**Coverage Waiting Period -** Benefits are available immediately for injuries sustained from a Covered Accident; however, there is a 30 day coverage waiting period for any benefits relating to an illness.

- No benefits will be paid for the diagnosis of a Critical Illness or Emergency Treatment for a Covered Illness during this 30-day Coverage Waiting Period.

This coverage may remain in effect, with timely premium payment, until you choose to terminate coverage. We may cancel this Policy on the last day of a month (or the 14th day of a month if the Effective Date of the Policy is the 15th of any month) only for a reason permitted by law.

This Policy will automatically be renewed annually unless we choose to change the rates, benefits or any other Policy provisions. If there is a change in rates, benefits or Policy provisions, you will be given written notice 30 days prior to the date of the change. You may reject such change by providing us a request to terminate your Policy at least 15 days prior to the date such change is due to take place. If we do not receive any notice of termination, the Policy will be renewed annually from that time forward.

## Exclusions and Limitations

### Exclusions Pertaining to ALL of the Benefits under this Policy

The benefits of this Policy will not be payable for any loss due to:

1. participation in or attempting to commit a felony or the commission of a crime for which the Member has been convicted;
2. intentionally self-inflicted injuries, suicide, or any attempt at suicide, regardless of mental capacity; or
3. unlawful instigation and/or active participation in a riot or war; whether declared or undeclared, armed invasion or aggression, insurrection, or rebellion.

### Exclusions Pertaining to Accidental Death and Emergency Treatment Benefits Only

In addition to the Exclusions shown above, the Accidental Death and Emergency Treatment Benefits of this Policy will not be payable for any loss due to:

1. an Accidental Injury sustained prior to the Member's Effective Date of coverage;
2. participation in parachuting, bungee jumping or hang gliding sports, or an organized race or speed contest involving motor vehicles of any type;
3. being legally intoxicated or being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Physician;
4. any bacterial infection except pyogenic infections which occur due to a Covered Accidental Injury; however, bacterial infection, when the provisions of the Policy are met, will be considered a Covered Illness for Emergency Treatment Benefits;
5. service in the armed forces of any country;
6. engaging in any illegal or fraudulent occupation, work, or employment; or
7. operating or riding in any kind of aircraft except as a fare-paying passenger on a regularly scheduled commercial flight.

### Exclusions Pertaining to Critical Illness Benefits Only

This Policy pays Critical Illness Benefits only for a loss resulting from a Specified Critical Illness diagnosed in the United States or its Territories.

In addition to the Exclusions shown above, the Critical Illness Benefits of this Policy will not be payable for a loss incurred as a result of the following:

1. conditions other than the Specified Critical Illnesses shown in the Schedule of Benefits for Critical Illnesses; or
2. diagnosis of a Specified Critical Illness during the 30-day Coverage Waiting Period.

**Please Read the Policy Carefully -** This Outline of Coverage provides a very brief description of the important features of the Policy. Please note that this outline is not intended to be a part of the insurance contract. Only the actual Policy provisions are final and binding. The Policy itself sets forth in detail your rights and obligations as well as those of the insurance company. **Keep this document for your records.**

Please see the Policy for more detailed information concerning covered benefits, exclusions and limitations.

LifeMap Assurance Company
00 SW Market Street
P.O. Box 1271 E-8L
Portland, OR 97207-1271
(800) 756-4105

# Individual Critical Illness and Emergency Treatment
# How To Apply

- You may elect coverage for yourself, your Spouse, and your Dependent Children under the age of 26. You and your Spouse must enroll in coverage prior to age 65; however, you may continue to be covered by this policy after age 65.
- Complete the application in full. Missing information may cause your Effective Date to be delayed.
- Select the Plan Option that you are making application for.
- Calculate the premium for the Plan Option chosen, rate of payment (monthly or quarterly), and the age of each person you are making application for. (Refer to the following rate calculation pages.)
- If applying by mail, the initial premium payment must be included with your application.
- You may also apply online at www.LifeMapCo.com. If applying online you may elect to authorize automatic monthly or quarterly credit card payments or automatic electronic check payments.
- Sign the application and the Authorization for Use and Disclosure of Protected Health Information.
- If your application is approved, the Policy Effective Date will be 12:01 a.m. on the **latest** of the day **after** the date we receive your application by mail, the day **after** online application is submitted, or the date you request.
- If you answered “Yes” to any of the questions numbered 1 through 3 on the application, **the policy cannot be issued.**
- Send the completed application and your check or money order for the full initial payment amount (made payable to LifeMap Assurance Company) to:

LifeMap Assurance Company
PO Box 1271, MS E-8L
Portland, OR 97207-1271

## Refunds

If you are not satisfied with the Individual Critical Illness and Emergency Treatment Policy, you may return the policy within 10 days of delivery for a full refund of premium. After that time, any termination of coverage will be subject to the provisions of the Policy.

If you have any questions regarding this coverage, please call toll-free 1-800-794-5390.

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# Individual Critical Illness and Emergency Treatment Rate Page

**Instructions for Calculating Your Policy Premium and Total Payment**

1. Determine your premium by first choosing from the plan options below:

   Both plans offer an Accidental Death Benefit in the amount of $25,000 for you and your enrolled Spouse and $5,000 for each enrolled Dependent Child.

| **Critical Illness Benefit** - Payable once per Member per Lifetime | **Plan Option 1** | **Plan Option 2** |
|---|---|---|
| **Diagnosis of a Critical Illness*** | $5,000 | $10,000 |
| * The Critical Illness Benefit Amount reduces by 50% on the first premium due date after age 75**.** | | |

**Emergency Treatment Benefits** - Payable once per Member per Covered Accident or Illness, and twice per Member per Benefit Year.

| | Plan Option 1 | Plan Option 2 |
|---|---|---|
| **Emergency Medical Treatment** | | |
| Due to a Covered Accidental Injury | $250 | $500 |
| Due to a Covered Illness | $125 | $250 |
| **Hospital Admission** | | |
| Due to a Covered Accidental Injury | $500 | $1,000 |
| Due to a Covered Illness | $250 | $500 |
| **Emergency Dental Treatment for a Broken Tooth** | | |
| Repaired with a crown, denture or implant | $200 | $400 |
| Resulting in extraction | $50 | $100 |

2. Refer to the following rate chart. Choose whether you would like to pay your premium monthly or quarterly. Find the appropriate rate per person, based on each Member's age on the Effective Date, using the Plan Option chosen above.

3. Add each Member's rate, based on their age. This equals your Total Monthly or Quarterly Premium.

**Premium Rates per Person**

| | Plan Option 1 | | Plan Option 2 | |
|---|---|---|---|---|
| Issue Age | Monthly | Quarterly | Monthly | Quarterly |
| 18 - 29 | 7.36 | 22.08 | 13.74 | 41.22 |
| 30 - 39 | 10.56 | 31.68 | 20.13 | 60.39 |
| 40 - 49 | 18.19 | 54.57 | 35.39 | 106.17 |
| 50 - 64 | 33.30 | 99.90 | 65.62 | 196.86 |
| Dependent Child - must be under age 26 | 4.75 | 14.25 | 9.46 | 28.38 |

**Please see the example on the following page.**

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**Example**

1. Plan Option 1 chosen
2. I would like to pay my premium ☒ Monthly or ☐ Quarterly

| | | |
|---|---|---|
| Monthly / Quarterly Rate for the Primary Insured, age 33 | | $10.56 |
| Monthly / Quarterly Rate for the Spouse, age 29 | + | $ 7.36 |
| Monthly / Quarterly Rate for the first Dependent Child | + | $ 4.75 |
| Monthly / Quarterly Rate for the second Dependent Child | + | $ 4.75 |
| 3. **Total Monthly / Quarterly Premium Due** | **=** | **$27.42** |

**Your Rate Calculation**

1. Plan Option ______ chosen
2. I would like to pay my premium ☐ Monthly or ☐ Quarterly

| | | | |
|---|---|---|---|
| Monthly / Quarterly Rate for the Primary Insured, | age _____ | | $_________ |
| Monthly / Quarterly Rate for ________________________, | age _____ | + | $_________ |
| Monthly / Quarterly Rate for ________________________, | age _____ | + | $_________ |
| Monthly / Quarterly Rate for ________________________, | age _____ | + | $_________ |
| Monthly / Quarterly Rate for ________________________, | age _____ | + | $_________ |
| Monthly / Quarterly Rate for ________________________, | age _____ | + | $_________ |
| 3. **Total Monthly / Quarterly Premium Due** | | **=** | **$_________** |

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| Home Office Use Only |
| --- |
| Policy # |
| Eff. Date |
| Check # |

# Individual Critical Illness and Emergency Treatment Insurance Application

**For residents of Oregon and Washington,** the definition of a Spouse includes your legal husband, wife, state certified/registered domestic partner and non- state certified/registered domestic partner if you have completed and returned to us the Affidavit of Non-State Certified/Registered Domestic Partnership.

**For residents of Idaho and Utah,** the definition of a Spouse includes your legal husband or wife.

**NOTE:** Coverage begins at 12:01 a.m. on your Effective Date. Effective Dates are the first or the fifteenth of the month. Your Effective Date will be the **latest** of the next Effective Date **after** the date we receive your application by mail, **after** online application is submitted, or the date you request.

Coverage will take effect only upon receipt of full premium. If applying online, automatic monthly payments to a credit card or automatic monthly electronic check payments are available.

Missing information will result in the need for a new application. A new application may result in a delayed Effective Date. In no event may the Effective Date of this Policy be back-dated.

**Please complete all information on this page and on Page 2**

| Applicant's Name (Last, First, Middle) | | ☐ M ☐ F | Date of Birth |
| --- | --- | --- | --- |
| Social Security Number | ☐ Married ☐ Divorced ☐ Single | | Telephone Number ( ) |
| Home Address & Apt. No./Mailing Address | City | | State Zip |

**Plan Selection**

**I am making application for:**
☐ **Plan Option 1 or** ☐ **Plan Option 2** Please see the Outline of Coverage or the Rate Page for plan descriptions.

**Requested Effective Date**

Your requested Effective Date must be following the date we receive your application, after the date your application is signed, and within 60 days from the date of your signature, or a new application will be required.

In no event may the Effective Date of this Policy be back-dated.

☐ 1st OR ☐ 15th of ____________________ (month) _____________ (year)

**Dependents to be enrolled:** Dependent Children must be under 26 years of age.

| Name (Last, First, M.I.) | Social Security Number | Date of Birth | Sex | **Relationship** (Spouse, Child) |
| --- | --- | --- | --- | --- |
| | | | ☐ M ☐ F | |
| | | | ☐ M ☐ F | |
| | | | ☐ M ☐ F | |
| | | | ☐ M ☐ F | |

If enrolling additional dependents, please attach a separate sheet including the information above.

**Please complete the information on Pages 2 and 3 of this application before signing and returning to us.**

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## Individual Critical Illness and Emergency Treatment Insurance Application (continued)

**Premium**

| |
|---|
| **Would you like to pay your premium** ☐ **Monthly or** ☐ **Quarterly** |
| Total Monthly / Quarterly Premium Due $___________ See the Rate Page for instructions on your rate calculation. |
| + $ 10.00 Policy Fee (This is a one-time fee due at the time of application) |
| **Total Initial Payment Due = $___________ (Enclosed)** |

**Please answer Yes or No to all questions** for yourself, your Spouse and your Dependent Children.

| Question | Answer |
|---|---|
| 1. Are you, or any person to be insured, age 65 or older? | ☐ YES ☐ NO<br>**If YES, this policy cannot be issued.** |
| 2. Within the past 10 years has any person applying for coverage been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)? | ☐ YES ☐ NO<br>**If YES, this policy cannot be issued.** |
| 3. Within the past 5 years has any person applying for coverage been diagnosed or treated for any of the following:<br>a. a heart or circulatory disorder, stroke, transient ischemic attack (TIA), heart palpitations, or uncontrolled blood pressure;<br>b. diabetes;<br>c. disease or disorder of the urinary system including the kidneys and bladder;<br>d. cancer or malignancy of any kind (other than basal cell or squamous cell carcinoma of the skin);<br>e. major organ failure or transplant;<br>f. Systemic Lupus Erythematosus;<br>g. a neurological disorder (except for a controlled seizure disorder without a seizure in the past 2 years);<br>h. paralysis including paraplegia and quadriplegia; or<br>i. Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease). | ☐ YES ☐ NO<br>**If YES, this policy cannot be issued.** |

**Beneficiary Designation for Accidental Death Benefits.**

| Beneficiary's Name (Last, First, Middle) | | ☐ M ☐ F | Date of Birth |
|---|---|---|---|
| Social Security Number | Relationship to you | Telephone Number ( ) | |
| Home Address & Apt. No./Mailing Address | City | State | Zip |

According to the provisions of the Policy, if one of your Eligible Dependents dies as the result of a Covered Accident we will pay the applicable Benefit Amount to you. If you die as the as the result of a Covered Accident we will pay the applicable Benefit Amount to your Beneficiary.

**Please complete the information on Pages 1 and 3 of this application before signing and returning to us.**

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## Individual Critical Illness and Emergency Treatment Insurance Application (continued)

I understand that:

1) if my application for coverage is accepted, the Effective Date will be the latest of the next Effective Date after the date my application is received by LifeMap Assurance Company by mail, after my online application is submitted, or the date I request; and
2) if my application for coverage is not accepted, any premium I paid will be promptly refunded.

I acknowledge and understand LifeMap Assurance Company (LIFEMAP) may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) from time to time for the purpose of business operations necessary to administer benefits, to review or pay claims; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

1) a physician, dentist, pharmacist or other health care practitioner;
2) a clinic, hospital, long-term care or other medical facility;
3) any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
4) an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

**Disclosure:** If you have an insurance producer, they may receive bonuses, commissions, administrative service fees or other compensation, including non-cash compensation, from LifeMap. Incentives may be based on any of several factors, including the products you buy, your insurance producer's volume of business with LifeMap and the other services your insurance producer provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your insurance producer.

**Insurance Fraud Warning:**

**Unless specific state language is provided below,** the following general fraud notice applies: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

**For residents of Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**Please Note: This is a supplemental policy** that only pays a benefit in the event of an Accidental Death, diagnosis of a Specified Critical Illness or Emergency Treatment for a Covered Accident or Illness. **This is a limited benefit policy. Coverage is not provided for major medical expenses.**

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all entitlements to benefits are void and the contract may be canceled or modified retroactively to its effective date.

► ______________________________ ______________________________
Applicant's Full Name (please print clearly) Applicant's Signature

► ______________ ______________ ______________________________
Date Signed Insurance Producer Number Licensed Producer's Name / Agency (Please Print)

**Please sign and return the Authorization Form on the following page with your application.**

LifeMap Assurance Company
200 SW Market Street
P.O. Box 1271 E-8L
Portland, OR 97207-1271
(800) 756-4105

# Authorization for Use and Disclosure of Protected Health Information

I authorize any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to LifeMap Assurance Company (LifeMap) or its representatives health information (including alcohol, chemical dependency, genetic testing or HIV treatment) pertaining to me and/or my eligible dependents. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan and eligibility for benefits or payment of claims. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose to not sign this authorization, LifeMap may be unable to enroll my family or me in the health plan or to pay claims that were incurred while we had insurance coverage with LifeMap.

I may cancel this authorization at any time by sending a written request to LifeMap. Cancellation of this authorization will not affect any action LifeMap took before it received this request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this policy and all claims arising from the policy have been settled, or in 24 months from the date below, whichever comes first. A photocopy of this authorization is as valid as the original.

Federal law requires LifeMap to tell me that if the party to whom LifeMap discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, part 2). Federal law prohibits redisclosure of this information without specific written authorization.

▶ ______________________________________________ ____________________
Primary Insured's Full Name (please print clearly) Date Signed

▶ ______________________________________________
Primary Insured's Signature *If signed by a personal representative of the Insured, please complete the following:

▶ ______________________________________________
Name of the representative of the Primary Insured (Please print)

Relationship to Primary Insured: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*

*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

▶ ______________________________________________ ____________________
Primary Insured Spouse's Signature Date Signed

**THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES**
(Notes recorded and separately maintained by a mental health professional documenting
or analyzing the contents of conversation during a counseling session.)

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P.O. Box 1271 E-8L
Portland, OR 97207-1271
(800) 756-4105

# AFFIDAVIT OF NON-STATE REGISTERED DOMESTIC PARTNERSHIP

An Affidavit of Non-State Registered Domestic Partnership is required before any domestic partner benefits may be granted. One affidavit may be used for any of the insurance benefits available to domestic partners.

**Name of Policyholder: ________________________________________ ID #: _____________________________________**

**Domestic Partner's Name: ____________________________________ Date Domestic Partnership Began: _____________**

I certify that _______________________________ and I are domestic partners and that we meet the following criteria:
Name of Domestic Partner

- We are each 18 years of age or older;
- We share a close personal relationship and are responsible for each other's common welfare;
- We are each other's sole domestic partner;
- We share the same regular and permanent residence, with the current intent to continue doing so indefinitely;
- We are jointly financially responsible for "basic living expenses" including food, shelter, and medical expenses
- We are not legally married to anyone, nor have had another domestic partner within the previous 30 days;
- We are not related by blood closer than would bar marriage in our state of residence; and
- We were both mentally competent to contract when our domestic partnership began.

**CHANGE IN DOMESTIC PARTNERSHIP:**

I_________________________________ agree to inform LifeMap Assurance Company within 30 days
Name of Policyholder
of any change in our domestic partnership status that would make the domestic partner no longer eligible for benefits by filing a *Termination of Non-State Registered Domestic Partnership Statement.*

Upon termination or dissolution of this domestic partnership, the policyholder named herein agrees that he/she cannot file another affidavit for a minimum of 90 days from the date of termination.

**ACKNOWLEDGEMENT:**

We understand that this information will be held confidential and will be subject to disclosure only upon express written authorization, in any action involving the enrollment or eligibility of the domestic partner, or if otherwise required by law. We understand that this declaration of responsibility for our common welfare may have legal implications under State law. We further understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, arising from false or misleading statements contained in the Affidavit of Non-State Registered Domestic Partnership. We also certify under penalty of perjury, under our State laws, that the foregoing is true and correct.

Policyholder's Signature: _______________________________________________________Date: ___________________

Domestic Partner Signature: _____________________________________________________Date: ___________________

Policyholder and Domestic Partner's Home Address:

_________________________________________________________________________________________
Address

____________________________________, __________________ ________________
City State Zip

Return your signed Affidavit of Non-State Registered Domestic Partnership to LifeMap Assurance Company. Your completed affidavit should accompany any necessary benefit enrollment forms.

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LifeMap Assurance Company
200 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
(800) 756-4105

# PRIVACY NOTICE

(Retain with your insurance records)

We, at LifeMap Assurance Company (LifeMap), know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. Because we endeavor to earn and keep your trust, we have long-standing privacy policies, robust training, and full-time staff dedicated to protecting privacy. We also maintain physical, administrative, and technical safeguards to protect your personal information from unauthorized access. Even if you are no longer a LifeMap member, we protect the confidentiality of your personal information as if you were.

**Marketing**
While other companies may sell or rent your contact information, LifeMap never sells or rents your personal information for marketing purposes. If you want LifeMap to share your personal information with a nonaffiliated third party so the third party can market to you, you must give us your express permission.

**Your Personal Information**
We collect personal information such as your name, contact information, health information, and financial information from you, your providers, and other insurers that provide coverage to you. We use this information to provide services to you and to conduct insurance transactions. You may receive a copy of your personal information by contacting us at the phone number or address below. We will not disclose your personal information unless we are permitted or required by law or you give your permission. As permitted or required by law, we may provide personal information to our affiliates and agents, reinsurers, insurance administrators, consultants, or regulatory and governmental authorities. We obligate entities receiving this information on our behalf to protect it in the same way that we protect it.

**Changes to Our Practices**
We may change our privacy practices in an effort to provide even better protection. If we change our privacy practices in a material way, we will notify current customers in writing.

**Contact Us**
If you have any questions about our privacy program, you may contact us at (800) 794-5390 or write to:

LifeMap Privacy Official
P.O. Box 1271, Mailstop E12P
Portland, OR 97207