefits paid or then payable under any attached benefit riders while the rider was in force.

ACCIDENT AND SICKNESS HOSPITALIZATION BENEFIT RIDER - FORM RG16ASH-MI

Accident and Sickness Hospitalization Benefit: \$100 - \$450 / per day: \$ _____

For ages 75+, daily benefit period available is 3 or 6 days, \$100-\$300

Maximum Benefit Period: 3 6 10 / days

Waiting Period for Covered Sickness: 30 Days

This rider pays an Accident and Sickness Hospitalization Benefit for:

- 1. A Loss incurred as a result of a covered Injury, which was initially treated in an Emergency Room or Outpatient Facility within 48 hours after the covered Injury occurred, and with admittance to a Hospital immediately following.
- 2. A Loss as a result of a covered Sickness. Benefits are payable only when:
 - a. Incurred while the Policy and Rider are in force;
 - b. The Waiting Period, if any, has been satisfied; and
 - c. Not otherwise excluded from coverage under the Policy and Rider.

We will pay the Accident and Sickness Hospitalization Benefit Amount for each day of Hospital Confinement due to a covered Accident or Sickness. Benefits are not payable beyond the Maximum Benefit Period of Hospital Confinement for any One Period of Hospital Confinement.

The first Hospital Confinement Day for the Accident and Sickness Hospitalization Benefit Amount is payable upon a Hospital Confinement of at least 24 consecutive hours by reason of a covered Injury or Sickness, for which benefits are payable and there is a charge for room and board.

Any one continuous period of hospitalization which begins while the Rider is in force, won't be affected by the Policy or Rider terminating.

ACCIDENT AND SICKNESS HOSPITALIZATION BENEFIT RIDER EXCLUSIONS:

This rider does not provide benefits for Loss as a result of:

- 1.) Injury 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.
- 2.) Injury received while traveling or operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft including those, which are not motor-driven.
- 3.) The commission of or attempt to commit a felony or to which a contributing cause was being engaged in an illegal occupation or other Willful Criminal Activity.
- 4.) Injury to the spine, or the cervical, thoracic spinal, dorsal, sacro-iliac, or lumbar regions unless loss begins not less than 6 months after the covered person's effective date of coverage.
- 5.) Repetitive motion injuries, strains, all types of hernia, tendinitis, bursitis and heat exhaustion not related to a specific injury.
- 6.) Injury resulting from testing cars/trucks on any racetrack or speedway.
- 7.) Injury sustained while taking part in any of the following activities: as a rider in or driving in competitive motor sports, water sport races, stunt show or speed test, or while testing any vehicle on any racecourse or speedway; spelunking (exploring caves); mountaineering, scaling up or down cliffs or mountain walls; practice for or participation in a rodeo; flying in an ultra-light, hang gliding, parachuting, parasailing, parakiting, or bungee cord jumping.
- 8.) Participating in any sporting event for pay or prize money.
- 9.) Injuries incurred and resulting from hazardous occupations such as circus workers, commercial fishermen, crop dusters, farm laborers, firefighters, lumberjacks, oil field workers, police, quarry workers, rodeo riders, security guards, underground miners, or window washers.
- 10.) Injuries arising out of or in the course of employment and which is payable or covered under any workers' compensation or occupational disease act or law.
- 11.) Injuries incurred more than forty (40) miles outside the territorial limits of the United States or Canada, unless such loss is incurred while the covered person is on a trip of not more than sixty (60) days.
- 12.) Pregnancy, except for complications of pregnancy; or hospital confinement due to giving birth within the first nine (9) months after the effective date of coverage under this rider as a result of a normal pregnancy, including cesarean.

AMBULANCE SERVICE BENEFIT RIDER - FORM RG16ASB-MI

This rider pays an Ambulance Service Benefit of \$200 if a licensed ground ambulance service transports you to or from a medical facility. The ambulance service must be Medically Necessary. This Benefit is payable no more than 4 times per Calendar Year and is subject to a lifetime maximum benefit of \$2,500.

AMBULANCE SERVICE BENEFIT RIDER EXCLUSIONS

This rider does not pay benefits for:

- 1.) Services which are not Medically Necessary.
- 2.) Services which are received without charge or legal obligation to pay.
- 3.) Services which would not routinely be paid in the absence of insurance.
- 4.) Services received outside the United States.
- 5.) Loss as a result of war, or any action of war, declared or undeclared; service in the armed forces of any country.
- 6.) The commission of or attempt to commit a felony or to which a contributing cause was being engaged in an illegal occupation or other Willful Criminal Activity.
- 7.) Injury or sickness arising out of or in the course of employment or which is compensable under any workers' compensation or occupational disease act or law.

CAREGIVER BENEFIT RIDER – FORM RG23CG

This rider pays a fixed indemnity benefit when Covered Home Care services are provided to you, due to a Functional Disability, by an informal Caregiver.

Before the Caregiver Benefit Amount will be payable under this rider:

1. A Licensed Health Care Practitioner must certify that the Covered Home Care services are needed because you have a Functional Disability or are Functionally Disabled as defined within this rider;
2. You must undergo, and complete, an Assessment with a Qualified Caregiver Support Provider;
3. We must receive a copy of the Tailored Caregiver Plan of Care developed as a result of the Assessment; and
4. You must be receiving Covered Home Care.

Assessment means the process by which a Qualified Caregiver Support Provider, in cooperation with a Caregiver, develops a Tailored Caregiver Plan of Care that the Caregiver must comply with while performing your Covered Home Care.

Caregiver means a member of your Immediate Family, or other person, who, on a day-to-day basis, provides at least one (1) hour of Covered Home Care directly to you in your Home. A Caregiver does not include a person who qualifies as a Home Health Care Practitioner, as defined by the Short-Term Home Health Care Benefit Rider, if such rider is attached to your Policy.

Covered Home Care means medical and non-medical services and/or treatments (as described below) provided to you, in strict accordance with a Tailored Caregiver Plan of Care, by a Caregiver in your Home. Medical and non-medical services and treatments include nursing care, physical therapy, occupational therapy, speech therapy, nutritionist services, meal preparation, laundry, light housekeeping, shopping for food, medications or medical supplies, and transportation to and from appointments. Covered Home Care is incurred on the date the service and/or treatment is provided. Covered Home Care must occur while this rider is in force. Any service and/or treatment provided prior to the Effective Date of this rider, or after this rider has terminated, is not Covered Home Care.

Functionally Disabled/Functional Disability means an Insured who is:

1. Unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. Requires Substantial Supervision to protect such individual from threats to one's health and/or safety due to Cognitive Impairment.

Qualified Caregiver Support Provider means an entity who utilizes a caregiver support platform that has been reviewed, and determined to be an evidence-based program, by the U.S. Department of Health and Human Services.

BENEFITS PROVIDED BY THE CAREGIVER RIDER

Caregiver Benefit Amount: \$ 3,500

Caregiver Benefit Lifetime Maximum: \$ 7,000

LIMITATIONS ON CAREGIVER BENEFITS

In addition to exceptions contained within the Policy, we will not pay the Caregiver Benefit Amount under this rider for:

1. Services or treatments provided prior to the Effective Date of this rider;
2. Services or treatments provided after the termination of this rider;
3. Services or treatments provided outside a Period of Care;
4. Services or treatments provided by an individual for which benefits have been paid under your policy or any other rider attached to your Policy;
5. Services or treatments which are inconsistent with, or not included within, the Tailored Caregiver Plan of Care;
6. Services or treatments provided during Days in which you do not receive at least one (1) hour of Covered Home Health Care;
7. Services or treatments which are the result of a pre-existing condition in accordance with the Policy's provisions relating to pre-existing conditions; or
8. Services or treatments resulting from an Assessment completed by a Qualified Caregiver Support Provider that is (1) owned, or operated, by a member of your Immediate Family or (2) a business entity that you or your Immediate Family have a financial interest in or business relationship with.

INITIAL PREMIUM

COVERAGE DESCRIPTION	PREMIUM
Short-Term Home Health Care Policy <i>(Check box for Plan selected)</i> <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C	\$ _____
Accident and Sickness Hospitalization Benefit Rider	\$ _____
Ambulance Service Benefit Rider	\$ _____
Critical Accident Benefit Rider	\$ _____
Dental / Vision Benefit Rider	\$ _____
Return of Premium Upon Death Benefit Rider	\$ _____
Caregiver Benefit Rider	\$ _____
Policy Fee:	\$ 20.00
TOTAL PREMIUM:	\$ _____