AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

(called "we", "our", "us" or "Company")

CERTIFICATE OF INSURANCE

This certificate explains the policy of insurance underwritten by us. It is not the contract of insurance. The group policy (called the "policy"), as issued to the policyholder by us, alone makes up the agreement under which insurance coverage is provided and benefits are determined. The policy may be inspected at the office of the policyholder during normal business hours.

CONSIDERATION

Your coverage under the policy is issued to you in consideration of your enrollment form or other form of application and the payment of the first premium. Your coverage under the policy is effective from 12:01 a.m. Standard Time on your effective date.

INSURING CLAUSE

We certify coverage under the policy is in effect for persons: (a) who are eligible to become covered persons; and (b) who are in fact covered persons; and (c) for whom the required premium has been paid when due. All such coverage is subject to the terms of the policy.

NOTICE OF THIRTY (30) DAY RIGHT TO EXAMINE CERTIFICATE

You may, within 30 days after receipt of this certificate, return it to us or to our agent. Upon such return of the certificate, it will be void as of the effective date; any premium paid will be refunded.

Important Cancellation Information – Please read the provision entitled "Termination of Coverage" found on Page 5.

This certificate contains a pre-existing condition limitation. See the "Pre-existing Condition Limitation" on Page 7.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the company.

In this certificate the insured certificate holder will be referred to as "you", "your" or "yours".

This certificate supersedes and replaces any certificate previously issued to you under the policy.

PLEASE READ YOUR CERTIFICATE CAREFULLY!

THIS IS LIMITED BENEFIT CANCER AND SPECIFIED DISEASE COVERAGE WHICH ONLY PROVIDES BENEFITS FOR CANCER AND SPECIFIED DISEASES AS DEFINED OR OTHER OPTIONAL BENEFITS DESCRIBED HEREIN

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville Florida 32224

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS		PREMIUMS NUMBER OF YEARS PAYABLE	ANNUAL AMOUNT
GVCC2NC (12/04)	CANCER AND SPECIFIED DISEASE COVERAGE		LIFE**	$XX.XX
			LIFE**	
	CANCER SCREENING BENEFIT	$25.00	LIFE**	$XX.XX
			TOTAL	$XX.XX

**SUBJECT TO TERMINATION OF COVERAGE PROVISION

INDIVIDUAL COVERAGE

The effective date and issue age of each benefit is the Effective Date and Issue Age of the Certificate unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL SEMI-ANNUAL QUARTERLY MONTHLY

BILLABLE PREMIUM

$XX.XX

Premium Payment Method: PAYROLL ALLOTMENT - MONTHLY

INSURED: LOW

ISSUE AGE: XX

EFFECTIVE DATE: JUNE 15, 2015

CERTIFICATE NUMBER: NC136472

GROUP POLICY NUMBER: 83126

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FORM: GVCC2NC (12/04) CANCER COVERAGE (P1)

CANCER CERTIFICATE NUMBER: NC136472

CANCER CERTIFICATE - GVCC2NC (12/04)

SEE BENEFITS SECTION OF CERTIFICATE FOR DETAILS OF BENEFITS

BENEFITS	AMOUNT
A. CONTINUOUS HOSPITAL CONFINEMENT DAYS 1-70	$100.00/DAY
B. EXTENDED BENEFITS DAYS 71+	UP TO $100.00/DAY
C. GOVERNMENT OR CHARITY HOSPITAL	$100.00/DAY
D. PRIVATE DUTY NURSING SERVICES	UP TO $100.00/DAY
E. EXTENDED CARE FACILITY	UP TO $100.00/DAY
F. AT HOME NURSING	UP TO $100.00/DAY
G. HOSPICE CARE	
1. FREESTANDING HOSPICE CARE CENTER	UP TO $100.00/DAY
2. HOSPICE CARE TEAM	UP TO $100.00/VISIT
H. RADIATION/CHEMOTHERAPY	UP TO $2,500.00/12 MONTHS
I. BLOOD, PLASMA, AND PLATELETS	UP TO $2,500.00/12 MONTHS
J. SURGERY	UP TO $1,500.00 PER UNIT OF COVERAGE SEE SCHEDULE OF SURGICAL PROCEDURES 1.00 UNIT OF COVERAGE
K. ANESTHESIA	UP TO 25% OF SURGERY BENEFIT
L. BONE MARROW OR STEM CELL TRANSPLANT	
1. AUTOLOGOUS TRANSPLANT	UP TO $500.00/12 MONTHS
2. NON-AUTOLOGOUS TRANSPLANT	UP TO $1,250.00/12 MONTHS
3. NON-AUTOLOGOUS TRANSPLANT FOR THE TREATMENT OF LEUKEMIA	UP TO $2,500.00/12 MONTHS
M. AMBULATORY SURGICAL CENTER	UP TO $250.00/DAY
N. SECOND SURGICAL OPINION	UP TO $200.00
O. INPATIENT DRUGS AND MEDICINE	UP TO $25.00/DAY
P. PHYSICIAN'S ATTENDANCE	UP TO $50.00/DAY
Q. AMBULANCE	UP TO $100.00/CONFINEMENT
R. NON-LOCAL TRANSPORTATION	COACH FARE OR $0.40/MILE
S. OUTPATIENT LODGING	UP TO $50.00/DAY UP TO $2,000.00/12 MONTHS
T. FAMILY MEMBER LODGING AND TRANSPORTATION	UP TO $50.00/DAY COACH FARE OR $0.40/MILE
U. PHYSICAL OR SPEECH THERAPY	UP TO $50.00/DAY
V. NEW OR EXPERIMENTAL TREATMENT	UP TO $5,000.00/12 MONTHS
W. PROSTHESIS	UP TO $2,000.00/AMPUTATION
X. COMFORT/ANTI-NAUSEA	UP TO $200.00/YEAR
Y. WAIVER OF PREMIUM	AFTER 90 DAYS

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GENERAL PROVISIONS

COVERAGE SUBJECT TO POLICY

The coverage described in this certificate is subject in every way to the terms of the policy that is issued to the policyholder. It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between us and the policyholder. Your consent is not required for this. Neither are we required to give you prior notice.

ELIGIBILITY OF FAMILY MEMBERS

Family members eligible to be covered persons are:

1. you; and
2. your spouse on the effective date; and
3. unmarried children of you or your spouse, including adopted children, children during pendency of adoption procedures, foster children if living in a regular parent-child relationship with the employee and stepchildren, who are under 22 years old or under 26 years old and full-time students at an educational institution of higher learning beyond high school.

A child born to you or your covered spouse, while this policy is in force as a family policy, will be a covered person. This coverage begins at the moment of birth of such child for benefits otherwise payable to a covered person under this policy. Any person who becomes a family member after the effective date (except newborns, foster children and adopted children) must be added by endorsement. No additional premium will be required for newborns, foster children, adopted children or family members added by endorsement if this policy is in force as a family policy.

Under individual coverage, newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for the newborn child (children), you must notify us within 31 days of the child's birth. Upon notification, we will convert your coverage to family coverage and advise you of the additional premium due. If you have individual coverage and you marry and desire coverage for your spouse, you must notify us of your marriage within 31 days of the marriage and we will convert your coverage to family coverage and advise you of the additional premium due.

The provisions of this section also apply to foster children, adopted children and children during pendency of adoption proceedings as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by you within 31 days after the date of birth and you have temporary custody, coverage must be provided from the moment of birth.
3. Coverage shall begin on the date of placement.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

ELIGIBILITY DATE

The date you are eligible for coverage is the later of:

1. the policy effective date; or
2. the date you become a member of the eligible class.

WHEN YOU CAN ENROLL OR DISCONTINUE YOUR COVERAGE

1. You may apply for coverage during:
   a. your initial enrollment period; or
   b. at any other time, subject to evidence of insurability.
2. You may discontinue your coverage at any time.

GENERAL PROVISIONS (CONT)

WHEN EVIDENCE OF INSURABILITY IS REQUIRED

Evidence of Insurability is required if you:

1. voluntarily canceled your coverage and are reapplying; or
2. are applying for coverage at any time after your initial enrollment period.

CERTIFICATE OF COVERAGE

We will issue certificates of coverage to the policyholder for delivery to you. This certificate provides a description of the group policy and states:

1. the benefits provided under the group policy; and
2. to whom benefits are payable; and
3. the limitations, exclusions and requirements that apply to the coverage under the policy.

If there is any discrepancy between the provisions of this certificate and the provisions of the policy, the provisions of the policy govern.

EFFECTIVE DATE OF COVERAGE

Your coverage will be effective on the effective date shown on page 3 of your certificate.

For any change in coverage that is not subject to evidence of insurability, the change in coverage is effective on the date we receive such request for change in coverage.

For any change in coverage that is subject to evidence of insurability the change in coverage is effective on the date we approve such change.

ABSENT FROM WORK ON THE DATE COVERAGE WOULD NORMALLY BEGIN

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment. This applies to your initial coverage, as well as any increase or additions to coverage that occurs after your initial coverage is effective.

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which you made any required premium payments; or
3. the last day you are in active employment; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible.

We will provide coverage for a payable claim that occurs while you are covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

If the child is a covered person, the child's coverage ends on the policy anniversary next following the date the child is no longer eligible. This is the earlier of: (a) when the child marries; or (b) reaches age 22 (26 if a full-time student attending an educational institution of higher learning beyond high school). Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon you for support and maintenance.

Dependent coverage continues as long as this policy remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, then coverage continues during the period for which such premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

AGENCY

For purposes of the policy, the employer acts on its own behalf or as your agent. Under no circumstances will the employer be deemed the agent of American Heritage Life.

GENERAL PROVISIONS (CONT)

CONVERSION PRIVILEGE

If your coverage terminates for reasons other than non-payment of premium, or if coverage of a spouse covered under this policy terminates due to divorce or your death, or if coverage of a covered child terminates due to the child becoming married or reaching age 22 (26 if a full-time student), such covered person can obtain a policy of insurance (called the converted policy), without evidence of insurability. Obtaining that policy is subject to the following conditions:

1. Application for the converted policy must be made to us within 31 days (within 60 days of final divorce decree in case of divorce) after the coverage terminates. The effective date of the converted policy will be the date on which this coverage terminates.
2. The converted policy premium is at the rate for the class of risk at the applicant's age for insurance provided as of the date of the conversion.
3. Any conditions excluded in this coverage are excluded in the converted policy. No other pre-existing conditions are excluded. The Pre-Existing Condition Limitation and Contestability provisions are waived to the extent that such periods have been met under this coverage. Benefits payable to the applicant under the converted policy are reduced by benefits payable under this coverage.
4. The converted policy will be a similar policy or a policy providing lesser benefits at the applicant's option.

When conversion is due to divorce, other dependents covered under this coverage may be covered under such new policy or under this coverage as you and your former spouse may elect. They may not be covered under both.

If either this coverage or a new policy is in force on you or your former spouse, and either of you re-marry, such new spouse may be covered under the appropriate policy. We must be advised of the re-marriage by the completion of a new application for such new spouse. This new application is subject to our approval. You or your former spouse must pay the premiums appropriate to such new policy in order to have it issued and maintained in force.

GRACE PERIOD

The policyholder is entitled to a grace period of 31 days for the payment of any premium due except for the first premium. The policy continues in force during the grace period, unless the policyholder gives us written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policyholder is liable to us for the payment of any pro rata premium for the time the policy is in force during a grace period.

ENTIRE CONTRACT

The contract consists of the following items:

1. the group policy; and
2. any amendments and endorsements; and
3. the applications and other written statements of the policyholder; and
4. any individual applications, enrollment forms, and evidences of insurability of the covered persons.

Any statements made by the policyholder or by a covered person, in the absence of fraud, are representations and not warranties. Only written statements signed by the policyholder or the covered person will be used in defense of a claim. A copy of any written statement, if applicable, will be furnished to the policyholder or the covered person or his beneficiary, if any, if a claim is denied based upon such a statement.

CONTESTABILITY

After 2 years from the effective date of the policy, no misstatement of the policyholder, made in any application(s), can be used to void the policy. After two years from the effective date of any covered person's coverage, no misstatement of a covered person, made in writing, can be used to void coverage or deny a claim for loss incurred.

CLERICAL ERROR

Clerical error on the part of the policyholder or us will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an adjustment will be made in the premiums. Complete proof must be supplied by the policyholder documenting any clerical errors.

LEGAL ACTION

No action at law or in equity may be brought to recover on the policy prior to expiration of 60 days after written proof of loss has been furnished. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

LIMITATIONS/EXCEPTIONS

A. PRE-EXISTING CONDITION LIMITATION

We do not pay for any loss due to a pre-existing condition as defined during the 12 month period beginning on the date that person became a covered person.

B. OTHER LIMITATIONS AND EXCEPTIONS

We do not pay for any loss except for losses due directly from cancer or a specified disease and any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim.

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BENEFITS INFORMATION

PAYMENT OF BENEFITS

If cancer or a specified disease is diagnosed on or after the covered person's effective date, we pay according to the Benefits provisions in this certificate, subject to the Limitations/Exceptions provision and all other provisions contained in this certificate.

If cancer or a specified disease is diagnosed while the covered person is hospital confined, benefits begin retroactively to the day of admission or 10 days prior to the date of diagnosis if this is more favorable.

If positive diagnosis is made for cancer or a specified disease within 12 months after a tentative diagnosis, benefits are paid from the date of tentative diagnosis if the tentative diagnosis is made on or after the effective date, subject to the Pre-existing Condition Limitation provision.

If a covered person dies while an inpatient in a hospital and cancer or a specified disease is not diagnosed until after the covered person's death, benefits will begin retroactively to the day of admission, up to a maximum of 45 days prior to death.

SCHEDULE OF BENEFITS

We pay the following benefits for the necessary treatment of cancer or a specified disease, and for any other condition directly caused or aggravated by the cancer or specified disease. Treatment must be received in the United States or its territories.

For those benefits for which we pay actual charges up to a specified maximum amount, except benefits H., I., L., V. and W., if specific charges are not obtainable as proof of loss, we will pay 50% of the applicable maximum for the benefits payable.

No benefits are payable for the treatment of cancer or a specified disease except those expressly stated in this Schedule of Benefits.

A. Continuous Hospital Confinement. If a covered person is admitted to and confined as an inpatient in a hospital for the treatment of cancer or specified disease, we pay the amount shown on page 3A per day for each day. The maximum number of days payable is 70 days for each period of continuous hospital confinement.

B. Extended Benefits. If a covered person is confined in a hospital for the treatment of cancer or a specified disease for more than 70 days of continuous hospital confinement, we pay actual charges up to the amount shown on page 3A per day for: hospital room and board; medicine; laboratory tests; and other hospital charges. This benefit begins on the 71st day of continuous hospital confinement. This benefit is payable in lieu of all other benefits payable during the continuous hospital confinement beginning on the 71st day under the Schedule of Benefits (except the Waiver of Premium Benefit). This benefit continues as long as the covered person is continuously hospital confined.

C. Government or Charity Hospital. In lieu of all other benefits in this policy (except the Waiver of Premium Benefit), we pay the amount shown on page 3A per day for each day a covered person is confined to: 1.) a hospital operated by or for the U.S. Government (including the Veteran's Administration); or 2.) a hospital that does not charge for the services it provides (charity). The confinement must be for the treatment of cancer or a specified disease.

D. Private Duty Nursing Services. While a covered person is an inpatient receiving cancer or specified disease treatment, we pay the actual charges, up to the amount shown on page 3A per day if such covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by a physician for cancer or specified disease treatment and must be provided by a nurse.

E. Extended Care Facility. We pay actual charges up to the amount shown on page 3A per day for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement in the extended care facility must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. This benefit is limited to the number of days of the previous continuous hospital confinement.

F. At Home Nursing. While a covered person is receiving treatment for cancer or specified disease, we pay actual charges up to the amount shown on page 3A per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician and must begin within 14 days after a covered confinement as an inpatient in a hospital. This benefit is limited to the number of days of the previous continuous hospital confinement.

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G. Hospice Care. When a covered person is:
1. diagnosed with cancer or a specified disease; and
2. determined by a physician to be terminally ill as a result of cancer or a specified disease; and
3. expected to live 6 months or less;

we pay one of the following two benefits for hospice care:

(1) ***Freestanding Hospice Care Center***. We pay actual charges up to the amount shown on page 3A per day for confinement in a licensed freestanding hospice care center. The covered person must be diagnosed by a physician as terminally ill and the attending physician must approve the confinement. This benefit is payable only if a covered person is admitted to a freestanding hospice care center within 14 days after a period of inpatient hospital confinement. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or

(2) ***Hospice Care Team***. We pay actual charges up to the amount shown on page 3A per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. This benefit is payable only if: the covered person has been diagnosed as terminally ill; and the attending physician has approved such services; and home care services begin within 14 days after a period of hospital confinement. We do not pay for: food services or meals other than dietary counseling; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

H. Radiation/Chemotherapy. We pay actual charges, up to the limit stated below for radiation therapy and chemotherapy received by a covered person as part of treatment for cancer or a specified disease. This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period shown on page 3A.

We only pay this benefit for cancer or specified disease treatment consisting of:
1. cancericidal chemical substances for the purpose of modification or destruction of cancer or specified disease; and
2. X-ray radiation; and
3. radium and cesium implants; and
4. cobalt.

This benefit does not pay for: treatment planning; or treatment consultation; or treatment management; or the design and construction of treatment devices; or basic radiation dosimetry calculation; or any type of laboratory tests; or X-ray or other imaging used for diagnosis or disease monitoring; or the diagnostic tests related to these treatments. This benefit also does not pay for any devices or supplies including intravenous solutions and needles related to these treatments.

I. Blood, Plasma and Platelets. We pay actual charges, up to the limit stated below, for:
1. blood, plasma and platelets (including transfusions and administration charges); and
2. processing and procurement costs; and
3. cross-matching;

received by a covered person in conjunction with cancer or specified disease treatment. This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. We do not pay for blood replaced by donors.

J. Surgery. When surgery is performed on a covered person:
1. for the purpose of treating a diagnosed cancer or specified disease; or
2. for the purpose of diagnosing cancer or specified disease and that surgery results in a diagnosis of cancer or specified disease; or
3. that is the first surgery performed subsequent to a diagnosis of cancer or specified disease that is performed for the purpose of verifying the complete removal of the cancer or specified disease.

We pay the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure per unit of coverage shown on page 3A. If any surgical procedure for the treatment or diagnosis of a cancer or specified disease other than those listed in the Schedule of Surgical Procedures is performed, we pay the actual charges, up to the unit value for the surgical procedure as set forth in the 1964 California Relative Value Schedule (C.R.V.S.) multiplied by $10.00 per unit of coverage. If the surgical procedure has no unit value or is not shown in the 1964 C.R.V.S., we pay the actual charges, up to an amount we reasonably determine to be consistent (based upon relative difficulty) with the Schedule of Surgical Procedures per unit of coverage. Two or more procedures performed at the same time through one incision or entry point are considered one operation; we pay the amount for the procedure with the greatest benefit. Payment will never exceed the maximum per unit of coverage. Surgery performed on an outpatient basis is paid at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in this Schedule of Benefits.

K. Anesthesia. We pay actual charges of an anesthetist not to exceed 25% of the amount paid for the Surgery Benefit (benefit J.) for anesthesia received.

L. Bone Marrow or Stem Cell Transplant. We pay the amounts shown on page 3A for the following types of bone marrow or stem cell transplants performed on a covered person for cancer or specified disease treatment:
1. A transplant which is other than non-autologous.
2. A transplant which is non-autologous for the treatment of cancer or specified disease other than leukemia.
3. A transplant which is non-autologous for the treatment of leukemia.

This benefit is payable only once per covered person per calendar year.

M. Ambulatory Surgical Center. We pay the actual charges for the use of an ambulatory surgical center, up to the amount shown on page 3A for a surgical procedure covered under the Surgery Benefit (benefit J.) that is performed at an ambulatory surgical center.

N. Second Surgical Opinion. If surgery is recommended by a physician due to the diagnosis of cancer or specified disease and the covered person chooses to obtain the opinion of a second physician, we pay the actual charges for the second opinion, up to the amount shown on page 3A. This second opinion must be: rendered prior to surgery being performed; and obtained from a physician not in practice with the physician rendering the original recommendation.

O. Inpatient Drugs and Medicine. We pay actual charges made by the hospital for drugs and medicine, related to cancer or specified disease treatment, while hospital confined up to the amount shown on page 3A per day, for each day of continuous hospital confinement. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit (benefit H).

P. Physician's Attendance. We pay actual charges for a visit by a physician while a covered person is receiving cancer or specified disease treatment during hospital confinement up to the amount shown on page 3A per day. This benefit is limited to one visit by one physician per day of hospital confinement. A visit means personal attendance by the physician. Admission to the hospital as an inpatient is required.

Q. Ambulance. We pay actual charges up to the amount shown on page 3A per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined for cancer or specified disease treatment.

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BENEFITS INFORMATION (CONT)

R. Non-Local Transportation. We pay the following benefit for cancer or specified disease treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally: 1.) actual cost of round trip coach fare on a common carrier; or 2.) the amount shown on page 3A, up to 700 miles, for round trip personal vehicle transportation. Mileage is measured from the covered person's home to the nearest treatment facility as described above. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. We do not pay for: transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

S. Outpatient Lodging. We pay a daily lodging benefit when a covered person receives radiation or chemotherapy treatment for cancer or specified disease (benefit H.) on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. The benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to the amount shown on page 3A per day during treatment. This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

T. Family Member Lodging and Transportation. We pay the following benefits for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment for cancer or specified disease:

1. ***Lodging***-The actual cost of a single room in a motel, hotel, or other accommodations acceptable to us, up to the amount shown on page 3A per day. This benefit is limited to 60 days for each period of continuous hospital confinement; and
2. ***Transportation***-The actual cost of round trip coach fare on a common carrier or a personal vehicle allowance of the amount shown on page 3A per mile, up to 700 miles per continuous hospital confinement. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. We do not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit (benefit R.), when the family member lives in the same city or town as the covered person.

U. Physical or Speech Therapy. We pay actual charges up to the amount shown on page 3A per day, for physical or speech therapy for restoration of normal body function.

V. New or Experimental Treatment. We pay actual charges, up to the limit stated below, for new or experimental treatment for cancer or specified disease when:

1. the treatment is judged necessary by the attending physician; and
2. no other generally accepted treatment produces superior results in the opinion of the attending physician.

This benefit is limited to the amount shown on page 3A per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in this Schedule of Benefits.

W. Prosthesis. We pay actual charges up to the amount shown on page 3A for prosthetic devices which are prescribed as a direct result of surgery for cancer or specified disease treatment and which require surgical implantation. This benefit is limited to the amount shown on page 3A per covered person, per amputation.

X. Comfort/Anti-Nausea Benefit. We pay the actual charges, up to the amount shown on page 3A per calendar year for anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. We will not pay this benefit for medication administered while the covered person is an inpatient.

Y. Waiver of Premium. If, while this coverage is in force, the employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, we pay premiums due after such 90 days for as long as the insured remains disabled. The term "disabled" means that you are:

1. unable to work at any job for which the employee is qualified by education, training or experience; and
2. not working at any job for pay or benefits; and
3. under the care of a physician for the treatment of cancer.

OPTIONAL BENEFIT(S)

Cancer Screening. We pay this benefit if a covered person has a cancer screening test performed. We pay the amount shown on page 3 per calendar year per covered person for any one of the cancer screening tests. Each covered person is covered for no more than the amount shown on page 3 per calendar year. We pay this benefit regardless of the result of the test. There is no limit as to the number of years we pay for cancer screening tests. The eligible cancer screening tests are:

1. Bone marrow testing; and
2. CA15-3 (cancer antigen 15-3 – blood test for breast cancer); and
3. CA125 (cancer antigen 125 – blood test for ovarian cancer); and
4. CEA (carcinoembryonic antigen – blood test for colon cancer); and
5. Chest X-ray; and
6. Colonoscopy; and
7. Flexible sigmoidoscopy; and
8. Hemocult stool analysis; and
9. Mammography; and
10. Pap smear; and
11. PSA (prostate specific antigen – blood test for prostate cancer); and
12. Serum Protein Electrophoresis (test for myeloma).

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SCHEDULE OF SURGICAL PROCEDURES
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S	UNIT OF SURGERY COVERAGE
BRAIN		
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	61510	$1,250.00
Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial	61512	$1,500.00
Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion	61575	$1,250.00
Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computerized axial tomography	61751	$1,400.00
BREAST		
Biopsy of breast; needle core (separate procedure)	19100	$ 25.00
Biopsy of breast; incisional	19101	$ 150.00
Excision of malignant tumor (except 19140), male or female, one or more lesions	19120	$ 150.00
Mastectomy, partial	19160	$ 150.00
Mastectomy, simple, complete	19180	$ 300.00
Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle	19240	$ 600.00
DIGESTIVE SYSTEM		
Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with collection of specimen(s) by brushing or washing (separate procedure)	43235	$ 150.00
Gastrectomy, total; with esophagoenterostomy	43620	$1,000.00
Colectomy, partial; with anastomosis	44140	$ 800.00
Proctectomy; complete, combined abdominoperineal, with colostomy, one or two stages	45110	$1,000.00
Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	45378	$ 280.00
Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	45385	$ 500.00
EXTERNAL GENITALIA		
FEMALE		
Vulvectomy, simple; partial	56620	$ 400.00
Vulvectomy, simple; complete	56625	$ 550.00
Vulvectomy, radical, partial	56630	$ 800.00
Vulvectomy, radical, complete, with inguinofemoral, iliac, and pelvic lymphadenectomy	56640	$1,000.00

SCHEDULE OF SURGICAL PROCEDURES (CONT)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S	UNIT OF SURGERY COVERAGE
EXTERNAL GENITALIA (cont)		
MALE		
Biopsy of testis, needle (separate procedure)	54500	$ 20.00
Orchiectomy, radical, for tumor; inguinal approach	54530	$ 400.00
LIVER		
Biopsy of liver; percutaneous needle	47000	$ 50.00
Biopsy of liver, wedge (separate procedure)	47100	$ 400.00
Hepatectomy, resection of liver; partial lobectomy	47120	$ 800.00
LUNG		
Bronchoscopy; with biopsy	31625	$ 200.00
Biopsy, lung or mediastinum, percutaneous needle	32405	$ 50.00
Removal of lung, total pneumonectomy	32440	$1,000.00
MUSCULOSKELETAL		
Biopsy, bone, trocar or needle; superficial (e.g., ilium, sternum, spinous process, ribs)	20220	$ 50.00
Excision of tumor, soft tissue of neck or thorax; deep, subfascial, intramuscular	21556	$ 100.00
Laminectomy for biopsy/excision of intraspinal neoplasm; extradural, cervical	63275	$1,000.00
PROSTATE		
Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	52601	$ 800.00
Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	55801	$ 800.00
Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	55845	$1,300.00
SKIN		
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion (pathology report required)	11100	$ 30.00
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); each separate/additional lesion (pathology report required)	11101	$ 15.00

SCHEDULE OF SURGICAL PROCEDURES (CONT)
PER UNIT OF SURGERY COVERAGE

SURGICAL PROCEDURE	PROCEDURE CODE FOR 1964 C.R.V.S	UNIT OF SURGERY COVERAGE
SKIN (cont)		
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm. or less	11600	$ 60.00
Excision, malignant lesion, trunk, arms, or legs; lesion diameter 2.1 to 3.0 cm	11603	$ 120.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm. or less	11620	$ 100.00
Excision, malignant lesion, scalp, neck, hands, feet, genitalia, lesion diameter 2.1 to 3.0 cm.	11623	$ 250.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less	11640	$ 150.00
Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 2.1 to 3.0 cm.	11643	$ 300.00
Chemosurgery (Mohs' micrographic technique); first state, fresh tissue technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, and microscopic examination of specimens by the surgeon, of up to 5 specimens	17304	$ 200.00
UTERUS		
Colposcopy (vaginoscopy); with biopsy(s) of the cervix and/or endocervical curettage	57454	$ 60.00
Endometrial and/or endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	58100	$ 30.00
Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	58120	$ 150.00
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	58150	$ 600.00
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tubes(s), with or without removal of ovary(s)	58210	$1,000.00
Vaginal hysterectomy	58260	$ 600.00
VASCULAR INJECTION PROCEDURE		
Placement of central venous catheter for therapeutic reasons (subclavian, jugular, or other vein) (e.g., for hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	36489	$ 100.00
Insertion of implantable venous access port, with or without subcutaneous reservoir	36533	$ 400.00
Removal of implantable venous access port and/or subcutaneous reservoir	36535	$ 150.00

CONTINUITY OF COVERAGE

IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO AMERICAN HERITAGE LIFE

When the plan becomes effective, we provide coverage for you if:

1. you are not in active employment due to sickness as a result of cancer; and
2. you were covered by the prior group policy when it terminated; and
3. the prior group policy provided cancer coverage.

Your coverage is subject to payment of premium.

Your benefit will be limited to the amount that would have been paid by the prior carrier. We will reduce your benefits by any amount for which your prior carrier is liable.

IF YOU HAVE A LOSS DUE TO A PRE-EXISTING CONDITION AND YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO AMERICAN HERITAGE LIFE

We may pay benefits if your loss results from a pre-existing condition if you were:

1. in active employment and insured under this plan on its effective date; and
2. insured by the prior group policy when it terminated.

The prior group policy's coverage must be substantially similar to this coverage and have been in effect within 60 days of this plan's effective date in order for this provision to apply.

In order to receive benefits you must satisfy the time limit in the Pre-existing Condition provision under:

1. our plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy item 1 or 2 above, we will not pay any benefits.

If you satisfy either item 1 or item 2, we will determine our payments according to the American Heritage Life policy provisions.

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CLAIMS INFORMATION

NOTICE OF CLAIM

We encourage the employee to notify us of claim as soon as possible so that a claim decision can be made in a timely manner. Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this policy, or as soon as is reasonably possible. Notice given by or on behalf of the employee or the beneficiary to us at 1776 American Heritage Life Drive, Jacksonville, Florida 32224-6688, or to any authorized agent of ours, with your name and certificate number, is notice to us.

CLAIM FORMS

The claim form is available from your employer, or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, send us written proof of claim without waiting for the form.

FILING A CLAIM

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to us.

PROOF OF YOUR CLAIM

If this certificate provides for periodic payment of a continuing loss, written proof of loss must be furnished to us within 180 days after the end of each period for which we are liable. For any other loss, written proof must be given to us within 180 days after each loss. If it is not possible to give us written proof in the time required, we will not reduce or deny any claim for this reason, as long as the proof is filed as soon as reasonably possible. In any event, the proof required must be given to us no later than 1 year from the time specified unless the employees are legally incapacitated.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right, at our own expense, to have any covered person examined by a physician of our choosing, as often as may be reasonably required while a claim is pending. We may have an autopsy performed during the period of contestability, where it is not forbidden by law. The autopsy must be performed in this state.

PAYMENT OF CLAIMS

After receiving written proof of loss, we pay all benefits then due under this certificate. Benefits for any other loss covered by this certificate are paid as soon as we receive proper written proof. We will make payments to you unless you assign such payments. Any amounts unpaid at your death may, at our option, be paid either to the named beneficiary or to your estate. If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000, to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

ASSIGNMENT

An assignment of the coverage under this certificate is not binding on us, unless:

1. it is a written request; and
2. it is received and recorded by us at our home office.

We are not responsible for the validity of any assignment. An assignment is subject to any payment we make or other action we take before we record the assignment. An assignment may not change the owner or beneficiary.

CLAIMS INFORMATION (CONT)

OVERPAID CLAIM

We have the right to recover any overpayments due to:

1. fraud; or
2. any error we make in processing a claim.

You must reimburse us in full. We will work with you to develop a reasonable method of repayment if you are financially unable to repay us in a lump sum.

We will not recover more money than the amount you were paid.

CLAIM REVIEW

If a claim is denied, we will give written notice of:

1. the reason for denial; and
2. the policy provision that relates to the denial; and
3. your right to ask for a review of your claim; and
4. any additional information that might allow us to change our decision.

You may, upon written request, read any reports that are not confidential. For a small fee, we will make copies of those reports for your use.

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GLOSSARY

Active Employment. Means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under eligible class in each plan.

Your work site must be:

1. your employer's usual place of business; or
2. an alternative work site at the direction of your Employer; or
3. a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

Ambulatory Surgical Center. A licensed surgical center consisting of: an operating room; facilities for the administration of general anesthesia; and a post surgery recovery room that the patient is admitted to and discharged from within the same working day. This includes an ambulatory surgical center that is a part of a hospital.

Autologous Bone Marrow Transplant. A procedure in which bone marrow is removed from a patient, stored, and then given back to the patient following intensive treatment.

Bone Marrow Transplant. A procedure to replace bone marrow destroyed by treatment with high doses of anticancer drugs or radiation. A transplant may be autologous (the person's own marrow saved before treatment), allogeneic (marrow donated by someone else), or syngeneic (marrow donated by an identical twin).

Cancer. The disease manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes: Hodgkin's Disease; leukemia; lymphoma; carcinoma; sarcoma; or malignant tumor. It does not include other conditions that may be considered precancerous, such as: leukoplakia; actinic keratosis; carcinoid; hyperplasia; polycythemia; nonmalignant melanoma; moles; or similar diseases or lesions. Clinical diagnosis of cancer shall be accepted as evidence that cancer exists in an insured when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the diagnosis of cancer and the covered person received definitive treatment for cancer. If the requisite pathological clinical diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

Common Carrier. Only the following: commercial airlines; or passenger trains; or intercity buslines. It does not include taxis; or intracity buslines; or private charter planes.

Continuous Hospital Confinement. One continuous confinement or two or more hospital confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Continuous Hospital Intensive Care Unit Confinement. One continuous confinement or two or more hospital intensive care unit confinements not separated by more than 30 days. If there are more than 30 days between confinements, they are considered separate confinements.

Covered Person. Any of the following:

1. any eligible family member (including you) named in the enrollment form or evidence of insurability form and acceptable for coverage by us; or
2. any eligible family member added after the effective date; or
3. a newborn child.

Date of Diagnosis. The earliest of the date of: tentative diagnosis; or clinical diagnosis; or the day the tissue specimen, culture(s) and/or titer(s) are taken, upon which the positive or tentative diagnosis of cancer or specified disease is made.

Employee. Means a person who is a citizen or resident of the United States or Canada in active employment with the Employer.

Employer. Means the individual, company or corporation where you are in active employment, and includes any division, subsidiary, or affiliated company named in the policy.

Evidence of Insurability. Means a statement of your medical history which American Heritage Life will use to determine if you are approved for coverage. Evidence of insurability will be provided at your own expense.

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GLOSSARY (CONT)

Extended Care Facility. A licensed nursing facility under the direction of a physician which provides continuous skilled nursing service under the supervision of a graduate registered nurse (R.N.) and maintains daily medical records on each patient. It does not include any institution, or part thereof, used primarily as a place for the aged, drug addicts, alcoholics, or rest.

Freestanding Hospice Care Center. A center which is not a hospital, a wing, or section of a hospital, providing 24 hour a day care for the terminally ill under the medical direction of a physician.

Grace Period. Means the period of time following the premium due date during which premium payment may be made.

Hospital. Means a public or private institution which is primarily engaged in providing to inpatients, by or under supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Hospital does not include any institution which is mainly a rest home, nursing home, convalescent home, or home for the aged.

Hospital Intensive Care Unit. A hospital area of special care including cardiac or coronary care units, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds, or wards normally used for patient confinement. In addition the unit must provide the following:

1. 24 hour continuous nursing care attended by nurses assigned to the unit on a full time basis; and
2. direction and/or supervision by a full time physician director or a standing "intensive care" committee of the medical staff; and
3. special medical apparatus used to treat the critically ill.

Initial Enrollment Period. Means one of the following periods during which you may first apply in writing for coverage under this plan:

1. if you are eligible for coverage on the plan effective date, a period before the plan effective date as set by the employer; or
2. if you become eligible for coverage after the plan effective date, the period ending 31 days after the date you are first eligible to apply for coverage.

Insured. The person accepted for coverage by us who has completed and signed the enrollment form or evidence of insurability and whose name appears on the Certificate Specification Page.

Intoxication. A temporary state of being as determined by the laws of the state in which the loss occurred.

Material And Substantial Duties. Means duties that:

1. are normally required for the performance of your regular occupation; and
2. cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, we will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Non-Autologous Bone Marrow Transplant. Allogeneic or syngeneic graft of living bone marrow from one human being to another.

Nurse. Any one of the following who is not a member of the covered person's immediate family or employed by the hospital where the covered person is confined:

1. licensed practical nurse (L.P.N.); or
2. licensed vocational nurse (L.V.N.); or
3. graduate registered nurse (R.N.).

Oncologist. A legally licensed Doctor of Medicine certified to practice in the field of Oncology.

Pathologist. A legally licensed Doctor of Medicine certified by the American Board of Pathology to practice Pathological Anatomy.

Payable Claim. Means a claim for which American Heritage Life is liable under the terms of the policy.

Physician. Means:

1. a person performing tasks that are within the limits of his medical license; and
2. a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

American Heritage Life will not recognize the employee, his spouse, children, parents, or siblings as a physician for a claim that he sends to us.

Plan. Means a line of coverage under the policy.

Policyholder. Means the Employer to whom the policy is issued.

GLOSSARY (CONT)

Positive Diagnosis (of cancer). A diagnosis by a licensed doctor of medicine certified by the American Board of Pathology to practice Pathological Anatomy, or an Osteopathic Pathologist. Diagnosis is based on a microscopic examination of fixed tissue, or preparations from the hemic system (except for skin cancer). We accept clinical diagnosis of cancer as evidence that cancer existed in a covered person when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis and the covered person received definitive treatment for the cancer.

Positive Diagnosis (of a specified disease). A diagnosis by a qualified physician based on generally accepted diagnostic procedures and criteria.

Pre-Existing Condition. A disease or physical condition for which medical advice or treatment was received by the covered person during the 12 month period prior to the effective date of the covered person's coverage.

Radiologist. One who is licensed to administer X-ray therapy, radium therapy, or radio-active isotopes therapy and is certified by the American Board of Radiology.

Re-Enrollment Period. Means a period of time as set by your employer and us during which you may apply, in writing, for coverage under this plan, or change your coverage under this plan if you are currently enrolled.

Specified Disease. Only any one of the following:

(1) Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
(2) Muscular Dystrophy
(3) Poliomyelitis
(4) Multiple Sclerosis
(5) Encephalitis
(6) Rabies
(7) Tetanus
(8) Tuberculosis
(9) Osteomyelitis
(10) Diphtheria
(11) Scarlet Fever
(12) Cerebrospinal Meningitis (bacterial)
(13) Brucellosis
(14) Sickle Cell Anemia
(15) Thallasemia
(16) Rocky Mountain Spotted Fever
(17) Legionnaire's Disease (confirmation by culture or sputum)
(18) Addison's Disease
(19) Hansen's Disease
(20) Tularemia
(21) Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
(22) Typhoid Fever
(23) Myasthenia Gravis
(24) Reye's Syndrome
(25) Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)
(26) Lyme Disease
(27) Systemic Lupus Erythematosus
(28) Cystic Fibrosis
(29) Primary Biliary Cirrhosis

Stem Cell Transplant. A method of replacing immature blood and bone marrow cells that were destroyed by cancer treatment. The stem cells are given to the person after treatment to help the bone marrow recover and continue producing healthy blood cells.

Temporary Layoff or **Leave of Absence.** Means you are absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

Tentative Diagnosis. A tentative diagnosis is established based upon dated medical records which indicate a diagnosis of a probable or possible cancer or specified disease.

We, **Us**, and **Our.** Means American Heritage Life Insurance Company.

You. Means a person who is eligible for American Heritage Life coverage.

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AMERICAN HERITAGE LIFE INSURANCE COMPANY

HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

ENDORSEMENT

This Endorsement is made a part of the Group Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this Endorsement.

I. The CONVERSION PRIVILEGE of the General Provisions section is deleted in its entirety.

II. PORTABILITY PRIVILEGE is added to the General Provisions section as follows:

PORTABILITY PRIVILEGE

We will provide cancer or specified disease insurance portability coverage, subject to these provisions.

Such coverage will not be available for you, unless:

1. coverage under the policy terminates under the General Provision entitled "Termination of Coverage"; and
2. we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and
3. the request is made on a form we furnish or approve for that purpose.

No portability coverage will be provided for you, if your cancer or specified disease insurance under the policy terminated due to your failure to make required premium payments.

COVERAGE

The benefits, terms and conditions of the portability coverage will be the same as those provided under the policy for cancer or specified disease when the insurance terminated. Portability coverage may include any eligible dependents who were covered under the policy. Any change made to the policy after you are insured under the portability privilege will not apply to that insured unless it is required by law.

Portability coverage will be effective on the day after cancer or specified disease insurance under the policy terminates.

PREMIUMS

Premiums are due and payable in advance to us at our home office. Premium due dates are the first day of each calendar month. The premium rates are based on the table of rates in effect on any premium due date. We have the right to change the rate table on any premium due date. Written notice will be given at least 31 days before the change is to take effect.

GRACE PERIOD

The grace period, as defined, will apply to each certificate holder of portability coverage as if such insured is the policyholder.

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TERMINATION OF INSURANCE

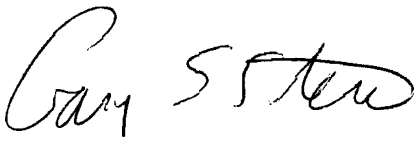
Insurance under this portability privilege will automatically end on the earliest of the following dates:

1. The date you again become eligible for cancer or specified disease insurance under the policy.
2. The last day for which premiums have been paid, if you fail to pay premiums when due, subject to the grace period.
3. With respect to insurance for dependents:
    a. the date your insurance terminates; or
    b. the date the dependents ceases to be eligible under the policy.

A dependent child whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, if he or she is otherwise eligible.

TERMINATION OF THE POLICY

If the policy terminates, insureds and family members will be eligible to exercise the portability privilege on the termination date. Portability coverage may continue beyond the termination date, subject to the timely payment of premiums. Benefits for portability coverage will be determined as if the policy had remained in full force and effect.



Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Jacksonville, Florida
(the "Company")

ENDORSEMENT

This Endorsement is made a part of the Group Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this Endorsement. This certifies that, effective January 1, 2011, the Group Policy has been amended requiring the following changes in your certificate:

I. The "Eligibility of Family Members" provision is deleted in its entirety and replaced with the following:

ELIGIBILITY OF FAMILY MEMBERS

Family members eligible to be covered persons are:

1. you; and
2. your spouse on the effective date; and
3. unmarried children of you or your spouse, including adopted children, children during pendency of adoption procedures, foster children and stepchildren, who are dependent on you for support and maintenance and under 26 years old.

A child born to you or your covered spouse, while this policy is in force as a family policy, will be a covered person. This coverage begins at the moment of birth of such child for benefits otherwise payable to a covered person under this policy. Any person who becomes a family member after the effective date (except newborns, foster children and adopted children) must be added by endorsement. No additional premium will be required for newborns, foster children, adopted children or family members added by endorsement if this policy is in force as a family policy.

Under individual coverage, newborn children are automatically covered from the moment of birth for a period of 31 days. If you desire uninterrupted coverage for the newborn child (children), you must notify us within 31 days of the child's birth. Upon notification, we will convert your coverage to family coverage and advise you of the additional premium due. If you have individual coverage and you marry and desire coverage for your spouse, you must notify us of your marriage within 31 days of the marriage and we will convert your coverage to family coverage and advise you of the additional premium due.

The provisions of this section also apply to foster children, adopted children and children during pendency of adoption proceedings as follows:

1. Coverage is retroactive from the moment of birth for a child with respect to whom a decree of adoption by you has been entered within 31 days after the date of birth.
2. If adoption proceedings have been instituted by you within 31 days after the date of birth and you have temporary custody, coverage must be provided from the moment of birth.
3. Coverage shall begin on the date of placement.

Coverage must be provided as long as you have custody of the child pursuant to decree of the court and required premiums are paid.

II. The "Termination of Coverage" provision is deleted in its entirety and replaced with the following:

TERMINATION OF COVERAGE

Your coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which you made any required premium payments; or
3. the last day you are in active employment; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible.

We will provide coverage for a payable claim that occurs while you are covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

If the child is a covered person, the child's coverage ends on the end of the month that the child is no longer eligible. This is the earlier of: (a) when the child marries; or (b) reaches age 26; or (c) is no longer dependent on you. Coverage does not terminate on an unmarried child who:

1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under this policy; and
3. is chiefly dependent upon you for support and maintenance.

Dependent coverage continues as long as this policy remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, then coverage continues during the period for which such premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida
(the "Company")

ENDORSEMENT

This Endorsement is made a part of the Group Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this Endorsement. This certifies that, effective January 1, 2016, the Group Policy has been amended requiring the following changes in your certificate:

I. The “Notice of Thirty (30) Day Right to Examine Certificate” is deleted in its entirety.

II. The “WHEN YOU CAN ENROLL OR DISCONTINUE COVERAGE” provision of the GENERAL PROVISIONS is deleted in its entirety and replaced with the following:

WHEN YOU CAN ENROLL, CHANGE OR DISCONTINUE YOUR COVERAGE

1. You may apply for coverage during:
   a. your initial enrollment period; or
   b. at a re-enrollment.
2. You may increase coverage at the next enrollment period.
3. You may decrease coverage at the next enrollment period.
4. You may discontinue your coverage at the next enrollment period.

III. The “TERMINATION OF COVERAGE” provision of the GENERAL PROVISIONS is deleted in its entirety and replaced with the following:

TERMINATION OF COVERAGE

You coverage under the policy ends on the earliest of:

1. the date the policy is canceled; or
2. the last day of the period for which you made any required contributions; or
3. the last day of the month you are in active employment; or
4. the date you are no longer in an eligible class; or
5. the date your class is no longer eligible.

We will provide coverage for a payable claim that occurs while you are covered under the policy.

If your spouse is a covered person, your spouse's coverage ends upon valid decree of divorce or your death.

If your child is a covered person, your child's coverage will end on the issue day of the month that follows when the child: (a) reaches age 26; or (b) otherwise does not meet the requirements of an eligible dependent.

Coverage does not end for an incapacitated dependent child who:

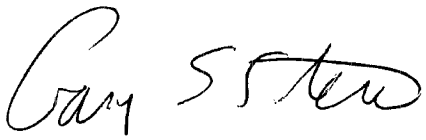
1. is incapable of self-sustaining employment by reason of mental or physical incapacity; and
2. became so incapacitated prior to the attainment of the limiting age of eligibility under the policy; and
3. is chiefly dependent upon you for support and maintenance.

Coverage for an incapacitated dependent child continues as long as the policy/certificate remains in force and the child remains in such condition. Proof of the incapacity and dependency of the child must be furnished, in writing, to us when the child reaches the limiting age of eligibility. Thereafter, such proof must be furnished as often as may be required, but no more often than annually after the child’s attainment of the limiting age for eligibility.

If we accept a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, then coverage continues during the period for which such premium was accepted. This does not apply where such acceptance was based on a misstatement of age.

Issue day means the same day of the month as the effective date of coverage.

All other requirements of the policy and/or certificate not specifically stated within this endorsement still apply.



Secretary

AMERICAN HERITAGE LIFE INSURANCE COMPANY

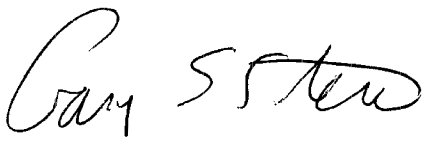
Jacksonville, Florida
(the "Company")

ENDORSEMENT

This Endorsement is made a part of the Group Certificate to which it is attached. It is subject to all of the provisions, limitations and exclusions of the Group Policy not inconsistent with this Endorsement. This certifies that, effective January 1, 2011, the Group Policy has been amended requiring the following changes in your certificate:

The Certificate Specifications page (page 3) of your certificate is amended to increase the benefit amount of your Cancer Screening Benefit from $75.00 per year to $100.00 per year.

The premium amount on the Certificate Specifications page (page 3) of your certificate has not changed.



Secretary

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AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6687
(904) 992-1776

A Stock Company

THIS IS LIMITED BENEFIT SPECIFIED DISEASE COVERAGE WHICH ONLY PROVIDES BENEFITS FOR CANCER AND SPECIFIED DISEASES AS DEFINED OR OTHER OPTIONAL BENEFITS DESCRIBED HEREIN