Allianz Life Insurance Company of North America
Home Office: Minneapolis, MN
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
(888) 503-8106

Subject to the terms and conditions described in this Policy, Allianz Life Insurance Company of North America agrees to pay to you the benefits described in this Policy. We make this agreement and issue this Policy in consideration of: (a) the statements made in your signed application; and (b) payment of the initial premium. This Policy takes effect at 12:01 A.M. Standard Time on the Policy Effective Date and is for:

Guaranteed Renewable Long Term Care Insurance

THIS POLICY IS INTENDED TO BE A QUALIFIED LONG TERM CARE INSURANCE CONTRACT AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE OF 1986 and will be endorsed to conform to changes in that definition. You should consult with your attorney, accountant, or tax advisor regarding the tax implications of purchasing this long term care insurance.

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long term care which you may incur during the period of coverage. You are advised to periodically review this Policy in relation to the changes in the cost of long term care.

CAUTION: The issuance of this Long Term Care Insurance Policy is based upon your responses to the questions on your application. A copy of your application is enclosed. If responses are incorrect or untrue, we may have the right to deny benefits or rescind your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.

IMPORTANT NOTICE: Please read the copy of the application attached to this Policy. Carefully check the application and write to the Company, ALLIANZ LIFE INSURANCE COMPANY OF NORTH AMERICA, P.O. Box 4243, Woodland Hills, CA 91365-4243, within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the Policy and the Policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

To obtain information about your coverage or for assistance in resolving complaints, you may contact the Company at the following toll free number: **1-888-503-8106**.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY: If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us.

RENEWABILITY: This Policy is guaranteed renewable for life. To renew, pay the premium due by the Premium Due Date or within the Grace Period. We cannot cancel or refuse to renew this Policy. Premiums are subject to change. We can only change the premium for this Policy if we change premiums for everyone in your state with the same Policy form. We must give you at least 45 days written notice at your last address shown in our records before we change your premium.

YOUR 30 DAY RIGHT TO EXAMINE YOUR POLICY: If you are not satisfied with this Policy, you may return it to our agent or us within 30 days from the date you receive it. We will then refund any premium you have paid and the Policy, all riders and attachments will be considered void from the start.

Read this Policy carefully. It is a legal contract between you and us.

Executed for the Company at its Home Office in Minneapolis, Minnesota.

Michael T. Westermeyer
Secretary

Margery G. Hughes
President

GUIDE TO YOUR POLICY

DEFINITIONS

You, Your means the person (or persons, for joint coverage) named as the insured(s) on the Benefit Schedule.

We, Us, Our means Allianz Life Insurance Company of North America.

Activities of Daily Living (ADLs) are the following:

- Bathing: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence: the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Dressing: putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Toileting: getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: moving into or out of a bed, chair, or wheelchair.

Adult Day Care is a program of services provided through an Adult Day Care Center that includes:

- care for six (6) or more individuals; and
- health-related services; and
- Maintenance or Personal Care Services; and
- recreational and social services provided during the day in a community group setting.

The purpose of such a program is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center is a facility licensed under state law, if any, to provide Adult Day Care. It provides Adult Day Care services to adults who do not require 24-hour institutional care, but are not capable of full-time, independent living.

Assisted Living Facility is a facility engaged primarily in providing ongoing care and related services, to adults who require such services, in one location, and which meets all of the following criteria:

- provides services for a period exceeding 24 hours; and
- provides continuous room and board (e.g., housing and food services); and
- provides Maintenance or Personal Care required by residents due to their inability to perform the Activities of Daily Living or due to Cognitive Impairment; and
- is licensed under Florida law to provide such care as described.

Assisted Living Facility does not include Hospitals. Unless otherwise excluded in this Policy, Assisted Living Facilities include facilities otherwise named (such as adult congregate living facility), but which meet the above criteria. For confinement in a facility in any other state, the appropriate licensing laws of that state (if such licensing is required) will apply to that facility.

Benefit Schedule is page 3 of this Policy that shows: insured information; Policy information; and benefit information.

Chronically Ill means that within the previous 12 months, you have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity; or
- having a severe Cognitive Impairment.

Cognitive Impairment is your deterioration or loss of intellectual capacity, which requires Substantial Supervision by another person to protect yourself or others from threats to health and safety. It is measured by clinical evidence and standardized tests that reliably measure your impairment in:

- short or long term memory;
- your orientation as to person (such as who you are), place (such as your location) and time (such as day, date and year);
- deductive or abstract reasoning.

A Cognitive Impairment includes Alzheimer's disease and similar forms of irreversible dementia.

Facility Care is care provided to you in a Nursing Home or an Assisted Living Facility.

Family includes you or your spouse; and the mother, father, sister, brother, and children of either you or your spouse.

Home and Community Services are Qualified Long Term Care Services provided to you through: Adult Day Care; Home Care; and Hospice Care.

Home Care is a program of services provided to you through a Home Health Care Agency, including:

- professional nursing care by or under the supervision of a RN or nurse; or
- care by a Home Health Aide; or
- therapeutic care services by or under the supervision of a speech, occupational, physical, or respiratory therapist licensed under state law, if any; or
- homemaker services.

Home Care can be provided to you in a setting other than a Nursing Home, Hospital, or an Assisted Living Facility.

Home Health Aide is a person, other than a RN or nurse, who provides: Maintenance or Personal Care; medical; speech; occupational; physical; or respiratory therapeutic care services under the supervision of a Home Health Care Agency.

A Home Health Aide must be duly licensed or certified under state law, if any; and acting within the scope of his or her license or certification at the time the treatment or service is performed.

Home Health Care Agency is a Hospital, agency, or other provider licensed under state law, if any, to provide Home Care.

Hospice Care is Qualified Long Term Care Services provided in the event you are diagnosed with a terminal disease. Hospice Care helps you, your primary caregiver and your Family with the physical, social and spiritual needs brought about by your terminal illness.

Hospital is an institution or facility that is:

- licensed as a Hospital by the proper authority of the state in which it is located; or
- accredited as a Hospital by the Joint Commission on Accreditation of Hospitals (JCAH).

Licensed Health Care Practitioner is:

- a physician as defined in section 1861(r)(1) of the Social Security Act; or
- a Registered Nurse; or
- a Licensed Social Worker.

The Licensed Health Care Practitioner must not be a member of your Family. Nor can the Licensed Health Care Practitioner nor any member of the Licensed Health Care Practitioner's Family be an owner or in any way control the operation of a facility in which you receive care or treatment.

Licensed Social Worker is a duly licensed social worker acting within the scope of their license at the time the treatment or service is performed.

The Licensed Social Worker must not be a member of your Family. Nor can the Licensed Social Worker nor any member of the Licensed Social Worker's Family be an owner or in any way control the operation of a facility in which you receive care or treatment.

Maintenance or Personal Care Services is any care provided primarily to give needed assistance to you as a result of your being Chronically Ill (including protection of your health and safety due to a severe Cognitive Impairment).

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Mental or Nervous Disorders are: affective disorders; anxiety disorders; personality disorders; psychotic disorders; or other mental or emotional disease or disorders. This does not include Alzheimer's, Parkinson's, or other demonstrable organic diseases such as senile dementia.

Nursing Home is a facility or a distinctly separate part of a hospital or other institution which:

- is licensed by the appropriate licensing agency to engage primarily in providing nursing care and related services to inpatients; and
- provides 24-hour a day nursing service; and
- has a nurse on duty or on call at all times; and
- maintains clinical records for all patients.

Nursing Home does not include:

- facilities or parts thereof used or licensed as an Assisted Living Facility; or
- convalescent homes, board and rest homes, homes for the aged, residential care facilities, domiciliary and retirement care facilities, or training centers; or
- government or veterans facilities or any other facility where the patient is not required to pay.

Nursing Home Care means Qualified Long Term Care Services performed in a Nursing Home or an Assisted Living Facility, or Maintenance or Personal Care Services performed in an Assisted Living Facility.

Plan of Care is a written plan prescribed by a Licensed Health Care Practitioner developed in consultation with you, based upon an assessment indicating you are Chronically Ill.

The Plan of Care will recommend the necessary services to be performed. In addition, it will specifically identify the frequency and type of care most suitable to meet your needs, as well as the most appropriate providers for such care.

Policy is this contract with Allianz Life Insurance Company of North America.

Policy Effective Date is the date coverage under this Policy is first in force. This date is shown on the Benefit Schedule.

Qualified Long Term Care Services are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services, and Maintenance or Personal Care Services which are required by you when you are Chronically Ill, and are provided pursuant to a Plan of Care.

Registered Nurse (RN) means a duly licensed registered graduate professional nurse acting within the scope of their license at the time the treatment or service is performed.

The RN must not be a member of your Family. Nor can the RN, nor any member of the RN's Family, be an owner or in any way control the operation of a facility in which you receive care or treatment.

Respite Care is short term Qualified Long Term Care Services provided to relieve family or friends who are providing long term care to you in your residence.

Substantial Assistance means hands-on or stand-by assistance of another person without which you would be unable to perform the Activities of Daily Living.

Substantial Supervision means continual supervision by another person to protect you or others from threats to health or safety. Such supervision may include cueing by verbal prompting, gestures, or other similar demonstrations.

BENEFIT PROVISIONS

Eligibility for Benefits

While this Policy is in force, you will be eligible for benefits if you are certified as being Chronically Ill, which means that within the previous 12 months, you have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance, at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity; or
- having a severe Cognitive Impairment.

Payment of Benefits

While this Policy is in force, you will receive benefits if:

- you satisfy the Eligibility for Benefits provision; and
- you receive services covered under this Policy; and
- you satisfy the claim requirements in the CLAIM PROCEDURES section; and
- you are in a Benefit Payment Period; and
- your claim is not subject to any limitation or exclusion contained in this Policy.

Elimination Period

Your Elimination Period must be satisfied before we will pay you benefits, unless otherwise noted. Your Elimination Period is the number of days on which you:

- meet the requirements defined in the Eligibility for Benefits provision; and
- are receiving either Nursing Home Care, or **if you have coverage under this Policy for Home and Community Services,** are receiving Home and Community Services; and
- are not receiving benefits under this Policy.

Your Elimination Period is shown on the Benefit Schedule. Each day of covered services under this Policy, unless otherwise noted, counts towards your Elimination Period. Once you have satisfied the Elimination Period, no future Elimination Period is required. Days may be accumulated under separate claims in order to satisfy the Elimination Period. The Elimination Period applies to each insured individually in the case of joint coverage.

Benefit Payment Period

A Benefit Payment Period will:

- begin on the date following your completion of the Elimination Period; and
- end on the date you either: (a) no longer meet the Payment of Benefits requirements in this Policy; or (b) exhaust the Benefit Amount, whichever occurs first.

Benefit Amount

Your Benefit Amount is shown on the Benefit Schedule.

The Benefit Amount for Facility Care and the Benefit Amount for Home and Community Services **(if shown on the Benefit Schedule)** are separate amounts, and may not be combined.

Your Benefit Amount for Facility Care and your Benefit Amount for Home and Community Services are shown on the Benefit Schedule. All benefits paid under this Policy are subtracted from the applicable Benefit Amount.

Restoration of the Benefit Amount

The Benefit Amount may be restored, if for a period of 180 consecutive days:

- this Policy is in force; and
- you are not in a Benefit Payment Period; and
- you do not meet the Eligibility for Benefits requirements in this Policy (i.e. you must have recovered).

The Benefit Amount for Facility Care and the Benefit Amount for Home and Community Services **(if shown on the Benefit Schedule)** are restored separately, and may not be combined.

The Benefit Amount may be restored an unlimited number of times.

Nursing Home Benefit

During a Benefit Payment Period and while you are confined in a Nursing Home, we will pay a benefit for each day of Nursing Home Care you receive.

Payment will be the actual daily Nursing Home charges you incur, up to the Nursing Home Daily Benefit. Your Nursing Home Daily Benefit is shown on the Benefit Schedule. Benefits paid are subtracted from the Benefit Amount for Facility Care.

Assisted Living Facility Benefit

During a Benefit Payment Period and while you reside in an Assisted Living Facility, we will pay a benefit for each day of Nursing Home Care you receive.

Payment will be the actual daily Assisted Living Facility charges you incur, up to the Assisted Living Facility Daily Benefit. Your Assisted Living Facility Daily Benefit is shown on the Benefit Schedule. Benefits paid are subtracted from the Benefit Amount for Facility Care.

Home and Community Services Benefit

The Home and Community Services Benefit is covered and payable only if there is a dollar value shown on the Benefit Schedule for this benefit. Your Home and Community Services Daily Benefit, **if any**, is shown on the Benefit Schedule.

During a Benefit Payment Period, we will pay for covered Home and Community Services (Adult Day Care, Home Care, Hospice Care) you receive, so long as: you are not receiving Nursing Home Benefits or Assisted Living Facility Benefits; and you are not confined in a Hospital.

Payment will be the actual Home and Community Services charges you incur, up to the Home and Community Services Daily Benefit. Benefits paid are subtracted from the Benefit Amount for Home and Community Services.

Bed Reservation Benefit

During a Benefit Payment Period, we will pay you a Bed Reservation Benefit if you:

- are confined in a Nursing Home or reside in an Assisted Living Facility; and
- become hospitalized; and
- are billed by the Nursing Home or Assisted Living Facility to reserve your accommodations.

Payment will be the actual daily Nursing Home or Assisted Living Facility charges you incur, up to the Nursing Home Daily Benefit or Assisted Living Facility Daily Benefit, as appropriate. The Daily Benefits are shown on the Benefit Schedule. Benefits paid are subtracted from the Benefit Amount for Facility Care. This benefit is payable for a maximum of 21 days per calendar year.

Respite Care Benefit

If you meet the requirements in the Eligibility for Benefits provision, we will pay a Respite Care Benefit for:

- the actual daily charges you incur for each day of Nursing Home Care in a Nursing Home, up to the Nursing Home Daily Benefit; or
- the actual expenses you incur for each day you receive Home and Community Services (**if shown on the Benefit Schedule),** up to the Home and Community Services Daily Benefit.

Benefits paid are subtracted from the Benefit Amount for Facility Care or from the Benefit Amount for Home and Community Services, depending on the service provided. Days on which you receive a Respite Care Benefit will not count towards the Elimination Period. The Respite Care Benefit is payable for a maximum of 21 days per calendar year.

Alternative Plan of Care Benefit

An Alternative Plan of Care provides for Qualified Long Term Care Services which may include: equipment purchases or rentals; permanent or temporary modifications to your residence (such as ramps or rails); or care services not normally covered under the Home and Community Services Benefit. The Alternative Plan of Care is not available for providing Home and Community Services Benefits on policies providing Facility Care only. We reserve the right to make the final decision on any request for the Alternative Plan of Care Benefit.

We will pay for an Alternative Plan of Care if:

- you are in a Benefit Payment Period; and
- you, your Licensed Health Care Practitioner, and we agree that an Alternative Plan of Care is: (a) medically acceptable; and (b) the most cost efficient manner in which to provide benefits for your claim under this Policy; and
- you have not exhausted the Benefit Amount shown in the Benefit Schedule; and
- you agree that you will not receive payments for any other benefits under this Policy while Alternative Plan of Care benefits are being paid.

All benefits paid under an Alternative Plan of Care are subtracted from the Benefit Amount for Facility Care.

Personal Care Advisor

A Personal Care Advisor is available to assist you with questions regarding such matters as:

- Eligibility for Benefits; or
- appropriate level of care; or
- availability of facilities and other care and service resources in your area; or
- any other questions you may have about a claim for benefits.

You can contact your Personal Care Advisor by calling the toll-free number shown on the front of this Policy.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Limitations and Exclusions

No benefits will be paid for any confinement, care, treatment, or service(s):

- provided to you by a person in your Family;
- that results from attempted suicide or intentionally self-inflicted injury;
- that results from voluntary participation in a felony, attempted felony, or illegal occupation;
- provided outside the United States or Canada;
- that results from a sickness or injury for which benefits are provided under any state or federal worker's compensation law or similar law;
- for which you have no financial liability or that is provided at no charge in the absence of insurance;
- provided in a government facility (unless otherwise required by law);
- provided for the treatment of alcoholism or drug addiction, or in facilities operated primarily for such treatment;
- provided as a result of your being intoxicated or under the influence of a narcotic, except to the extent that the alcohol or narcotics are prescribed by a physician; or
- provided in facilities operated primarily for the treatment of Mental or Nervous Disorders.

Pre-Existing Conditions Limitation

A Pre-Existing Condition is a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services in the 6 months immediately prior to the Policy Effective Date.

We will not pay benefits for a loss due to a Pre-Existing Condition if the loss begins during the first 6 months after your Policy Effective Date. However, if a Pre-Existing Condition is disclosed on your application and you otherwise qualify for benefits, benefits will be paid for such a loss.

If this Policy is replacing another long term care Policy or certificate, we will waive any time periods applicable to Pre-Existing Conditions for similar benefits to the extent that similar exclusions have been satisfied under the original Policy or certificate.

CLAIM PROCEDURES

Notice of Claim

You must give us written Notice of Claim within 30 days after you begin receiving care or services covered under this Policy, or as soon thereafter as reasonably possible. You may give notice or you may have someone do it for you. The notice must provide us with sufficient information to identify you. It should be mailed to us at our Long Term Care Administrative Office, or to one of our agents.

Claim Forms

After you notify us of a claim, we will send you or your representative a claim form used for filing Proof of Loss. You or your representative must complete it and return it to us.

If we do not send you a claim form within 15 days of your notice to us, you may meet the Proof of Loss requirement by giving us a written statement within the time limit stated in the Proof of Loss section. The written statement must give us information sufficient to identify you and must outline the nature and extent of your loss.

Proof of Loss

You will be considered to have provided Proof of Loss when we receive a completed claim form and any necessary statements or bills which include the date, nature, and charges for all covered care you have received. Proof of Loss must be sent to us within 90 days after the date of your loss. If it is not possible to give us timely Proof of Loss, we will not reduce or deny your claim if Proof of Loss is filed as soon as you reasonably can provide the information to us.

If we do not pay benefits upon receipt of written Proof of Loss, we will mail you within 30 working days, a letter which states our reasons for not paying the claim, either in whole or in part. The letter will also provide you with a written itemization of any documents or other information needed to process the claim or any portions not paid.

In no event, except in the absence of legal capacity, can Proof of Loss be submitted later than one year from 90 days after the date of your loss.

Time of Payment of Claims

After we receive written proof of loss, we will pay monthly, all benefits then due for Long Term Care. Benefits for any other loss covered by this policy will be paid as soon as we receive proper written proof.

We will reimburse all claims, or any portion of any claim from you or your assignees for payment under this policy, within 45 days after our receipt of the claim. If a claim or a portion of a claim is contested by us, we will notify you or your assignees, in writing, that the claim is contested or denied, within 45 days after our receipt of the claim. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

Upon our receipt of any additional information we requested from you or your assignees, we will pay or deny the contested claim or a portion of the contested claim, within 60 days.

We will pay or deny any claim no later than 120 days after our receipt of the claim.

Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

All overdue payment shall bear interest at the rate of 10 percent per year.

Payment of Claims

We will pay all benefits to you or your assignee. Such payments will discharge us to the full extent of those payments. If unassigned benefits remain due upon your death, we will pay any amount remaining due as described in the Beneficiary section.

Extension of Benefits

Termination of this Policy will not terminate any benefits payable for Facility Care if your confinement begins while your Policy is in force and continues without interruption after the Policy terminates. Any benefits payable under this provision are subject to: the Benefit Amount; any applicable Elimination Period; and all other provisions and limitations of this Policy.

Coordination of Benefits with Medicare

Benefits are not payable under this Policy for expenses incurred to the extent that such expenses are reimbursable under Medicare or would be so reimbursable but for the application of a deductible or coinsurance amount.

Beneficiary

The Beneficiary will be the person or persons, named in the application or subsequently changed by written request, to receive any unassigned benefit payments due upon your death (second-to-die in the case of joint coverage).

You may change the Beneficiary at any time by giving us written notice. A change will not be effective until recorded by us. Once recorded, the change will apply as of the date the request was signed. We will not be liable for any action taken or payment made before a Beneficiary change is recorded. The Beneficiary's consent is not required to change the Policy or Beneficiary, unless the designation of the Beneficiary is irrevocable.

If you designate more than one person as Beneficiary, the interests of all Beneficiaries will be equal unless your designation specifically provides otherwise. The share of any Beneficiary who does not survive you shall pass equally to the surviving Beneficiaries, unless your designation specifically provides otherwise. If no Beneficiary is designated or no Beneficiary survives you, then your estate will be the Beneficiary.

Examinations
We may require that a physician or other individuals practicing within the scope of their licenses examine you, while a claim is pending or while you are receiving benefits, as often as reasonably required. We will pay for these examinations and will choose the individual to perform them.

Appealing a Claim
We will evaluate your claim based on the provisions of this Policy and the information given by you, your physician, and other available sources. We will inform you in writing if we deny your claim or any part of your claim. If you do not agree with a claim decision, you or your representative may appeal the denial. The appeal must be in writing to us and include all information that pertains to the claim. No special form is needed. We will review your request and notify you or your representative of our decision within 30 days of receiving the request.

Right of Recovery
If we make any errors in processing your claim, we have the right to recover any overpayment of benefits. We will recover by offset any amounts that have not been previously recovered at the time we make another benefit payment.

Legal Action
Legal action to recover benefits under this Policy may not be started earlier than 60 days after required Proof of Loss has been filed with us. Further, no legal action may be started after the expiration of the applicable Statue of Limitation from the time required Proof of Loss is required to be filed with us.

POLICY ADMINISTRATION

Entire Contract; Changes
This Policy and the attached application, plus any additional attachments, is the entire contract. No agent, employee, or person other than one of our officers has authority to change the Policy. Any change must be shown on your Policy and approved in writing.

Incontestability
If your Policy has been in force for less than six (6) months, upon a showing of misrepresentation that is material to the acceptance of coverage, we may rescind your Policy or deny an otherwise valid claim on your Policy.

If your Policy has been in force for at least six (6) months, but less than (2) years, and if we can show the misrepresentation is both material to the acceptance of coverage and that it pertains to the condition for which benefits are sought, we may rescind your Policy or deny an otherwise valid claim on your Policy.

After this Policy has been in force for two (2) years it is not contestable upon the grounds of misrepresentation alone. After two (2) years, the Policy may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

Misstatement of Age
If your age is misstated on the application, we may, at any time, adjust your benefits and/or premiums to reflect your correct age. If no coverage would have been provided based on your correct age, our liability will be limited to a refund of any premium paid for this Policy, and the Policy is null and void as of the Policy Effective Date.

Premium Due Dates

The first premium is due on the Policy Effective Date. After the first premium, premiums will be due in the amount and frequency shown on your premium statement.

Waiver of Premium

After you (either insured for joint coverage) have been confined in a Nursing Home or an Assisted Living Facility for a period of 90 days, and you meet the requirements in the Eligibility for Benefits provision, no premiums will be due following the 90th day. The 90 days need not be consecutive, but must be satisfied during a single claim period. Premiums already paid but no longer due will be refunded to you on a pro-rata basis.

Premiums will again be due after your confinement ends. Any subsequent confinement separated by a period of at least 180 consecutive days will be considered a new claim period, subject to a new 90 day waiting period as described above.

Payment Responsibility

You are responsible for payment of all your premiums due while coverage is in force. Payment shall be sent to us at our Long Term Care Administrative Office, or any other office that we may designate.

Unpaid Premium

Any premium due and unpaid may be deducted from any claim payment payable under this Policy.

Grace Period

Except for the first premium, you will have 31 days after each due date to pay the premium due.

If your premium is not paid by the 30th day of the Grace Period, we will notify you and an individual designated by you to receive notice of lapse due to non-payment of premium. Your Policy remains in force during the Grace Period.

If your premium is not paid by the 65th day after the due date, the Policy lapses.

Policy Termination

This Policy will terminate at 12:01 A.M. Standard Time and your coverage will end on the earliest of:

- the date we receive a written request from you (both insureds in the case of joint coverage) to cancel this Policy (or a later date specified by you in the cancellation request); or
- the date the Grace Period ends as described in the Grace Period provision; or
- the date of your death (second-to-die in the case of joint coverage).

Reinstatement – Lapse Due to Cognitive Impairment or Functional Incapacity

If your coverage has lapsed due to your Cognitive Impairment or functional incapacity, your coverage may be reinstated without an application if:

- you or your representative requests reinstatement within six (6) months after your last premium was due; and
- we receive evidence satisfactory to us that you have a Cognitive Impairment or functional incapacity; and
- we receive all past due and unpaid premiums and any nonforfeiture benefits paid to you.

Your Policy will then be reinstated as of the date of lapse and both you and we shall have the same rights that existed prior to the due date of the premium in default.

Reinstatement – Lapse Due to Nonpayment of Premium

Without requiring an application, we may accept your past due and unpaid premiums and any nonforfeiture benefits paid to you, up to one year after lapse. Those payments will reinstate your Policy and put it back in force.

If we require an application for reinstatement, your coverage may be reinstated within one year after lapse if:

- you request reinstatement in writing; and
- we receive all past due and unpaid premiums (for which we will give you a conditional receipt) and any nonforfeiture benefits paid to you; and
- you complete the application for reinstatement; and
- you are insurable under our underwriting rules in effect at the time you apply for reinstatement.

Reinstatement by application will be effective:

- on the date we approve your application; or
- on the 45th day following the date of the conditional receipt, if we have not previously declined your application in writing.

Your reinstated Policy will cover only loss due to:

- sickness incurred more than 10 days after the date of reinstatement; and
- injury sustained after the date of reinstatement.

Upon reinstatement of your Policy both you and we shall have the same rights that existed prior to the last due date prior to lapse.

Premium rates for the reinstated Policy will be based on your original issue age.

Joint Coverage Provision

This Policy provides equal coverage for two individuals if both apply and are issued coverage under this Policy. The name of each insured covered under the Policy is shown on the Benefit Schedule.

All benefits, Eligibility for Benefits, Payment of Benefits, Elimination Periods, Benefit Payment Periods, and Limitations and Exclusions described in this Policy or shown on the Benefit Schedule apply to each insured individually and separately, unless otherwise noted.

When more than one individual is covered under this Policy, if one of you dies, upon receipt of proof of death, coverage continues for the surviving insured at the premium rate that would have been charged for an individual Policy at the original issue age and risk class of the surviving insured. However, the premium will be based on the premium rate table in effect at the time of the death of the joint insured. Any unearned portion of the difference between the original joint premium and the new premium will be refunded on a pro-rata basis. The new premium for the continued coverage will be due on the Policy's next Premium Due Date.

If you divorce or legally separate and request termination of joint coverage, upon receipt of proof of divorce or legal separation, we will convert the joint Policy to separate individual policies with the same coverage, effective on the next Premium Due Date, terminating your joint coverage on that date. Your converted coverage will be at the same premium rate that would have been charged for an individual Policy at your original issue age and risk class. However, the premium will be based on the premium rate table in effect on the date the conversion is effective.

Each of you will have 30 days to examine your converted Policy. Otherwise, it may be returned to us or our agent within 30 days after it is received. We will then refund any premium paid for the converted coverage and the Policy will be considered void from the reissue date.

Other than divorce or legal separation, there is no right of conversion to an individual Policy. Coverage may be continued by timely payment of the joint premium rate, even if one of you no longer wants to be covered. In the event of the death of one of you, continued individual coverage will be offered as described above.

Policy Ownership

You (both insureds in the case of joint coverage) are the owner of this Policy unless otherwise provided in the application or changed by written request. While you are living, the owner may exercise every right and receive every benefit provided by this Policy. If the owner is not you and the owner dies while you are living, unless otherwise provided, all rights of the owner shall be transferred to the owner's executors or administrators.

Assignment

No assignment of interest under your Policy shall be binding upon us unless the original or a copy of the assignment is filed with us at our Long Term Care Administrative Office. We do not assume any responsibility for the validity of an assignment.

Refund of Unearned Premium

Upon your death (second-to-die in the case of joint coverage), we will refund any unearned premium for this Policy to your Beneficiary on a pro-rata basis. We will make this refund within 30 days of receipt of proof of your death.

If you (both insureds in the case of joint coverage) request in writing to cancel this Policy, we will refund any unearned premium to you on a pro-rata basis. Cancellation will be effective upon: receipt of your request; or a later date specified by you. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

Conformity with State Statutes

Any part of this Policy that, on the Policy Effective Date, conflicts with the laws of the state in which you reside on such date, is hereby amended to meet the minimum requirements of those laws.

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GUARANTEED RENEWABLE
LONG TERM CARE INSURANCE POLICY