STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

LIMITED BENEFIT PLANS – VERIFICATION SCRIPT

GEORGIA

❒Hello, This is _____ from Standard Life and Accident Insurance Company. The reason for this call is to confirm your selection of benefits for the Limited Medical plan and ensure everything was typed correctly. This call is being recorded for quality assurance.

❑ Name of the agent_____

❒Let me confirm your name: _____

❒Do you reside at (full address)._____

❒Today's date is xx/xx/xxxx.

❒ **VOICE CONSENT** We want to confirm that you agreed to the completion of your application for the Limited Benefit Plan over the telephone, and that the plan benefits, legal notices and cost of the insurance were reviewed with you. You agree that your voice consent will serve as your signature and you understand that Standard Life and Accident Insurance Company will rely on your signature unless you revoke this consent. You can update your information or revoke this consent at any time by calling Standard Life and Accident Insurance Company's Customer Service Center at 1-888-350-1488 or in writing to: Standard Life and Accident Insurance Company, One Moody Plaza, Galveston, Texas 77550.

If you are in agreement with this consent, please say yes.

❒**SPOUSE'S ACKNOWLEDGEMENT** (*if applying for coverage*)
We want to confirm that you have permission to answer health questions on behalf of your spouse and that you have full knowledge of your spouse's health history. You realize that coverage is provided based on statements and answers given on the application. Any incorrect or incomplete information even if you were just unaware of their medical history may result in loss of coverage or claim denial.

❒ **ACKNOWLEDGEMENT:** You understand that the coverage applied for provides limited benefits and is not a major medical or comprehensive medical benefit plan and is not a substitute for such coverage. The Policy is limited and is not designed to cover all medical expenses.
To confirm your understanding of these statements, please say yes.

❒ We want to make certain you understand the benefits provided by this coverage. We know this is rather long, but we feel it is important to assure that you have a clear understanding of exactly what is covered by this policy. This coverage is indemnity coverage. That means it does

not pay a set percentage of medical bills, rather this coverage pays a set dollar amount. These amounts are as follows:

READ FOR PLAN 1:

- Hospital Confinement Benefit $500 for sickness, $1,000 for injury; maximum of 365 days per year
- Intensive Care Benefit $1,000 per day for sickness, $2,000 for injury; maximum of 30 days per year
- Continuous Care after a Hospitalization benefit $250 per day for sickness, $500 for injury; maximum 30 days per year
- Inpatient Surgery benefit $500 per day
- Inpatient Anesthesia $100 per day
- Inpatient Substance abuse or Mental Illness treatment benefit $100 per day, maximum 30 days per year
- Outpatient Doctor's Office Visit benefit $50 per visit for sickness, $100 per visit for injury; maximum 2 per year
- Outpatient Diagnostic test, X-Ray or lab benefit $25 per day for sickness, $50 for injury; maximum 2 per year
- Ground Ambulance benefit $100 per day for sickness, $200 for injury; maximum 2 per year
- Air Ambulance benefit $1,000 per day for sickness, $2,000 for injury; maximum 2 per year
- Outpatient Surgery Benefit $500 per day
- Outpatient Anesthesia benefit $100 per day
- Ambulatory Surgery Center benefit $50 per day for sickness, $100 per day for injury
- Emergency Room visit $50 per day, 1 per year for sickness; $100 per day, 2 per year for injury
- Outpatient Wellness Visit benefit $50 per day, once per year
- Accidental Death benefit $10,000, or $20,000 if it is on a common carrier
- Dislocated Bone benefit – up to $1,500
- Fractured Bone benefit – up to $2,500
- Optional Critical Illness benefit - $5,000 for the first diagnosis

To confirm your understanding of these statements, please say yes. [Wait for response]

READ FOR PLAN 2:

- Hospital Confinement Benefit $1,000 for sickness, $2,000 for injury; maximum of 365 days per year
- Intensive Care Benefit $2,000 per day for sickness, $4,000 for injury; maximum of 30 days per year
- Continuous Care after a Hospitalization benefit $500 per day for sickness, $1,000 for injury; maximum 30 days per year
- Inpatient Surgery benefit $1,000 per day
- Inpatient Anesthesia $200 per day
- Inpatient Substance abuse or Mental Illness treatment benefit $150 per day, maximum 30 days per year
- Outpatient Doctor's Office Visit benefit $50 per visit for sickness, $100 per visit for injury; maximum 2 per year
- Outpatient Diagnostic test, X-Ray or lab benefit $50 per day for sickness, $100 for injury; maximum 2 per year

- Ground Ambulance benefit $125 per day for sickness, $250 for injury; maximum 2 per year
- Air Ambulance benefit $1,000 per day for sickness, $2,000 for injury; maximum 2 per year
- Outpatient Surgery Benefit $1,000 per day
- Outpatient Anesthesia benefit $200 per day
- Ambulatory Surgery Center benefit $75 per day for sickness, $150 per day for injury
- Emergency Room visit $75 per day, 1 per year for sickness; $150 per day, 2 per year for injury
- Outpatient Wellness Visit benefit $75 per day, once per year
- Accidental Death benefit $10,000, or $20,000 if it is on a common carrier
- Dislocated Bone benefit – up to $2.000
- Fractured Bone benefit – up to $5,000
- Optional Critical Illness benefit - $5,000 for the first diagnosis

To confirm your understanding of these statements, please say yes. [Wait for response]

READ FOR PLAN 3:

- Hospital Confinement Benefit of $1,500 for sickness, $3,000 for injury; maximum of 365 days per year
- Intensive Care Benefit $3,000 per day for sickness, $6,000 for injury; maximum of 30 days per year
- Continuous Care after a Hospitalization benefit $500 per day for sickness, $1,000 for injury; maximum 30 days per year
- Inpatient Surgery benefit $1,000 per day
- Inpatient Anesthesia $200 per day
- Inpatient Substance abuse or Mental Illness treatment benefit $150 per day, maximum 30 days per year
- Outpatient Doctor's Office Visit benefit $60 per visit for sickness, $120 per visit for injury; maximum 2 per year
- Outpatient Diagnostic test, X-Ray or lab benefit $75 per day for sickness, $150 for injury; maximum 2 per year
- Ground Ambulance benefit $150 per day for sickness, $300 for injury; maximum 2 per year
- Air Ambulance benefit $1,000 per day for sickness, $2,000 for injury; maximum 2 per year
- Outpatient Surgery Benefit $1,000 per day
- Outpatient Anesthesia benefit $200 per day
- Ambulatory Surgery Center benefit $100 per day for sickness, $200 per day for injury
- Emergency Room visit $100 per day, 1 per year for sickness; $200 per day, 2 per year for injury
- Outpatient Wellness Visit benefit $100 per day, once per year
- Accidental Death benefit $10,000, or $20,000 if it is on a common carrier
- Dislocated Bone benefit – up to $2.000
- Fractured Bone benefit – up to $5,000
- Optional Critical Illness benefit - $5,000 for the first diagnosis

To confirm your understanding of these statements, please say yes. [Wait for response]

READ FOR PLAN 4:

- Hospital Confinement Benefit of $2,000 for sickness, $4,000 for injury; maximum of 365 days per year
- Hospital Admission benefit $500, paid once for the day of admission
- Intensive Care Benefit $4,000 per day for sickness, $8,000 for injury; maximum of 30 days per year
- Continuous Care after a Hospitalization benefit $500 per day for sickness, $1,000 for injury; maximum 30 days per year
- Inpatient Surgery benefit $1,000 per day
- Inpatient Anesthesia $200 per day
- Inpatient Substance abuse or Mental Illness treatment benefit $200 per day, maximum 30 days per year.
- Outpatient Doctor's Office Visit benefit $70 per visit for sickness, $140 per visit for injury; maximum 2 per year
- Outpatient Diagnostic test, X-Ray or lab benefit $100 per day for sickness, $200 for injury; maximum 2 per year
- Ground Ambulance benefit $150 per day for sickness, $300 for injury; maximum 2 per year
- Air Ambulance benefit $1,500 per day for sickness, $3,000 for injury; maximum 2 per year
- Outpatient Surgery Benefit $1,000 per day
- Outpatient Anesthesia benefit $200 per day
- Ambulatory Surgery Center benefit $150 per day for sickness, $300 per day for injury
- Emergency Room visit $150 per day, 1 per year for sickness; $300 per day, 2 per year for injury
- Outpatient Wellness Visit benefit $100 per day, once per year
- Accidental Death benefit $10,000, or $20,000 if it is on a common carrier
- Dislocated Bone benefit – up to $2.500
- Fractured Bone benefit – up to $7,500
- Optional Critical Illness benefit - $10,000 for the first diagnosis

To confirm your understanding of these statements, please say yes. [Wait for response]

READ FOR PLAN 5:

- Hospital Confinement Benefit of $3,000 for sickness, $6,000 for injury; maximum of 365 days per year
- Hospital Admission benefit $750, paid once for the day of admission
- Intensive Care Benefit $6,000 per day for sickness, $12,000 for injury; maximum of 30 days per year
- Continuous Care after a Hospitalization benefit $500 per day for sickness, $1,000 for injury; maximum 30 days per year
- Inpatient Surgery benefit $1,500 per day
- Inpatient Anesthesia $300 per day
- Inpatient Substance abuse or Mental Illness treatment benefit $300 per day, maximum 30 days per year.
- Outpatient Doctor's Office Visit benefit $80 per visit for sickness, $160 per visit for injury; maximum 2 per year
- Outpatient Diagnostic test, X-Ray or lab benefit $200 per day for sickness, $400 for injury; maximum 2 per year
- Ground Ambulance benefit $200 per day for sickness, $400 for injury; maximum 2 per year

- Air Ambulance benefit $2,000 per day for sickness, $4,000 for injury; maximum 2 per year
- Outpatient Surgery Benefit $1,500 per day
- Outpatient Anesthesia benefit $300 per day
- Ambulatory Surgery Center benefit $200 per day for sickness, $400 per day for injury
- Emergency Room visit $200 per day, 1 per year for sickness; $400 per day, 2 per year for injury
- Outpatient Wellness Visit benefit $125 per day, once per year
- Accidental Death benefit $10,000, or $20,000 if it is on a common carrier
- Dislocated Bone benefit – up to $2.500
- Fractured Bone benefit – up to $10,000
- Optional Critical Illness benefit - $10,000 for the first diagnosis

To confirm your understanding of these statements, please say yes. [Wait for response]

❑You understand that no benefits are payable for sickness during the first 30 days following the Policy Effective Date**.**

❑ You Understand that Pre-existing conditions are excluded for 12 months.

❑ **Read only if 65 or over**
If eligible for Medicare, you have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare.

To confirm your understanding of these statements, please say yes.

❑You understand that there are additional exclusions and limitations contained in the policy and you will have 30 days to review the terms and if you are not completely satisfied you can return it for a full refund.
To confirm your understanding of these statements, please say yes.

Now I am going to read the questions from the application to confirm that everything was recorded correctly.

1. Your current height is _____feet, _____inches and weight is _____pounds?
(Spouse current height is _____feet, _____inches and weight is _____pounds?)

2. Is any Applicant or Proposed Insured currently pregnant, an expectant parent, or in the process of adopting? (If Yes, this coverage cannot be provided.)

3. Has any Applicant or Proposed Insured had a driver's license suspended, any traffic violations, DWI/DUI/OUI's or been arrested within the last 2 years? If Yes give DL number and State of Issue.

4. In the past 2 years has any Applicant or Proposed Insured been advised to have any diagnostic/screening tests or procedures which have not been performed? (If yes – who?)

5. Within the past 5 years has any Applicant or Proposed Insured had any abnormal test results, treatment or been recommended to have treatment for any of the following conditions:

Acquired Immune Deficiency Syndrome (AIDS)
AIDS Related Complex (ARC)
Alcohol or Drug Abuse
Alzheimer's Disease
Arterial Disease
Bipolar Disorder/ Manic Depression
Bone Disease
Cerebrovascular Accident (CVA)
Chronic Obstructive Pulmonary Disease (COPD)
Cirrhosis
Crohn's Disease (ileitis)
Fibromyalgia
Heart Attack, Heart Disease or Heart Surgery
Hepatitis
Human Immunodeficiency Virus (HIV)
Insulin Dependent Diabetes
Internal Cancer
Kidney Disease
Liver Disease
Lou Gehrig's Disease (ALS)
Lung Disease (All Others)
Lupus Erythematosus
Major Depression
Melanoma Cancer
Multiple Sclerosis
Muscle Disease
Muscular Dystrophy
Myositis
Organ Failure
Organ Transplant
Organic Brain Syndrome
Osteoporosis w/ history of bone fracture
Paralysis (any type of degree)
Peripheral Vascular Disease
Rheumatoid Arthritis
Senile Dementia
Stroke
Substance Abuse
Transient Ischemic Attack (TIA)
Ulcerative Colitis

6. Is any Applicant or Proposed Insured taking any prescription medications?
(If yes provide the name and details)

7. Has any Applicant or Proposed Insured been disabled or hospitalized in the last 6 months?
(If yes provide the name and details)

8. Has any Applicant or Proposed Insured ever taken part in skydiving, hang gliding parachuting, bungee jumping, rock or mountain climbing, scuba diving, racing (any type), motorcycle riding, professional sports, piloting an aircraft or rodeo events? (If yes please explain activity)

❒**DECLARATION AND AGREEMENT:** It is declared that all statements and answers in this application are complete and true to the best of your knowledge and belief. You understand that this information will be used to determine each person's eligibility for coverage under the Policy and any false statement or misrepresentation may result in loss of coverage or claim denial. You (and your Spouse or Dependent, if applying) must be eligible based on the Company's rules in effect on the date of Application and on the Policy Effective Date. Policy coverage (or Reinstatement of coverage), if approved and issued by the Company, will become effective on the date recorded in the Policy Schedule of Benefits and not the date the application is signed. You understand that no agent or producer can accept risks, modify policies, or waive any rights or requirements of the Company.

Any person presenting a false or fraudulent claim for payment of a loss or benefit, or knowingly presenting false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

To confirm your understanding of these statements, please say yes.

❑ Is the billing address for your credit card/bank acct the same as the mailing address?

PREMIUM AUTHORIZATION

CHECKING ACCOUNT

❑ You were quoted a monthly premium of $ _____ for the XXXX Plan. The first month's premium will be charged to your credit/debit/checking/account and the renewal premiums will be automatically drafted from your checking account every month. We have your checking account routing # recorded as XXXXXXXXX and we have your checking account # recorded as XXXXXXXX. **To confirm this information, please say, yes.**

CREDIT/DEBIT CARD

❒ Based upon the information that was provided, you have been quoted a monthly premium of $_____ for the ____ plan. You authorize Standard Life and Accident Insurance Company (SLAICO) to charge your credit/debit card number for the amount due. You understand that this Recurring Payment Authorization is to remain in effect until SLAICO has received notification of termination of this authorization. If the payment date falls on a weekend or holiday, I understand that the payment may be executed on the next business day.

If the amount initially charged changes, SLAICO will provide notification of the new amount prior to the first scheduled transaction date. If necessary, SLAICO may initiate adjustments for any charges made in error or for any refunds due.

You certify that you are the authorized user of this credit/debit card and you will not dispute the payment with your credit card company; provided that the transactions correspond to the terms indicated in this authorization form.

To confirm your understanding of these statements, please say yes.

❒ You understand that this coverage does not meet the minimum standards required by The Federal Health Care Reform Law. Therefore, if you do not purchase or have comprehensive medical insurance, or unless you are exempt from the tax for some other reason, you may be subject to a tax penalty.

❒So I can confirm your understanding and agreement to the overall terms and conditions of the program, please verify your understanding by saying last 4 digits of your social security number.

❒That completes your verification. I will submit your application to the Underwriter for processing. Again, thank you for your time, and have a great day!