KANAWHA INSURANCE COMPANY

[210 SOUTH WHITE STREET, POST OFFICE BOX 610, LANCASTER, SC 29721-0610]
TELEPHONE [1-800-635-4252]

GROUP CRITICAL ILLNESS INSURANCE POLICY

POLICY NUMBER: [##########]

ISSUED TO POLICYHOLDER: [XYZ, INC.]

INITIAL EFFECTIVE DATE: [MM/DD/YYYY] POLICY RENEWAL DATES: [MM/DD/YYYY]

PREMIUMS PAYABLE: [MONTHLY]

SITUS STATE: [ANY STATE]

This Policy is a legal contract between Kanawha Insurance Company ("Company") and the Policyholder. All the provisions on this page and the following are part of this Policy.

The insurance offered by the Company is shown on the Application for this Policy. Insurance selected by the Policyholder and issued by the Company is shown on the Schedule. Insurance on Covered Persons is shown in their Certificates.

This Policy may be renewed on each Policy Renewal Date by agreement between the Company and the Policyholder. Any change in the terms will be shown on an amendment or amended Schedule.

This Policy is non-participating. This means that it will not share in the Company's profits or surplus earnings and the Company will pay no dividends on it.

This Policy is issued in and governed by the laws of the Situs State.

The Policy application may have been captured electronically or on paper. Please carefully review answers to questions on the Application to make sure they are answered correctly. If an error exists, please notify Us immediately.

Signed for the Company

[James E. Nelson] [Stanley D. Johnson]

[Secretary] [Chairman and Chief Executive Officer]

THIS IS A GROUP CRITICAL ILLNESS POLICY. IT ONLY PROVIDES STATED BENEFITS FOR SPECIFIED ILLNESSES OR OTHER BENEFITS THAT MAY BE ADDED. THIS POLICY DOES NOT PROVIDE BENEFITS FOR ANY OTHER ILLNESS OR CONDITION.

THIS IS A LIMITED POLICY. READ IT CAREFULLY. THIS POLICY DOES NOT PROVIDE BENEFITS DURING THE FIRST TWELVE MONTHS AFTER THE EFFECTIVE DATE FOR CONDITIONS THAT WERE IN EXISTENCE PRIOR TO THE EFFECTIVE DATE.

[BENEFITS REDUCE AT AGE 70.]

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU OR YOUR EMPLOYEES ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM THE COMPANY.

[THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.]

GROUP CRITICAL ILLNESS INSURANCE POLICY

NON PARTICIPATING

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SCHEDULE

[**CRITICAL ILLNESS BENEFITS**

Insureds:	[Exempt Employees] [Other Named Class] [Other Named Class]
Maximum Issue Amount:	[Exempt Employees][$###,###] [Other Named Class] [$###,###] [Other Named Class] [$###,###]
Critical Illness Face Amount	[$###,###]

_____

Benefit Groups

[Vascular:

Heart Attack	[100%] of Face Amount
Heart Transplant	[100%] of Face Amount
Stroke	[100%] of Face Amount
[Coronary Artery Bypass Surgery	[25%] of Face Amount]]

[Cancer:

Invasive Cancer or Malignant Melanoma	[100%] of Face Amount
Carcinoma in Situ	[25%] of Face Amount]

[Other Critical Illnesses:

Major Organ Transplant	[100%] of Face Amount
End Stage Renal Failure	[100%] of Face Amount
Loss of Vision, Speech or Hearing	[100%] of Face Amount
Coma	[100%] of Face Amount
Severe Burns	[100%] of Face Amount
Permanent Paralysis due to Accident	[100%] of Face Amount
Occupational HIV Benefit	[100%] of Face Amount]

_____

[Subject to the Recurrence Benefits,] [payment of Benefits within a Benefit Group will not exceed [100%] of the Face Amount.] [Subject to the Recurrence Benefits,][payment of Benefits within the Vascular and Cancer Benefit Groups will not exceed [100%] of the Face Amount and Other Critical Illnesses Benefit Group will not exceed [50%] of the Face Amount.]

[Vascular][,][Cancer][and][Other] Critical Illness Benefits reduce by 50% at Age 70]

[Recurrence Benefit (limit one per Covered Person)	[100%] of the Benefit previously paid for the recurring Critical Illness]
[Loss of Work Benefit	Maximum [#] Months, Waiver of Premium when the Covered [Employee] is Laid Off, Locked Out or On Strike]

SCHEDULE

[Automatic Benefit Increase	Increases the Critical Illness Face Amount by [$2,000] on each increase date] [Employee] must be less than Age [##] on the increase date]
[Waiver of Premium Benefit	Waives Certificate Premiums when Covered [Employee] is Totally Disabled for more than 180 days. [Limit [6] months.]]
[Health Screening Benefit	If one or more covered Health Screening Tests are performed, [$###] per calendar year]

[Face Amount Payable [reduces by [xx%]] [at][on]	[Age ##]
[and] [Benefits] [end][at][on][on the following]]	[Age ##]

Policy Benefits are limited to the Maximum Issue Amount, or the Face Amount selected by the Covered [Employee], if less.

[Evidence of Insurability is required if any Face Amount applied for is [$###,###] or more.]

[Family Option:

[Spouse]	[Benefit Limited to] [50] % of the [Exempt] [Employee]'s Benefit]	[$###,###]
[Child(ren)]	[Benefit Limited to] [50] % of the [Exempt] [Employee's] Benefit]	[$###,###]

[[ELIGIBILITY

[Classes of Eligible [Employees]:]	**[Classes of Eligible Dependents:]**
[Exempt Employees]	[Spouses of Insured Eligible [Employees]]
[Other Named Class]	[Children of Insured Eligible [Employees]]
[Other Named Class]	

[[Eligibility Requirements for Eligible [Employees]]

[In order to Enroll, an Eligible [Employee] must be [Actively at Work (Active Employment)]:

[for [Exempt Employees] Actively At Work means [40] hours per [week]]

[for [Other Named Class] Actively At Work means [40] hours per [week]]

[for [Other Named Class] Actively At Work means [40] hours per [week]]]

[[[Waiting Periods for Eligible [Employees] are as follows:]

[[Exempt Employees] are Eligible to Enroll on Date of Employment]

[[Other Named Class] are Eligible to Enroll after Active Employment for [30 days]]

[[Other Named Class] are Eligible to Enroll after Active Employment for [90 days]]]

[However, if an Eligible [Employee] is not Actively At Work at the end of the Waiting Period, the Waiting Period will be extended until the Eligible [Employee] resumes work in a pattern that will establish Active Employment.]

[Eligible [Employees] must be Age [##] but not more than Age [##].] The Maximum Renewal Age is to Age [##]. [However, an [Employee] who remains Actively At Work after Age [##] will remain an Eligible Employee.]

[Additional Eligibility Requirements for Dependents]

[Waiting Periods for Eligible [Employees] apply to their Eligible Dependents.]

[Spouses of Insureds must be Age [##] but not more than Age [##].] [A Spouse who is an Eligible [Employee] may be covered as an Insured or a Spouse, but not both.]

[Children of Insureds must be Age [##] but not more than Age [24].] [A child who is an Eligible [Employee] may be covered as an Insured or a Child, but not both.]

[EFFECTIVE DATES FOR CHANGES IN AMOUNTS OF INSURANCE]

[Increases in the amount of insurance based on Policy provisions will occur [on the first day of the [Calendar Month] following the change].]

[If Evidence of Insurability is not required, increases requested by the Insured will occur [on the first day of the [Calendar Month] following the change request].]

[If Evidence of Insurability is required, increases requested by the Insured will occur [on the first day of the [Calendar Month] after We approve the Evidence of Insurability].]

[Decreases requested by the Insured will occur on [the first day of the [Calendar Month]] following receipt of the written request by the Policyholder.]

[Decreases on account of Age will occur on the [first day of the [Calendar Month]] following the Age change.]]

ELIGIBILITY TO ENROLL

A person is Eligible to Enroll when He or She:

- is a member of a Class of Eligible [Employees] listed on the Schedule; and
- meets the Eligibility Requirements shown on the Schedule.

EFFECTIVE DATE OF INSURANCE

Subject to payment of Premium, insurance starts when a person:

- joins a Class of Eligible [Employees];
- meets the Eligibility Requirements shown on the Schedule; and
- completes an Enrollment Form, if required.

However, if the Eligible [Employee] does not Enroll, insurance will not become effective until the first day of the [Calendar Month] following a later Enrollment.

We may require Evidence of Insurability if Enrollment takes place more than [30] days after [an][a] [Employee] first becomes Eligible.

The Face Amount available without Evidence of Insurability is shown on the Schedule.

EFFECTIVE DATE FOR CHANGES IN THE AMOUNT OF INSURANCE

Changes will occur on the dates specified on the Schedule.

BENEFITS

Benefits and Face Amounts selected by the Policyholder and approved by the Company are shown on the Schedule of this Policy.

Benefits shown on the Certificate are available:

- to persons Eligible;
- who have Enrolled for the Benefits;

- are covered under the terms and conditions of this Policy; and
- for whom Premiums are paid.

Changes to the amount of insurance based on Age, Class or other factors agreed to by the Company and the Policyholder are shown on the Schedule.

All Benefits of this Policy are subject to the Benefit Conditions, Limitations and Exclusions provision.

[VASCULAR BENEFITS

Heart Attack Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person has suffered a covered Heart Attack.

Heart Transplant Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person:

- demonstrates Heart Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the whole heart.

Heart Transplant under this Policy includes a heart lung transplant.

Stroke Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person has suffered a covered Stroke.

[Coronary Artery Bypass Surgery Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person has undergone a covered Coronary Artery Bypass Surgery.]]

[CANCER BENEFITS

Invasive Cancer or Malignant Melanoma Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person suffers from a covered Invasive Cancer.

Carcinoma in Situ Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person suffers from a covered Carcinoma in Situ.]

[OTHER CRITICAL ILLNESSES BENEFITS

Major Organ Transplant Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person:

- demonstrates Major Organ Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing Major Organ.

Major Organ Transplant does not include:

- Heart Transplant; or
- Heart Lung Transplant.

End Stage Renal Failure Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person suffers from a covered End Stage Renal Failure.

Loss of Vision, Speech or Hearing Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person suffers from a Covered:

- Loss of Vision;
- Loss of Speech; or
- Loss of Hearing.

Coma Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person suffers from a covered Coma.

Severe Burns Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person has suffered covered Severe Burns caused by an Accident.

Permanent Paralysis Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person suffers from a covered Permanent Paralysis caused by an Accident.

Occupational HIV Benefit

We will pay this Benefit when We receive Proof of Loss showing that a Covered Person suffers from an Occupational HIV.]

[RECURRENCE BENEFIT

We will pay this Benefit one time if a Covered Person is diagnosed for a second time with one of the named Critical Illnesses for which We paid a Benefit before. The Benefit is shown on the Schedule. This is subject to the following:

- the second diagnosis must follow the first by more than [12] months;
- the Covered Person must not have received treatment during a [12] consecutive month period between the two diagnoses; and
- the second diagnosis must take place while the Covered Person's coverage is in effect.

For the purposes of this Benefit, "treatment" does not include:

- preventative medications in the absence of disease; or
- routine scheduled follow-up visits to a Physician.

This Benefit is available once for a Covered Person during the entire time that His Certificate is in force.

When this Benefit is paid, it ends for the Covered Person. No Recurrence Benefit will be paid thereafter for recurrence of any Critical Illness of the Covered Person.]

[LOSS OF WORK BENEFIT

We will provide this Benefit if the Insured suffers a Loss of Work that:

- starts more than 30 days after the Effective Date of Insurance; and
- continues for 30 or more consecutive days.

[The 30-day period after the Effective Date of Insurance will be reduced by one day for each day that a Replaced Policy was in force.]

We will waive Premiums of the Insured's Certificate. Premiums will be waived as they fall due beginning on the 31st day of the Loss of Work.

We will waive Premiums for a maximum of [six (6) months] during a continuous Loss of Work. Losses of Work separated by less than six (6) months are considered continuous.

We will waive Premiums for not more than [12] months for all Losses of Work occurring while this Benefit is in force.

We will refund any Premium paid but not due.]

[AUTOMATIC BENEFIT INCREASE

Subject to other terms of this Benefit, We will:

- increase the Face Amount by the amount shown on the Schedule; and
- give the Insured an endorsement showing the new Face Amount.

Increases will occur on the [first] through the [fifth] anniversaries of the Insured's [Date of Certificate] , so long as the [Employee] is less than Age [##] on that date.

[When a Recurrence Benefit is paid, it will include any increase since the last date of loss.]

However, if an increase will cause coverage to exceed the Maximum Issue Amount:

- We will limit the increase and the Premium charged for it so that the sum of coverage equals the Maximum Issue Amount; and
- this Benefit ends.

The Premium for the additional insurance will be based on the Age of Covered Persons on the increase dates.

Before each increase, We will send the Insured a statement showing:

- the amount of the increase; and
- the new total Certificate Premium.

Before or within 30 days after any increase:

- the Insured can decline it by sending Us a written request;
- the increase will then be void; and
- We will refund any Premium paid for the increase.

No increases will be offered:

- after the Insured declines an increase;
- when Premiums for the Insured's coverage are no longer paid by or through the Employer; or
- after the date that a Recurrence Benefit is paid.]

[WAIVER OF PREMIUM BENEFIT

We will waive Premiums from the first day of Total Disability when the Insured's Total Disability:

- starts while this Policy and His Certificate are in force or in the Grace Period;
- starts before the Certificate Anniversary following His 60th birthday; and
- continues without interruption for at least 180 days.

Waiver will start on the first day of Total Disability. We will waive Premiums:

- as they fall due while the Insured remains Totally Disabled; and
- using the mode of Premium payment that was in effect when Total Disability began.

We will not end a claim if the Insured attempts to return to work for 14 days or less.]

[HEALTH SCREENING BENEFIT

We will pay the amount shown on the Schedule if, during a [Calendar] Year, a Covered Person has one or more of the following tests performed more than 90 days after the Date of Certificate.

- Bone Marrow Testing
- CA-125 (blood test for ovarian cancer)
- Chest x-ray
- Flexible Sigmoidoscopy
- Mammography (including breast ultrasound)
- PSA (blood test for prostate cancer)
- Biopsy for Skin Cancer
- Electrocardiogram (EKG) (including stress EKG)
- Blood Test for Triglycerides]
- CA 15-3 (blood test for breast cancer)
- CEA (blood test for colon cancer)
- Colonoscopy
- Hemocult stool analysis
- Pap Smear (including ThinPrep Pap Test)
- Serum Protein Electrophoresis (test for myeloma)
- Stress test (bike or treadmill)
- Lipid Panel (total cholesterol count)
- Oral Cancer Screening using ViziLite, OraTest or other Current Dental Terminology © Code D0431

[The 90-day period will be reduced by one day for each day that a Replaced Policy was in force.]]

PAYMENT OF BENEFITS

We will pay Benefits when We receive Proof of Loss acceptable to Us. Benefits are subject to the Benefit Conditions, Limitations and Exclusions provision.

BENEFIT CONDITIONS, LIMITATIONS AND EXCLUSIONS

A Critical Illness must be diagnosed during the lifetime of the Covered Person.

Any loss due to a Pre-existing Condition will not be covered if the loss begins within [12] months after the Covered Person's Effective Date of Insurance. [However, Benefits may be paid for a loss due to a Pre-existing Condition of a Covered Person who was covered:

- by a Replaced Policy; and
- by this Policy on its Initial Effective Date.

1. We will review the claim. If this Policy's Pre-Existing Condition Exclusion does not apply, We will pay the Benefits of this Policy.

2. If the Covered Person does not satisfy this Policy's Pre-Existing Condition Exclusion, but can satisfy the Replaced Policy's pre-existing condition exclusion giving credit for all time insured under both policies; then We will pay the lesser of:

   (a) this Policy's Benefit without applying the Pre-Existing Condition Exclusion; or
   (b) the Benefit of the Replaced Policy.

   Any payment under "(a)" or "(b)" above will be in accord with all terms of the relevant policy.

3. If the Covered Person does not satisfy the Pre-Existing Condition Exclusion of this Policy or that of the Replaced Policy, no Benefit will be paid.]

When a named Critical Illness is contributed to or caused by another named Critical Illness, We will pay only one Benefit. The Benefit paid will be the larger. If the Benefits are equal, the Insured may choose the Benefit to be paid.

[A Tentative, Clinical or Pathological Diagnosis of Invasive Cancer during the 30-day period after a Covered Person's Effective Date of Insurance is not Covered.] [The 30-day period is reduced by one day for each day that a Replaced Policy was in force.]

[Benefits for Invasive Cancer or Carcinoma in Situ will not be payable based on a Tentative Diagnosis.]

[When We pay a sum equal to the Face Amount in a Benefit Group, the Automatic Benefit Increase ends for that Benefit Group.]

[The Automatic Benefit Increase ends when coverage is ported.]

[Except as provided in the Recurrence Benefit,]all Vascular Benefits end when We have paid [100% of] a Covered Person's Face Amount for any of the following:

- Heart Attack;
- Heart Transplant; [or]
- Stroke.]

[When We pay a Benefit for Coronary Artery Bypass Surgery, the Face Amount for other Vascular Benefits is reduced by [25%].]

[Except as provided in the Recurrence Benefit,]all Cancer Benefits end when We have paid [100%]of a Covered Person's Face Amount for Invasive Cancer.

[When We pay a Benefit for Carcinoma in Situ, the Face Amount for Invasive Cancer is reduced by [25%].]

[Except as provided in the Recurrence Benefit,] all Other Critical Illness Benefits end when We have paid [100%] of a Covered Person's Face Amount for any of the following:

- Major Organ Transplant;
- End Stage Renal Disease;
- Loss of Vision, Speech or Hearing;
- Coma;
- Severe Burns;
- Permanent Paralysis; or
- Occupational HIV.]

No Benefits of this Policy will be paid for loss that is contributed to, caused by, or occurs during;

- any intentionally self-inflicted injury;
- suicide, or attempted suicide, while sane or insane;
- active duty military service;
- participation in the commission or attempted commission of a felony;
- being intoxicated or under the influence of alcohol, drugs or any narcotic (including overdose) unless administered on, and taken in accordance with, the instructions of a Physician;
- psychosis; or
- alcoholism or drug addiction.

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of Claim must be given to Us within [30] days after the date of a loss. If that is not possible, We must be notified as soon as it is reasonably possible to do so.

When We receive written notice of Claim, We will send claim forms. If the Claim forms are not received within [15] days after the notice is sent, written proof of Claim can be sent to Us without waiting for the forms.

PROOF OF LOSS

Proof of Loss must be given to Us within [90] days after a loss occurs or starts.

If it is not possible to give proof within this time limit, it must be given as soon as reasonably possible. Proof of Loss may not be given later than one year after the time such proof is otherwise required, except if the individual is legally unable to provide it.

Proof of Loss includes a Claim Form or other documents satisfactory to Us.

Proof of Loss may also include statements completed by the Insured and/or the claimant, [the Employer] and the attending Physician documenting:

- the nature of the loss;
- the date, or inclusive dates, of loss; and
- the cause of loss.

[For the Waiver of Premium Benefit, We may require Proof of Loss on a monthly basis. We will not require such Proof of Loss on a monthly basis when it is no longer reasonably necessary to do so.]

[For the Loss of Work Benefit, Proof of Loss includes documentation from the Insured's Employer and/or union that He is Laid Off, Locked Out, or On Strike.]

On request, We will tell the Insured or other claimant what forms or documents are required.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

We will give the Insured or the claimant a Claim Form upon request. He or She is responsible for any costs to complete the Claim Form.

We may ask for other Proof of Loss from hospitals and Physicians. We will pay the reasonable cost of obtaining these records.

PAYMENT OF CLAIMS

Benefits will be paid to the Insured. If the Insured does not live to receive payment, any Benefit will be paid to His or Her:

- Beneficiary, if one is named; or
- estate.

If Benefits are payable to the Insured's estate or to a Beneficiary who cannot give Us a valid release, We can pay up to $1,000 to someone related to the Insured, by blood or marriage, whom We find is justly entitled to payment. Such a payment made in good faith will discharge Us to the extent of the amount paid.

The [Employee] may assign proceeds of a Claim. Assignment of a Certificate as collateral security is not allowed.

PAYMENT OF BENEFITS TO THE TEXAS DEPARTMENT OF HUMAN SERVICES

All benefits paid on behalf of a covered dependent Child under this Policy must be paid to the Texas Department of Human Services whenever;

1. The Texas Department of Human Services is paying under the Human Resources Code, Chapter 31 or 32, which is the financial and medical assistance service program administered pursuant to the Human Resources Code; and
2. The parent who purchased this Policy has possession or access to the covered dependent Child pursuant to a court order, or is not entitled to access or possession and is required to pay child support; and

We receive written notice affixed to the insurance claim, when the claim is first submitted, which states that all benefits paid pursuant to this provision must be paid directly to the Texas Department of Human Services.

TIME PAYMENT OF CLAIMS

Payment will be issued upon receipt of Proof of Loss acceptable to Us but not later than [30] days after receipt of Proof of Loss.

EXAMINATION AND AUTOPSY

We, at Our own expense, will have the right and opportunity to have a claimant examined by a Physician of Our choice. This right may be exercised as often as reasonably required.

We, at Our own expense, will have the right to have an autopsy performed in the case of death, where autopsy is not forbidden by law.

CONTINUATION OF INSURANCE

Insurance may be continued under certain conditions when the Insured is no longer an Eligible [Employee]. The Policyholder must treat all [Employees] in the same way when continuing coverage.

As Required by Law or Regulation

The Policyholder will continue insurance on Covered Persons if required to do so by state or federal law or regulation.

The Company does not have nor does it assume, either expressly or impliedly, any responsibility for any such Policyholder obligation.

[For Non-Medical Reasons

The Policyholder may continue insurance for up to [twelve (12) months] for Insured persons absent from work due to temporary layoff, suspension of business operations, or Policyholder-approved leave of absence.]

[For Illness or Accidental Injury

The Policyholder may continue insurance for Insured persons absent from work due to Total Disability. This continuation will end on the earliest of the following dates:

- [180 days] after Total Disability began;
- [the date from which We approve a Waiver of Premium;] [or]
- the Policy termination date.]

[PORTABILITY

Portability Benefit

Portability allows a Covered [Employee] to keep this Policy's Benefits at certain times when His coverage would otherwise end. This is subject to the Benefit Conditions, Limitations and Exclusions.

Coverage is provided under the terms and conditions of this Policy.

When Portability is Available

Subject to the Portability Benefit Conditions and Limitations provision, a Covered [Employee] may port Benefits when He or She:

- has been continuously covered by this Policy for at least [6] months;
- is less than Age [70];
- is not Totally Disabled; and
- is no longer Actively At Work as an Employee.

This Policy must be in force on the date that the Covered [Employee] ports coverage.

How to Exercise Portability

The Covered [Employee] must, within [46] days after the date that His or Her coverage would end:

- submit written application on a form approved by the Company; and
- pay the first Premium for ported coverage.

Effective Date of Ported Insurance

When the first Premium for ported insurance is paid, coverage will start on the date that coverage under this Policy would have ended.

Premiums and Premium Due Dates

The Covered Employee must pay Premiums to the Company by [monthly bank draft] or other mode of Premium payment that We approve.

After insurance is effective there is a 31-day Grace Period for each Premium due. If the Premium due is not paid, the Grace Period begins on the day of the month that coverage began. Coverage remains in effect during the Grace Period.

The Premium rate and Premium changes that apply to a Class will apply to former Class members who have ported.

Premiums may differ between certificates based on the amount of insurance or changes in the amount of insurance.

We may add a billing fee to the Class rate applicable to ported Certificates.

If Premiums for a Class change, We will provide at least a [45-day] advance written notice to persons who have ported coverage.]

Amount of Insurance

Subject to the Changes to Amount of Ported Coverage provision, insurance provided will be that which was in effect on the day prior to the Effective Date of Ported insurance.

Changes to Amount of Ported Coverage

Benefits provided under the Portability provision cannot be increased.

If the [Employee decreases or ends a Ported Benefit, any change in Premium will take place on [the first day of the [Calendar Month]] after We receive the request.

When insurance decreases or ends for a Class, the decrease or termination will apply to former members of the Class who have ported.

Termination of Ported Insurance

Ported insurance for the Covered [Employee] and any covered Eligible Dependents ends on the earliest of the following dates:

- when the Insured requests termination;
- at the end of the Grace Period, if the Premium is not paid;
- when the [Employee] reaches the Maximum Renewal age;
- a date or Age for termination of insurance for the Covered Person shown on the Schedule;
- for a Spouse or Child, when He or She no longer meets this Policy's definition of Spouse or Child;
- for a Spouse, Age [##];
- for a Child, Age [##];
- on the next Premium due date following the Insured's death;
- when coverage of the Class to which the Insured belonged prior to Porting ends; or
- when this Policy ends.

Portability Benefit Conditions and Limitations

Unless stated, any changes to the Policy apply to ported insurance.

A Totally Disabled Insured is not eligible to use this Benefit.

[A Covered [Employee] cannot port while absent from work due to:

- temporary layoff;
- suspension of business operations; or
- Policyholder-approved leave of absence for non-medical reasons.]

An Insured is not eligible to port while Policy coverage is continued based on a state or federal law, regulation or rule.

An Insured is not eligible to Port when this Policy ends.]

TERMINATION OF INSURANCE – COVERED PERSONS

Subject to the Continuation of Insurance [and Portability] provision[s], all insurance ends on the earliest of the following dates:

- [the [Employee]'s retirement;]
- the Maximum Renewal Age shown on the Schedule[, except that an [Employee] who remains Actively At Work may continue the coverage];
- the end of the Grace Period, if Premium for this coverage is not paid;
- the end of the [Calendar Month] when the Covered Person is no longer Eligible;
- this Policy's termination date;
- the end of the [Calendar Month] when We receive a request to end this insurance;
- [the date that a Spouse reaches Age [##];]
- [the date that a Child reaches Age [25]; [or]
- the Covered [Employee's] death.

[If a Recurrence Benefit is paid for a Covered Person, the Recurrence Benefit for that person ends.]

When the Insured's coverage ends, insurance on other persons covered by the certificate will also end.

Termination of insurance on a Covered Person or of the Policy is without prejudice to claims that occur or start prior to the date of termination.

VOLUNTARY TERMINATION

We must receive notification of voluntary terminations. The date that coverage ends will be the last day of the [Calendar Month] in which the termination took place. If the Policyholder fails to report voluntary termination of Covered Persons, Our liability shall be limited to a return of Premium back to the date on which insurance should have ended, less any Claims paid during this period.

POLICY RENEWAL, AMENDMENT AND TERMINATION

POLICYHOLDER RENEWAL

With Our consent, the Policyholder may renew coverage on each Policy Renewal Date. This is subject to the payment of Premiums.

Insurance will end at 11:59 p.m. local time at the Policyholder's mailing address as shown in Our records on the day before the anniversary date if it is not renewed, unless it ends as provided in the Termination of Policy provision.

POLICY AMENDMENT

With Our consent, the Policyholder may amend Policy provisions to add, modify or delete Benefits or other provisions.

On any Policy Renewal Date, We may amend this Policy to add, modify or delete Benefits or other provisions. We will give the Policyholder at least [31-days] advance written notice of any such change.

Deletion or reduction of a Benefit is without prejudice to any Claim that took place or started prior to the date of the change.

A change in or deletion of Benefits may change the Premiums charged.

POLICY TERMINATION

The Policyholder has the right to cancel this Policy on any Premium due date. Written notice must be given to Us at least [45] days before the date this Policy is to end.

We have the right to cancel this Policy on:

- any Policy Renewal Date; or
- any Premium due date.

[However, if We have given a Rate Guarantee, We will not cancel this Policy except at the end of such Rate Guarantee period.] We will give the Policyholder at least [45] days' notice before this Policy is to end.

This Policy and its insurance shall end if the Policyholder fails to pay the Premium before the end of the Grace Period.

Termination is without prejudice to any Claim that takes place or starts prior to the date of termination.

PREMIUM PROVISIONS

PREMIUMS

Premiums are payable to the Company.

The first Premium is due on the Initial Effective Date. Later Premiums are due according to the mode of Premium payment shown on the face page of this Policy.

We actuarially determine the Premiums. We reserve the right to change the Premiums as stated in the Change in Premium provision.

CHANGE IN PREMIUM

We may change the Premium rates:

- [when the number of Insureds covered changes by [20%] or more after the Initial Effective Date, or the last renewal date, if later;]
- [the number of Insureds covered falls below [###,###] after the Initial Effective Date, or the last renewal date, if later;]
- [whenever Policy terms or conditions are modified;]
- [there is a material change in the risk insured];
- [the Policyholder is sold or merges with another entity];
- [the Policyholder purchases, acquires or establishes a new affiliate or subsidiary]; or
- [on any Policy Renewal Date.]

[However, if the Company has given a Rate Guarantee, We will not change Premiums except at the end of such Rate Guarantee period.]

We will provide the Policyholder with at least 60 days advance notice of any Premium rate change.

PREMIUM REFUNDS

If We receive Premiums for periods after Eligibility ends, We will refund Premiums paid after the end of Eligibility. [In all other cases, We will refund Premiums paid since the last Policy Renewal Date.]

GENERAL PROVISIONS

AGREEMENTS AND POLICY CHANGES

No change in this Policy shall be valid unless made by endorsement or amendment. Such a change is valid only if signed by Our Chairman, Chief Executive Officer, President, a Vice President or the Secretary.

No other person can waive any Policy terms or make any agreements about this policy that are binding on Us.

ASSIGNMENT

The Insured may assign proceeds of a Claim.

Assignment of this Policy or of a Certificate is not allowed.

We are not responsible:

- for the validity of any Assignment; or
- to honor any Assignment unless it is given to Us with any claim subject to the Assignment.

Our payment in good faith as outlined above will fully discharge Us with respect to the amount(s) paid.

BENEFICIARY, CHANGE OF BENEFICIARY

Benefits will be paid as stated in the Payment of Claims provision.

The Insured may add or change the Beneficiary by filing a form with the Policyholder.

We are not:

- responsible for the validity of any Beneficiary designation, or
- required to honor any Beneficiary designation unless it is given to Us with any affected claim.

CERTIFICATES

We will give a Certificate to the Policyholder for delivery to each Insured stating:

- the insurance protection provided, including;
- any insurance for Spouse and/or Children; [and]
- to whom the insurance Benefits are payable[;] [and]
- [the Portability rights provided by this Policy.]

CLERICAL ERROR

No Clerical Error by the Policyholder will:

- delay the Effective Date of a Covered Person's insurance;
- end insurance otherwise validly in force; or
- continue insurance otherwise validly terminated.

CONFORMITY WITH STATE

Any Policy wording that, on the Initial Effective Date, is in conflict with the statutes of the Situs State is hereby amended to meet the minimum requirements of such statutes.

DATA REQUIRED

The Policyholder will give Us all data and proof that We may reasonably need to administer this Policy.

[DATE OF BIRTH

If a Covered Person's date of birth is misstated, We will adjust the Benefits payable. The Benefits will be those which We would have issued based on the correct information.]

ENTIRE CONTRACT

This Policy, the Application attached to this Policy, Enrollment forms and Evidence of Insurability as well as any endorsements and amendments shall make up the entire contract.

Statements made by the Policyholder or Insured individuals shall be deemed representations and not warranties.

EVIDENCE OF INSURABILITY

We may require evidence that a person meets our underwriting standards for this insurance.

[FIDUCIARY

For purposes of the Employee Retirement Income Security Act of 1974 (ERISA) , the Policyholder is the:

- Plan Sponsor;
- Plan Administrator; and
- Named Fiduciary.

Neither the Company, its parent nor any of its affiliates is the Plan Sponsor, Plan Administrator or Named Fiduciary.

The Company does not have nor does it assume, either expressly or impliedly any responsibility for the Policyholder's obligations or compliance under:

- ERISA;
- COBRA; or
- any other applicable federal or state law, regulation or rule.]

GRACE PERIOD

This Policy has a Grace Period of thirty-one (31) days for the payment of any Premium due except the first.

During the Grace Period, this Policy is in force, unless the Policyholder gives Us written notice to cancel it before the end of the Grace Period. The Policyholder shall be liable to Us for the payment of a pro-rata premium for the time this Policy was in force during the Grace Period.

INCONTESTABILITY

The validity of this Policy will not be contested except for nonpayment of Premiums after it has been in force for [two (2)] years from its Initial Effective Date.

In the absence of fraud, no statement made by any person insured shall be used in any contest unless a copy of the statement is or has been furnished to:

- the person insured; or,
- in the event of death or incapacity of the person insured, to His or Her beneficiary or personal representative.

In the absence of fraud and except for claims incurred within [two (2)] year[s] after a Covered Person's Effective Date of Insurance, no statement made by any person insured when applying for insurance will be used to contest the validity of that insurance after:

- the insurance has been continuously in force for [two (2)] years during the lifetime of the person insured; and
- unless it is contained in a written form signed by the Insured.

This provision shall not preclude the assertion at any time of defenses based upon Policy provisions that relate to eligibility for coverage.

LEGAL ACTIONS

Legal action cannot be taken against Kanawha Insurance Company:

- Sooner than 60 days after due Proof of Loss has been filed; or
- 3 years after the time written Proof of Loss is required to be filed according to the terms of the Policy.

NON-PARTICIPATING

This Policy is a non-participating policy. We will not pay dividends on this Policy.

DEFINITIONS

For the purposes of this Policy when these words are used in this Policy, they have the meanings stated.

Accident means a sudden, unexpected, violent and external event that causes bodily Injury to a Covered Person.

[Actively At Work (Active Employment) means the person must be working:

- on a full-time basis and paid regular earnings;
- at least the minimum number of hours shown in the Schedule;
- at the Employer's usual place of business; or
- at a location to which the Employer's business requires the person to travel.

A person must be considered Actively At Work if the Employee was actually at work on the day immediately preceding:

- a weekend;
- holidays;

- paid vacations;
- any non-scheduled work day;
- excused leave of absence (except medical leave and lay-off); or
- emergency leave of absence (except emergency medical leave required by His Illness or Injury).

[Persons classified as [part-time][or][temporary] workers by the Employer or Policyholder are not Actively At Work except as agreed between the Policyholder and the Company.]

[Persons on strike are [not] Actively At Work [except][as] agreed by the Policyholder and the Company.]

[The Active Employment must be for an Employer that has a workforce of Employees who are Eligible for Policy Coverage.]]

Application means the forms the Policyholder completed when applying for this Policy that are attached to this Policy.

Age means the Age of a Covered Person on His or Her last birthday as of the Initial Effective Date.

If coverage is effective after the Initial Effective Date, Age means age as of the last birthday preceding the request for insurance coverage.

[Association means an entity that:

- has been actively in existence for at least [5] years;
- has been formed and maintained in good faith for purposes other than obtaining insurance;
- does not condition its membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee);
- makes insurance coverage it offers available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member);
- does not make insurance coverage it offers available other than in connection with a member of the association; and
- meets any additional requirements that may be imposed under laws of the Situs State.]

Benefit Group means a set of Critical Illnesses that is shown on the Schedule for which the Policy pays Benefits.

[Calendar Month means any of the named months, January through December.]

[**Calendar Year** means a 12 month period, [January 1 through December 31.]]

Carcinoma In Situ means a diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

Carcinoma in Situ does not include:

- Prostate cancer histologically classified as Gleason score of less than 7, or TNM classification less than T2NOMO;
- Malignant melanoma of less than 1.0 mm. maximum thickness as determined by histological examination using the Breslow method;
- other skin malignancies;
- pre-malignant lesions (such as intraepithelial neoplasia); or
- benign tumors or polyps.

Carcinoma in Situ must be identified pursuant to a Pathological or Clinical Diagnosis. Pathological or Clinical Diagnosis must occur after the Effective Date of Insurance.

Certificate of Insurance (Certificate) means the document We issue for delivery to each Insured stating the protection to which He or She is entitled, to whom We will pay Benefits and a statement of any family member's or dependent's coverage.

[Child (Children) means a person who is a:

- natural or adopted child of the Insured or Spouse;
- Child placed with the Insured for adoption;
- an unmarried grandchild who is age 24 or younger and dependent upon the Insured or Spouse for federal income tax purposes at time of the child's application for coverage; or
- stepchild of the Insured.

Child does not include a:

- person not meeting the above Child definition;
- Child living outside of the United States (unless living with an Insured); or
- Child on active military duty for a period in excess of [30] days.]

[**Class** means a group of persons that We and the Policyholder have agreed to insure.]

Clinical Diagnosis means a clinical identification of Invasive Cancer or Carcinoma in Situ based on history, laboratory study and symptoms. We will pay benefits for a Clinical Diagnosis only if:

- a pathological diagnosis cannot be made because it is medically inappropriate or life threatening;
- there is medical evidence to support the diagnosis; and
- a Physician is treating the Covered Person for Cancer.

[**Coma** means a state of complete and continuous unconsciousness not less than [24-96] hours in duration which exhibits an inability to be aroused or to respond to external stimuli aside from primitive avoidance reflexes.

The diagnosis of Coma must be made by a board-certified Neurologist.

Benefits are not payable for medically-induced comas.

Payment of benefit is based upon Date of Diagnosis made after the Effective Date of Insurance.]

[Coronary Artery Bypass Surgery means major surgery requiring median sternotomy (division of breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a cardiologist.

Diagnosis of coronary heart disease must be made by accepted angiography testing.

The following procedures are not considered coronary artery by-pass surgery: balloon angioplasty, laser embolectomy, atherectomy, stent placement, or other non-surgical procedures.

Payment of benefits is based upon Date of Diagnosis made after the Effective Date of Insurance.]

[Covered Employee means the Eligible Employee, when covered by this Policy.]

[Covered Employee also means a person who has ported coverage as allowed by the Portability provision.]

[Covered Member means the Eligible Member, when covered by this Policy.]

[Covered Member also means a person who has ported coverage as allowed by the Portability provision.]

Covered Person means an eligible [Employee] or Eligible Dependent who is covered under this Policy. Persons eligible for coverage are shown on the Schedule.

[**Credit Union** means an institution that is chartered to operate as a Credit Union by the National Credit Union Administration or by a state regulatory body.]

Critical Illness means:

[• Heart Attack;
• Heart Transplant; [or]
• Stroke[;] [or]
• [Coronary Artery Bypass Surgery;]]
[• Invasive Cancer or Malignant Melanoma; [or]
• Carcinoma in Situ[;]] [or]
[• Major Organ Transplant;
• End Stage Renal Failure;
• Loss of Vision, Speech or Hearing;
• Coma;
• Severe Burns;
• Permanent Paralysis; or
• Occupational HIV.

Date of Diagnosis means the earliest of the date of:
- Tentative Diagnosis;
- Clinical Diagnosis; or
- the day the tissue specimen, culture and/or titer(s) are taken, upon which the Tentative or Pathological Diagnosis of Invasive Cancer or Carcinoma in Situ is made.

Eligible Dependents means a Spouse, His or Her Child(ren) and the Child(ren) of an Eligible [Employee].

We must approve eligibility of the Spouse and Child(ren) of an [Employee].

Each such person must meet the Eligibility requirements shown in the Schedule.

If a Child is covered by this Policy, the Child's Eligibility will not end if the Child is and remains:
- unmarried;
- incapable of self-sustaining employment due to mental incapacity or physical handicap; and
- chiefly dependent on the [Employee] or Spouse for support.

However, in no event will Eligibility or coverage of any Child continue beyond the date that the [Employee's] coverage ends.

The [Employee] must furnish Us with proof of physical or mental incapacity within 31 days after the Child's Eligibility would otherwise end. Thereafter, We may require proof, but not more frequently than annually.

[Eligible Employee means a person who:
- is in Active Employment of the Policyholder; and
- meets the Enrollment Eligibility, Qualification Period and Maximum Renewal Age provisions shown in the Schedule.]

[Eligible Person means someone who:

- is a Member in good standing of the Policyholder; and
- meets any other Eligibility Requirements for Eligible Members shown on the Schedule.]

[Employer means an entity that employs a workforce of persons in Active Employment. Employer includes any division, subsidiary or affiliated company named in the Application.]

End-Stage Renal Failure means End Stage Renal disease which:

- results in chronic irreversible failure of both kidneys to function; and
- which requires a Covered Person to undergo regular renal dialysis at least weekly.

The diagnosis of End Stage Renal Failure must be made by a Physician, after the Effective Date of Insurance .

Enroll means application by an [Eligible Employee] for Policy coverage. By agreement between the Company and the Policyholder, Enrollment may:

- require completion of an Enrollment Form by the [Eligible Employee];
- be automatic, in which case it is not necessary for the [Eligible Employee] to complete an Enrollment Form; and
- require Evidence of Insurability.

Evidence of Insurability means a form acceptable to Us showing that a person meets Our requirements for coverage under this Policy.

Heart Attack (Myocardial Infarction) means the death of a portion of the heart muscle resulting from blockage of one or more coronary arteries. A covered Heart Attack is one that:

- displays new EKG changes consistent with and supporting the diagnosis of Heart Attack;
- exhibits elevation of cardiac enzymes above generally accepted laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used);
- is confirmed by imaging studies such as thallium scans, MUGA scans or stress echocardiograms; and
- occurs after the Effective Date of Insurance.

The Date of Diagnosis is the date of ischemic death of an area of the heart muscle, as confirmed by the above criteria. Diagnosis is to be made based on generally accepted principles of medicine at the time the diagnosis is made.

The following are not considered as a Heart Attack:

- an EKG change consistent with transient ischemic change;
- angina;
- chance finding of EKG changes suggestive of a previous Heart Attack; or
- the death of the heart muscle coincidental with death from other causes.

Heart attack that occurs during or within [24] hours after a cardiac or coronary artery procedure is excluded.

Payment of benefit is based upon Date of Diagnosis made after the Effective Date of Insurance.

Heart Failure means clinical evidence showing disease of or injury to the heart that is, by generally accepted medical standards, sufficient to require a human to human replacement of the whole heart.

The diagnosis of Heart Failure must be made after the Effective Date of Insurance.

Heart Transplant means that a Covered Person:

- demonstrates Heart Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its recognized successor for a human to human replacement of the whole heart.

Illness means sickness or disease of a Covered Person.

Initial Effective Date means the date that coverage begins under this Policy.

Injury means the bodily harm resulting directly from an Accident and independently of all other causes.

Insured means an [Eligible Employee] who is covered by this Policy.

Invasive Cancer means a malignant tumor characterized by:

- the uncontrolled growth and spread of malignant cells; and
- the invasion of local or distant tissue.

This includes Leukemia and Lymphoma.

Payment of Benefit is based upon Date of Diagnosis. The diagnosis must be a Pathological Diagnosis, and must be made more than [30] days after the Effective Date of Insurance. We will accept a Clinical Diagnosis in place of a Pathological Diagnosis only if:

- a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a physician is treating the Insured for cancer.

We will not pay Benefits based on a Tentative Diagnosis.

The following are not considered Invasive Cancer for purposes of this Benefit:

- Carcinoma in Situ;
- All skin cancers, unless there is evidence of metastasis;
- Malignant melanoma of less than 1.0 mm. maximum thickness as determined by histological examination using the Breslow method; or
- Prostate cancer histologically classified as Gleason score of less than 7, or TNM classification less than T2NOMO.

[Laid Off means that the Insured's job has been ended or suspended by His employer due to:

- a decrease in output by the Employer;
- a decrease in staff due to economic conditions;
- a reorganization that eliminates the Insured's job; or
- a reorganization that eliminates the Employer's need for the Insured's job skills.

Laid Off does not include termination for cause or because the Insured is no longer physically able to perform the job.]

Locked Out means that the Insured's place of employment has been shut down by His employer during a labor dispute. The Lockout must be lawful.

[Loss of Hearing means clinically-proven irreversible loss of hearing in both ears, with an auditory threshold of more than [90] decibels, as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months after diagnosis.

No benefit will be paid if, in general medical opinion, surgery, a hearing aid, device, or implant could result in the partial or total restoration of hearing.

The diagnosis must be made by physical examination by an audiologist after the Effective Date of Insurance.

[For Optional Child Benefit, the Covered Person must be age three (3) years or older at the time of diagnosis.]]

[**Loss of Speech** means the clinically-proven total, permanent and irreversible loss of the ability to speak as a result of Illness or Injury that has continued without interruption for a period of at least six (6) consecutive months.

No benefit will be payable if, in general medical opinion, surgery, a device or implant could result in the partial or total restoration of speech.

The diagnosis must be made by physical examination by a speech pathologist after the Effective Date of Insurance.

[For Optional Child Benefit, the Covered Person must be age three (3) years or older at the time of diagnosis.]]

[**Loss of Vision,** means clinically-proven, irreversible reduction of sight in both eyes as a result of Illness or Injury. The corrected visual acuity must be:

- less than [20/200];or
- a visual field restriction to [20] degrees or less in both eyes.

There must be clear proof that blindness was due to Illness or Injury, and that the condition has continued without interruption for a period of at least six (6) consecutive months after diagnosis.

No benefit will be paid if, in general medical opinion, surgery, a device, or implant could result in the partial or total restoration of sight.

The diagnosis must be made:

- by physical examination by an opthamologist; and
- after the Effective Date of Insurance.

[For Optional Child Benefit, the Covered Person must be age three (3) years or older at the time of diagnosis.]]

[Loss of Work means that the Insured is Laid Off, Locked Out or On Strike, or any combination of the three.]

[Major Organ Failure means clinical evidence showing disease of or injury to one of the following Major Organs that is, by generally accepted medical standards, sufficient to require a human to human replacement of the whole organ:

- liver;
- kidney;
- pancreas or pancreas-kidney; or
- lung or lungs.]

The diagnosis of Major Organ Failure must be made after the Effective Date of Insurance.

Major Organ Transplant means that a Covered Person:

- demonstrates Major Organ Failure; and
- is registered with and on the waiting list of the United Network for Organ Sharing or its successor for a human to human replacement of the failing organ.

[Member means a person who is in a Class shown on the Schedule [and in good standing as defined by the [Association's] requirements and bylaws.]]

[Occupational HIV means that the Covered Person initially contracted and was diagnosed with Human Immunodeficiency Virus (HIV) after the Date of Certificate. Benefits will only be paid if all of the following conditions are met:

- the cause of the HIV must be from an accidental needle stick/sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the twelve (12) months preceding diagnosis, after the Effective Date of Insurance and while His insurance is in force;
- the accident must have occurred while the Covered Person was following the normal occupational duties and reported in accordance with the established occupational procedures for such accidents;
- the Covered Person must have undergone a blood test within five (5) days of the accident which indicated the absence of HIV or antibodies to such a virus; and
- within twelve (12) months of the accident, the Covered Person must undergo a follow up blood test indicating the presence of HIV or antibodies to such a virus.]

[**On Strike (Strike)** means that the Insured and other employees acting together

- have ceased work, or
- are refusing to work or to continue to work for the Insured's employer.

The Strike must be authorized under the rules of a union or unions representing the Insured and other striking employees.

The union or unions authorizing the strike must be recognized by the Insured's employer for collective bargaining purposes.]

The Strike must be lawful and must not take place while a labor contract is still in effect.]

Pathological Diagnosis means identification of cancer based on a microscopic study of fixed tissue or preparations from the hemi (blood) system.

The diagnosis must be:

- made by a certified pathologist; and
- in keeping with the standards set by the American Board of Pathology.

Permanent Paralysis means only:

- Hemiplegia;
- Paraplegia; or
- Quadriplegia.

The loss must:

- be expected to be permanent;
- have been present continuously for at least [180] days
- be caused by Injury sustained in an Accident occurring after the Effective Date of Insurance;
- have been first diagnosed after the Effective Date of Insurance;
- be evidenced by the total and irreversible loss of use of two or more limbs; and
- be marked by loss of muscle function in two arms, two legs, or one arm and one leg.

Paralysis does not include paralysis that results from a Stroke.

Physician means a medical doctor or other person recognized by law or regulation in the state where services are rendered as a Physician. The person must be licensed and practicing in the United States.

Physician does not include:

- You;
- a person related to You by blood or marriage; or
- a medical doctor or other person practicing outside of the United States.

Policy means the group Policy issued to the Policyholder.

[Policy Month means a period of time:

- beginning on the day of the month corresponding to the Initial Effective Date; and
- continuing through the end of the preceding day in the next Calendar Month.]

[Policy Year Means a period of time:

- beginning on the Initial Effective Date or its anniversary; and
- continuing through the end of the day preceding the next anniversary.]

Policyholder means the entity so named on the Policy face page.

Pre-existing Condition means any of the following which a Physician has treated or for which a Physician has advised treatment of the Covered Person within 12 months before the Covered Person's Effective Date of Insurance:

- [Heart Attack;] [or]
- [Stroke][;]
- [Invasive Cancer;] [or]
- [Carcinoma in Situ;]
- [Coma;]
- [End-Stage Renal Failure;]
- [Loss of Vision, Speech or Hearing;]
- [Severe Burns;]
- [Permanent Paralysis;][or]
- [Occupational HIV].

Pre-existing Condition also means [any of] the following which a Physician has treated or for which a Physician has advised treatment (by transplant, bypass surgery, medication or otherwise) of the Covered Person within 12 months before the Covered Person's Effective Date of Insurance:

- [failure of the liver, kidney(ies), pancreas, or lung(s);]
- [failure of the heart;] [or]
- [coronary artery disease][.]

Pre-existing Condition also means that a Physician has given a Tentative Diagnosis of Invasive Cancer or Carcinoma in Situ of the covered Person within [12] months before the Covered Person's Effective Date of Insurance.

[Pre-existing Condition also means a condition causing Total Disability which a Physician has treated or for which a Physician has advised treatment of the [Employee] within 12 months before the [Employee]'s Effective Date of Insurance.]

Proof means evidence satisfactory to Us for insurability or for other matters which require Proof.

[Rate Guarantee means a written agreement by the Company that rates charged for the insurance provided by the Policy will not change for a specified period.]

Renal Failure means End Stage Renal Failure.

Replaced Policy means a policy or certificate, the premiums for which are paid by or through the Policyholder. It must:

- have a paid-to date within [60] days of this Policy's Date of Application;
- be replaced by this Policy; and
- end upon issue of this Policy.

At Our request, the Policyholder must give Us Proof about a[n] [Employee]'s Replaced Policy.

Schedule means page(s) so labeled in this Policy and the Certificate.

[Severe Burns means that the Covered Person has sustained third degree burns covering at least [20%] of the surface area of His body. Third degree means the destruction of the skin through the entire thickness or depth of the dermis and the layer of tissue below the skin (subcutaneous tissue). The diagnosis of Severe Burns must be made by a physician board-certified in Plastic Surgery and after the Effective Date of Insurance.]

Spouse means**[:]**

[1.] the person recognized as the covered Insured's husband or wife under the laws of the state in which the Insured lives[:] [or]

[2.] [the person recognized by the Insured's state of residence as[:]

- [the Insured's Domestic Partner [(California)];]
- [a party to a Civil Union with the Insured [(Connecticut)][,][(New Jersey)][,][and][(Vermont)] ;]

- [a Reciprocal Beneficiary of the Insured [(Hawaii)]; or
- [someone for whom we must provide the coverage of this Policy on a spousal equivalent basis under the laws or regulations of that state.]]

[When We provide coverage under this definition "2", We will continue to provide coverage after the Insured or Spouse moves to a state that does not recognize the relationship described.]

[We will not continue to provide coverage under these definitions "1" and "2" for the Spouse when a legal action ends a relationship described.]

[3.] [persons who, by written agreement between the Company and the Policyholder, may be covered by this Policy on a spousal equivalent basis.]

This Policy will at no time cover more than one person as an Insured's Spouse.

Strike, see the Definition of "On Strike."

Stroke means death of brain tissue due to a cerebrovascular event resulting in neurological damage including infarction, hemorrhage or embolization of brain tissue from an extra cranial source for at least [60] days.

Stroke does not mean a transient ischemic attack, transient global amnesia, chronic cerebrovascular insufficiency, attacks of vertebrobasilar ischemia or a cerebrovascular event resulting from Accidental Injury.

Diagnosis of a Stroke must be based on all of the following criteria;

- documented neurological impairment or deficits;
- evidence of brain tissue damage shown by neuroimaging (CT, MRI, or PET Tomography or similar test);
- permanent neurological deficit measured three months or more after the event that results in a score of 2 or higher on the Modified Rankin Scale for stroke outcome; and
- which was made after the Effective Date of Insurance.

Tentative Diagnosis means a diagnosis of Invasive Cancer or Carcinoma in Situ based upon dated medical records.

Totally Disabled (Total Disability) means, for the first [24] months of a disability, that the Covered [Employee] is:

- unable to perform the substantial and material duties of His regular occupation;
- not working in any other occupation; and
- under the care of a Physician for the disability.

[After [24] months of Total Disability, Totally Disabled means that the Insured is:

- unable to perform the duties of any gainful occupation for which He is reasonably fitted by training, education or experience; and
- under the care of a Physician for the disability.]

We will not require care of a Physician when it is no longer needed for the sound medical care of the condition causing Total Disability.

We, Us, Our and Company all mean Kanawha Insurance Company.

You and **Your** mean the covered [Employee].

Any reference to "He," "Him" or "His" will also refer to "She" or "Her," "they," "them" or "their."