COMBINED INSURANCE®
A Legal Reserve Stock Corporation

COMBINED INSURANCE COMPANY OF AMERICA
[Home Office: 111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601 • 1-800-544-9382
Policyholder Service Address: P. O. Box 1160 • Glenview, Illinois 60025-8160]

CRITICAL ILLNESS INSURANCE POLICY

THIS IS A LIMITED BENEFIT POLICY. PLEASE READ IT CAREFULLY.

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE. YOU MAY RENEW THIS POLICY BY PAYING EACH PREMIUM ON THE PREMIUM DUE DATE, SUBJECT TO THE GRACE PERIOD.

This is Your Policy. You are the Insured. This Policy is in force as of the Policy Effective Date. The Policy Effective Date is shown in the Policy Specifications.

This Policy was issued in consideration of the statements in the application and payment of the first premium. If any information in Your application is not correct or complete, write to Us within 10 days of receipt of this Policy. Incorrect or incomplete information may result in the denial of a claim, rescission, or termination of this Policy.

NOTICE OF THIRTY DAY RIGHT TO EXAMINE THIS POLICY

If You are not satisfied with this Policy, You can return it to Us at the Policyholder Service Address above within 30 days after You receive it. At that time, You should ask Us in writing to cancel it. This Policy will be cancelled and any premium paid will be refunded.

RENEWABILITY

We guarantee that we will renew this Policy for Your lifetime. It shall continue in force so long as the premium is paid on or before the due date or within the Grace Period.

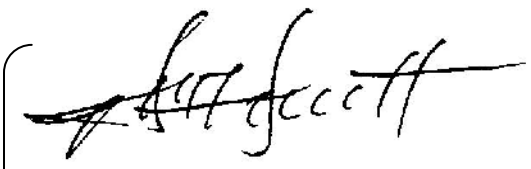
PREMIUM ADJUSTMENT

We have the right to adjust the premium for this Policy as determined necessary by Us. Written notice of an adjustment will be mailed to You at least 30 days in advance. A premium adjustment will take effect on a monthly anniversary following the date We sent the notice of adjustment. When a Dependent's coverage ends, any resulting change in premium will be made on the next monthly anniversary of the Policy Effective Date.

[PRE-EXISTING CONDITION LIMITATIONS

A Pre-existing Condition is not covered unless such condition begins after [12] months from the Policy Effective Date.]

For Combined Insurance Company of America



Brad Bennett, President

Rebecca L. Collins, Secretary

Form No. 16648

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Policy Specifications

Insured: [John Doe]

Policy Number: [Specimen]

Policy Effective Date: [June, 1, 2013]

Premium Amount: [$20.22]

Premium Mode: [Monthly]

Schedule of Benefits

Covered Person:	Name:	Face Amount:	Maximum Benefit Amount:	Issue Age:
Insured	[John Doe]	[$100,000]	[$300,000]	[ ]
[Spouse]	[Jane Doe]	[$50,000]	[$150,000]	[ ]
[Child(ren)]	[Jim Doe]	[$50,000]	[$150,000]	[ ]

Benefit payments are limited to the Maximum Benefit Amount per Covered Person.

Waiting Period: [30] days

Standard Critical Illness Benefit: 100% of Face Amount

	Insured	[Spouse	[Child(ren)]
Covered conditions include:			
[Alzheimer's Disease	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Amyotrophic Lateral Sclerosis (ALS)	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Benign Brain Tumor	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Cancer	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Coma	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[End Stage Renal (Kidney) Failure	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Heart Attack	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Loss of Sight, Hearing or Speech	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Major Organ Failure	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Multiple Sclerosis	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Paralysis or Dismemberment	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Parkinson's Disease	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Severe Burns	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Stroke	[NOT] COVERED	[NOT] COVERED]	[NOT] COVERED]]

Standard Critical Illness Benefit is payable once per [covered condition as listed per] Covered Person. Benefits are limited to the Maximum Benefit Amount for each Covered Person per lifetime. Payment of this benefit will reduce the available Maximum Benefit Amount.

[Occupational Critical Illness Benefit: [100%] of Face Amount
This benefit is payable only for the Insured or Spouse. No benefits are payable for covered Child(ren).

	Insured	[Spouse
Covered conditions include:		
Occupational Hepatitis B, C or D	[NOT] COVERED	[NOT] COVERED
Occupational Human Immunodeficiency Virus (HIV)	[NOT] COVERED	[NOT] COVERED]

Only one Occupational Critical Illness Benefit will be payable per Insured or Spouse per lifetime. Payment of the benefit will reduce the available Maximum Benefit Amount.]

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Partial Critical Illness Benefit: [25%] of Face Amount

	Insured	[Spouse	[Child(ren)
Covered conditions include:			
[Carcinoma In Situ	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Coronary Artery Obstruction	[NOT] COVERED	[NOT] COVERED]	[NOT] COVERED]]

Partial Critical Illness Benefit is payable once per covered condition per Covered Person. Payment of this benefit will reduce the available Maximum Benefit Amount.

[Skin Cancer Benefit: [$250]	Insured	[Spouse	[Child(ren)
	[NOT] COVERED	[NOT] COVERED]	[NOT] COVERED]

This benefit is payable once per Covered Person. Payment of this benefit will reduce the available Maximum Benefit Amount.]

[Recurrence Critical Illness Benefit: [25%] of Face Amount

	Insured	[Spouse	[Child(ren)
Covered conditions include:			
[Benign Brain Tumor	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Cancer	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Coma	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Heart Attack	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Severe Burns	[NOT] COVERED	[NOT] COVERED	[NOT] COVERED]
[Stroke	[NOT] COVERED	[NOT] COVERED]	[NOT] COVERED]]

Recurrence Critical Illness Benefit is payable for covered conditions up to [2] times per Covered Person regardless of how many covered conditions recur. Payment of this benefit will reduce the available Maximum Benefit Amount.]

[Childhood Critical Illness Benefit: [100%] of Face Amount
This benefit is payable only for the covered Child(ren)

	Child(ren)
Covered conditions include:	
[Cerebral Palsy	[NOT] COVERED]
[Congenital Birth Defects	[NOT] COVERED]
[Cystic Fibrosis	[NOT] COVERED]
[Down Syndrome	[NOT] COVERED]
[Muscular Dystrophy	[NOT] COVERED]
[Type 1 Diabetes Mellitus	[NOT] COVERED]

Childhood Critical Illness Benefit is payable once per covered Child. Payment of this benefit will reduce the available Maximum Benefit Amount.]

[Benefit Reduction
[On the Policy anniversary following a Covered Person's] [70th] birthday:
The Face Amount for such Covered Person will be reduced [50%].
The available Maximum Benefit Amount for such Covered Person will be reduced [50%].

Premiums will not change as a result of this benefit reduction.]

[Additional Benefit Riders:
[Automatic Maximum Benefit Increase]
[Annual Wellness Benefit]
[Cancer Treatment]
[Family Care]
[Hospital Admission]
[Membership Endorsement for Health Care Referral]
[Mortgage and Rent Helper]
[Waiver of Premium]

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Definitions

Actively at Work means the Insured is at work for pay on a permanent basis at least [17½] hours per week performing the normal duties of the Insured's job.

[Alzheimer's Disease means a progressive degenerative disease of the brain and memory that is diagnosed by aboard-certified or board-eligible neurologist or another Physician trained in the diagnosis of Alzheimer's Disease andother dementias resulting in the inability to perform two (2) or more of the following activities:

1) Bathing
2) Dressing
3) Toileting
4) Transferring
5) Continence
6) Eating]

[Amyotrophic Lateral Sclerosis (ALS) means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.]

[Benign Brain Tumor means a non-cancerous tumor of the brain which is diagnosed by a Physician. The tumor must result in persistent neurological deficits including but not limited to:

- loss of vision;
- loss of hearing; or
- balance disruption.**]**

[Cancer means leukemia or a malignant tumor characterized by uncontrolled cell growth and spread of malignant cells and the invasion of distant tissue. Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue ore specimen. The following are not considered Cancer for purposes of this Policy:

- Pre-malignant conditions or conditions with malignant potential;
- Carcinoma In Situ;
- Stage 1 Hodgkin's Disease and Stage 1 Prostate Cancer; or
- Basal cell carcinoma and squamous cell carcinoma of the skin and melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75mm.]

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

[Cerebral Palsy means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of Cerebral Palsy are often accompanied by disturbances or sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder. Diagnosis must be made by a licensed pediatrician or other Physician trained to make a diagnosis of Cerebral Palsy.**]**

Child means the Insured's child who is an Eligible Dependent as defined in this Policy and shown as covered on the Schedule of Benefits.

[Coma means a coma resulting from a severe traumatic brain injury that results in a continuous state of profound unconsciousness resulting for a period of 30 or more consecutive days, defined as the absence of:

1) eye opening;
2) motor response; and
3) verbal response.

The term "coma" does not include any medically induced coma.**]**

[Congenital Birth Defects means the malformation or an organ or organ system that results in the newborn child being confined to a Hospital for thirty (30) or more consecutive days beginning within the first week after birth or date of placement.

Examples include but are not limited to the following:

- Heart defects.
- Lung defects.
- Spina Bifida.
- Cleft lip or palate.
- Limb malformations.
- Development disorders of the brain.

Congenital Birth Defects includes a newborn child who is born with Loss of Sight. Congenital Birth Defects does not include prematurity.**]**

[Coronary Artery Obstruction means a diagnosis of at least 75% cross-sectional occlusion of one or more major coronary arteries (left main, left anterior descending, circumflex or right coronary artery) as demonstrated by coronary angiography, and as interpreted by a qualified cardiologist, or cardiac surgeon or interventional radiologist. Diagnosis is to be made based on generally accepted principles of medicine in the United States at the time the diagnosis is made.]

Covered Person means a person listed on the Schedule of Benefits as covered under this Policy.

[Cystic Fibrosis means a definite diagnosis of cystic fibrosis by a licensed family practitioner, pediatrician or pulmonologist where the covered Child has chronic lung disease and pancreatic insufficiency. The diagnosis made via a sweat test should be based upon sweat chloride concentrations greater than 60mmol/L.**]**

Dependent means:

1) The Insured's Eligible Dependent whose coverage is in force; and
2) The Insured's Eligible Dependent child or grandchild for whom coverage is continued under the Continuation for Incapacitated Children provision of this Policy.

[Domestic Partner/Partner in a Civil Union means a person who resides with and is financially interdependent with the Insured.]

[Down Syndrome means diagnosis of down syndrome through a study of the 21st chromosome.

Down Syndrome includes:

- Trisomy 21 – an individual has three instead of two #21 chromosomes.
- Translocation – an extra part of the 21st chromosome is attached to another chromosome.
- Mosaicism – the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

Diagnosis must be confirmed by a licensed pediatrician or another Physician trained in the diagnosis of Down Syndrome.]

Eligible Dependent means a person who is:
1) The Insured's Spouse;
2) The Insured's newborn child;
3) The Insured's natural child, legally adopted child, child in the waiting period prior to finalization of adoption by the Insured, or step-child; provided that such child is unmarried and under age [27]; or
4) The Insured's unmarried grandchild under age [27] who is a dependent for federal income tax purposes.

[End Stage Renal (Kidney) Failure means chronic irreversible failure of the function of both kidneys such that the Covered Person must undergo at least weekly hemodialysis or peritoneal dialysis.]

Face Amount is the amount shown on the Schedule of Benefits for each Covered Person.

[Heart Attack means interruption of coronary blood flow that results in damage to the heart muscle. The Heart Attack must be diagnosed by a Physician based upon elevated cardiac enzymes (troponins or CK-MB) or in the absence a report that documents the cardiac enzymes, specific EKG changes that are consistent with cardiac ischemia, according to the American College of Cardiology and the American College of Electrocardiography.]

Hospital is an institution in the United States or Canada which meets all of the following requirements:

1) operates pursuant to state or provincial law for Hospitals located in the United States or Canada;
2) operates primarily for the care and treatment of sick or injured persons as Inpatients;
3) provides 24 hour nursing service;
4) has facilities available for diagnosis and surgery either on its own premises or in facilities available to the Hospital on a pre-arranged basis; and
5) has a staff of at least one licensed Physician available at all times.

Hospital does not include rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitation facilities, including rehabilitation hospitals.

Immediate Family means You, Your Spouse, and any of Your, or Your Spouse's children, parents, grandparents, brothers, sisters, and their respective spouses.

Insured means the person named in the Policy Specifications.

[Loss of Hearing, Sight or Speech. "Loss of Hearing" means total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by use of any hearing aid or device shall not be considered an irrevocable loss. "Loss of Sight" means total and irreversible loss of sight in both eyes. **"**Loss of Speech" means damage to vocal cords due to injury that results in the total and permanent inability to speak. The Loss of Hearing, Sight or Speech must be diagnosed by a Physician after the Policy Effective Date. If we pay one of the following conditions: Loss of Hearing, Sight or Speech for a Covered Person, we will not pay for the other two conditions for that Covered Person.]

[Major Organ Failure means the diagnosis of major organ failure of the heart, liver, lung or pancreas or any combination of these organs resulting in the Covered Person being placed on the UNOS (United Network of Organ Sharing) list for a transplant.]

Maximum Benefit Amount is the amount shown on the Schedule of Benefits. Total benefits payable under this Policy are limited to the Maximum Benefit Amount for each Covered Person.

[Multiple Sclerosis means the occurrence of at least two episodes of well-defined neurological abnormalities, with objective evidence of lesions at more than one site within the central nervous system. In order for Multiple Sclerosis to be covered under this policy, a Neurologist must make a definitive diagnosis of Multiple Sclerosis, supported by modern imaging and/or investigative techniques. A Neurologist means a Doctor of Medicine certified by the American Board of Psychiatry and Neurology.]

[Muscular Dystrophy means a confirmed diagnosis of one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins and the death of muscle cells and tissue. The confirmed diagnosis or Muscular Dystrophy must be made by a specialist Physician.**]**

[Occupational Hepatitis B, C, or D means a viral hepatitis, types B, C, and D contracted by the Covered Person as a result of the Covered Person's documented accidental exposure in the workplace to blood or other bodily fluids from a person known to be infected with Hepatitis. Hepatitis under this provision does not include type-A hepatitis. In order for Occupational Hepatitis to be covered under this Policy:

- The Covered Person had not tested positive for Occupational Hepatitis prior to Covered Person's effective date of coverage under this Policy;
- The Covered Person was performing his or her normal occupational duties at the time of the accidental exposure;
- The accidental exposure was documented by an accident report in accordance with the established occupational procedures at the Covered Person's workplace; and
- The diagnosis of Hepatitis must be confirmed by blood testing administered under the direction of a Physician.

Hepatitis infection acquired outside the workplace is not considered Occupational Hepatitis.**]**

[Occupational Human Immunodeficiency Virus (HIV) means HIV contracted by the Covered Person as a result of the Covered Person's documented accidental exposure in the workplace to blood or other bodily fluids from a person known to be infected with HIV. In order for Occupational HIV to be covered under this Policy:

- The Covered Person had not tested positive for Occupational HIV prior to the Covered Person's effective date of coverage under this Policy;
- The Covered Person was performing his or her normal occupational duties at the time of the accidental exposure;
- The accidental exposure was documented by an accident report in accordance with the established occupational procedures at the Covered Person's workplace;
- The diagnosis of HIV infection must be confirmed by blood testing administered under the direction of a Physician; and
- The date of a positive HIV antibody test for HIV must be subsequent to a prior negative test with a lapse of between 90 and 180 days between the two tests.

HIV infection acquired outside the workplace is not considered Occupational HIV.**]**

[Paralysis or Dismemberment. "Paralysis" means complete and irrecoverable loss of sensory and motor functions of two or more limbs which is diagnosed by a Physician after the Policy Effective Date. "Dismemberment" means the loss by actual and complete severance of two or more limbs which occurred after the Policy Effective Date. Limb means an entire hand or foot at or above the wrist or ankle. If we pay for either the following conditions: Paralysis or Dismemberment for a Covered Person, we will not pay for the other condition for that Covered Person.**]**

[Parkinson's Disease means a chronic, progressive neurodegenerative disorder characterized by any combination of four cardinal signs: rest tremor, rigidity, bradykinesia and gait disturbance diagnosed after the Policy Effective Date by a psychiatrist or neurologist or another Physician trained in the diagnosis of Parkinson's Disease, and resulting in the inability to perform two (2) of the following activities:

1) Bathing
2) Dressing
3) Toileting
4) Transferring
5) Continence
6) Eating]

Physician means a person performing tasks that are within the limits of his or her medical license and is:

1) Licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2) A legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

A Physician cannot be the Insured or a member of the Insured's Immediate Family, the Insured's business or professional partner, or any person who has a financial affiliation or business interest with the Insured.

Policy Effective Date means the date coverage under this Policy becomes effective. The Policy Effective Date is shown on the Policy Specifications. This date will be used to determine Policy years, months, and anniversaries. [While Interim Coverage is in effect, all references to the Policy Effective Date, except the reference under the "Payment of Premium" provision of the "General Provisions" section of this Policy, shall mean the date of Your application.]

[**Pre-existing Condition** means a condition for which a Covered Person received medical advice or treatment within [12] months immediately prior to the Policy Effective Date.]

[Severe Burns means third degree burns covering at least 20% of Your body which are diagnosed by a Physician.**]**

[Skin Cancer means:
- Stage 1 melanoma; or
- Basal cell or squamous cell carcinoma of the skin.]

Spouse means the person to whom the Insured is legally married [or the Insured's Domestic Partner/Partner in a Civil Union , as defined under this Policy and as shown on the Schedule of Benefits].

[Stroke means a sudden impairment of brain function, due to acute cerebral hemorrhage, or acute cerebral occlusion that results in permanent damage, diagnosed by a Physician, based on abnormal neurologic findings on physical examination, or new abnormalities on CNS imaging studies. Stroke does not mean head injury, concussion, transient ischemic attack, or chronic cerebrovascular insufficiency.]

[Type 1 Diabetes Mellitus once known as juvenile diabetes or insulin-dependent diabetes, is a chronic condition in which the pancreas produces little or no insulin. The diagnosis of Type 1 Diabetes Mellitus must be made by a board certified or board-eligible endocrinologist or other specialist of diabetes.**]**

Waiting Period means the period of time following the Policy Effective Date during which no benefits are available. The Waiting Period is shown on the Schedule of Benefits.

We, Our, Us or the Company means Combined Insurance Company of America.

You or Your means the Insured named in the Policy Specifications.

BENEFITS

Refer to the Schedule of Benefits for benefit amounts and Maximum Benefit Amounts. [If the listed condition is "Not Covered" for the Insured, Spouse or Child, then no benefits are payable under this Policy for such condition for such Covered Person.] Benefits are limited to the Maximum Benefit Amount for each Covered Person and subject to the conditions, limitations, exclusions, and waiting periods of this Policy. The amount You receive is based on the amount of coverage in effect on the date of diagnosis.

[Standard Critical Illness Benefit
We will pay this benefit, subject to the terms and limitations of this Policy, if all of the following conditions are met:

- The Covered Person is diagnosed with a covered condition;
- The diagnosis was made after the Policy Effective Date and Waiting Period; and
- The diagnosis was made while this coverage is in force as shown on the Schedule of Benefits and defined in this Policy.

The amount that will be paid is limited to the Covered Person's Face Amount in effect on the date of diagnosis subject to the available Maximum Benefit Amount.

Benefits are limited to the Maximum Benefit Amount for each Covered Person per lifetime.]

[Standard Critical Illness Benefit
We will pay this benefit, subject to the terms and limitations of this Policy, if all of the following conditions are met:

- The Covered Person is diagnosed with a covered condition;
- The diagnosis was made after the Policy Effective Date and Waiting Period; and
- The diagnosis was made while this coverage is in force as shown on the Schedule of Benefits and defined in this Policy.

The amount that will be paid is limited to the Covered Person's Face Amount in effect on the date of diagnosis subject to the available Maximum Benefit Amount even if the Covered Person experiences more than one Critical Illness at the same time.

If a Covered Person has been diagnosed with a covered condition for which a benefit has been paid and that Covered Person is subsequently diagnosed with a **different** covered condition, we will pay the Covered Person's Face Amount subject to the available Maximum Benefit Amount shown in the Schedule of Benefits for the subsequent and different covered condition if:

- The date of diagnosis of the subsequent covered condition is more than [6] months after any previous date of diagnosis for a covered condition;
- The subsequent date of diagnosis is while coverage under this Policy is in force; and
- The Maximum Benefit Amount has not been paid for that Covered Person.

All benefits paid will reduce the available Maximum Benefit Amount.**]**

[Occupational Critical Illness Benefit

We will pay this benefit when an Insured or Spouse covered under this Policy is diagnosed with a covered condition while this coverage is in force as shown on the Schedule of Benefits and defined in this Policy. The amount You will receive is based on the amount of coverage in effect on the date of diagnosis.

All benefits paid will reduce the available Maximum Benefit Amount.**]**

Partial Critical Illness Benefit

We will pay this benefit, subject to the terms and limitation of this Policy, if all of the following conditions are met:

- The Covered Person is diagnosed with a covered condition;
- The diagnosis was made after the Policy Effective Date and Waiting Period; and
- The diagnosis was made while this coverage is in force as shown on the Schedule of Benefits and defined in this Policy.

All benefits paid under this provision will reduce the available Maximum Benefit Amount.

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[Recurrence Critical Illness Benefit
We will pay this benefit when a Covered Person has recurrence of a covered condition as shown on the Schedule of Benefits if:

- The Standard Critical Illness Benefit for this condition was payable for the Covered Person;
- The condition is shown as Covered in the Recurrence Critical Illness Benefit on the Schedule of Benefits;
- The Covered Person was treatment free for this covered condition during the [6] months prior to the date of diagnosis of this recurrence;
- The Covered Person has returned to work for at least [6] months prior to the date of diagnosis of this recurrence;
- The date of diagnosis of this recurrence of this condition is while coverage under this Policy is in force; and
- The Maximum Benefit Amount has not been paid for that Covered Person.

The amount You will receive is based on the amount of coverage in effect on the date of diagnosis. All benefits paid will reduce the available Maximum Benefit Amount.**]**

[Childhood Critical Illness Benefits
We will pay this benefit when a covered Child is diagnosed with a covered condition while this coverage is in force as shown on the Schedule of Benefits and defined in this Policy. The amount You will receive is based on the amount of coverage in effect on the date of diagnosis.

This benefit is payable once per covered Child. All benefits paid will reduce the available Maximum Benefit Amount.**]**

[Skin Cancer Benefit

We will pay this benefit, subject to the terms and limitations of this Policy and after the Waiting Period shown on the Schedule of Benefits, when the Covered Person is diagnosed with:

- Stage 1 melanoma; or
- Basal cell or squamous cell carcinoma of the skin.

In no event will the amount payable exceed the Skin Cancer benefit amount shown on the Schedule of Benefits.

Any benefits paid under this provision will reduce the available Maximum Benefit Amount.]

EXCLUSIONS

This Policy will not pay for losses resulting from any intentionally self-inflicted injury.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE

ELIGIBILITY FOR COVERAGE

You are eligible for coverage under this Policy if:

1) Your application is approved by Us; and
2) You are Actively at Work on the date the application for this Policy is signed.

An Eligible Dependent is eligible for coverage on the later of:

1) The date You are eligible for insurance; or
2) The date You acquire the Dependent.

An Eligible Dependent is deemed to be acquired as follows:

a) Spouse: On the date of the marriage or the date the Domestic Partnership/Civil Union is established;
b) Natural Child: On the date of birth;
c) Adopted Child: On the date the child is placed in Your custody pursuant to an interim or permanent court order of adoption;
d) Stepchild: On the date of Your marriage to the child's parent or the date the Domestic Partnership/Civil Union is established; or
e) Grandchild: On the date the child is dependent on You or Your Spouse for Federal Income Tax purposes.

ADDITION OF ELIGIBLE DEPENDENTS

1) Newborns: Coverage for a newborn is effective from the moment of birth provided that We receive written notice of the newborn within 45 days after birth, and You pay all required premiums within 31 days after receiving a notice of amount due. If notification of a newborn is received more than 45 days after birth, coverage will be effective on the date written notification is received by Us, provided You pay all required premiums within 31 days after receiving a notice of amount due;
2) Newly Adopted Children: Coverage for an adopted child is effective from the date of an interim or permanent court order of placement. For coverage to continue, We must receive written notice of adoption within 45 days after the date of the interim or permanent court order; and You must pay all required premiums within 31 days after receiving a notice of amount due. Failure to provide notice within the required time period will not end coverage if it is shown that the notice was furnished as soon as reasonably possible. If notification of the interim or permanent court order of adoption is received more than 45 days after the date of the interim or permanent court order, coverage will be effective on the date written notification is received by Us, provided You pay all required premiums within 31 days after receiving a notice of amount due; or
3) Other than a Newborn or Newly Adopted Child: You must complete and sign an application that includes Your Dependents. If approved by Us, the additional coverage will be effective on the monthly anniversary of the Policy Effective Date following approval.

[INTERIM COVERAGE

This Policy will be in force from the date of Your application for coverage to the Policy Effective Date if:

1) A payroll deduction authorization or request for electronic funds transfer (EFT) payment is executed on the date of Your application; and
2) The proposed Covered Persons are insurable for insurance according to Our rules and practices in effect on the date of Your application.]

TERMINATION OF COVERAGE
Your coverage will terminate at the earliest of:

1) The end of the period for which premium is paid, subject to the Grace Period;
2) The monthly anniversary of the Policy Effective Date following the date We receive Your written request to have Your insurance terminated;
3) The date of Your death; [or]
[4] The date a new Critical Illness Insurance Policy issued by Combined Insurance Company of America becomes effective; or]
[5] The date on which the Maximum Benefit Amount shown on the Schedule of Benefits has been paid in full for all Covered Persons.

Dependent coverage will terminate at the earliest of:

1) The end of the period for which premium is paid, subject to the Grace Period;
2) The monthly anniversary of the Policy Effective Date following the date a Dependent ceases to be a Dependent as defined;
3) The date Your coverage terminates, except as provided in the Dependent Conversion provision;
4) The monthly anniversary of the Policy Effective Date following the date We receive Your written request to terminate Dependent coverage for Your Spouse and/or Dependent child(ren); or
5) The date on which the Dependent's the Maximum Benefit Amount shown on the Schedule of Benefits has been paid in full.

CONTINUATION FOR INCAPACITATED CHILDREN
Dependent children insured hereunder who are incapable of self-sustaining employment due to mental illness, developmental disability, or mental retardation or physical handicap, and who became incapacitated prior to the age at which Dependent coverage would otherwise terminate and who are chiefly dependent on You for support and maintenance, may continue to be covered regardless of age.

You must claim incapacitated status within 31 days of such child attaining the age at which coverage for the Dependent would otherwise terminate. We will require proof of incapacity as often as necessary, but not more than once a year. We have the right to examine the Dependent but not more than once a year. Coverage for an incapacitated Dependent child will end on the earliest of:

1) The date the Dependent marries;
2) The date the Dependent obtains self-sustaining employment;
3) The date the Dependent ceases to be incapacitated;
4) The date the Dependent ceases to be chiefly dependent upon You for support and maintenance;
5) Sixty (60) days after a written request for proof of incapacity, if proof is not provided within such 60 days;
6) The date You or Your Dependent refuses to allow Us to examine the Dependent; or

7) The monthly anniversary of the Policy Effective Date following the date We receive Your written request to terminate Dependent coverage for Your Dependent child(ren).

DEPENDENT CONVERSION
If coverage of the Spouse listed in the Policy Specifications terminates due to Your death or divorce or annulment of Your marriage, or termination of the Domestic Partnership/Civil Union, the Spouse may purchase an individual critical illness policy. The Spouse may elect to include coverage for Dependent children under the new policy if coverage for Dependent children is terminated under this Policy due to Your death or by Your request at the time of the divorce, annulment, or termination of the Domestic Partnership/Civil Union.

The Spouse must apply for conversion within 60 days after the death, divorce, annulment or termination of the Domestic Partnership/Civil Union and pay the premium for the continued coverage within 31 days after application is made. No evidence of insurability will be required.

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The effective date of the new policy will be the effective date of the termination of coverage under this Policy. The benefits provided in the new policy shall be substantially the same as the benefits provided under this Policy. The premium for the new policy will be that applicable to the attained age of the Spouse and the form and amount of insurance issued. The class of risk under the new policy will be the same as the class of risk under this Policy, or the most comparable class available.

CLAIM PROVISIONS

NOTICE OF CLAIM
Written notice of claim must be given to Us at Our address shown on the first page of this Policy or as otherwise designated in writing by Us within 20 days after loss covered by this Policy occurs or starts. If notice is not given within that time, it must be given as soon as reasonably possible. Notice must be received by Us. The notice should include Your name, address, telephone number, and Policy Number as shown in the Policy Specifications.

CLAIM FORMS
When We receive the notice of claim, We will send the claimant forms for filing Proof of Loss. If these forms are not sent to the claimant within 15 days of our receipt of the notice of claim, the claimant will meet the Proof of Loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision below.

PROOF OF LOSS
Proof of Loss means the written claim form and other information requested by Us substantiating the nature and extent of the loss. Proof of Loss must be completed and returned to Us within 90 days after the covered loss begins, or as soon as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after one year from the date Proof of Loss is otherwise required. You must give us the information We need to determine the reasonableness of any delay, if a benefit is payable, and how much the benefit should be.

TIME OF PAYMENT OF CLAIMS
Benefits payable under this Policy will be paid immediately upon Our receipt of written Proof of Loss that is satisfactory to Us.

PAYMENT OF CLAIMS
After We receive written Proof of Loss and process Your claim, We will pay any benefits due. Benefits will be paid to You. Any accrued benefits unpaid at Your death will be paid to the Beneficiary. If You did not name a Beneficiary, or if no Beneficiary survives You, any benefits due will be paid to Your estate. If benefits are payable to an estate or to a person who cannot give a valid release, We may in our discretion pay up to $1,000 to someone related to You or Your Beneficiary by blood or marriage. We will be discharged from all liability for any such payment made in good faith.

UNPAID PREMIUM
On payment of a claim under this Policy, any premium then due and unpaid will be deducted from Your claim payment.

REFUND OF PREMIUM AT DEATH
Upon notice of Your death, We will refund to the Beneficiary the portion of any premium that applies to a period beyond the end of the Policy month in which death occurred.

GENERAL PROVISIONS

ENTIRE CONTRACT
This Policy is a legal contract between You and Us. The entire contract consists of the Policy, application, and any endorsements, riders or amendments. No change in this Policy will be effective until approved by the President, a Vice President, or the Secretary of our Company. This approval must be noted on or attached to this Policy. No agent or broker has the authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES
After two (2) years from the Policy Effective Date, We cannot use misstatements, except fraudulent misstatements, in Your application form to void coverage or deny a claim for loss incurred after the expiration of the two (2) year period.

LEGAL ACTIONS
You cannot bring a legal action to recover benefits under Your Policy for at least 60 days after You have given Us written Proof of Loss. You cannot start such an action more than three (3) years after the date Proof of Loss is required.

PAYMENT OF PREMIUM
This Policy is issued in consideration of the application form information You have provided and payment of the first premium. The first premium is due on the Policy Effective Date. Subsequent premiums are due and payable in advance. If You do not pay the premiums when due, this Policy will terminate subject to the Grace Period. The amount and frequency of premium payments are shown in the Policy Specifications.

All premiums are payable to Us or as otherwise designated in writing by Us. Premiums are payable while coverage continues. Premiums may be paid annually, semi-annually, quarterly, monthly or, subject to Company rules. You may change the frequency of premium payments by filing a written request in a form satisfactory to the Company.

GRACE PERIOD
After You pay the first premium, if a premium is not paid on or before the date it is due, it may be paid during the next 31 days. These 31 days are called the Grace Period. Coverage shall remain in force during the Grace Period. If any premium is unpaid at the end of the Grace Period, coverage shall automatically terminate and this Policy will no longer be in force. This Grace Period does not apply if You request termination of this Policy.

REINSTATEMENT
If coverage ends for failure to pay premium, You may apply for reinstatement by submitting an application form and the required premium. Such application form must be submitted within six (6) months from the date coverage ended. If We approve Your application, this Policy will be reinstated on the date of approval of such application form. If We do not notify You that We have approved or disapproved the reinstatement application form, this Policy will be reinstated on the 45th day after We receive Your completed reinstatement application form and the required premium has been paid to Us.

The reinstated Policy will cover only losses that result from covered Critical Illnesses that occur after the date the Policy is reinstated.

In all other respects, the rights of all parties will remain the same, subject to any provisions noted on or attached to the reinstated Policy. The statements in Your application form for the reinstated Policy will be measured from the date of reinstatement with respect to the time periods stated in Time Limit on Certain Defenses provision.

CONFORMITY WITH STATE STATUTES
Any provision of this Policy which, on its effective date, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

MISSTATEMENT OF AGE OR TOBACCO USAGE
If a Covered Person's age has not been stated correctly, an adjustment in premium, coverage, or both, will be made. The adjustment will correct the coverage to what the premium paid would have bought at the Covered Person's true age. This change will be based on our rates in effect on the Policy Effective Date.

If the Coverage Person did not accurately state he or she used tobacco, an adjustment in premium, coverage, or both will be made.

BENEFICIARY
The Beneficiary for benefits payable upon Your death will be the Beneficiary named in the Policy application, unless You have changed the Beneficiary designation. Unless specifically designated as irrevocable, You may change the Beneficiary designation by written notice satisfactory to Us. An irrevocable Beneficiary designation may only be changed with the consent of such irrevocable Beneficiary. Unless You specify otherwise, the Beneficiary change will take effect as of the date the written notice was signed by You, subject to any payment or other action taken by Us prior to receipt of such notice. The consent of any Beneficiary, other than an irrevocable Beneficiary, is not required to surrender or assign this Policy, or to make any other changes in this Policy.

If any Beneficiary dies before You, that Beneficiary's interest will pass to any other designated Beneficiaries according to their respective interests. If more than one Beneficiary is designated in a class, each Beneficiary who survives You will receive an equal portion of any benefits payable unless otherwise set forth in the Beneficiary designation.

PHYSICAL EXAMINATION AND AUTOPSY
We have the right to have a Covered Person examined when and as often as is reasonable during the handling of a claim and do an autopsy where it is not forbidden by law. If We initiate the request, either or both will be done at Our expense.

NOTICE
If there are any questions about this Policy or if anyone seeks to replace this Policy, please contact a Combined Insurance Company of America agent or the Home Office of the Company. All inquiries should be in writing, stating the Policy Number.