Washington National®

WASHINGTON NATIONAL

critical solutions®

CRITICAL ILLNESS
SUPPLEMENTAL
HEALTH INSURANCE

AGENT GUIDE

CS-BOOK-AGT

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SECTION 1: COVERAGE DESCRIPTION

INTRODUCTION

Critical illness insurance is supplemental health insurance that pays a lump-sum benefit when an insured person is diagnosed with a specified critical illness. Because of the shortfall that often exists with traditional major medical plans and high-deductible health plans, consumers may be left with a significant financial burden after a critical diagnosis.

With Washington National Critical Solutions, financial stress can be alleviated and your clients can become free to:

- Focus on their recovery.
- Spend time with family and friends.
- Protect their home and other assets.

SELECTING THE RIGHT COVERAGE LEVEL IS EASY FOR YOUR CLIENTS

Step 1: Choose from three coverage types.

1. **Critical illness cancer only provides payment upon the diagnosis of cancer.**
2. **Critical illness without cancer provides payment upon the diagnosis of heart attack, stroke or end-stage renal failure.**
3. **Critical illness with cancer provides payment upon the diagnosis of cancer, heart attack, stroke or end-stage renal failure.**

Step 2: Choose from two benefit options.

1. **Option A offers clients a lump-sum benefit payment of $10,000 to $70,000.**
2. **Option B offers clients a lump-sum payment of $10,000 to $70,000—plus additional indemnity benefits to help provide extra security if clients are treated for a specified critical illness.**

BENEFIT COMPARISON GRID

COVERAGE	CRITICAL ILLNESS CANCER ONLY[1]		CRITICAL ILLNESS WITHOUT CANCER[1]		CRITICAL ILLNESS WITH CANCER[1]	
Coverage	Provides payment upon the first diagnosis of cancer		Provides payment upon the first diagnosis of heart attack, stroke or end-stage renal failure		Provides payment upon the first diagnosis of cancer, heart attack, stroke or end-stage renal failure	
Options	A	B	A	B	A	B
BENEFITS						
Lump-sum payment (one lump-sum payment per insured; not payable for skin cancer)	Choice of: $10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000	Choice of: $10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000	Choice of: $10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000	Choice of: $10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000	Choice of: $10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000	Choice of: $10,000 $20,000 $30,000 $40,000 $50,000 $60,000 $70,000
Wellness benefit		$50 per year per insured for a screening exam		$50 per year per insured for a screening exam		$100 per year per insured for a screening exam
Hospital confinement		• $200 per day, 1–30 days • $400 per day, 31+ days		• $200 per day, 1–30 days • $400 per day, 31+ days		• $200 per day, 1–30 days • $400 per day, 31+ days
Radiation and chemotherapy		• $200 per day by medical personnel • $200 per drug with $1,600 monthly maximum if self-administered				• $200 per day by medical personnel • $200 per drug with $1,600 monthly maximum if self-administered
Consultation benefit		One-time benefit of $250 for cancer diagnosis		One-time benefit of $250 for heart/stroke or renal failure diagnosis		• One-time benefit of $250 for cancer diagnosis • One-time benefit of $250 for heart/stroke or renal failure diagnosis
Cash Value and 100% or 50% Return of Premium riders	Riders can be added to all coverages to provide premium-return options, based on state availability.					

[1]The primary insured and spouse must select the same coverage, riders and benefit levels. The lump-sum benefit level for child(ren) is limited to $10,000.

POLICY BENEFIT DESCRIPTIONS

Benefits may differ by state. Please refer to state-specific sample policy language.

LUMP-SUM BENEFIT

- **$10,000, $20,000, $30,000, $40,000, $50,000, $60,000 or $70,000**

This benefit is paid when an insured person is first diagnosed with cancer (except skin cancer), heart attack, stroke or end-stage renal failure, based on the selected coverage. This benefit is payable only once for each insured, regardless of the number of different initial occurrences of a specified critical illness. For this claim to be considered, a clinical or pathological diagnosis is needed and a completed claim form (H-ICI-GCI) is required. Coverage for child(ren) is available at $10,000.

WELLNESS BENEFIT

- **$50 per year for critical illness cancer only coverage and critical illness without cancer coverage**
- **$100 per year for critical illness with cancer coverage**

This preventive benefit is limited to one test per person per calendar year. A diagnosis of cancer, heart attack, stroke or end-stage renal failure is not required for this benefit to be paid. After a 30-day waiting period, the benefit is paid to the insured for covered screenings. Covered screenings vary based on the coverage your client selects.

All covered wellness benefit screenings listed below are included for the critical illness with cancer Option B policy. Select screenings are available for the critical illness cancer only Option B policy and the critical illness without cancer Option B policy.

COVERAGE	CRITICAL ILLNESS CANCER ONLY	CRITICAL ILLNESS WITHOUT CANCER	CRITICAL ILLNESS WITH CANCER
Covered wellness benefit screenings	• Biopsy • Breast ultrasound • CA 125 • CEA (blood test for colon cancer) • Chest x-ray • Colonoscopy • Flexible sigmoidoscopy • Hemocult stool specimen • Mammogram • Pap smear • PSA (blood test for prostate cancer) • Thermography • ThinPrep • Virtual colonoscopy	• Blood test for triglycerides • Carotid Doppler • Echocardiogram • Electrocardiogram • Fasting blood glucose test • Lipid panel (total cholesterol count) • Serum cholesterol test to determine level of HDL and LDL • Stress test on a bicycle or treadmill	• Biopsy • Blood test for triglycerides • Breast ultrasound • CA 125 • Carotid Doppler • CEA (blood test for colon cancer) • Chest x-ray • Colonoscopy • Echocardiogram • Electrocardiogram • Fasting blood glucose test • Flexible sigmoidoscopy • Hemocult stool specimen • Lipid panel (total cholesterol count) • Mammogram • Pap smear • PSA (blood test for prostate cancer) • Serum cholesterol test to determine level of HDL and LDL • Stress test on a bicycle or treadmill • Thermography • ThinPrep • Virtual colonoscopy

HOSPITAL CONFINEMENT BENEFIT

- **$200 per day, 1–30 days**
- **$400 per day, 31+ days**

Benefits are paid for each day an insured is confined to a hospital due to a diagnosis of cancer, heart attack, stroke or end-stage renal failure, based on the selected coverage. Confinements separated by fewer than 30 days are considered the same period of confinement. If cancer is first diagnosed while an insured is hospital-confined, he or she is eligible for benefits retroactively to the date of admission to the hospital, but not for more than 30 days prior to the diagnosis date. If skin cancer is diagnosed while the insured is hospital confined, he or she will be eligible for benefits only for the day(s) he or she actually received treatment for skin cancer.

Washington National will not pay benefits for a hospital confinement that begins during the first 30 days after the coverage effective date.

RADIATION AND CHEMOTHERAPY BENEFIT

- **$200 per day by medical personnel**
- **$200 per drug with $1,600 monthly maximum if self-administered**

This benefit is payable for these services:

- Radiation therapy, including but not limited to the insertion of interstitial or intracavity application of radium or radioisotopes
- Cytotoxic chemical substances and their administration
    - Injections by medical personnel in a physician's office, clinic or hospital, payable on the date of injection only
    - Self-injected medications, payable on the date of injection only
    - Medications dispensed by pump or implant, subject to the limitations described below
    - Oral chemotherapy, regardless of where administered, subject to the limitations described below

If delivery of radiation or chemotherapy is by a method other than those listed above, benefits are subject to a combined calendar-month maximum of eight times the daily amount, which is $1,600 per calendar month.

This benefit is subject to the following limitations:

- Laser surgery is not considered radiation treatment.
- Injections by medical personnel in a physician's office, clinic or hospital are limited to the daily amount of $200.
- Self-injected medications are limited to $200 per drug and are subject to the combined calendar-month maximum of $1,600.
- Medications dispensed by pump or implant are limited to $200 per drug for each of the initial prescriptions and each refill, subject to the combined calendar-month maximum of $1,600 for all such medications.
- Oral chemotherapy taken on an outpatient basis is payable only once per prescription on the date filled and is limited to $200 per drug, subject to the combined calendar-month maximum of $1,600 for all such medications.
- Oral chemotherapy taken on an inpatient basis is payable per drug, per period of confinement, and is limited to $200 per drug, subject to the combined calendar-month maximum of $1,600 for all such medications.
- Benefits for medications that are self-injected, dispensed by pump or implant or taken orally are limited to $200 per drug, subject to the combined calendar-month maximum of $1,600 for all such medications.
- Benefits are not payable for any treatment planning, treatment management, laboratory tests, x-ray or other imaging used for diagnosis or disease monitoring, or other diagnostic tests related to these treatments.
- Benefits are not payable for any devices or supplies, such as intravenous solutions and needles, related to these treatments.

At the time of administration, all treatments must be fully or investigationally approved for cancer treatment by the U.S. Food and Drug Administration or the National Cancer Institute. Treatment may be performed on an outpatient or inpatient basis.

CONSULTATION BENEFIT

- **$250 per specified critical illness diagnosis**

This benefit is payable when the insured is diagnosed with cancer, heart attack, stroke or end-stage renal failure (one time, depending on the coverage selected) and consults a physician or alternative care practitioner for a treatment plan.

An alternative care practitioner defined for this policy is a naturopathic doctor, homeopathic practitioner, ayurvedic practitioner, acupuncturist, herbalist, hypnotherapist, massage therapist or nutritionist.

SECTION 2: OPTIONAL PREMIUM-RETURN RIDERS

There is an additional cost for these optional riders. These riders are available through age 74 and are based on the policyowner's age at issue. State abbreviations may apply to the rider form number when used. These riders are not available with policies purchased as part of a Section 125 plan. All riders are not available in all states. Check **WNbizlink.com** or contact agent care to determine which rider, if any, is available in a specific state.

RETURN OF PREMIUM (ROP) RIDERS

Two ROP riders are available with Washington National Critical Solutions. Once a ROP rider is selected, it cannot be switched to a different ROP rider. For example, you cannot change a 50% ROP rider to a 100% ROP rider.

100% RETURN OF PREMIUM RIDER (FORM R1022ROP)

With the 100% ROP rider, a policyowner can receive a check for all premiums paid—minus claims incurred—every 20 years or on the rider anniversary date following his or her 75th birthday, if that comes sooner.

If the policyowner is 66 or older when a ROP period begins and has kept the policy and rider in force, he or she receives one-half of premiums paid—minus any claims incurred—every 10 years.

50% RETURN OF PREMIUM RIDER (FORM R1041ROP)

With the 50% ROP rider, the policyowner can receive a check for one-half of the premiums paid—minus claims incurred—every 20 years or on the rider anniversary date following his or her 75th birthday, if that comes sooner.

If the policyowner is 66 or older when a ROP period begins and has kept the policy and rider in force, he or she receives one-quarter of premiums paid—minus any claims incurred—every 10 years.

CASH VALUE (CV) RIDER (R1022CV)

With the CV rider, the policyowner can receive a check for all premiums paid—minus claims incurred—every 25 years or on the rider anniversary date following his or her 75th birthday, if that comes sooner. The policyowner is required only to keep the policy and this rider in force until maturity. When money is returned, the policyowner can continue coverage and collect again.

Beginning with the sixth year, upon surrender of the policy the policyowner receives a percentage of premiums paid, minus claims incurred. The longer the rider is in force, the larger this percentage becomes.

If the policyowner is 60 or older when a CV period begins and has kept the policy and rider in force, he or she receives all premiums paid—minus any claims incurred—every 15 years.

SECTION 3: ELIGIBILITY AND UNDERWRITING GUIDELINES

WHO IS COVERED?

Four coverage options are offered in this policy:

- Individual
- Individual and spouse
- Individual and child(ren)
- Individual, spouse and child(ren)

"**Spouse**" means the insurable person named as spouse on the application and legally married to the insured on the effective date of the policy.

"**Child(ren)**" means the insured's and spouse's natural child, stepchild, legally adopted child, child placed with the insured for adoption, foster child or the court-appointed guardianship, order or administrative order of a child (including a grandchild), who is:

- Insurable and named on the application.
- Unmarried.
- Chiefly dependent on the insured or spouse for support.
- No older than the limiting age of 24.

"**Child(ren)"** also includes dependent children, regardless of age, who:

- Are mentally or physically handicapped.
- Became or become handicapped prior to the limiting age.
- Cannot support themselves because of their handicap.

ISSUE AGES FOR THE PRIMARY INSURED AND SPOUSE

- 18–74 with ROP or CV rider
- 18–85 without ROP or CV rider

Issue-age limits apply to the primary insured and the spouse. For example, if the primary insured is 74 or younger and the spouse is between 75 and 85, a policy with a ROP or CV rider cannot be issued if the spouse is on the policy. However, separate individual policies can be issued based on each individual's age.

ISSUE LIMITS FOR THE PRIMARY INSURED AND SPOUSE

Remember these guidelines when selling Washington National Critical Solutions:

- A person can have more than one Washington National Critical Solutions product as long as he or she doesn't own two Option B policies that cover the same illnesses.
    - For example, a person can own a critical illness cancer only Option A policy and a critical illness without cancer Option B policy. A person could ***not*** own a critical illness cancer only Option B policy and a critical illness with cancer Option B policy.
- The primary insured and spouse must select the same coverage, riders and benefit levels.
- The lump-sum benefit level for child(ren) is limited to $10,000.

- The maximum allowable lump-sum coverage a dependent child could have between all Washington National products is $25,000. Coverage cannot be issued if this maximum would be exceeded.
- If individuals want to change their benefits or add benefits, they need to upgrade or downgrade their policy.
- With Option B, no individual can have more than $1,000 hospital confinement per day combined coverage from all carriers. An agent should check for other owned policies. Please note:
    - Policy types that should be considered include sickness, hospital indemnity and specified disease (cancer, heart/stroke and critical illness).
    - Policies that should **not** be considered include major medical and accident.
- An individual cannot own more than $110,000 in lump-sum insurance on any one covered illness.

PRE-EXISTING CONDITIONS

Pre-existing conditions vary by state; refer to the state-specific sample policy language.

A pre-existing condition is defined as the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a 12-month period preceding the insured's coverage effective date, or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 12-month period preceding the coverage effective date. A pre-existing condition can exist even though a diagnosis has not yet been made. No benefits are payable for a pre-existing condition during the first 12 months after the coverage effective date.

WAITING PERIOD

The waiting period varies by state; refer to the state-specific sample policy language.

This policy contains a 30-day waiting period. If an insured is diagnosed with or treated for any specified critical illness during the first 30 days of coverage under this policy, no benefits are provided for loss resulting from that diagnosed specified critical illness until 12 months after the insured's coverage effective date.

LIMITATIONS AND EXCLUSIONS

Limitations and exclusions vary by state; refer to the state-specific sample policy language.

Benefits are not paid for loss contributed to, caused by or resulting from having or being diagnosed with any other disease, sickness or incapacity, even if the disease or condition was caused, complicated or aggravated by the specified critical illness; participating or attempting to participate in an illegal act or working at an illegal job; being legally intoxicated or so intoxicated that mental or physical abilities are seriously impaired; being under the influence of any illegal drugs or being under the influence of a narcotic, unless such narcotic is taken under the direction of and as directed by a physician; injuring or attempting to injure oneself intentionally, regardless of mental capacity; committing or attempting to commit suicide, regardless of mental capacity; participating in any sporting event for pay or prize money; being exposed to war or any act of war, declared or not, or participating in or contracting with the armed forces (including Coast Guard) of any country or international authority; and alcoholism, drug abuse or chemical dependency.

Critical illness without cancer coverage and critical illness with cancer coverage: Heart attack does not include any other disease or injury involving the cardiovascular system; cardiac arrest not caused by a myocardial infarction is not a heart attack. Heart attacks or strokes occurring during or as the result of any medical procedures are not covered. Renal failure caused by a traumatic event, including surgical trauma, is not covered.

HEIGHT AND WEIGHT REQUIREMENTS

The proposed primary insured and spouse must fall within the following height and weight guidelines when applying for critical illness with cancer or critical illness without cancer coverage.

HEIGHT AND WEIGHT CHART

Height	Minimum	Maximum
Up to 4'10	79	199
4'11	81	205
5'0	84	212
5'1	86	220
5'2	90	227
5'3	93	234
5'4	96	242
5'5	98	249
5'6	101	257
5'7	104	265
5'8	107	273
5'9	110	281
5'10	113	289
5'11	116	298
6'0	120	306
6'1	124	315
6'2	127	323
6'3	131	332
6'4	134	341
6'5	137	350
6'6	141	359
6'7	145	368
6'8	148	378
6'9 or taller	152	387

THIS CHART IS NOT A REQUIREMENT FOR CRITICAL ILLNESS CANCER ONLY COVERAGE.

PRECANCEROUS CONDITIONS

Multiple conditions are considered preleukemic, premalignant or having malignant potential by pathological definition. Some of these conditions represent a significant risk of progressing to a full diagnosis of cancer. The chart below highlights these conditions but does not represent a complete list.

If the preleukemic, premalignant or condition with malignant potential question is answered "yes," the applicant is not eligible for critical illness cancer only or critical illness with cancer coverage. The applicant is eligible for critical illness without cancer coverage.

If the question is answered "no" and such condition is subsequently found to have existed when the application was signed and the applicant had knowledge of it, any cancer claims for this individual may be denied and the policy likely rescinded.

Achlorhydria—gastric	Erythroplasia	Malignant tumor
Blood disorder	Esophageal web	Myelofibrosis with myeloid metaplasia
Bowen's disease	Essential thrombocytopenia	Neoplasia
Barrett's esophagus	Familial adenomatous polyposis	Neoplastic polyps
Carcinoma	Familial dysplastic nevus syndrome	Obstructive pulmonary disease (COPD)
Carcinoma in situ (CIS)	Gastric adenomatous polyps	Polycythemia vera
Cervical dysplasia (diagnosed in stage 2 or higher)	Hepatitis B or C	Refractory anemia (RA)
Chronic 5q syndrome	Hodgkin's disease	Refractory cytopenia (RC)
Cirrhosis	Keratocanthoma	Sarcoma
Cryptorchidism	Lentigo maligna	Testicular feminization syndrome
Dysplasia	Leukemia	Tylosis palmaris et plantaris
Dysplastic nevi	Leukoplakia	Villous adenoma
Emphysema	Lymphoma	

Note: If an applicant is unsure whether a diagnosed or treated condition is considered preleukemic, premalignant or having malignant potential, the writing representative should inquire about the condition and compare the diagnosis to the list above. If the condition is on the list, the applicant cannot be covered at this time.

If the condition is not included in the above list and the agent is unsure whether the condition is allowable, he or she should check "no" and list the condition and any relevant information about that condition in the "special

instructions" section of the application. The new business department will determine whether the named condition is preleukemic, premalignant or having malignant potential and whether the applicant is eligible for coverage.

HEART CONDITIONS

The following list of common heart conditions will cause an applicant to be declined critical illness without cancer and critical illness with cancer coverage. If any of these conditions exists, question 6 on the application must be answered "yes." The applicant remains eligible for critical illness cancer only coverage.

Heart conditions (including heart disease)

Rhythm and conduction disorders (arrhythmia)

We will exclude any person who in the last five years has had treatment recommended or prescribed for:

- Bradycardia in any form
- Heart block in any form
- Tachycardia in any form
- Rhythm or conduction disorders in any form

Treatment for these conditions may include medication, as well as prescribed bed rest or surgery, such as the implantation of a pacemaker. Some specific conditions are:

- Atrial flutter
- Atrial fibrillation
- Atrioventricular blocks
- Bundle branch blocks
- Premature beats
- Sick sinus syndrome
- Ventricular fibrillation
- Wolff-Parkinson-White syndrome

Exceptions

Rhythm and conduction disorders for which treatment has not been prescribed or recommended are not excluded from coverage. If no other condition exists, the health question should be answered "no."

Myocardial, endocardial and pericardial diseases

We will exclude from coverage any person who in the last five years has had any form of:

- Myocarditis
- Endocarditis
- Pericarditis
- Cardiomyopathy

Congenital heart defects

We will exclude from coverage any person who has an uncorrected congenital heart defect.

Some specific conditions are:

- Anomalous pulmonary venous connection
- Atrial septal defect
- Cardiac malposition
- Coarctation of the aorta
- Congenital complete heart block
- Ebstein's anomaly
- Eisenmenger syndrome
- Patent ductus arteriosus
- Tetralogy of Fallot
- Transposition of the great vessels
- Truncus arteriosus
- Ventricular septal defect

Valvular heart disease

We will exclude from coverage any person with disease of the:

- Aortic valve
- Mitral valve
- Pulmonic valve
- Tricuspid valve

Some specific conditions are:

- Aortic insufficiency
- Aortic regurgitation
- Aortic stenosis
- Mitral insufficiency
- Mitral regurgitation
- Mitral stenosis
- Pulmonic insufficiency
- Pulmonic regurgitation
- Pulmonic stenosis
- Rheumatic heart disease
- Syphilitic disease
- Tricuspid insufficiency
- Tricuspid regurgitation
- Tricuspid stenosis

Angina and heart attack

We will exclude from coverage any person who in the last five years has had:

- Any angina pectoris (chest pain)
- Any myocardial infarction (heart attack)

Some specific conditions are:

- Coronary arterial spasm
- Dressler's syndrome
- Left ventricular aneurysm and pseudoaneurysm
- Silent myocardial infarction

Exception

When no other condition exists, angina that is not caused by heart disease will not cause a person to be excluded from coverage. In this case, the health question should be answered "no."

Disorder, disease or abnormality of the coronary arteries

We will exclude from coverage any person who in the last five years has had:

- Any coronary artery abnormality
- Any coronary artery disease
- Any coronary artery disorder

Some specific conditions are:

- Atheromatous deposits of the coronary arteries
- Coronary artery stenosis
- Coronary artery occlusion
- Thrombosis formation in the coronary arteries

Arteriosclerosis

We will exclude from coverage any person who has ever had arteriosclerosis of the coronary arteries (otherwise known as hardening of the arteries).

Chronic disease of the pericardium
We will exclude from coverage any person who in the last five years has had chronic pericarditis (chronic means frequent recurrence).

Transient ischemic attack and stroke
We will exclude from coverage any person who in the last five years has had:

- Any transient ischemic attack (TIA or ministroke)
- Any stroke

Some specific conditions are:

- Cerebral aneurysm
- Cerebral embolism
- Cerebral hemorrhage
- Cerebral thrombosis
- Cerebrovascular accident
- Subarachnoid hemorrhage

SALES TO PERSONS ELIGIBLE FOR MEDICARE OR MEDICAID[1]

Federal statute makes it illegal to issue a health insurance policy that duplicates Medicare benefits to anyone who is eligible for Medicare, unless the policy pays without regard to other insurance and the applicant at the time of application is shown a disclosure statement prescribed in the regulation for that type of insurance. Persons may qualify for Medicare if they are 65 or older, have permanent kidney failure or are disabled regardless of age. Because our policies pay without regard to other insurance, Washington National may sell them to people who qualify for Medicare, as long as the applicant signs the appropriate disclosure statement and submits it with the application. The application will not be processed if the statement is not signed or not attached. The disclosure form number is CIC-1010. This guideline applies only if the policyowner is eligible for Medicare; therefore, Washington National does not need a disclosure statement if only a spouse or dependent child is eligible for Medicare. The disclosure statements and the pamphlet "Guide to Health Insurance for People with Medicare" (form MEDICARE-GUIDE) are available to order from **WNbizlink.com.** These guidelines apply to new business and conversions, but not reinstatements.

Persons eligible for Medicaid MUST understand that participating in Medicaid likely will reduce or eliminate their Washington National benefits. Even though each state's Medicaid regulations vary, the use of taxpayer dollars to pay these medical expenses mandates that Washington National reimburse the public program first, based on those regulations.

[1] *The comments regarding Medicare and Medicaid simply reflect our current interpretation of the programs. It is not our intent to give advice on Medicare or Medicaid. Please consult a qualified adviser.*

PRIVACY OVERVIEW

Washington National Insurance Company ("the company") must adhere to various legal and regulatory requirements. The company and its agents each have a responsibility to be in compliance with state insurance laws and regulations. It is the obligation of each licensed insurance agent to be aware of all laws, regulations and requirements for their state so that they conduct all sales activities in a manner that complies with these laws and regulations.

Additionally, we have set high standards in connection with the sale and servicing of our insurance products. Agents are expected to conduct business with honesty and integrity, as outlined in the Washington National sales representative agreement.

This agreement provides an overview of ethical and compliance expectations as they relate to advertising, field conduct, disclosure, suitability, replacement and unfair trade practices. This agreement is not intended to be a complete listing of all compliance requirements.

Personally identifiable information ("PII") is information that clearly identifies a distinct individual (a consumer, customer, associate or agent). Examples of PII are name, address, Social Security number, information about health and finances, and other information that is not generally available to the public.

A copy of the consumer privacy notice is available at **WNbizlink.com** under the "Materials" link. Agents should review this form to familiarize themselves with how we handle PII and what consumers can do to change or access it.

Agents are required by law to take an active role in preventing PII from being disclosed to unauthorized parties. If you suspect PII is lost, stolen or disclosed to an unauthorized party, it is critical that you immediately report the situation to the home office by submitting a DATA ALERT form. This form and instructions for submitting it are located on **WNbizlink.com**. It may be completed online and submitted by email to privacy@cnoinc.com.

Since independent agents are legally responsible for consumers' personal information while under an agents' control, completing and submitting a DATA ALERT should be approached with a sense of urgency and priority.

Questions about privacy regulations should be directed to privacy@cnoinc.com.

If you have concerns about fraud, ethical issues, harassment or other questionable activities, you can call InTouch at (855) 835-5266. Your call is completely anonymous. An independent company will answer your call, transcribe your message and send it to Washington National in writing. Also, you can email your issues to **tellcno@getintouch.com.**

SECTION 4: EFFECTIVE DATES

DIRECT BUSINESS

The effective date is the date the application is received in the home office, unless otherwise requested. It cannot be earlier than the date the application is received in the home office.

WORKSITE BUSINESS

The effective date of worksite payroll deduction business can be no earlier than the date the application is received in the home office.

- All payroll business is given an effective date of the 1st of the month.
- If the application is received on or before the 15th of the month, the effective date will be the 1st of the month following the date the application is received in the home office.
- If the application is received after the 15th of the month, the effective date will be the 1st of the next month following the date the application is received in the home office.
- Payroll clerk deductions should begin on the policy effective date so that funds are available to remit when the first bill is due.

CREDIT UNIONS

If applications are received on the 1st through the 15th day of the month, the effective date is 60 days from the first day of the month the application is received.

For applications received on the 16th through the 31st of the month, the effective date is 90 days from the first day of the month that the application is dated.

The new business department must approve any exceptions to the guidelines stated above.

WAITING PERIOD

In most states, Washington National Critical Solutions has a 30-day waiting period. The waiting period does not begin until the effective date of coverage, which is assigned according to the guidelines state above. There is a 30-day waiting period when adding another person to the policy or increasing coverage, unless the insured is replacing a cancer or heart/stroke supplemental insurance policy from Washington National.

COMMON ERRORS

The following errors require investigation by the underwriting department. The incorrect or incomplete application will be returned to the agent for correction or completion. Additionally, the policy will not be issued until the application is received by the home office and processed. An application may be returned for correction or completion for any of the following reasons:

- Incorrect application
- Incorrect premium shown on application
- No date shown on application
- Missing/incorrect signature on application

- Missing applicant's age and/or birth date or Social Security number
- Health questions not answered
- Replacement question not answered when required
- Representative not licensed in the state where application is written
- Appropriate boxes not checked on the application
- Missing spouse's age and/or birth date or Social Security number missing (if electing spouse coverage)
- Application altered but not initialed by client
- Information missing on electronic funds transfer form (CI-747)
- Any other required information or forms not provided

SECTION 5: PREMIUM PAYMENT

MINIMUM PREMIUM

The minimum premium payment per year on this policy is $180. Any applications received at a lower premium amount are rejected.*

*GA does not follow this requirement.

RATING MULTIPLE INSUREDS

This policy is rated by each individual under the policy. The primary insured and spouse must select the same coverage, riders and benefit levels. The lump-sum benefit level for child(ren) is limited to $10,000.

DIRECT AND PAYROLL

Washington National Critical Solutions may be sold to applicants who are:

- Aged 18 to 85 without the ROP or CV rider.
- Aged 18 to 74 with the ROP or CV rider.

These age guidelines apply to the primary insured and the spouse.

Only individual, age-banded, tobacco and nontobacco rates are available. Direct and payroll sales use the same rates.

On all new payroll groups, a worksite case profile form (WIS-GRPPRO) must be completed and signed by an officer of the group. This form is required for all payroll sales.

Note: A payroll group must have at least five applicants to qualify for coverage.

AUTOMATIC CHECK (PAC/ACH)

When submitting automatic check business, the following items should be attached:

- Electronic funds transfer form (CI-747) for initial and future deductions
- Applicant's check, payable to Washington National Insurance Company, for one month's premium
- A voided check with bank routing transit numbers and account number printed on the slip for the account from which deductions will be made. (Experience shows that far fewer bank processing errors occur when a voided check is provided.) Deductions can be made from checking or savings accounts. Please indicate the type of account on the authorization form.

The automatic check deduction day is the day each month when a policyholder's premium is automatically deducted from his or her checking or savings account. Policyholders should select their preferred day of the month (between the 1st and the 28th) on the electronic funds transfer form (CI-747). If no day is specified, the default deduction day is the date the application is received in the home office. (Applications received on the 29th, 30th or 31st are assigned deduction days of the 1st, 2nd and 3rd, respectively.)

If at least one modal premium is received under the original payment method, coverage under Washington National Critical Solutions may be continued when the policyholder changes jobs, retires or leaves the group for any other reason.

Washington National will bill directly to the policyholder semiannually or annually only. Available payroll modes are 9-, 10-, 12- (monthly), 13-, 24-, 26- and 52-pay.

TAXABILITY OF BENEFITS

To avoid the policy being a tax-reportable product, the employee must pay 100% of premiums.

The standard policy can be sold under a Section 125 plan, but the riders are not available under a Section 125 plan. If sold under Section 125, a tax form 1099 will be generated when benefits are paid to employees per code guidelines.

If an employer pays or is treated as paying all or part of the premium, the benefit may be considered taxable income unless excluded under one or more provisions of the Internal Revenue Code. Policyholders should contact a tax adviser for specific information.

SECTION 6: POLICY CHANGES: UPGRADES/DOWNGRADES AND REINSTATEMENTS

It is important that agents do not confuse a conversion with an upgrade or downgrade.

- An upgrade is defined as increasing the benefits within the current coverage, adding a rider or moving from Option A to Option B.
- A downgrade reduces benefits.
- A conversion is defined as changing coverage from one product to another.

On upgrades and downgrades, the current policy number is retained. Conversions are not allowed on this policy.

ADMINISTRATIVE REQUIREMENTS

- For an upgrade, a new application (AP-1040 or state variation) must be completed and will be underwritten. If approved, the increased benefits become effective on the next monthly anniversary date of the existing policy. The original policy number is retained.
- All applications for upgrades must be submitted with an upgrade transmittal form (0061-R1). The policy number must be listed on the application in the space provided in Section 1.
- The total premium for the policy that will be effective after the upgrade should be listed in the column labeled "premium total."
- Enter the amount of money being submitted with the upgrade application in the blank labeled "amount collected."
- Downgrades may be requested in writing from the policyholder. This letter must include his or her signature to be processed.
- If a multiple-insured policy [individual and children, individual and spouse or individual, spouse and child(ren)] is being upgraded or downgraded, all members must upgrade or downgrade to the same coverage type and the same option amount.

UPGRADES

The following upgrades are allowed:

- Increasing the lump-sum benefit amount
- Moving from critical illness cancer only or critical illness without cancer to critical illness with cancer coverage
- Increasing from Option A to Option B
- Adding a ROP or CV rider
- Adding a spouse and/or child(ren)
    - A new application (AP-1040 or appropriate state variation) is required.
    - In the special instructions section of the application, note that a spouse and/or children is/are being added. Also include the policy number of the policy being upgraded.

The coverage effective date is the next monthly anniversary date upon receipt of the application by the home office. Rates are based on the coverage effective date and use the insured's attained age.

Upgrades can be submitted on a new business application (AP-1040 or state variation) with an upgrade transmittal form (0061-R1).

Note: Policyholders cannot apply for upgrades until at least 30 days after the policy effective date.

DOWNGRADES

The following downgrades are allowed:

- Decreasing the lump-sum benefit amount
- Removing a family member
- Decreasing from Option B to Option A
- Removing the ROP or CV rider

Downgrades can be requested by the policyholder in a letter containing his or her signature.

Note: The applicant or spouse cannot improve his or her tobacco class at upgrade or downgrade.

REINSTATEMENTS

Washington National will reinstate a policy up to 90 days after the lapse, with commission going to the writing agent. A new application is required for reinstatement.

Washington National will reinstate a policy between 90 and 180 days after the lapse only if the policy was active less than five years. The commission on these transactions goes to the reinstating agent.

GENERAL RULES FOR REINSTATEMENTS

- Once approved, the policy will be reinstated with the same policy number. The coverage lapse will be shown and the new effective date will indicate when coverage resumed.
- Resumption of a canceled policy (if not canceled at issue) is considered a reinstatement.
- All requests must be made in writing.
- Premiums are not accepted for the inactive coverage period.
- Claims incurred during the inactive coverage period are paid.
- The ROP maturity date is extended by the number of days the coverage is inactive unless the maturity date is set by the policyholder's 75th birthday.
- For any upgrades executed upon reinstatement, first-year commissions are credited to the reinstating agent based on the incremental premium increase.
- There is a 10-day waiting period after reinstatement.
- Reinstatement is not allowed after a Cash Value payment has been sent to an insured.

If a policy lapses or has terminated for more than 180 days, it cannot be reinstated. When any client who wants a new policy, the transaction will be treated as a new sale.

If you have questions or need more information, contact health agent care, (888) 754-3406, between 8 A.M. and 6 P.M. ET Monday through Friday.

SECTION 7: SUBMITTING BUSINESS

APPLICATION REQUIREMENTS AND DETAILS

These items must be left with the policyholder at application:

- Outline of coverage (OC1039 or state variation)
- Signed HIPAA form (MEDAUTH-FORM-PRE)

The following forms are required with the application in certain situations:

- New business transmittal form (C-NBT), for all business
- Signed HIPAA form (MEDAUTH-FORM-PRE), for all business
- Electronic funds transfer form (CI-747), if an applicant chooses to pay premium by bank draft
- Payroll deduction authorization form (CHIC-AUTH), if the applicant is having premium payroll deducted
- Replacement insurance form (CIC-REPLACESPECDIS), if the applicant intends to terminate or allow existing coverage to lapse and be replaced
- Conditional receipt (COND-RECEIPT), if the applicant pays the initial premium by check
- Medicare disclosure notice (CIC-1010), if the applicant is eligible for Medicare

For any additional state-required forms, please visit **WNbizlink.com**.

NEW AND UPGRADE APPLICATIONS

New and upgrade applications should be mailed to:

DIRECT SALES	WORKSITE SALES
Attn: New Business Department Washington National Insurance Company 11825 N. Pennsylvania St. Carmel, IN 46032 OR P.O. Box 1908 Carmel, IN 46082-1908 OR Fax: (800) 906-3926	Attn: Worksite New Business Washington National Insurance Company 11825 N. Pennsylvania St. Carmel, IN 46032 OR P.O. Box 2036 Carmel, IN 46082-2036 OR Fax: (800) 981-8413 OR Email: WIS@WashingtonNational.com

No paper check is required when you fax business to us. To help avoid confusion and delays when faxing business, do not send the original copy of the application to the home office. The application also can be submitted electronically using WNezApp 2.0℠. Check **wnbizlink.com** for state availability.

REINSTATEMENT APPLICATIONS

Reinstatement applications and downgrade requests should be mailed to:

DIRECT SALES	WORKSITE SALES
Attn: Policy Change Department Washington National Insurance Company 11825 N. Pennsylvania St. Carmel, IN 46032 OR P.O. Box 2022 Carmel, IN 46082-2022 OR Fax: (800) 906-3926	Attn: Worksite New Business Washington National Insurance Company 11825 N. Pennsylvania St. Carmel, IN 46032 OR P.O. Box 2036 Carmel, IN 46082-2036 OR Fax: (800) 981-8413 OR Email: WIS@WashingtonNational.com

DELIVERY RECEIPT

Agents may hand-deliver a Washington National Critical Solutions policy packet to a policyholder.

- For the agent to receive the policy packet, the "mail to agent" box on the application must be marked. Otherwise, the policy will be mailed directly to the policyholder.
- If the "mail to agent" option is selected on the application, the agent must have the policyholder sign the delivery receipt included in the policy packet. If this form is not returned to the above address when this option is selected, the policyholder will receive a follow-up letter from us requesting the delivery receipt be returned.

If the policy is mailed directly to the policyholder, the delivery receipt will be included in the policy packet. A follow-up letter will be mailed to the policyholder asking for the policy receipt if it is not returned. No adverse action will be taken if the receipt is not returned.

WNezApp 2.0

WNezApp 2.0 is an electronic application tool that helps agents ensure all required information is included in an application, eliminating the most common reasons for pending business and allowing business to be processed more efficiently. Based on the initial state selection, all required forms and language are presented during the application process. Rates are calculated for you. If you enter incorrect information, you won't be able to move to the next section of the application until you fix it. An error message will indicate the mistake so you can locate it quickly and move on. WNezApp 2.0 is the easiest, most efficient way to submit new applications.

Request this free software at **WNbizlink.com**.

SECTION 8: COMPENSATION

NEW SALES

First-year and renewal commissions are paid on the base policy and riders from the date the application is received in the home office, according to the percentages shown on the schedule of commissions in effect with your marketing agreement.

UPGRADES

When upgrading coverage within the Washington National Critical Solutions product, new commissions are calculated on the incremental increase in premium between the original coverage and the new coverage. Commissions on the incremental premium are calculated according to the same schedule in effect for new sales.

DOWNGRADES

When downgrading coverage within the Washington National Critical Solutions product (i.e., going from Option B to Option A), the original writing agent will continue to receive commission on any premium not exceeding the original amount. Commission on any incremental increase in premium is calculated according to the same schedules in effect for new sales.

REINSTATEMENTS

When the coverage lapse or termination is 90 days or less, the policy can be reinstated, subject to new underwriting with the following guideline: The original writing agent will continue to receive commissions due on the reinstated policy.

When a policy lapses or has been terminated between 90 and 180 days, the policy will be reinstated, subject to new underwriting. In addition:

- The original writing agent will *not* continue to receive commissions on the reinstated policy; rather, the reinstating agent will receive renewal commissions.
- If the client wants a new policy, the transaction will be treated as a new sale, generating first-year commissions and production credit.
- If the policy is upgraded at the time of reinstatement, first-year commissions will be paid on the premium increase. Production credit will be given to the reinstating agent.

If a policy lapses or has terminated for more than 180 days, it cannot be reinstated.

ADVANCES/CHARGEBACKS

Advances are the prepayment of commission based on annualized premium. Advances are calculated by agent setup on all newly issued business, including upgrades. (Not all agents are on advances.)

Annual premium x commission rate x advance rate = advance amount
Example: $420 x 35% x 60% = $88.20

Advance balances are recovered as commission is earned on a policy-by-policy basis. The advance balance of any policy that is terminated before the advance is fully recovered will be recouped (charged back) immediately and transferred to the secondary balance. The agent's 1099 earnings include advances paid and are reduced by advances recouped.

COMMISSION EARNINGS

The following formula is used to calculate commission earnings:

Commissionable premium collected x commission rate = commission earned

Earned commissions and advance activity are applied first to pay off any outstanding primary account debt. Earned commission and advance activity in excess of debt in primary and minus secondary paybacks are paid to the agent via electronic funds transfer.

ELECTRONIC FUNDS TRANSFER (EFT)

Advances and commissions are paid via EFT, which helps expedite the payment of advances and commissions and eliminates the wait for a check.

COMMISSION PAYMENTS

The minimum payment is $25. Primary balances that do not meet the minimum payout accumulate until the minimum is met. At that time, an EFT is issued for the accumulated net balance. The file transmission is sent to our bank on Monday of each week, excluding holidays.

COMMISSION STATEMENTS

A statement with detail by policy of premium processed and commission activity is generated weekly for all activity during that week's pay period for every active agent and manager.

All business processed Monday through Friday is reflected on the weekly commission statements.

Commission statements are available at **WNbizlink.com**, posted by 8 A.M. ET each Monday.

SECTION 9: MARKETING MATERIALS

MARKETING MATERIALS AND FORMS USAGE

The insurance industry is state-regulated. For that reason, Washington National policies often vary by state regarding both the availability of a product and the forms required to sell the policy.

If you have questions regarding product availability or the differences in form requirements, please consult the home office or the marketing department. Under no circumstance should an agent *assume* that policies available in one state are available in another state or that the required forms are the same.

WNbizlink.com

Our online portal, **WNbizlink.com** provides easy-to-find product information, news and field updates. Forms and marketing materials are available at **WNbizlink.com** or by contacting agent care. Registration is required for first-time users. Log in to view materials from your computer screen, print them or download them for later use.

On-hand supplies are mailed within 48 hours after an order is received. All supplies are sent by regular ground delivery. There is no charge for most materials and no charge for UPS ground-mail shipping; select expedited shipping for an additional charge. To check the status of your order, call agent care at (888) 754-3406. A representative can help you place an order or determine the status.

For technical assistance, contact the WNbizlink help desk, (800) 888-4918, ext. 72269.

CREATING ADVERTISING AND MARKETING MATERIALS

Advertising is anything intended to generate interest in a specific insurance product, company or agent. This includes but is not limited to website information and other online services; product brochures; newsletters; agent recruiting materials; prospecting letters; print, radio, television and all other forms of media advertising; illustration and presentation materials; and business cards and stationery.

Do not publish, advertise or promote any material concerning our contracts or our companies unless we first approve and authorize such use in writing. Failure to submit advertising may result in termination of the agent's contract.

Please mail, fax or email materials to:
Sales Quality
11825 N. Pennsylvania St.
Carmel, IN 46032
Fax: (317) 817-4155
Email: sales.quality@WashingtonNational.com

If you have questions about the use of advertising materials or our approval process, contact sales quality, **(800) 888-4918, ext. 74669**.

Please allow sufficient time for the review and approval process.

Written approval from the sales quality department must be obtained before such material may be published or used in any way. For example, you are authorized to use a comparison statement between a competitor's product and those offered by a Washington National only if that statement is first approved in writing by the home office.

SECTION 10: CLAIM INFORMATION

Claim form H-ICI-GCI, used for Washington National Critical Solutions claims, is available at **WNbizlink.com**.

The policyholder and the attending physician must complete all required sections of the claim form. All necessary documentation—such as hospital bills, doctor bills, etc.—should be attached to the completed form. Claim forms should be mailed to:

Washington National Insurance Company
Attn: Claims Office
Specified Disease Products
P.O. Box 2024
Carmel, IN 46082-2024

Policyholders: (866) 481-9266
Agents: (888) 754-3406

Information concerning a policyholder who has been paid benefits on his or her Washington National policy may be used only if written permission is first obtained from the policyholder and has not reached its expiration date.

SECTION 11: FORMS

State-specific forms and marketing materials are available at **WNbizlink.com**.

NEW BUSINESS APPLICATION (AP-1040 OR STATE VARIATION)

This application should be used to apply for a new or modified Washington National Critical Solutions policy.

PRIVACY NOTICE (WNPRIV-FORM-APP)

A privacy notice must be left with each application at the time of sale. This form does not require any signatures.

MEDICAL AUTHORIZATION FORM (MEDAUTH-FORM-PRE)

A medical authorization form must be completed with every application. One copy must be submitted with the new business application and one must be left with applicant.

NEW BUSINESS TRANSMITTAL FORM (C-NBT)

This form must accompany applications being sent to the home office for new business, conversions and upgrades. One form is required for every 10 applications submitted.

WORKSITE NEW GROUP CASE PROFILE FORM (WIS-GRPPRO)

A group profile must be completed and submitted with applications for each new group.

PAYROLL DEDUCTION AUTHORIZATION FORM (PREM-AUTH)

This form authorizes the employer to deduct premiums from the employee's payroll check. It should be completed for payroll sales and left with the group's payroll administrator.

CONDITIONAL RECEIPT FORM (COND-RECEIPT)

This form must be completed and left with the customer whenever premium is collected at the point of sale.

ELECTRONIC FUNDS TRANSFER FORM (CI-747)

This form is required whenever an applicant wants to have his or her first or subsequent monthly premiums deducted from a checking or savings account. Refer to page 18 of this agent guide for more details.

REPLACEMENT NOTICE (CIC-REPLACESPECDIS)

The replacement notice must be given to and signed by the applicant (and spouse, if applicable) whenever the application intends to terminate or allow existing coverage to lapse and be replaced by a Washington National Critical Solutions policy.

The application book includes two copies of this form. The applicant copy must be left with the applicant; the home office copy must be submitted to the home office with the application.

UPGRADE TRANSMITTAL FORM (0061-R1)

This form must be submitted with any upgrade request.

MEDICARE SUPPLEMENT NOTICE (CIC1010)

This form must be submitted for any applicant who is eligible for Medicare.

Insurers and their representatives are not permitted by law to offer tax or legal advice. The general information here was written to support the sales, marketing or service of insurance policies offered by Washington National Insurance Company. Based upon individuals' particular circumstances and objectives, they should seek specific advice from their own qualified and duly-licensed independent tax or legal advisors. No one may rely upon or use the information here for the purpose of avoiding any tax or tax penalty that may be imposed by the Internal Revenue Code or other applicable law.

Washington National Insurance Company
Home Office
11825 N. Pennsylvania Street
Carmel, IN 46032

WashingtonNational.com

(12/14) 158725
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