



AMERICAN SENTINEL INSURANCE COMPANY

HARRISBURG, PA TOTAL DISABILITY INCOME INSURANCE

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the 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 your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY.**

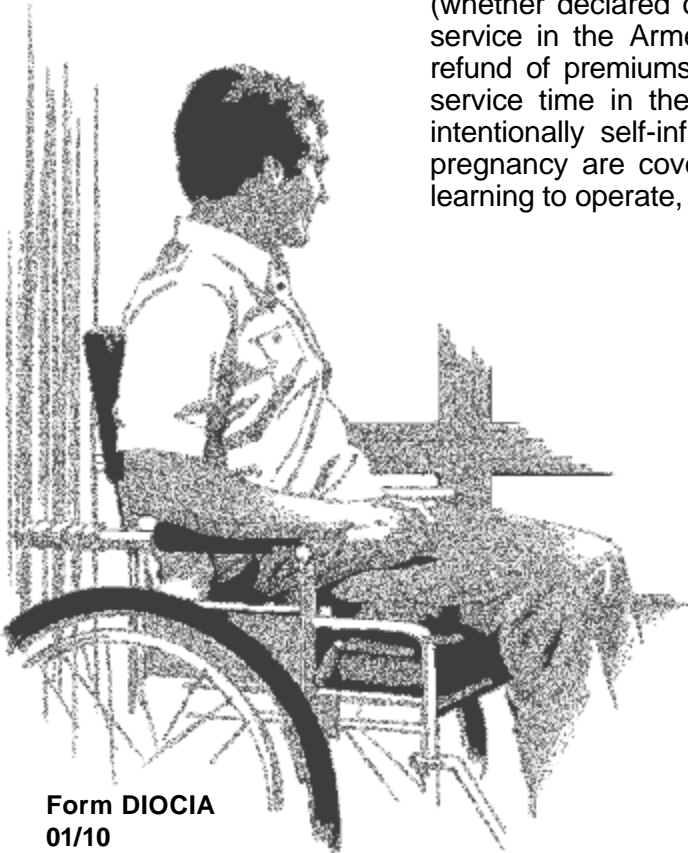
TOTAL DISABILITY INCOME PROTECTION COVERAGE. Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, 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 accident or sickness which affects you: (1) if employed, to the following extent: (a) you are unable to perform all the substantial and material duties of your regular occupation (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 Accident beginning on the _____ day of Total Disability, or for a covered Sickness beginning on the _____ day of Total Disability. The benefit per Accident or Sickness is payable for as long as the elected Maximum Benefit Period.

EXCLUSIONS: The policy does not cover loss caused by: (1) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto (Upon written request, refund of premiums will be made to you as applicable on a pro-rata basis for service time in the Armed Forces/Military); (2) suicide; attempted suicide or intentionally self-inflicted injuries; (3) pregnancy except that complications of pregnancy are covered as any other Sickness or Accident; or, (4) operating, learning to operate, or serving as a member of a crew of an aircraft.

RENEWABILITY OF THIS POLICY The policy is guaranteed renewable to the premium due date on or next following the Insured's (herein called you/your) 65th birthday. We reserve the right to modify our premium rates applicable to policies of the same class. Any change in premium rates, shall be made only on a class basis. Premium rates changes are subject to prior approval of the Iowa State Insurance Department. Your original insuring age shall be used to determine the new premium rate. You will be notified at least 31 Days before an increase would become effective. Any rate change shall be implemented on a policy anniversary date. 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 \$ _____
Monthly \$ _____

OCCUPATIONAL CLASSIFICATIONS

A		G		P	
Accountant.....	1	Garage Employees – Mechanic and all others.....	3	Painter (house).....	4
Actor, actress – no acrobatics.....	2	Gardener.....	3	Pawnbroker.....	2
Athlete refer to H.O.....	X	Geologist – field work, no mining.....	2	Photographer.....	2
Architect.....	2	Glazier.....	3	Plumber.....	4
Artist – commercial, cartoonist, designer, or illustrator.....	1	Golf course – caretaker.....	3	Police.....	3
Attorney.....	1	Instructor, proprietor of driving range.....	2	Postmaster.....	1
Auditor.....	1	Grocer.....	2	All other postal employees.....	4
Automobile Salesman, dealer, or accessory merchant.....	3			Printer – photograph, lithography or engraving.....	2
				Produce broker.....	2
B		H		R	
Baker.....	3	Hotel – manager, proprietor, waiter, waitress, bellboy, operator, housekeeper.....	3	Radio, TV – Salesman, dealer; no repair and no installation.....	2
Barber.....	2			Repairman.....	3
Bartender.....	3			TV Installation.....	3
Beautician.....	2	I		Radiographer/X-ray Tech.....	2
Bricklayer.....	4	Inspector – bank, building, credit, food, drug, etc.....	2	Realtor.....	2
Broker.....	1	Heavy work – iron, bridge structure, telephone, telegraph pole or wire work.....	4	Respiratory Therapist.....	2
Butcher.....	3			Restaurant – employees.....	2
				Roofer.....	4
C		J		S	
Carpenter.....	4	Janitor.....	3	Salesman – office and travel duties; no delivering.....	1
Cashier (only).....	1	Junk dealer.....	4	Sculptor.....	3
Chemist.....	2				
Cleaner, dyer.....	3	L		T	
Clergy.....	1	Laborer.....	4	Tailor.....	2
Collector of Accounts.....	2	Labor union official.....	3	Teacher – classroom instruction of all kinds except physical training, trade instructor.....	1
Contractor.....	4	Landscaper.....	3	Physical training, trade instructor....	2
Cook.....	3	Laundry-workers.....	3	Television, radio, motion pictures - manager, announcer, producer.....	2
		Letter carrier.....	4	Stagehand.....	4
				Trucker.....	3
D		M		U	
Day Care Provider.....	2	Machinist.....	4	Undertaker – mortician, embalmer, funeral director.....	2
Decorator.....	2	Mason.....	4	Upholsterer.....	3
Dentist, dental lab worker.....	2	Masseur.....	3		
Detective.....	3	Merchant or clerk.....	2	V	
Doctor.....	2	Musician, music teacher.....	2	Veterinarian.....	3
Dog Groomer.....	3				
Domestic help – butler, maid, cook, caretaker, housekeeper, chauffeur, etc.....	2	N		W	
Driver – bus, coach, taxi or truck.....	3	Newspaper – editor, reporters, publisher.....	2	Welder.....	4
Druggist.....	2	Nurse.....	3		
				Maximum Amounts	
E		O		Class 1 & 2	UP TO 1,500/MOS
Electrician.....	3	Oculist, optometrist.....	2	Class 3	UP TO 1,200/MOS
Engineer.....	2	Office personnel – executive, clerk, salesman, lawyer, accountant (office and travel duties; no delivering).....	1	Class 4	UP TO 1,000/MOS
Office duties only.....	1				
F					
Farmer.....	4				
Fireman.....	4				
Florist.....	3				
Funeral Director.....	2				
Furrier.....	3				

Total Disability Benefits from this policy and all other policies carried or applied for by the applicant shall not exceed seventy percent (70%) of average monthly income from the applicant's occupation.

Semi-annual rate – Add \$5.00 and divide by 2; Quarterly rate – Add \$10.00 and divide by 4; Monthly rate – Add \$20.00 and divide by 12. Monthly billing requires two months advance premium and automatic check withdrawal. Please request an ACH Form.

Where there is any question as to the proper classification, contact the home office.

FORM DIOCIA

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

6 Month Accident / 6 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	\$25.49	\$33.14	\$40.78	\$50.98
	30-30	19.49	25.34	31.18	38.98
	60-60	16.49	21.44	26.38	32.98
26-35	0-15	32.75	42.58	52.40	65.50
	30-30	25.75	33.48	41.20	51.50
	60-60	22.75	29.58	36.40	45.50
36-45	0-15	42.03	54.64	67.25	84.06
	30-30	34.03	44.24	54.45	68.06
	60-60	30.03	39.04	48.05	60.06
46-55	0-15	50.27	65.35	80.43	100.54
	30-30	40.27	52.35	64.43	80.54
	60-60	35.27	45.85	56.43	70.54
56-60	0-15	53.56	69.63	85.70	107.12
	30-30	41.56	54.03	66.50	83.12
	60-60	35.56	46.23	56.90	71.12

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 Agency _____

Application for Total Disability Insurance

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

Agent's Signature _____

Occupational Classification _____

Printed Name _____

Amount Applied For: \$ _____ per month

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

PREMIUM _____

If semi-annual, add \$5.00 and divide by 2;

If quarterly, add \$10.00 and divide by 4;

If monthly, add \$20.00 and divide by 12.

Maximum Benefit Period Desired: 6 Months 12 Months

Proposed Insured _____ Male Female

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 accident; and b) no benefits are payable for the first _____ days of disability due to sickness? Yes No

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

Company Monthly Benefit Benefit Period

10. Will this insurance replace any other accident and sickness 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 | Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental or Nervous Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma or Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pregnancy (Are you pregnant?) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

13. Have you been diagnosed or treated for AIDS or ARC or tested positive for HIV? Yes No

Please give details of "YES" answers for Questions 11, 12 & 13: _____

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

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 I authorize American Sentinel Insurance Company to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, insurance company or the Bureau of Motor Vehicles to release to American Sentinel Insurance Company information regarding me for the purpose of evaluating this application for insurance. I also authorize American Sentinel Insurance Company to disclose all such information to any physician or any other insurance company in order to evaluate a claim or an application for insurance. This authorization shall remain valid for a period of two years from the issue date of this policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available upon request to the Company.

Dated this _____ day of _____, _____

Signed by Proposed Insured _____

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