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BANKERS LIFE AND CASUALTY COMPANY

A Legal Reserve Stock Company • Home Office: 222 Merchandise Mart Plaza • Chicago, Illinois 60654-2001

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

Caution: The issuance of this insurance policy is based upon Your responses to the questions on Your application. A copy of Your application will be attached to the policy. If Your answers are incorrect or untrue, We 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.

NAME OF INSURED		**POLICY NUMBER**
FIRST PREMIUM		**ISSUE DATE**
FIRST RENEWAL DATE	**GR-N325**	**POLICY FORM**

We, **BANKERS LIFE AND CASUALTY COMPANY**, promise to pay You, **the Insured**, the benefits provided by this policy. Benefits are subject to this policy's definitions, provisions, limitations, and exclusions.

GUARANTEED RENEWABLE - RENEWAL CONDITIONS

This policy is guaranteed renewable and may be renewed for each Family Member on any renewal date as long as such Family Member lives. To renew, pay the renewal premium at the intervals available to You at time of renewal. You must pay it by its due date or during the 31 days that follow. We can't refuse to renew this policy or place any restrictions on it if You pay the renewal premium on time.

PRE-EXISTING CONDITIONS LIMITATION

Pre-existing conditions are those medical conditions for which treatment was given or recommended by a Doctor within 6 months before the effective date of coverage.

Any loss due to a pre-existing condition isn't covered unless the loss begins more than 6 months after the Effective Date of coverage.

YOUR THIRTY DAY RIGHT TO RETURN THIS POLICY

If You are not satisfied with this policy, You may return it to Us within 30 days after You receive it. You may return it to Us by mail or to the agent who sold it. We'll then refund any premium paid and this policy will be void.

EFFECTIVE DATE

This policy begins at 12:01 a.m. Standard Time where You live on the Issue Date shown on the Schedule page. It ends, subject to the grace period, at 12:01 a.m. on the date any renewal premium is due.

READ THIS POLICY CAREFULLY AND REVIEW ALL POLICY LIMITATIONS!

This policy is a legal contract between You and Us. See the "Policy Guide" on page 1A.

This policy has been signed by Our President and Secretary on its Issue Date.

Secretary John J. Robb **President**

Countersigned by_____
Licensed Resident Agent

LIMITED BENEFIT CONVALESCENT CARE POLICY

POLICY GUIDE

APPLICATION NO. 0000000N325-STD

BANKERS LIFE AND CASUALTY COMPANY
222 MERCHANDISE MART PLAZA, CHICAGO, ILLINOIS 60654-2001
TELEPHONE 1-312-396-6000

SCHEDULE

NAME OF INSURED	[JOHN J. DOE]	[999,999,999]	POLICY NUMBER
FIRST PREMIUM	[$552.00]	[JANUARY 1, 1999]	ISSUE DATE
FIRST RENEWAL DATE	[JANUARY 1, 2000]	GR-N325	POLICY FORM

THE FOLLOWING BENEFITS APPLY TO THE INSURED FAMILY MEMBER SHOWN BELOW:

ELIMINATION PERIOD PER ANY ONE PERIOD OF EXPENSE: [20] DAYS OF SERVICES RECEIVED (DOES NOT APPLY TO HOSPICE SERVICES)

MAXIMUM BENEFIT FOR ANY ONE PERIOD OF EXPENSE: [$9,000.00]
BASED UPON A MAXIMUM BENEFIT MULTIPLIER OF: [90]

PART I, MAXIMUM DAILY BENEFIT AMOUNT FOR:
NURSING HOME CARE, ASSISTED LIVING FACILITY CARE AND BED RESERVATION EXPENSES, UP TO [$100.00]

PART II, MAXIMUM WEEKLY BENEFIT AMOUNT FOR:
HOME HEALTH CARE, ADULT DAY CARE AND HOSPICE CARE EXPENSES, UP TO [$700.00]

[OPTIONAL ANNUAL COMPOUND BENEFIT INCREASE: 5% COVERED]

FAMILY MEMBER			PLAN NO.	ANNUAL PREMIUM
DOE, JOHN		MALE		
BIRTHDATE:	12/01/38	AGE: 60	N325	[$276.00]

TOTAL FAMILY MEMBER ANNUAL PREMIUM: [$276.00]

[ ] INDICATES VARIABLE DATA

SCHEDULE CONTINUED ON NEXT PAGE.....

APPLICATION NO. 0000000N325-STD

BANKERS LIFE AND CASUALTY COMPANY
222 MERCHANDISE MART PLAZA, CHICAGO, ILLINOIS 60654-2001
TELEPHONE 1-312-396-6000

SCHEDULE

NAME OF INSURED [JOHN J. DOE] [999,999,999] POLICY NUMBER

FIRST PREMIUM [ ] [JANUARY 1, 1999] ISSUE DATE

FIRST RENEWAL DATE [JANUARY 1, 2000] GR-N325 POLICY FORM

THE FOLLOWING BENEFITS APPLY TO THE INSURED FAMILY MEMBER SHOWN BELOW:

ELIMINATION PERIOD PER ANY ONE PERIOD OF EXPENSE: [20] DAYS OF SERVICES RECEIVED (DOES NOT APPLY TO HOSPICE SERVICES)

MAXIMUM BENEFIT FOR ANY ONE PERIOD OF EXPENSE: [$9,000.00]
BASED UPON A MAXIMUM BENEFIT MULTIPLIER OF: [90]

PART I, MAXIMUM DAILY BENEFIT AMOUNT FOR FACILITY:
NURSING HOME CARE, ASSISTED LIVING FACILITY CARE AND BED RESERVATION EXPENSES, UP TO [$100.00]

PART II, MAXIMUM WEEKLY BENEFIT AMOUNT FOR:
HOME HEALTH CARE, ADULT DAY CARE AND HOSPICE CARE EXPENSES, UP TO [$700.00]

[OPTIONAL ANNUAL COMPOUND BENEFIT INCREASE: 5% COVERED]

FAMILY MEMBER				PLAN NO.	ANNUAL PREMIUM
DOE, JANE		FEMALE			
BIRTHDATE:	12/15/38	AGE:	60	N325	[$276.00]

TOTAL FAMILY MEMBER ANNUAL PREMIUM: [$276.00]

TOTAL POLICY ANNUAL PREMIUM: [$552.00]

[ ] INDICATES VARIABLE DATA

CONSIDERATION

We issued this policy in consideration of Your application (a copy is attached) and payment of the First Premium. This payment will keep the policy in force until the First Renewal Date. The First Premium and the First Renewal Date are shown on the Schedule page.

RENEWAL PREMIUM

We may change the premium rates for this policy. We can change the premium only if We change it for all policies like Yours in Your state on a class basis. We'll provide You with written notice of any change in the premium in the time required by Your state.

FAMILY MEMBER ADDITIONS

Your spouse is the only person You may add to this policy. To add Your spouse, send Us a completed application showing his or her eligibility. You must also send Us the needed premium. We'll add Your spouse if We approve the written application and the premium has been paid.

If You die, Your spouse, if covered under this policy, will become the Insured.

GENERAL DEFINITIONS

"Calendar Year" is the period beginning on the Issue Date and ending December 31 of that year. Thereafter it is the period from January 1 through December 31 of each following year.

"Covered Expenses" are defined and limited below in the provisions titled PART I and PART II COVERED EXPENSES.

"Doctor" means any licensed practitioner of the healing arts acting within the scope of his or her license in treating any injury or sickness. It doesn't include a member of the Immediate Family.

"Family Member" means You, and Your spouse if named on the Schedule page or added to this policy.

"Hospital" means a place which is defined as a hospital and approved for payment as a hospital by Medicare, or accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

Hospital doesn't mean convalescent, nursing, rest or skilled nursing facilities, nor places that primarily treat the aged, drug addict or alcoholic, including units in a Hospital used for such care.

"Immediate Family" means You, Your spouse, and the children, siblings, grandchildren, and parents of either You or Your spouse.

"Licensed Health Care Practitioner" means any licensed Doctor, registered professional nurse or licensed social worker. It doesn't include a member of the Immediate Family.

"Medicaid" means "The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

"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 Illness" means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder or any kind. It doesn't mean a demonstrable organic brain disease, such as Parkinson's Disease, Alzheimer's Disease or senile dementia.

"We", **"Us"**, and **"Our"** refer to Bankers Life and Casualty Company.

"You", **"Your"**, and **"Yours"** refer to the Insured named on the Schedule.

BENEFIT PROVISIONS

Important terms used within the following Benefit Provisions are shown in bold print and quotation marks and defined therein.

A. CONDITIONS FOR BENEFIT ELIGIBILITY

Before benefits under this policy are payable:

(1) a Licensed Health Care Practitioner must certify that the Covered Expenses provided below are needed because the Family Member:
  (a) has a Functional Incapacity; OR
  (b) is Cognitively Impaired; OR
(2) a Doctor must certify the Family Member requires such services for Medically Necessary Care; AND
(3) a Elimination Period, if any, must be satisfied.

We may periodically review the necessity of care and treatment. Our review may include: (1) diagnosis, symptoms, complaints, and complications of a condition; (2) the reason for the services being rendered; (3) a Licensed Health Care Practitioner's orders; (4) schedule of treatment; (5) physical limitations and impairments; and (6) the objectives of the Licensed Health Care Practitioner's Home Health Care Plan.

"Cognitive Impairment" means a deterioration or loss in intellectual capacity which requires Substantial Supervision to protect oneself or others from threats to health and safety. Cognitive Impairment is measured by clinical evidence or standardized tests that reliably measure impairment in one's: (1) short or long-term memory; (2) orientation as to people, places, or time; and (3) deductive or abstract reasoning.

Such loss of intellectual capacity can result from the following covered conditions: Alzheimer's Disease, Parkinson's Disease, senile dementia or other nervous or mental disorders of organic origin.

"Elimination Period" means the number of days a Family Member must receive services included under Part I or Part II Covered Expenses before benefits are payable. The Elimination Period has to be satisfied for any one period of expense, under this policy, for such Family Member. It restores when benefits are restored. It does not apply to Hospice Care. The Elimination Period for a Family Member is shown on the Schedule page.

CONDITIONS FOR BENEFIT ELIGIBILITY (Continued):

"Functional Incapacity" means one's inability to engage in two or more of the activities of daily living without the Hands-on Assistance or Standby Assistance of another person. For the purposes of this policy, the activities of daily living used to measure Functional Incapacity, and their definitions, are:

"Bathing" - to wash 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 a 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 table, a plate, cup or other receptacle 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.

"Hands-on Assistance" means physical assistance without which one would be unable to perform an activity of daily living.

"Medically Necessary Care" means all medical services and supplies which: (1) are provided in accordance with accepted standards of medical practice; (2) are provided as needed by the patient's condition; (3) do not exceed in scope, duration, or intensity that level of care which is needed to provide safe, adequate and appropriate care; and (4) where ongoing treatment is not provided solely for the patient's, patient's family, or Doctor's convenience.

"Standby Assistance" means another person must be within arm's reach of an individual to prevent, by physical intervention if necessary, injury while performing an activity of daily living.

"Substantial Supervision" means continual supervision (which may include cuing by verbal prompting, gestures or other demonstrations) by another person that is necessary to protect a Cognitively Impaired person from threats to his or her own health or safety.

B. BENEFIT PAYMENTS

Subject to the Conditions for Benefit Eligibility and the Benefit Limitations provisions, We'll pay for the charges incurred, up to: (1) the Maximum Daily Benefit amount, per day, for the total of all Part I Nursing Home Care, Assisted Living Facility Care and Bed Reservation Covered Expenses; and (2) the Maximum Weekly Benefit amount for the total of all Part II Home Health Care, Hospice Care and Adult Day Care Covered Expenses.

An expense is incurred on the date the service or treatment is given or the supply is bought. To be covered, the expense must be incurred while this policy is in force for the Family Member.

"Maximum Daily Benefit" for Part I Covered Expenses means the maximum amount We'll pay per day for a Family Member, after any applicable Elimination Period, for Nursing Home Care, Assisted Living Facility Care or Bed Reservation Covered Expenses. The Maximum Daily Benefit amount for such Family Member is shown on the Schedule page.

BENEFIT PAYMENTS (Continued)

"Maximum Weekly Benefit" for Part II Covered Expenses means the maximum amount We'll pay per Week for each Family Member, after any applicable Elimination Period, for Home Health Care, Adult Day Care and Hospice Care Covered Expenses. The Maximum Weekly Benefit amount applies to Part II Covered Expenses only and is shown on the Schedule page.

A **"Week"** means a period of seven (7) days beginning on Sunday and ending on the following Saturday. For Any One Period of Expense that begins on any day other than Sunday, the Maximum Weekly Benefit is payable from such day until the following Saturday.

C. BENEFIT LIMITATIONS

We won't pay more per day than the Maximum Daily Benefit amount shown on the Schedule page for the total of all Part I Nursing Home Care, Assisted Living Facility Care and Bed Reservation Covered Expenses. We won't pay more per Week than the Maximum Weekly Benefit amount shown on the Schedule page for the total of all Part II Home Health Care, Hospice Care and Adult Day Care Covered Expenses.

We won't pay more than the Maximum Benefit for Any One Period of Expense for the total of all Covered Expenses (Part I and Part II) combined. We won't pay benefits under both Part I and Part II when expenses are incurred on the same day. In such case, benefits will be payable for the earliest incurred expense for that day.

"Any One Period of Expense" begins when a Family Member first incurs a charge for Covered Expenses under this policy. It ends on the earlier of when: (1) after six consecutive months, during which the Family Member has not required any treatment or services for those conditions which caused the prior One Period of Expense; OR (2) the Maximum Benefit has been exhausted.

"Maximum Benefit" means the maximum amount We'll pay a Family Member for the combined total of all Covered Expenses (Part I and Part II) during Any One Period of Expense. This amount is equal to the Maximum Daily Benefit amount times the Maximum Benefit Multiplier. The Maximum Benefit amount for a Family Member is shown on the Schedule page.

"Maximum Benefit Multiplier" is the number used to multiply the Maximum Daily Benefit by in order to equal the Maximum Benefit amount payable for Any One Period of Expense. The Maximum Benefit Multiplier is shown on the Schedule page.

D. PART I COVERED EXPENSES

1. NURSING HOME CARE:
   The charges incurred for care (including room, board, services and supplies) provided during a Nursing Home stay for all levels of care: skilled, intermediate or custodial.

   "Nursing Home" means a place which:
   a. is legally operated to provide nursing care (skilled, intermediate, custodial) for sick and injured persons at their own expense;
   b. has 24 hour nursing service by or under the supervision of a licensed nurse;
   c. has beds for patients who need care; and
   d. has a Doctor available to furnish emergency medical care.

   "Nursing Home" also means a wing, area or floor of a Hospital specifically set aside for nursing care.

   Nursing Home doesn't mean: a Hospital, a place that primarily treats Mental Illness, drug addiction or alcoholism, a home for the aged, a rest home, a place that primarily provides domiciliary, residency or retirement care, or a place owned or operated by a member of the Immediate Family.

PART I COVERED EXPENSES (Continued)

2. ASSISTED LIVING FACILITY CARE:
The charges incurred for care (including room, board, services and supplies) provided during a stay in an Assisted Living Facility.

"Assisted Living Facility" is a place providing room, board and personal care services to persons in need of assistance because of Medical Necessity, Functional Incapacity or Cognitive Impairment, but given at a level of care less intense than that which would be received in a Nursing Home. Assisted Living Facilities can include other facilities providing the same type of care and services but are otherwise known as: personal care, domiciliary care, supported care, intermediate care, custodial care, sheltered care, or residential health care facilities. An Assisted Living Facility does not include congregate housing, individual residences or independent living units. An Assisted Living Facility must:

a. provide 24 hour a day care and services to at least 10 inpatients in one location;
b. have a trained and ready-to-respond employee on duty at all times to provide care;
c. provide 3 meals a day and accommodate special dietary needs;
d. be licensed by the appropriate licensing agency (if any) to provide such care;
e. have formal arrangements for the services of a Doctor or nurse to furnish emergency medical care; and
f. have appropriate methods and procedures for handling and administering drugs and biologicals.

3. BED RESERVATION:
The charges incurred to reserve the Family Member's bed if hospitalization becomes necessary while he or she is confined in a Nursing Home or an Assisted Living Facility and:

a. We are paying benefits for the Nursing Home or Assisted Living Facility stay; and
b. the Nursing Home or Assisted Living Facility continues to charge the Family Member to reserve the bed.

We'll pay up to the Maximum Daily Benefit, not to exceed 21 days each Calendar Year. Any unused days cannot be carried forward into the next year.

E. PART II COVERED EXPENSES

1. HOME HEALTH CARE:
The charges incurred for the following services and supplies provided by a Home Health Care Agency or a Qualified Home Health Care Provider:

a. visits by a: licensed nurse; licensed nutritional specialist; Home Health Aide; or legally qualified physical, occupational, speech or inhalation therapist;
b. prescription drugs, medicines, medical supplies and laboratory services which are of a type customarily provided in a Hospital or Nursing Home;
c. rental (not to exceed purchase price) of a wheelchair, hospital bed and other durable portable equipment used for therapeutic treatment;
d. Personal Care Services; and
e. Homemaker Services Incidental to Personal Care Services.

"Home Health Aide" means a licensed or certified home health care worker, other than a Doctor, nurse or professional therapist, who performs Personal Care Services.

"Home Health Care Agency" means an agency or organization that:

a. specializes in giving nursing care or therapeutic services in the home;
b. is licensed to provide such care or services by the appropriate licensing agency where they are performed or is certified as a Home Health Care Agency under Title XVIII of the Social Security Act of 1965, as amended;
c. is operating within the scope of its license or certification; and
d. maintains a complete medical record and plan of care for each patient.

"Home Health Care Plan" means a medical or nonmedical program of care set up and supervised by a Licensed Healthcare Practitioner. We may require a copy of the initial Home Health Care Plan and any changes later made to it.

"Homemaker Services Incidental to Personal Care Services" means only the following services and only when a Family Member is receiving Personal Care Services.

a. domestic or cleaning services;
b. laundry services;
c. food shopping and errands;
d. meal preparation and cleanup;
e. transportation assistance to and from medical appointments; and
f. heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

"Personal Care Services" means assistance with performing activities of daily living used to measure Functional Incapacity.

"Qualified Home Health Care Provider" means an individual or organization licensed or certified to provide home health care services. The Qualified Home Health Care Provider must be included in the Home Health Care Plan as the provider of home health care services.

2. HOSPICE CARE:

The charges incurred by a terminally ill Family Member for services and supplies given by a Hospice.

A Family Member is "terminally ill" if his or her Doctor certifies that the Family Member: (a) has no reasonable prospect of cure; (b) has a life expectancy of less than 6 months; (c) needs Hospice services for palliation or management of the terminal illness and related conditions; and (d) would have to be confined in a Hospital or Nursing Home if Hospice care services weren't available.

Benefits payable for Hospice Care are not subject to the Elimination Period. Benefits paid for Hospice Care will not count toward satisfying the Elimination Period for any other benefit payable under this policy which is subject to the Elimination Period.

"Hospice" means an agency meeting the regulatory requirements for a hospice in the state where the services are given. If such state has no regulatory requirements, the agency must: (a) be primarily engaged in providing pain relief, symptom management and support service to dying persons and their families; and (b) provide nursing care under the supervision of a registered nurse.

3. ADULT DAY CARE:

The charges incurred for the following services provided at an Adult Day Care Facility:

a. visits by a licensed nurse;
b. occupational, physical or speech therapy;
c. social, recreational and educational events designed to improve the patient's self-awareness and level of functioning;
d. training and help with the activities of daily living.

An **"Adult Day Care Facility"** means an organization that provides a program of adult day health care and:

a. is state licensed, if the state in which it is located licenses Adult Day Care Facilities;
b. operates at least 5 days a week for a minimum of 6 hours a day and is not an overnight facility;
c. maintains a written record for each client that includes a Plan of Care and a record of all services provided;
d. has established procedures for obtaining appropriate aid in the event of a medical emergency;
e. has formal arrangements for providing the services of: a dietician; a licensed physical therapist; a licensed speech therapist; and a licensed occupational therapist; and
f. its staff includes a full-time director; and one or more nurses in attendance during operating hours for at least 4 hours a day.

It doesn't include a place owned or operated by a member of the Immediate Family.

F. OPTIONAL ANNUAL BENEFIT INCREASE

If the following option applies to a Family Member's coverage, it will show on the Schedule page.

ANNUAL COMPOUND INCREASES BENEFIT OPTION

When this coverage is shown as "COVERED" on a Schedule page, and the policy is in force, all Maximum Benefit amount(s) (Part I Maximum Daily Benefit, Part II Maximum Weekly Benefit and the Maximum Benefit for Any One Period of Expense) will increase by five percent on each policy anniversary. Such increases will be applied to the maximum benefit amounts then in effect on such policy anniversary.

If the resulting benefit amount is not a multiple of $0.25, We will round the amount to the next highest multiple of $0.25.

During Any One Period of Expense which crosses the policy anniversary date, We'll pay benefits for expenses incurred after the anniversary date at the new increased benefits amount.

G. EXCLUSIONS

We won't cover expenses incurred:

1. for illness or injury due to war or act of war;
2. due to intentionally self-inflicted injury while sane or insane;
3. to the extent they are paid under Medicare or any other government insurance plan (except Medicaid);
4. for services or supplies provided by a member of the Immediate Family or a person who ordinarily lives in the Family Member's home;
5. for Home HealthCare services and supplies not included in the Home HealthCare Plan;
6. due to Mental Illness or nervous disorders without demonstrable organic disease; (Loss due to Parkinson's Disease, Alzheimer's Disease or senile dementia is covered.)
7. for which no charge is customarily made in the absence of insurance; or
8. for personal, comfort or convenience items, (such as television, radio or telephone).

H. RESTORATION OF POLICY BENEFITS

This policy's Maximum Benefit for Any One Period of Expense will be fully restored when a Family Member has not required treatment or services covered under this policy for six consecutive months for the same cause or causes for which a previous Period of Expense began. If this policy includes the Annual Benefit Increase Option, as shown on the Schedule page, the amount restored will include any accumulated benefit increases provided as of the policy's last anniversary.

BENEFIT AND PREMIUM CHANGE

The risk We assumed on this policy's Issue Date is based on the laws and regulations governing the system for the delivery and financing of health insurance then in effect. It's possible that the federal government, or state legislation, may change the system and therefore change the nature of the risk We assumed. If this occurs, We'll make any necessary change to policy benefits. We'll make such a change by adding: (a) an amendment to the policy; (b) a new schedule page; or (c), both (a) and (b).

Before making any such change, We'll get the necessary approval from the agency in Your state that regulates insurance. We'll tell You if such coverage change needs a premium change. Until the effective date of any coverage change, benefits will be based upon the risk We assumed on this policy's Issue Date.

Any premium change may be made only after We give You the appropriate advance notice required by Your state.

UNIFORM PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy with any attached papers is the entire contract between You and Us. No change in this policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions. The application is a part of this policy.

TIME LIMIT ON CERTAIN DEFENSES: a) After 2 years from the effective date of coverage, only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred which starts the 2 year period; (b) No claim for loss incurred which starts after 2 years from the effective date of coverage will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

GRACE PERIOD: This policy has a 31 day grace period. This means that if a premium isn't paid on or before the date it's due, it may be paid during the following 31 days. During the grace period this policy will stay in force.

REINSTATEMENT: If the premium isn't paid before the grace period ends, this policy will lapse. Later acceptance of premium by Us (or by any agent authorized to accept payment) without requiring an application for reinstatement, will reinstate this policy.

If We or Our agent require an application You'll get a conditional receipt for the premium. If the application is approved, this policy will be reinstated as of the approval date. Lacking such approval, this policy will be reinstated on the 45th day after the date of the conditional receipt unless We previously notified You in writing of Our disapproval.

In all other respects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy.

NOTICE OF CLAIM: Written notice of claim must be given within 60 days (6 months in Montana) after a covered loss starts or as soon as possible. The notice can be given to Us at the address shown on page 1 of this policy or to any one of Our agents. Notice should include Your name and the policy number.

CLAIM FORMS: When We get notice of claim, We'll send You forms for filing proof of loss. If these forms aren't given to You within 15 days, You'll meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proof of Loss section.

PROOF OF LOSS: For periodic payment of a continuing loss, You must give Us written proof of loss within 90 days after the end of each period for which We are liable. For any other loss, You must give Us written proof within 90 days after the end of such loss.

If it wasn't reasonably possible for You to give Us proof in the time required, We won't reduce, nor deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one year (15 months in Hawaii) from the time specified unless You were legally unable to act.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid as soon as We receive proper written proof of loss.

PAYMENT OF CLAIMS: Benefits will be paid to You. Any benefits due and unpaid at Your death may be paid to Your estate.

If benefits are payable to Your estate, We can pay up to $1,000 ($3,000 in Florida) to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We'll be discharged to the extent of any such payment made in good faith.

PHYSICAL EXAMINATION: We, at Our expense, have the right to have a Family Member examined as often as reasonably necessary while a claim is pending.

LEGAL ACTION: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after three years (five years in Kansas; six years in South Carolina) from the time written proof of loss is required to be given.

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 live on that date is amended to conform to the minimum requirements of such laws.

ADMINISTRATIVE REMEDIES

Any controversy arising out of or relating in any manner to the policy, including without limitation any disputes relating to a claim for benefits, is subject to certain administrative procedures that must be exhausted by the Individual Insured under the terms of the policy (collectively "Family Member") prior to the Family Member pursuing any other remedy that may be available in law or equity. These administrative remedies are (I) Appeal of Decision; and (II) Arbitration.

1. Appeal of Decision

   (1) If Bankers Life and Casualty Company (Company) makes a decision which the Family Member wishes to appeal, a written request must be sent within sixty (60) days of the date of Company's written notice of its decision. The appeal shall be addressed to Bankers Life and Casualty Company, Attn: V.P., Claims, 222 Merchandise Mart Plaza; Chicago, IL 60654-2001.

   (2) The Family Member's written request must provide:

      (a) The policy number, name of the insured, and a written statement of the reasons for the appeal and the facts of the matter; and

      (b) copies of any evidence or other supporting documentation.

   (3) (a) Within forth-five (45) days after the date of receipt of a timely-filed request for reconsideration, Company must provide written notice to the Family Member that:

         (i) the decision has been reversed or modified;
         (ii) the decision has been reaffirmed; or
         (iii) additional information is being requested from the Family Member (which shall include any information from third parties, such as health care providers).

      (b) Within thirty (30) days after the requested information is received, Company must notify the Family Member as provided in (I) or (II) herein.

      (c) If the Family Member does not provide the information requested within sixty (60) days of the requesting date, Company will reconsider the decision based on the information in the file.

2. Arbitration

   After exhaustion of the Appeal of Decision procedures, any dispute arising out of or related in any manner to the Policy that remains shall be settled by arbitration in accordance with the Insurance Dispute Resolution Program, as amended, and as administered by the American Arbitration Association. Judgement on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

LIMITED BENEFIT CONVALESCENT CARE POLICY