



READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and American Sentinel Insurance Company. It is therefore, important that you **READ YOUR POLICY CAREFULLY.**

Total Disability Income Protection Coverage. This category of coverage is designed to provide, to persons insured, benefits for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Benefits are not provided for basic hospital, basic medical-surgical, or major medical expenses.

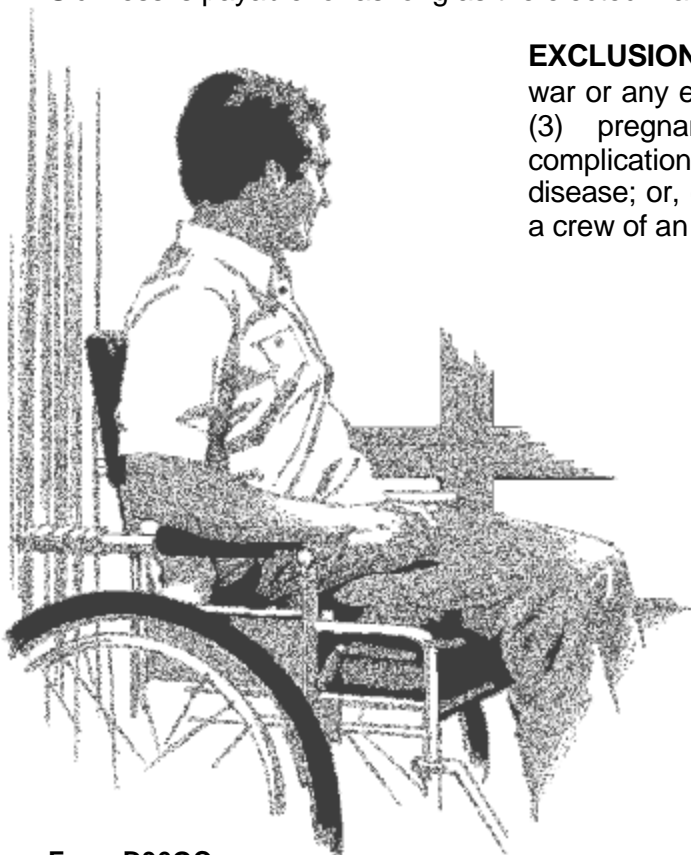
BENEFITS OF THE POLICY The policy will pay the monthly income benefit selected below when you are Totally Disabled. Totally Disabled (or Total Disability) means a condition caused by injury or sickness which affects you: (1) if employed, to the following extent: (a) during the first year of disability, you are unable to perform each and every duty of your occupation; and (b) after one (1) continuous year, you are unable to perform each and every duty of any business or occupation for which you are reasonably fitted by education, training or experience; or (2) if non-employed, to the extent that you are continuously unable to perform the normal activities of a person the same age and sex.

The policy pays a monthly income of \$_____ for a covered Injury beginning on the _____ day of Total Disability, or for a covered Sickness beginning on the _____ day of Total Disability. The benefit per Injury or Sickness is payable for as long as the elected Maximum Benefit Period.

EXCLUSIONS: The policy does not cover loss caused by: (1) declared war or any enemy action; (2) suicide or intentionally self-inflicted injuries; (3) pregnancy, childbirth, miscarriage or abortion except that complications of pregnancy are covered as any other Sickness or disease; or, (4) operating, learning to operate, or serving as a member of a crew of an aircraft.

RENEWABILITY OF THE POLICY The policy is guaranteed renewable to the premium due date on or next following your sixty-fifth (65th) birthday. We have the right to modify our premium rates. If premium rates change, you will be given written notice by mail at least 40 days before the end of the grace period applicable to the first increased premium. Any change is made only on a class basis. Your original insuring age is used to determine the new premium rate. As long as the policy continues in force, we cannot place any restrictive riders thereon with respect to coverage already in force.

Premium: Annual \$ _____
Semi-Annual \$ _____
Quarterly \$ _____



INJURY AND SICKNESS (Annual Premium Rates – Disability Income Per \$100 Monthly Benefit)

12 Month Injury / 12 Month Sickness

<u>Issue Age</u>	<u>Elimination Period</u>	<u>Class 1</u>	<u>Class 2</u>	<u>Class 3</u>	<u>Class 4</u>
18-25	0-15	\$27.12	\$35.26	\$43.39	\$54.24
	30-30	21.12	27.46	33.79	42.24
	60-60	18.12	23.56	28.99	36.24
26-35	0-15	34.84	45.29	55.74	69.68
	30-30	27.84	36.19	44.54	55.68
	60-60	24.84	32.29	39.74	49.68
36-45	0-15	45.68	59.38	73.09	91.36
	30-30	37.68	48.98	60.29	75.36
	60-60	33.68	43.78	53.89	67.36
46-55	0-15	57.12	74.26	91.39	114.24
	30-30	47.12	61.26	75.39	94.24
	60-60	42.12	54.76	67.39	84.24
56-60	0-15	66.12	85.96	105.79	132.24
	30-30	54.12	70.36	86.59	108.24
	60-60	48.12	62.56	76.99	96.24

Plan features of American Sentinel's Individual Disability Policy

- Fully portable (policy is individually owned)
- 24 hour coverage – worldwide (occupational and non-occupational)
- Guaranteed renewable policy (cannot be cancelled due to health problems)
- Accident and Sickness coverage
- Benefits not offset by Workers' Compensation and Social Security
- Covers most *blue* and white collar occupations
- Uni-sex rates

Simplified Underwriting

- No physical examinations, blood, urine, attending physician's statements, or investigative reports required
- No income documentation
- Will consider *all* earned income ranges
- Will not deny coverage on employed persons with unearned income

Design Your Plan from These Options

- 6 month or 1 year Benefit Period
- 0 day accident – 15 day sickness Elimination Period
- 30 day accident – 30 day sickness Elimination Period
- 60 day accident – 60 day sickness Elimination Period



AMERICAN SENTINEL INSURANCE COMPANY

P.O. Box 61140, Harrisburg, PA 17106-1140
717-540-0600 • 800-692-7338 • FAX 717-657-9499

Application for Total Disability Insurance

Agency _____

Agent's Signature _____

Printed Name _____

Occupational Classification _____

Amount Applied For: \$ _____ per month

Elimination Period Desired: **Injury** **Sickness**
 0 day 15 day
 30 day 30 day
 60 day 60 day

PREMIUM _____

If semi-annual, add \$2.00 and divide by 2;
If quarterly, add \$4.00 and divide by 4;
If monthly, add \$20.00 and divide by 12.

Maximum Benefit Period Desired: 6 Months 12 Months
 Male Female

Proposed Insured _____

Birth Date _____ Age _____ Social Security No. _____ - - _____ Height _____ Weight _____

1. _____ ()
Resident Address Street City State Zip Home Phone

2. _____
Occupation (Position or Title) Duties Performed Marital Status

3. _____
Employer Business Address

4. ()
Business Phone Type of Business How long with present employer?

5. If with present employer less than one year, who was your previous employer?
Business Address _____ Phone () _____ How long? _____

6. Average monthly earned income \$ _____

7. If you become disabled, will your salary be continued? Yes No

8. Do you understand and agree that, under the terms of this insurance a) no benefits are payable for the first _____ days of disability due to Injury (accident); and b) no benefits are payable for the first _____ days of disability due to sickness? Yes No

9. What other accident or disability coverage is in force or applied for in all companies?

Company Monthly Benefit Benefit Period

10. Will this insurance replace any disability coverage currently in force? Yes No

11. Have you within the past 5 years had medical or surgical advice or treatment or been hospital confined? Yes No

12. Have you ever received medical care, advice or been diagnosed from a licensed health care provider for:

- | | | | | | |
|-------------------------|------------------------------|-----------------------------|-------------------------------------|------------------------------|-----------------------------|
| Abnormal Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental or Nervous Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma or Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immune Deficiency Syndrome - (AIDS) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Please give details of "YES" answers for Questions 11 & 12: _____

I have read the answers and statements made in this application and declare that they are true and complete to the best of my knowledge and belief. I understand that any policy issued and delivered to me will be in effect on the date approved by the Home Office.

Signature of Proposed Insured _____ Application Date _____

AUTHORIZATION TO WHOM IT MAY CONCERN: I request and authorize you, to the extent that it is lawful, to disclose, whenever requested to do so by AMERICAN SENTINEL INSURANCE COMPANY or its representative, any and all information and records available on or prior to the date below when I was under your observation. A Photostat of this authorization is to be considered acceptable.

Dated this _____ day of _____, _____

Signed by Proposed Insured _____

FORM D96A