MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

PREMIUMS MAY BE INCREASED UPON THE RENEWAL DATE.

LUMP SUM CANCER INSURANCE POLICY

REVIEW YOUR APPLICATION

Please review the attached copy of your application. Your application becomes a part of your policy. If anything in your application is incorrect or if any past medical history has been left out, you must tell us right away. We issued your policy on the basis that all information shown in the application is correct and complete. If it is not, your policy may not be valid.

30-DAY RIGHT TO RETURN POLICY

You have 30 days from the date of its delivery to review your policy. If during that time you are not satisfied with it, you can return your policy to us or your agent. We will promptly refund all premiums you paid. Your policy will then be considered never to have been issued.

GUARANTEED RENEWABLE UNTIL LUMP SUM BENEFIT PAID OR END OF TERM PERIOD

Your policy is guaranteed renewable until we pay 100% of the *primary insured's lump sum benefit*, or until the *term period* shown on the policy schedule ends, whichever occurs first. Unless a material misrepresentation was made on your application, we cannot cancel your policy before the end of each grace period.

PREMIUMS CAN CHANGE

We will not increase your policy's premium due to any change in your age or health or our payment of benefits to you. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same *class*. We will give you at least 60 days advance written notice prior to any such premium change. Your premium can also change if you elect to increase or decrease your benefits after the *policy effective date*.

This Policy Is a Legal Contract Between You and Us
NOTICE TO BUYER: THIS IS A SPECIFIED DISEASE POLICY.
THIS POLICY PROVIDES LIMITED BENEFITS.
BENEFITS PROVIDED ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES. READ YOUR POLICY CAREFULLY
WITH THE OUTLINE OF COVERAGE.
THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
THIS POLICY CONTAINS A 30-DAY PROBATIONARY PERIOD FOR CANCER.
THIS POLICY CONTAINS A PRE-EXISTING CONDITION LIMITATION
IF ONE IS SHOWN AS APPLICABLE ON THE POLICY SCHEDULE. THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED. To Inquire About Your Coverage, or to Express a Concern, Refer to the Policy Schedule for Toll-Free Numbers.

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DEFINITIONS

The defined terms used in your policy are shown below. We have italicized these terms wherever they appear to make them easier for you to find (except for *we*, *us*, *our*, *you*, and *your*).

Beneficiary means the person(s) or legal entity the *primary insured* names in the application or in a later written request to receive benefits payable under this policy in the event of their death.

Cancer means a malignant neoplasm which is characterized by the uncontrolled growth and spread of malignant cells and which is not specifically hereafter excluded. The term *cancer* as related to this policy also includes carcinoma in situ, blood cancers (such as leukemia, myelodysplastic syndrome and lymphoma), malignant melanoma and other skin cancers that are metastatic. *Cancer* must be confirmed with a *pathological diagnosis*. If a *pathological diagnosis* cannot be made because it is medically inappropriate or life threatening, we will accept a *clinical diagnosis*.

Cancer as defined by this policy does not include the following conditions: pre-cancerous conditions such as leukoplakia, hyperplasia, polycythemia, benign moles, or similar lesions; pre-malignant lesions (such as intraepithelial neoplasia or tumors of low malignant potential); benign tumors or polyps; or any type of skin *cancer* other than malignant melanoma or metastatic skin malignancies.

Class means persons who have the same application date, policy form, sex, tobacco status, issue age, issue year, rate classification, coverage, and state of policy issuance as listed on the policy schedule as you do.

Clinical diagnosis means a *diagnosis* of *cancer* based on the study of symptoms and diagnostic test results. We will accept a *clinical diagnosis* only if the following conditions are met:

(a) A *pathological diagnosis* cannot be made because it is medically inappropriate or life-threatening;
(b) There is medical evidence to support the *diagnosis*; and
(c) A *physician* is treating the *insured person* for *cancer*.

Covered condition means *cancer*, unless this condition is shown as not covered for an *insured person* on the policy schedule.

Diagnosed or ***diagnosis*** means the definitive establishment of a *covered condition* through the use of clinical and/or laboratory findings. The *diagnosis* must be made by a *physician* who is also a duly licensed specialist where specified under this policy.

In the case of *cancer*, we will require a *pathological diagnosis*. If a *pathological diagnosis* cannot be made because it is medically inappropriate or life threatening, we will accept a *clinical diagnosis*.

Injury means bodily harm to an *insured person* which:

(a) is the direct result of an accident or trauma that occurs while this policy is in force; and
(b) is not related to sickness, bodily infirmity or any other cause.

Insured person means you. *Insured person* also means your partner and/or any dependent child if coverage for them has been added by an attached rider.

Lump sum benefit means the dollar amount we will pay in one installment for a single *covered condition* claim as described in the BENEFITS section. The initial *lump sum benefit* amount of 100% is shown on the policy schedule.

Pathological diagnosis means a *diagnosis* of *cancer* based upon a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of *diagnosis* must be done by a *physician* who is a duly licensed pathologist and whose diagnosis of malignancy conforms with the standards set by the American College of Pathology.

Physician means a person, other than you or a member of your immediate family, who is duly licensed to practice medicine in the United States, and who is legally qualified to diagnose and treat sickness and *injury*. He or she must be providing services within the scope of his or her license. He or she must be a duly licensed specialist where required under this policy.

Policy effective date means the date on which coverage begins under your policy. The *policy effective date* is shown on the policy schedule.

Policy renewal date means the date your policy's premium is due. The frequency of the *policy renewal date*, or premium mode, will vary depending on whether you pay premiums on a monthly, quarterly, semiannual, annual or other basis.

Primary insured means the person named as the Insured on the policy schedule on the *policy effective date*.

Term period means the length of time during which your policy provides coverage. The *term period* is shown on the policy schedule. It begins on the *policy effective date*. It ends on the *Term Period* End Date shown on the policy schedule, unless you chose a lifetime term. If your policy lapses and is later reinstated, resulting in a break in coverage, the *term period* will still end on the end date shown on the policy schedule. If we pay 100% of the *primary insured's lump sum benefit* before the *term period* ends, the *term period* ends prematurely and your policy will terminate.

We, us, or ***our*** means Mutual of Omaha Insurance Company, Omaha, Nebraska.

You or ***your*** means the person named as the Insured on the policy schedule and who is also referred to as the *primary insured*.

BENEFITS

If a *physician diagnoses* an *insured person* with a *covered condition* while this policy is in force, we will pay 100% of the *lump sum benefit* shown on the policy schedule. Once we have paid 100% of the *lump sum benefit* for the *primary insured*, this policy will end, unless lump sum benefits continue under an attached rider.

EXCLUSIONS AND LIMITATIONS

COVERED CONDITION LIMITATION

Your policy pays benefits only for loss resulting from a *covered condition*. It does NOT cover any other type of sickness or *injury*, unless such other coverage has been added by rider.

EXCLUSION

We will not pay benefits for loss that occurs while this policy is not in force;

PRE-EXISTING CONDITION LIMITATION

Your policy contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the *policy effective date*.

A pre-existing condition is a condition:

(a) for which medical advice, *diagnosis*, care, or treatment was recommended by or received from a *physician* within 12 months prior to the *policy effective date*; or
(b) which manifested itself within 12 months prior to the *policy effective date* in a manner that would have caused a reasonably prudent person to seek *diagnosis*, care or treatment by a *physician*.

30-DAY PROBATIONARY PERIOD FOR CANCER

Your policy has a 30-day probationary period for *cancer*. Subject to the **Pre-Existing Condition Limitation** provision requirements, in order to be covered, *cancer* must be:

(a) *diagnosed* while this policy is in force; and
(b) *diagnosed* at least 30 days after the *policy effective date* or at least 30 days after any policy reinstatement date.

If an *insured person* is *diagnosed* with *cancer* during the policy probationary period, we will not pay benefits for that *insured person*. Coverage for that *insured person* will end as of the *policy effective date*. We will refund any unearned premium for that *insured person*.

GOVERNMENT ENTITLEMENTS NOTICE

An *insured person's* receipt of *covered condition* benefits may affect their eligibility for Medicaid and other governmental benefits and entitlements.

TIME OF COVERAGE

Your coverage starts on the *policy effective date* at 12:01 a.m. where you reside. It ends at 12:01 a.m. where you reside on the first *policy renewal date*. Each time you renew your policy by paying the premium within the 31-day grace period, a new period begins when the old period ends.

END OF INSURANCE

Your policy will end on the earliest of:

(a) the date we pay 100% of the *lump sum benefit* for the *primary insured*, unless lump sum benefits continue under an attached rider;
(b) the date the *term period* shown on the policy schedule ends;
(c) the date we receive your written or verbal request to cancel your policy, or any future date you specify in your request (in either case, the grace period will not apply);
(d) the *policy renewal date*, if the premium was not paid before the end of the grace period;
(e) the date of the *primary insured's* death; or
(f) the date coverage ends for the *primary insured* in accordance with the **30-Day Probationary Period for Cancer** provision.

In the event of cancellation or death, we will promptly refund the unearned portion of any premium paid.

The end of insurance will not affect any claim that began while your policy was in force.

CLAIMS PROVISIONS

NOTICE OF CLAIM

Written notice of a claim must be given to us within 20 days after a covered loss starts, or as soon as reasonably possible. You may give the required notice or someone else may do it for you. The notice should include your name and policy number. Notice should be mailed to us in Omaha, Nebraska at our address shown on your policy's face page.

CLAIM FORMS

When we receive your notice of a claim, we will send you forms for filing proof of loss. If we do not send you these forms within 15 days of such notice, you may give us a written statement of the nature and extent of your loss. We must receive this statement within the time frame shown in the PROOF OF LOSS section.

PROOF OF LOSS

Written proof of loss must be given to us within 90 days after the onset of such loss. If it is not reasonably possible to give us written proof within the required time, we will not reduce or deny your claim for this reason if the proof is supplied as soon as reasonably possible. In any case, proof must be given no more than 12 months from the time specified, unless you were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

We will pay benefits for a covered loss immediately upon receipt of proper adequate written proof of loss.

PAYMENT OF CLAIMS

We will pay benefits to the person who is the *primary insured* at the time of claim, if living. If the *primary insured* is deceased, we will pay benefits to their *beneficiary* or to their estate if no *beneficiary* is named or living.

If any benefits are payable to an estate or to a *beneficiary* or minor not legally able to give a valid release, we may pay up to $1,000 to someone related to the *primary insured* or the *beneficiary* by blood or marriage or a *beneficiary* who is considered by us to be equitably entitled to the benefits. If we make payment in good faith, we will be fully discharged to the extent of that payment.

POLICY PROVISIONS

CONSIDERATION

In consideration of the first premium you paid, the application you completed, and our reliance on your answers to the application questions, we have put this policy in force as of the *policy effective date*. That date is shown on the policy schedule.

ENTIRE CONTRACT AND CHANGES

This policy is a contract between you and us. The entire contract consists of:

(a) the policy;
(b) the attached signed application;
(c) any supplemental applications made part of the policy;
(d) any riders; and
(e) any endorsements or amendments.

No change in this policy will be effective until approved by a company officer. This approval must be noted on or attached to the policy. No agent can change this policy or waive any of its provisions. Any rider, endorsement, or application added after the *policy effective date* which reduces or eliminates coverage under this policy will require your signed acceptance to be valid.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date a person becomes insured under this policy, only fraudulent misstatements in the application can be used to void the policy or deny any claim for loss incurred after the two-year period.

After two years from the date of reinstatement of an *insured person's* coverage, only fraudulent misstatements in the reinstatement application can be used to void the policy or deny any claim for loss incurred after the two-year period.

No claim for loss incurred after two years from the date a person becomes insured under this policy will be reduced or denied because a sickness or physical condition not excluded from coverage by name or specific description existed prior to the *policy effective date*.

GRACE PERIOD

Your policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period. If the premium has not been paid during the grace period and a claim is payable during the grace period, we can deduct the premium payment from any payment of the claim.

REINSTATEMENT

Your policy will lapse if you do not pay your premium before the end of the grace period. If we accept a late premium without requiring you to complete an application for reinstatement, your policy will be reinstated.

If we require you to complete a reinstatement application, we will reinstate your policy as of the approval date. If we do not approve your application within 45 days of the application date, we will reinstate your policy on the 45th day following the date of the application, unless we have previously given you written notice of its disapproval.

Your reinstated policy will only cover loss that results from a *covered condition* that is *diagnosed* after the date of reinstatement. In all other respects, your rights and our rights will remain the same as before the policy lapsed, subject to any provisions noted on or attached to the reinstated policy. After the policy has been reinstated, the time period in the **Time Limit on Certain Defenses** provision will be measured from the date of reinstatement as to the statements contained in the reinstatement application. The **30-Day Probationary Period for Cancer** provision will also apply after any policy reinstatement date.

PHYSICAL EXAMINATIONS AND AUTOPSY

We have the right to have an *insured person* examined, at our expense, as often as reasonably necessary while a claim is pending. We may also have an autopsy done, at our expense, unless prohibited by law.

CHANGE OF BENEFICIARY

You can change your *beneficiary* at any time by giving us written notice. The *beneficiary's* consent is not required for this or any other change in your policy.

To change a *beneficiary*, send a written request to us at our address shown on your policy's face page. When we record and acknowledge your request, the change will be effective as of the date you signed the request. The change will not apply to any payments we made or other action taken by us before recording.

MISSTATEMENT OF AGE

If the age of an *insured person* has been misstated, all benefits payable will be those which the premium paid would have purchased at the correct age. If we would not have issued coverage for an *insured person* based on their correct age, our liability will be limited to a refund of all premium paid for that person.

LEGAL ACTIONS

You cannot bring a legal action to recover under this policy until at least 60 days after you have given us written proof of loss. You cannot bring a legal action more than three years from the date written proof of loss is required.

UNPAID PREMIUM

When we pay benefits for a claim under this policy, we may reduce those benefits by the amount of any premium then due and unpaid.

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 reside on that date, is amended to conform to the minimum requirements of those laws.

MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

PREMIUMS MAY BE INCREASED UPON THE RENEWAL DATE.

LUMP SUM HEART ATTACK AND STROKE INSURANCE POLICY

REVIEW YOUR APPLICATION

Please review the attached copy of your application. Your application becomes a part of your policy. If anything in your application is incorrect or if any past medical history has been left out, you must tell us right away. We issued your policy on the basis that all information shown in the application is correct and complete. If it is not, your policy may not be valid.

30-DAY RIGHT TO RETURN POLICY

You have 30 days from the date of its delivery to review your policy. If during that time you are not satisfied with it, you can return your policy to us or your agent. We will promptly refund all premiums you paid. Your policy will then be considered never to have been issued.

GUARANTEED RENEWABLE UNTIL LUMP SUM BENEFIT PAID OR END OF TERM PERIOD

Your policy is guaranteed renewable until we pay 100% of the *primary insured's lump sum benefit*, or until the *term period* shown on the policy schedule ends, whichever occurs first. Unless a material misrepresentation was made on your application, we cannot cancel your policy before the end of each grace period.

PREMIUMS CAN CHANGE

We will not increase your policy's premium due to any change in your age or health or our payment of benefits to you. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same *class*. We will give you at least 60 days advance written notice prior to any such premium change. Your premium can also change if you elect to increase or decrease your benefits after the *policy effective date*.

This Policy Is a Legal Contract Between You and Us
NOTICE TO BUYER: THIS IS A SPECIFIED DISEASE POLICY.
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IF ONE IS SHOWN AS APPLICABLE ON THE POLICY SCHEDULE. THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED. To Inquire About Your Coverage, or to Express a Concern, Refer to the Policy Schedule for Toll-Free Numbers.

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DEFINITIONS

The defined terms used in your policy are shown below. We have italicized these terms wherever they appear to make them easier for you to find (except for *we*, *us*, *our*, *you*, and *your*).

Beneficiary means the person(s) or legal entity the *primary insured* names in the application or in a later written request to receive benefits payable under this policy in the event of their death.

Class means persons who have the same application date, policy form, sex, tobacco status, issue age, issue year, rate classification, coverage, and state of policy issuance as listed on the policy schedule as you do.

Coronary angioplasty surgery means balloon angioplasty or other forms of catheter based percutaneous transluminal coronary artery therapy to correct narrowing or blockage of one or more coronary arteries. This surgery must be performed by a *physician* who is a duly licensed cardiologist.

Coronary artery bypass surgery means coronary artery revascularization surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. This surgery must be performed by a *physician* who is a duly licensed cardiothoracic surgeon.

Covered condition means any of the following medical conditions or surgeries (unless a condition is shown as not covered on the policy schedule).

(a) Coronary angioplasty surgery;
(b) *Coronary artery bypass surgery;*
(c) *Heart attack (myocardial infarction); and*
(d) *Stroke*.

Diagnosed or ***diagnosis*** means the definitive establishment of a *covered condition* through the use of clinical and/or laboratory findings. The *diagnosis* must be made by a *physician* who is also a duly licensed specialist where specified under this policy.

In the case of *coronary angioplasty surgery* or *coronary artery bypass surgery*, the *diagnosis* includes the performance of the surgical treatment as defined in this policy.

Heart attack (myocardial infarction) means the death of a portion of the heart muscle, resulting from blockage of one or more coronary arteries. *Heart attack* includes ST elevation, non-ST elevation, Q wave and non-Q wave presentations. In order to be covered, the *diagnosis* of *heart attack* must be based upon a clinical setting consistent with such *diagnosis* and either:

(a) new electrocardiographic changes consistent with and supporting a clinical *diagnosis* of *heart attack (myocardial infarction)*; or
(b) a concurrent diagnostic elevation of cardiac biomarkers.

Injury means bodily harm to an *insured person* which:

(a) is the direct result of an accident or trauma that occurs while this policy is in force; and
(b) is not related to sickness, bodily infirmity or any other cause.

Insured person means you. *Insured person* also means your partner and/or any dependent child if coverage for them has been added by an attached rider.

Lump sum benefit means the dollar amount we will pay in one installment for a single *covered condition* claim as described in the BENEFITS section. The initial *lump sum benefit* amount of 100% is shown on the policy schedule.

Physician means a person, other than you or a member of your immediate family, who is duly licensed to practice medicine in the United States, and who is legally qualified to diagnose and treat sickness and *injury*. He or she must be providing services within the scope of his or her license. He or she must be a duly licensed specialist where required under this policy.

Policy effective date means the date on which coverage begins under your policy. The *policy effective date* is shown on the policy schedule.

Policy renewal date means the date your policy's premium is due. The frequency of the *policy renewal date*, or premium mode, will vary depending on whether you pay premiums on a monthly, quarterly, semiannual, annual or other basis.

Primary insured means the person named as the Insured on the policy schedule on the *policy effective date*.

Stroke means a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least 24 hours following the occurrence of the stroke. Brain tissue damage should be confirmed by neuroimaging (CT, MRI, MRA, PET or similar imaging technique). *Stroke* does not include transient ischemic attack (TIA), chronic cerebrovascular insufficiency, or neurologic impairment from trauma, infection, hypoxemia or anoxia.

Term period means the length of time during which your policy provides coverage. The *term period* is shown on the policy schedule. It begins on the *policy effective date*. It ends on the *Term Period* End Date shown on the policy schedule, unless you chose a lifetime term. If your policy lapses and is later reinstated, resulting in a break in coverage, the *term period* will still end on the end date shown on the policy schedule. If we pay 100% of the *primary insured's lump sum benefit* before the *term period* ends, the *term period* ends prematurely and your policy will terminate.

We, us, or ***our*** means Mutual of Omaha Insurance Company, Omaha, Nebraska.

You or ***your*** means the person named as the Insured on the policy schedule and who is also referred to as the *primary insured*.

BENEFITS

If a *physician diagnoses* an *insured person* with a *covered condition* while this policy is in force, we will pay a percentage of the *lump sum benefit* shown on the policy schedule. The percentage payable for each type of *covered condition* is listed below. If we pay less than 100% of the *lump sum benefit* for a type of *covered condition*, the *lump sum benefit* remaining available for future claims for that *insured person* will be reduced by that amount. We will not reduce your policy's premium when a portion of the *lump sum benefit* is paid. Once we have paid 100% of the *lump sum benefit* for the *primary insured*, this policy will end, unless lump sum benefits continue under an attached rider.

Type of Covered Condition	**Percentage of Lump Sum Benefit Payable**
Heart Attack (Myocardial Infarction)	**100%**
Stroke	**100%**
Coronary Angioplasty Surgery	**25% (payable ONCE per *insured person* during the life of your policy)**
Coronary Artery Bypass Surgery	**25% (payable ONCE per *insured person* during the life of your policy)**

EXCLUSIONS AND LIMITATIONS

COVERED CONDITION LIMITATION

Your policy pays benefits only for loss resulting from a *covered condition*. It does NOT cover any other type of sickness or *injury*, unless such other coverage has been added by rider.

EXCLUSION

We will not pay benefits for loss that occurs while this policy is not in force.

PRE-EXISTING CONDITION LIMITATION

Your policy contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the *policy effective date*.

A pre-existing condition is a condition:

(a) for which medical advice, *diagnosis*, care, or treatment was recommended by or received from a *physician* within 12 months prior to the *policy effective date*; or

(b) which manifested itself within 12 months prior to the *policy effective date* in a manner that would have caused a reasonably prudent person to seek *diagnosis*, care or treatment by a *physician*.

GOVERNMENT ENTITLEMENTS NOTICE

An *insured person's* receipt of *covered condition* benefits may affect their eligibility for Medicaid and other governmental benefits and entitlements.

TIME OF COVERAGE

Your coverage starts on the *policy effective date* at 12:01 a.m. where you reside. It ends at 12:01 a.m. where you reside on the first *policy renewal date*. Each time you renew your policy by paying the premium within the 31-day grace period, a new period begins when the old period ends.

END OF INSURANCE

Your policy will end on the earliest of:

(a) the date we pay 100% of the *lump sum benefit* for the *primary insured*, unless lump sum benefits continue under an attached rider;
(b) the date the *term period* shown on the policy schedule ends;
(c) the date we receive your written or verbal request to cancel your policy, or any future date you specify in your request (in either case, the grace period will not apply);
(d) the *policy renewal date*, if the premium was not paid before the end of the grace period; or
(e) the date of the *primary insured's* death.

In the event of cancellation or death, we will promptly refund the unearned portion of any premium paid.

The end of insurance will not affect any claim that began while your policy was in force.

CLAIMS PROVISIONS

NOTICE OF CLAIM

Written notice of a claim must be given to us within 20 days after a covered loss starts, or as soon as reasonably possible. You may give the required notice or someone else may do it for you. The notice should include your name and policy number. Notice should be mailed to us in Omaha, Nebraska at our address shown on your policy's face page.

CLAIM FORMS

When we receive your notice of a claim, we will send you forms for filing proof of loss. If we do not send you these forms within 15 days of such notice, you may give us a written statement of the nature and extent of your loss. We must receive this statement within the time frame shown in the PROOF OF LOSS section.

PROOF OF LOSS

Written proof of loss must be given to us within 90 days after the onset of such loss. If it is not reasonably possible to give us written proof within the required time, we will not reduce or deny your claim for this reason if the proof is supplied as soon as reasonably possible. In any case, proof must be given no more than 12 months from the time specified, unless you were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

We will pay benefits for a covered loss immediately upon receipt of proper adequate written proof of loss.

PAYMENT OF CLAIMS

We will pay benefits to the person who is the *primary insured* at the time of claim, if living. If the *primary insured* is deceased, we will pay benefits to their *beneficiary* or to their estate if no *beneficiary* is named or living.

If any benefits are payable to an estate or to a *beneficiary* or minor not legally able to give a valid release, we may pay up to $1,000 to someone related to the *primary insured* or the *beneficiary* by blood or marriage or a *beneficiary* who is considered

by us to be equitably entitled to the benefits. If we make payment in good faith, we will be fully discharged to the extent of that payment.

POLICY PROVISIONS

CONSIDERATION

In consideration of the first premium you paid, the application you completed, and our reliance on your answers to the application questions, we have put this policy in force as of the *policy effective date*. That date is shown on the policy schedule.

ENTIRE CONTRACT AND CHANGES

This policy is a contract between you and us. The entire contract consists of:

(a) the policy;
(b) the attached signed application;
(c) any supplemental applications made part of the policy;
(d) any riders; and
(e) any endorsements or amendments.

No change in this policy will be effective until approved by a company officer. This approval must be noted on or attached to the policy. No agent can change this policy or waive any of its provisions. Any rider, endorsement, or application added after the *policy effective date* which reduces or eliminates coverage under this policy will require your signed acceptance to be valid.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date a person becomes insured under this policy, only fraudulent misstatements in the application can be used to void the policy or deny any claim for loss incurred after the two-year period.

After two years from the date of reinstatement of an *insured person's* coverage, only fraudulent misstatements in the reinstatement application can be used to void the policy or deny any claim for loss incurred after the two-year period.

No claim for loss incurred after two years from the date a person becomes insured under this policy will be reduced or denied because a sickness or physical condition not excluded from coverage by name or specific description existed prior to the *policy effective date*.

GRACE PERIOD

Your policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period. If the premium has not been paid during the grace period and a claim is payable during the grace period, we can deduct the premium payment from any payment of the claim.

REINSTATEMENT

Your policy will lapse if you do not pay your premium before the end of the grace period. If we accept a late premium without requiring you to complete an application for reinstatement, your policy will be reinstated.

If we require you to complete a reinstatement application, we will reinstate your policy as of the approval date. If we do not approve your application within 45 days of the application date, we will reinstate your policy on the 45th day following the date of the application, unless we have previously given you written notice of its disapproval.

Your reinstated policy will only cover loss that results from a *covered condition* that is *diagnosed* after the date of reinstatement. In all other respects, your rights and our rights will remain the same as before the policy lapsed, subject to any provisions noted on or attached to the reinstated policy. After the policy has been reinstated, the time period in the **Time Limit on Certain Defenses** provision will be measured from the date of reinstatement as to the statements contained in the reinstatement application.

PHYSICAL EXAMINATIONS AND AUTOPSY

We have the right to have an *insured person* examined, at our expense, as often as reasonably necessary while a claim is pending. We may also have an autopsy done, at our expense, unless prohibited by law.

CHANGE OF BENEFICIARY

You can change your *beneficiary* at any time by giving us written notice. The *beneficiary's* consent is not required for this or any other change in your policy.

To change a *beneficiary*, send a written request to us at our address shown on your policy's face page. When we record and acknowledge your request, the change will be effective as of the date you signed the request. The change will not apply to any payments we made or other action taken by us before recording.

MISSTATEMENT OF AGE

If the age of an *insured person* has been misstated, all benefits payable will be those which the premium paid would have purchased at the correct age. If we would not have issued coverage for an *insured person* based on their correct age, our liability will be limited to a refund of all premium paid for that person.

LEGAL ACTIONS

You cannot bring a legal action to recover under this policy until at least 60 days after you have given us written proof of loss. You cannot bring a legal action more than three years from the date written proof of loss is required.

UNPAID PREMIUM

When we pay benefits for a claim under this policy, we may reduce those benefits by the amount of any premium then due and unpaid.

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 reside on that date, is amended to conform to the minimum requirements of those laws.

MUTUAL OF OMAHA INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

PREMIUMS MAY BE INCREASED UPON THE RENEWAL DATE.

LUMP SUM CRITICAL ILLNESS INSURANCE POLICY

REVIEW YOUR APPLICATION

Please review the attached copy of your application. Your application becomes a part of your policy. If anything in your application is incorrect or if any past medical history has been left out, you must tell us right away. We issued your policy on the basis that all information shown in the application is correct and complete. If it is not, your policy may not be valid.

30-DAY RIGHT TO RETURN POLICY

You have 30 days from the date of its delivery to review your policy. If during that time you are not satisfied with it, you can return your policy to us or your agent. We will promptly refund all premiums you paid. Your policy will then be considered never to have been issued.

GUARANTEED RENEWABLE UNTIL LUMP SUM BENEFIT PAID OR END OF TERM PERIOD

Your policy is guaranteed renewable until we pay 100% of the *primary insured's lump sum benefit*, or until the *term period* shown on the policy schedule ends, whichever occurs first. Unless a material misrepresentation was made on your application, we cannot cancel your policy before the end of each grace period.

PREMIUMS CAN CHANGE

We will not increase your policy's premium due to any change in your age or health or our payment of benefits to you. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same *class*. We will give you at least 60 days advance written notice prior to any such premium change. Your premium can also change if you elect to increase or decrease your benefits after the *policy effective date*.

This Policy Is a Legal Contract Between You and Us
NOTICE TO BUYER: THIS IS A SPECIFIED DISEASE POLICY.
THIS POLICY PROVIDES LIMITED BENEFITS.
BENEFITS PROVIDED ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES. READ YOUR POLICY CAREFULLY
WITH THE OUTLINE OF COVERAGE.
THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
THIS POLICY CONTAINS A 30-DAY PROBATIONARY PERIOD FOR CANCER.
THIS POLICY CONTAINS A PRE-EXISTING CONDITION LIMITATION IF ONE IS SHOWN AS APPLICABLE ON THE POLICY SCHEDULE. THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED. To Inquire About Your Coverage, or to Express a Concern, Refer to the Policy Schedule for Toll-Free Numbers.

Chairman of the Board and Chief Executive Officer

Corporate Secretary

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DEFINITIONS

The defined terms used in your policy are shown below. We have italicized these terms wherever they appear to make them easier for you to find (except for *we*, *us*, *our*, *you*, and *your*).

Alzheimer's disease means a progressive degenerative disease of the brain. The *diagnosis* must be supported by medical evidence that an *insured person* exhibits loss of intellectual capacity resulting in impairment of memory and judgment. This impairment results in a significant reduction in mental and social functioning, such that an *insured person* requires permanent daily personal supervision and is unable to perform independently three or more of the following activities of daily living: transferring (moving in or out of a bed or chair), dressing, bathing, feeding, toileting, and continence. No other dementing organic brain disorders or psychiatric illnesses will satisfy the definition of *Alzheimer's disease*, nor will they be considered a *covered condition*. The *physician* making the *diagnosis* of *Alzheimer's disease* must be a duly licensed neurologist.

Beneficiary means the person(s) or legal entity the *primary insured* names in the application or in a later written request to receive benefits payable under this policy in the event of their death.

Blindness means the permanent and uncorrectable loss of sight in both eyes. In order for *blindness* to be covered, an *insured person's* corrected visual acuity must be worse than 20/200 in both eyes, or their field of vision must be less than 20 degrees in both eyes. The *physician* making the *diagnosis* of *blindness* must be a duly licensed ophthalmologist.

Cancer means a malignant neoplasm which is characterized by the uncontrolled growth and spread of malignant cells and which is not specifically hereafter excluded. The term *cancer* as related to this policy also includes carcinoma in situ, blood cancers (such as leukemia, myelodysplastic syndrome and lymphoma), malignant melanoma and other skin cancers that are metastatic. *Cancer* must be confirmed with a *pathological diagnosis*. If a *pathological diagnosis* cannot be made because it is medically inappropriate or life threatening, we will accept a *clinical diagnosis*.

Cancer as defined by this policy does not include the following conditions: pre-cancerous conditions such as leukoplakia, hyperplasia, polycythemia, benign moles, or similar lesions; pre-malignant lesions (such as intraepithelial neoplasia or tumors of low malignant potential); benign tumors or polyps; or any type of skin *cancer* other than malignant melanoma or metastatic skin malignancies.

Class means persons who have the same application date, policy form, sex, tobacco status, issue age, issue year, rate classification, coverage, and state of policy issuance as listed on the policy schedule as you do.

Clinical diagnosis means a *diagnosis* of *cancer* based on the study of symptoms and diagnostic test results. We will accept a *clinical diagnosis* only if the following conditions are met:

(a) A *pathological diagnosis* cannot be made because it is medically inappropriate or life-threatening;
(b) There is medical evidence to support the *diagnosis*; and
(c) A *physician* is treating the *insured person* for *cancer*.

Coronary angioplasty surgery means balloon angioplasty or other forms of catheter based percutaneous transluminal coronary artery therapy to correct narrowing or blockage of one or more coronary arteries. This surgery must be performed by a *physician* who is a duly licensed cardiologist.

Coronary artery bypass surgery means coronary artery revascularization surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. This surgery must be performed by a *physician* who is a duly licensed cardiothoracic surgeon.

Covered condition means any of the following medical conditions or surgeries (unless a condition is shown as not covered on the policy schedule).

(a) *Alzheimer's disease*;
(b) *Blindness*;
(c) *Cancer*;
(d) *Coronary angioplasty surgery*;
(e) *Coronary artery bypass surgery*;
(f) *Deafness*;
(g) *Heart attack (myocardial infarction)*;
(h) *Kidney (renal) failure*;
(i) *Major organ transplant surgery*;
(j) *Paralysis*; and

(k) *Stroke*.

Deafness means a permanent loss of hearing in both ears with an auditory threshold of more than 90 decibels in each ear. The *physician* making the *diagnosis* of *deafness* must be a duly licensed otolaryngologist.

Diagnosed or ***diagnosis*** means the definitive establishment of a *covered condition* through the use of clinical and/or laboratory findings. The *diagnosis* must be made by a *physician* who is also a duly licensed specialist where specified under this policy.

In the case of *cancer*, we will require a *pathological diagnosis*. If a *pathological diagnosis* cannot be made because it is medically inappropriate or life threatening, we will accept a *clinical diagnosis*.

In the case of *coronary angioplasty surgery* or *coronary artery bypass surgery*, the *diagnosis* includes the performance of the surgical treatment as defined in this policy.

In the case of *major organ transplant surgery*, the *diagnosis* includes our verification that the *insured person* has been registered by the United Network of Organ Sharing (UNOS).

Heart attack (myocardial infarction) means the death of a portion of the heart muscle, resulting from blockage of one or more coronary arteries. *Heart attack* includes ST elevation, non-ST elevation, Q wave and non-Q wave presentations. In order to be covered, the *diagnosis* of *heart attack* must be based upon a clinical setting consistent with such *diagnosis* and either:

(a) new electrocardiographic changes consistent with and supporting a clinical *diagnosis* of *heart attack (myocardial infarction)*; or
(b) a concurrent diagnostic elevation of cardiac biomarkers.

Injury means bodily harm to an *insured person* which:

(a) is the direct result of an accident or trauma that occurs while this policy is in force; and
(b) is not related to sickness, bodily infirmity or any other cause.

Insured person means you. *Insured person* also means your partner and/or any dependent child if coverage for them has been added by an attached rider.

Kidney (renal) failure means the chronic and irreversible failure of both kidneys (end stage renal disease), which requires treatment with regular dialysis. The *diagnosis* of kidney failure must be made by a *physician* who is a duly licensed nephrologist.

Lump sum benefit means the dollar amount we will pay in one installment for a single *covered condition* claim as described in the BENEFITS section. The initial *lump sum benefit* amount of 100% is shown on the policy schedule.

Major organ transplant surgery means clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue to be replaced with the organ(s) or tissue from a suitable donor under generally accepted medical procedures. Those organs or tissues covered by this definition are limited to liver, kidney, lung, entire heart, small intestine, pancreas, pancreas/kidney or bone marrow. In order for the major organ transplant to be covered, the *insured person* must be registered by the United Network of Organ Sharing (UNOS).

Paralysis means the total and permanent loss of muscle function of two or more limbs as a result of *injury* to the nerve supply to those limbs, confirmed to have been present for a continuous period of at least 180 days by a *physician* who is a duly licensed neurologist. A "limb" means an arm or leg.

Pathological diagnosis means a *diagnosis* of *cancer* based upon a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of *diagnosis* must be done by a *physician* who is a duly licensed pathologist and whose diagnosis of malignancy conforms with the standards set by the American College of Pathology.

Physician means a person, other than you or a member of your immediate family, who is duly licensed to practice medicine in the United States, and who is legally qualified to diagnose and treat sickness and *injury*. He or she must be providing services within the scope of his or her license. He or she must be a duly licensed specialist where required under this policy.

Policy effective date means the date on which coverage begins under your policy. The *policy effective date* is shown on the policy schedule.

Policy renewal date means the date your policy's premium is due. The frequency of the *policy renewal date*, or premium mode, will vary depending on whether you pay premiums on a monthly, quarterly, semiannual, annual or other basis.

Primary insured means the person named as the Insured on the policy schedule on the *policy effective date*.

Stroke means a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least 24 hours following the occurrence of the stroke. Brain tissue damage must be confirmed by neuroimaging (CT, MRI, MRA, PET or similar imaging technique). *Stroke* does not include transient ischemic attack (TIA), chronic cerebrovascular insufficiency, or neurologic impairment from trauma, infection, hypoxemia or anoxia.

Term period means the length of time during which your policy provides coverage. The *term period* is shown on the policy schedule. It begins on the *policy effective date*. It ends on the *Term Period* End Date shown on the policy schedule, unless you chose a lifetime term. If your policy lapses and is later reinstated, resulting in a break in coverage, the *term period* will still end on the end date shown on the policy schedule. If we pay 100% of the *primary insured's lump sum benefit* before the *term period* ends, the *term period* ends prematurely and your policy will terminate.

We, us, or ***our*** means Mutual of Omaha Insurance Company, Omaha, Nebraska.

You or ***your*** means the person named as the Insured on the policy schedule and who is also referred to as the *primary insured*.

BENEFITS

If a *physician diagnoses* an *insured person* with a *covered condition* while this policy is in force, we will pay a percentage of the *lump sum benefit* shown on the policy schedule. The percentage payable for each type of *covered condition* is listed below. If we pay less than 100% of the *lump sum benefit* for a type of *covered condition*, the *lump sum benefit* remaining available for future claims for that *insured person* will be reduced by that amount. We will not reduce your policy's premium when a portion of the *lump sum benefit* is paid. Once we have paid 100% of the *lump sum benefit* for the *primary insured*, this policy will end, unless lump sum benefits continue under an attached rider.

Type of Covered Condition	Percentage of Lump Sum Benefit Payable
Alzheimer's Disease	**100%**
Blindness	**100%**
Cancer	**100%**
Deafness	**100%**
Heart Attack (Myocardial Infarction)	**100%**
Kidney (Renal) Failure	**100%**
Major Organ Transplant	**100%**
Paralysis	**100%**
Stroke	**100%**
Coronary Angioplasty Surgery	**25% (payable ONCE per *insured person* during the life of your policy)**
Coronary Artery Bypass Surgery	**25% (payable ONCE per *insured person* during the life of your policy)**

RETURN OF PREMIUM AT DEATH BENEFIT

If you die while your policy is in force, we will pay a lump sum return of premium at death benefit to your *beneficiary*. If your *beneficiary* is deceased, or cannot be located, we will pay this benefit to your estate.

The amount we pay will be 100% of all premiums you paid for your policy and attached riders, minus the amount of benefits, including return of premium and cash value benefits, we paid under your policy and attached riders, if any. The premiums we return will be calculated without interest after we have finalized all pending claims. If a loss is incurred prior to your death, but we do not receive notice of it until after we have paid the return of premium at death benefit, we will reduce any benefits we pay for the claim by the amount we paid for the return of premium at death benefit. If the amount of benefits we paid exceeds the amount of premiums you paid for your policy and riders, no return of premium benefit will be payable.

EXCLUSIONS AND LIMITATIONS

COVERED CONDITION LIMITATION

Your policy pays benefits only for loss resulting from a *covered condition*. It does NOT cover any other type of sickness or *injury*, unless such other coverage has been added by rider.

EXCLUSIONS

We will not pay benefits for:

(a) loss that occurs while this policy is not in force;
(b) loss resulting from service in the armed forces or auxiliary units;
(c) loss caused by intentionally self-inflicted *injury*, while sane or insane;
(d) loss resulting from an *insured person's* commission or attempted commission of a felony;
(e) loss sustained while engaging in an illegal occupation;
(f) loss resulting from an *insured person* being intoxicated (as determined and defined by the laws of the jurisdiction in which the loss or cause of loss occurred; for the purposes of this exclusion, the laws governing the operation of motor vehicles while intoxicated will apply); or
(g) loss resulting from an *insured person* being under the influence of any controlled substance (except for narcotics given on the advice of a *physician*).

PRE-EXISTING CONDITION LIMITATION

Your policy contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the *policy effective date.*

A pre-existing condition is a condition:

(a) for which medical advice, *diagnosis,* care, or treatment was recommended by or received from a *physician* within 12 months prior to the *policy effective date*; or
(b) which manifested itself within 12 months prior to the *policy effective date* in a manner that would have caused a reasonably prudent person to seek *diagnosis,* care or treatment by a *physician*.

30-DAY PROBATIONARY PERIOD FOR CANCER

Your policy has a 30-day probationary period for *cancer*. Subject to the **Pre-Existing Condition Limitation** provision requirements, in order to be covered, *cancer* must be:

(a) *diagnosed* while this policy is in force; and
(b) *diagnosed* at least 30 days after the *policy effective date* or at least 30 days after any policy reinstatement date.

If an *insured person* is *diagnosed* with *cancer* during the policy probationary period, we will not pay benefits for that *insured person*. Coverage for that *insured person* will end as of the *policy effective date*. We will refund any unearned premium for that *insured person*.

GOVERNMENT ENTITLEMENTS NOTICE

An *insured person's* receipt of *covered condition* benefits may affect their eligibility for Medicaid and other governmental benefits and entitlements.

TIME OF COVERAGE

Your coverage starts on the *policy effective date* at 12:01 a.m. where you reside. It ends at 12:01 a.m. where you reside on the first *policy renewal date*. Each time you renew your policy by paying the premium within the 31-day grace period, a new period begins when the old period ends.

END OF INSURANCE

Your policy will end on the earliest of:

(a) the date we pay 100% of the *lump sum benefit* for the *primary insured*, unless lump sum benefits continue under an attached rider;
(b) the date the *term period* shown on the policy schedule ends;

(c) the date we receive your written or verbal request to cancel your policy, or any future date you specify in your request (in either case, the grace period will not apply);
(d) the *policy renewal date*, if the premium was not paid before the end of the grace period;
(e) the date of the *primary insured's* death; or
(f) the date coverage ends for the *primary insured* in accordance with the **30-Day Probationary Period for Cancer** provision.

In the event of cancellation, we will promptly refund the unearned portion of any premium paid.

The end of insurance will not affect any claim that began while your policy was in force.

CLAIMS PROVISIONS

NOTICE OF CLAIM

Written notice of a claim must be given to us within 20 days after a covered loss starts, or as soon as reasonably possible. You may give the required notice or someone else may do it for you. The notice should include your name and policy number. Notice should be mailed to us in Omaha, Nebraska at our address shown on your policy's face page.

CLAIM FORMS

When we receive your notice of a claim, we will send you forms for filing proof of loss. If we do not send you these forms within 15 days of such notice, you may give us a written statement of the nature and extent of your loss. We must receive this statement within the time frame shown in the PROOF OF LOSS section.

PROOF OF LOSS

Written proof of loss must be given to us within 90 days after the onset of such loss. If it is not reasonably possible to give us written proof within the required time, we will not reduce or deny your claim for this reason if the proof is supplied as soon as reasonably possible. In any case, proof must be given no more than 12 months from the time specified, unless you were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

We will pay benefits for a covered loss immediately upon receipt of proper adequate written proof of loss.

PAYMENT OF CLAIMS

We will pay benefits to the person who is the *primary insured* at the time of claim, if living. If the *primary insured* is deceased, we will pay benefits to their *beneficiary* or to their estate if no *beneficiary* is named or living.

If any benefits are payable to an estate or to a *beneficiary* or minor not legally able to give a valid release, we may pay up to $1,000 to someone related to the *primary insured* or the *beneficiary* by blood or marriage or a *beneficiary* who is considered by us to be equitably entitled to the benefits. If we make payment in good faith, we will be fully discharged to the extent of that payment.

POLICY PROVISIONS

CONSIDERATION

In consideration of the first premium you paid, the application you completed, and our reliance on your answers to the application questions, we have put this policy in force as of the *policy effective date*. That date is shown on the policy schedule.

ENTIRE CONTRACT AND CHANGES

This policy is a contract between you and us. The entire contract consists of:

(a) the policy;
(b) the attached signed application;

(c) any supplemental applications made part of the policy;
(d) any riders; and
(e) any endorsements or amendments.

No change in this policy will be effective until approved by a company officer. This approval must be noted on or attached to the policy. No agent can change this policy or waive any of its provisions. Any rider, endorsement, or application added after the *policy effective date* which reduces or eliminates coverage under this policy will require your signed acceptance to be valid.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date a person becomes insured under this policy, only fraudulent misstatements in the application can be used to void the policy or deny any claim for loss incurred after the two-year period.

After two years from the date of reinstatement of an *insured person's* coverage, only fraudulent misstatements in the reinstatement application can be used to void the policy or deny any claim for loss incurred after the two-year period.

No claim for loss incurred after two years from the date a person becomes insured under this policy will be reduced or denied because a sickness or physical condition not excluded from coverage by name or specific description existed prior to the *policy effective date*.

GRACE PERIOD

Your policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period. If the premium has not been paid during the grace period and a claim is payable during the grace period, we can deduct the premium payment from any payment of the claim.

REINSTATEMENT

Your policy will lapse if you do not pay your premium before the end of the grace period. If we accept a late premium without requiring you to complete an application for reinstatement, your policy will be reinstated.

If we require you to complete a reinstatement application, we will reinstate your policy as of the approval date. If we do not approve your application within 45 days of the application date, we will reinstate your policy on the 45th day following the date of the application, unless we have previously given you written notice of its disapproval.

Your reinstated policy will only cover loss that results from a *covered condition* that is *diagnosed* after the date of reinstatement. In all other respects, your rights and our rights will remain the same as before the policy lapsed, subject to any provisions noted on or attached to the reinstated policy. After the policy has been reinstated, the time period in the **Time Limit on Certain Defenses** provision will be measured from the date of reinstatement as to the statements contained in the reinstatement application. The **30-Day Probationary Period for Cancer** provision will also apply after any policy reinstatement date.

PHYSICAL EXAMINATIONS AND AUTOPSY

We have the right to have an *insured person* examined, at our expense, as often as reasonably necessary while a claim is pending. We may also have an autopsy done, at our expense, unless prohibited by law.

CHANGE OF BENEFICIARY

You can change your *beneficiary* at any time by giving us written notice. The *beneficiary's* consent is not required for this or any other change in your policy.

To change a *beneficiary*, send a written request to us at our address shown on your policy's face page. When we record and acknowledge your request, the change will be effective as of the date you signed the request. The change will not apply to any payments we made or other action taken by us before recording.

MISSTATEMENT OF AGE

If the age of an *insured person* has been misstated, all benefits payable will be those which the premium paid would have purchased at the correct age. If we would not have issued coverage for an *insured person* based on their correct age, our liability will be limited to a refund of all premium paid for that person.

LEGAL ACTIONS

You cannot bring a legal action to recover under this policy until at least 60 days after you have given us written proof of loss. You cannot bring a legal action more than three years from the date written proof of loss is required.

UNPAID PREMIUM

When we pay benefits for a claim under this policy, we may reduce those benefits by the amount of any premium then due and unpaid.

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 reside on that date, is amended to conform to the minimum requirements of those laws.

MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

FAMILY COVERAGE RIDER

The premium you paid and the application you completed put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date* if no date is shown) _____

Rider Premium (included in the policy premium unless a separate amount is shown on the policy schedule)

DEFINITIONS

The definitions shown in your policy apply to this rider. In addition, the following definitions apply to this rider.

Age 26 means the first *policy renewal date* that coincides with or next follows a *dependent child's* 26th birthday.

Dependent or ***dependents*** means your covered *partner* and/or *dependent child*.

Dependent child means your or your *partner's* unmarried natural born child, adopted child, stepchild, or grandchild who is under *age 26* and insured in accordance with this rider's DEPENDENT ELIGIBILITY section.

Partner means the one person who is insured under this rider on the Rider Date and is:

(a) your spouse to whom you are legally married;
(b) your registered domestic partner; or
(c) an adult person who:
    1. shares a serious and committed personal relationship with you that is intended to be lifelong;
    2. has shared a common permanent residence with you on a continuous basis for the most recent three years;
    3. is not married, a domestic partner, or in a committed personal relationship to anyone else; and
    4. is not related to you in any way that would bar marriage in the state where you and he or she reside.

FAMILY COVERAGE BENEFITS

This rider adds *partner* and *dependent child* coverage to your policy.

Your policy's definition of *insured person* now includes your *partner* and/or any *dependent child*.

DEPENDENT ELIGIBILITY

Your *dependents* are eligible for coverage if you apply for them, they qualify for coverage on the date you sign your application and you pay the required premium.

A child born or adopted after the *policy effective date* is eligible for coverage as explained in the **Newborn and Adopted Children** provision.

An eligible *dependent child* also includes any of your children, your *dependent child's* children or children you are required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in Texas.

NEWBORN AND ADOPTED CHILDREN

We will automatically insure any newborn *dependent child* of yours who is born after the *policy effective date* and while your policy is in force. We will not charge any additional premium for your newborn's coverage. You must notify us in writing of the child's name and date of birth for our records. We will not ask for evidence of insurability. The newborn will not be subject to any waiting or probationary periods that might otherwise apply.

We will also automatically insure any *dependent child* adopted by you after the *policy effective date* and while your policy is in force. The automatic coverage period for such adoptive child will begin on the earliest of:

(a) the effective date of adoption;
(b) the date you are a party in a suit for which adoption is sought; or
(c) the date you have custody of a child under a temporary court order granting you conservatorship.

We will not charge any additional premium for the adopted child. You must notify us in writing of the child's name and date of birth for our records. We will not ask for evidence of insurability. The adopted child will not be subject to any waiting or probationary periods that might otherwise apply.

WHEN DEPENDENT CHILD ELIGIBILITY ENDS

A *dependent child* is no longer eligible for coverage, and insurance for such *dependent child* will end, on the earliest of:

(a) the date he or she reaches *age 26*;
(b) the date he or she gets married; or
(c) the date any of the conditions of this rider's END OF INSURANCE FOR A DEPENDENT section are met which end coverage for that *dependent child*.

You are responsible for notifying us when a *dependent child* meets any of the above listed conditions. Our acceptance of premium after this date is considered as premium only for the remaining *dependents* who are eligible for coverage under this rider.

If, on the date a *dependent child's* insurance would end because of reaching *age 26*, he or she is not capable of self-sustaining employment because of an intellectual disability or physical handicap, and is chiefly dependent on you for support and maintenance, we will continue coverage for such child. Coverage will continue as long as your policy remains in force and the incapacity continues. We may ask prior to the date coverage for a *dependent child* is to end whether or not he or she is incapacitated. Unless you send us satisfactory proof of such incapacity within 60 days of our inquiry, we may end the child's coverage under your policy.

DEPENDENT CHILD AND PARTNER CONVERSION OPTION

We will offer a conversion policy to a covered *dependent* if:

(a) *dependent child* coverage under this policy ends because a *dependent child* ceases to be eligible for coverage; or
(b) *partner* coverage ends under this policy due to a change in marital status or the end of a partnership.

Your former *dependent* must apply for and pay the premium for the new policy within 30 days after the end of their coverage under this policy. We will not require evidence of insurability. Upon our receipt of their completed application, we will issue a conversion policy only for the *dependent child* or *partner* which is then available and most comparable to this policy. Benefits under the new policy may be less than those provided to your former *dependent* under this policy and will exclude conditions not covered by this policy. Any benefit amounts we've paid for that *dependent* under this policy will be applied to any benefit limits under the conversion policy. We will reduce any waiting or probationary periods on the new policy by the number of months already satisfied on this policy.

PARTNER CONTINUATION OF INSURANCE

If the *primary insured's* insurance ends for any reason other than:

(a) cancellation of the policy;
(b) non-payment of premium;
(c) the end of the policy term period; or
(d) a diagnosis of cancer during the 30-Day Probationary Period for Cancer (if your policy contains this provision);

we can continue the policy with the *covered partner* as the *primary insured*. Your *partner* must notify us in writing of their wish to use this option. If we receive the required premium from your *partner* within 60 days after the end of the original *primary insured's* coverage under this policy, your *partner* can continue coverage under this policy. Continuation of insurance is subject to all policy provisions.

LAPSE AND REINSTATEMENT

If your policy lapses because you did not pay the premium before the end of the grace period, we may ask you to provide evidence of insurability before we agree to reinstate coverage for each *dependent*.

END OF INSURANCE FOR A DEPENDENT

Insurance for a specific *dependent* will end on the earliest of:

(a) the date we receive your written or verbal request to cancel that *dependent's* coverage (in which case the grace period will not apply);
(b) the *policy renewal date* on or immediately following the date eligibility ends for that *dependent*;
(c) the date of that *dependent's* death;
(d) the date coverage for a *dependent* ends in accordance with the **30-Day Probationary Period for Cancer** provision, if such provision is included in your policy; or
(e) the date we pay the full *lump sum benefit* for that *dependent*.

In the event of cancellation or death, we will promptly return any unearned portion of the premium paid.

The end of insurance will not affect any claim that began while your policy was in force.

END OF RIDER

This rider will end on the earliest of:

(a) the date your policy ends;
(b) the date you request removal of this rider from your policy; or
(c) the date the last *dependent* ceases to be eligible for *dependent* coverage.

MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

INTENSIVE CARE UNIT INDEMNITY BENEFITS RIDER

NOTICE TO BUYER: THIS IS AN INTENSIVE CARE UNIT INDEMNITY RIDER WHICH PROVIDES LIMITED BENEFITS. BENEFITS REDUCE AT AGE 65.

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date* if no date is shown) _____

Rider Premium (included in the policy premium unless a separate amount is shown on the policy schedule)

DEFINITIONS

The definitions shown in your policy apply to this rider. In addition, the following definitions apply to this rider.

Age 65 means the first *policy renewal date* that coincides with or next follows an *insured person's* 65th birthday.

Complication of pregnancy means:

(a) when the pregnancy is not terminated, a condition with a diagnosis which is distinct from pregnancy, adversely affected by pregnancy or caused by pregnancy. This includes acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and
(b) cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, hyperemesis gravidarum, eclampsia and toxemia.

Complication of pregnancy does not include false labor, occasional spotting, morning sickness, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a distinct medically-classified *complication of pregnancy*.

Confined or confinement means an *insured person* is admitted as a resident inpatient to the *intensive care unit* of a *hospital* because of *sickness* or *injury*. Such confinement must be recommended and supervised by a *physician*.

Hospital means any of the following places:

(a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located;
(b) a place operated for the care and treatment of resident inpatients with a registered nurse (RN) or physician always on the premises and with a laboratory and x-ray facility;
(c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals; or
(d) a place certified as a hospital by Medicare.

Not included is a hospital or institution or a part of a hospital or institution which is licensed or used principally:

(a) for the care or treatment of drug abuse, alcoholism or chemical dependency; or
(b) as a continued or extended care facility, skilled nursing facility, assisted living facility, rehabilitation facility, convalescent home, or nursing home.

ICU daily room indemnity benefit means the fixed amount we will pay for each day of *confinement* in an *intensive care unit.* The *ICU daily room indemnity benefit* is shown on the policy schedule.

Intensive care unit or ICU means a separate, specifically designated` facility of a *hospital* which provides the highest level of medical care to critically ill or injured patients. The facility must be permanently equipped and staffed by qualified personnel to provide close observation on a full-time basis. Intensive care unit includes a coronary care unit or renal care unit.

Normal childbirth or ***normal pregnancy*** means childbirth or pregnancy free of any *complication of pregnancy*.

Period of confinement means one or more *ICU hospital confinements* for the same or different causes that are separated by less than 60 days in a row. A *period of confinement* begins on the first day an *insured person* is admitted to an *intensive care unit*. It ends when an *insured person* has not been *hospital confined* in an *intensive care unit* for at least 60 days in a row.

Sickness means an illness, disease or physical condition which:

(a) causes loss beginning while this policy is in force; and
(b) is not excluded from coverage.

INTENSIVE CARE UNIT INDEMNITY BENEFITS

When an *insured person* is confined in the *intensive care unit* of a *hospital* as the result of a *sickness* or *injury*, we will pay the *ICU daily room indemnity benefit* shown on the policy schedule for each day of *confinement*.

Benefits payable for each *insured person* are limited to a maximum of 30 days during any one *period of confinement*.

Benefits payable under this rider will not reduce the *lump sum benefit* for any *insured person*.

BENEFIT REDUCTION AT AGE 65

After an *insured person* reaches *age 65*, we will reduce the *ICU daily room indemnity benefit* then in effect by 50% if such *insured person* was under age 60 when this rider was issued.

For an *insured person* who was age 60 or older when this rider was issued, the 50% reduction of the *ICU daily room indemnity* benefit amount will occur on the first *policy renewal date* occurring on or after the five-year anniversary of the Rider Date.

EXCLUSIONS AND LIMITATIONS

For the purposes of this rider only, the EXCLUSIONS AND LIMITATIONS section of your policy is removed and replaced by the following.

EXCLUSIONS

We will not pay benefits for:

(a) loss that occurs while this rider is not in force;
(b) loss resulting from service in the armed forces or auxiliary units;
(c) loss caused by intentionally self-inflicted injury, while sane or insane;
(d) loss resulting from an *insured person's* commission or attempted commission of a felony;
(e) loss sustained while engaging in an illegal occupation;
(f) loss resulting from an *insured person's* being intoxicated (as determined and defined by the laws of the jurisdiction in which the loss or cause of loss occurred; for the purposes of this exclusion, the laws governing the operation of motor vehicles while intoxicated will apply); or
(g) loss resulting from an *insured person's* being under the influence of any controlled substance (except for narcotics given on the advice of a *physician*).

PREGNANCY LIMITATION

We will not pay INTENSIVE CARE UNIT INDEMNITY BENEFITS for *normal childbirth*, *normal pregnancy* or voluntarily induced abortion. We will pay benefits under this rider for a *complication of pregnancy* on the same basis as any other *sickness*.

PRE-EXISTING CONDITION LIMITATION

This rider contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the Rider Date.

A pre-existing condition is a condition:

(a) for which medical advice, *diagnosis*, care, or treatment was recommended by or received from a physician within 12 months prior to the Rider Date; or
(b) which manifested itself within 12 months prior to the Rider Date in a manner that would have caused a reasonably prudent person to seek *diagnosis*, care or treatment by a *physician*.

END OF RIDER

This rider ends on the earlier of:

(a) the date your policy ends; or
(b) the date you request removal of this rider from your policy.

MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

CASH VALUE BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date* if no date is shown) _____

Rider Premium (included in the policy premium unless a separate amount is shown on the policy schedule)

DEFINITION

The definitions shown in your policy apply to this rider. In addition, the following definition applies to this rider.

Rider anniversary date means the annual anniversary of the Rider Date while this rider is in force.

CASH VALUE BENEFIT

If this rider ends at any time after the fifth *rider anniversary date*, we will pay a cash value benefit to you. We will pay the cash value benefit on the earliest of:

(a) the date you request removal of this rider from your policy;
(b) the date your policy lapses because you did not pay the premium before the end of the grace period; or
(c) the date your policy ends for any other reason.

The cash value benefit is a percentage of all premiums you paid for your policy and all riders, minus the amount of benefits we pay in claims for all *insured persons*, if any. The percentage is based upon the age of the oldest *insured person* on the Rider Date and the number of full years your rider was in force on the date this rider ended. This percentage is shown on the below Table of Cash Value Percentages.

We will calculate the cash value benefit using this formula: (Premiums Paid) ***multiplied by*** (Percentage from Table) ***minus*** (Any Claims Paid) ***equals*** (Cash Value Benefit).

If the cash value benefit becomes payable between *rider anniversary dates*, we will prorate the portion of the benefit due for a partial year. We will calculate the proration by taking the difference between the cash value percentage on the last and next *rider anniversary dates*, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time this rider ended. We will then add the proration to the cash value percentage on the last *rider anniversary date*.

If your policy lapses because you did not pay the required premium before the end of the grace period, we may, under certain circumstances, reinstate your policy as described in your policy's **Reinstatement** provision. We will not, however, reinstate this rider. If your policy lapses, we will automatically pay any cash value benefit that is due. This rider will then end.

We will pay the cash value benefit after we have paid all claims under your policy. If the amount we've paid in claims exceeds the cash value, no cash value benefit will be payable. If a claim begins while this rider is in force, but we do not receive notice of it until after we have paid the cash value, we will reduce any benefits we pay for the claim by the amount we paid for the cash value benefit. Once we pay the cash value benefit, this rider will end.

TABLE OF CASH VALUE PERCENTAGES

Number of Years Your Rider Was In Force	Age of Oldest Insured Person on the Rider Date									
	18-40	41	42	43	44	45	46	47	48	49
1	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
2	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
3	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
4	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
5	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
6	3%	4%	4%	4%	5%	5%	5%	6%	7%	7%
7	7%	8%	8%	9%	10%	10%	11%	12%	13%	15%
8	11%	12%	13%	13%	14%	16%	17%	18%	20%	22%
9	15%	16%	17%	18%	20%	21%	23%	25%	28%	30%
10	19%	20%	21%	23%	25%	27%	29%	32%	35%	39%
11	23%	24%	26%	28%	30%	33%	36%	39%	43%	47%
12	27%	29%	31%	33%	36%	39%	42%	46%	51%	56%
13	32%	34%	36%	39%	42%	45%	49%	54%	59%	66%
14	36%	38%	41%	44%	48%	52%	56%	62%	68%	76%
15	41%	43%	46%	50%	54%	58%	64%	70%	77%	86%
16	46%	48%	52%	56%	60%	65%	71%	78%	87%	100%
17	51%	54%	57%	62%	67%	73%	79%	87%	100%	100%
18	56%	59%	63%	68%	74%	80%	88%	100%	100%	100%
19	62%	65%	69%	75%	81%	89%	100%	100%	100%	100%
20	68%	71%	76%	82%	89%	100%	100%	100%	100%	100%
21	74%	77%	83%	89%	100%	100%	100%	100%	100%	100%
22	80%	83%	90%	100%	100%	100%	100%	100%	100%	100%
23	86%	90%	100%	100%	100%	100%	100%	100%	100%	100%
24	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%
More than 25 years	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

NON-DUPLICATION OF BENEFITS

This rider will not duplicate return of premium or cash value benefits payable under any other provision of your policy. If your policy contains a return of premium or cash value benefit provision, we will only pay benefits under the policy or rider provision which pays you the greater benefit.

END OF RIDER

This rider ends on the earlier of the date you request removal of this rider from your policy or the date your policy ends.

MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

LUMP SUM CANCER BENEFITS RIDER

NOTICE TO BUYER: THIS IS A LUMP SUM CANCER BENEFITS RIDER WHICH PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date* if no date is shown) _____

Rider Premium (included in the policy premium unless a separate amount is shown on the policy schedule)

DEFINITIONS

The definitions shown in your policy apply to this rider. However, the definitions of *covered condition* and *diagnosed* or *diagnosis* contained in your policy are removed and replaced by the versions below for the purposes of this rider. The following additional definitions also apply to this rider.

Cancer means a malignant neoplasm which is characterized by the uncontrolled growth and spread of malignant cells and which is not specifically hereafter excluded. The term *cancer* as related to this rider also includes carcinoma in situ, blood cancers (such as leukemia, myelodysplastic syndrome and lymphoma), malignant melanoma and other skin cancers that are metastatic. *Cancer* must be confirmed with a *pathological diagnosis.* If a *pathological diagnosis* cannot be made because it is medically inappropriate or life threatening, we will accept a *clinical diagnosis.*

Cancer as defined by this rider does not include the following conditions: pre-cancerous conditions such as leukoplakia, hyperplasia, polycythemia, benign moles, or similar lesions; pre-malignant lesions (such as intraepithelial neoplasia or tumors of low malignant potential); benign tumors or polyps; or any type of skin *cancer* other than malignant melanoma or metastatic skin malignancies.

Clinical diagnosis means a *diagnosis* of *cancer* based on the study of symptoms and diagnostic test results. We will accept a *clinical diagnosis* only if the following conditions are met:

(a) A *pathological diagnosis* cannot be made because it is medically inappropriate or life-threatening;
(b) There is medical evidence to support the *diagnosis;* and
(c) A *physician* is treating the *insured person* for *cancer.*

Covered condition means *cancer,* unless this condition is shown as not covered for an *insured person* on the policy schedule.

Diagnosed or ***diagnosis*** means the definitive establishment of a *covered condition* through the use of clinical and/or laboratory findings. The *diagnosis* must be made by a *physician* who is also a duly licensed specialist where specified under this rider.

In the case of *cancer,* we will require a *pathological diagnosis.* If a *pathological diagnosis* cannot be made because it is medically inappropriate or life threatening, we will accept a *clinical diagnosis.*

Pathological diagnosis means a *diagnosis* of *cancer* based upon a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of *diagnosis* must be done by a *physician* who is a duly licensed pathologist and whose *diagnosis* of malignancy conforms with the standards set by the American College of Pathology.

Rider lump sum benefit means the dollar amount we will pay in one installment for a single *covered condition* claim as described in the BENEFITS section of this rider. The initial *rider lump sum benefit* amount of 100% for the *primary insured* is shown on the policy schedule.

BENEFITS

If a *physician diagnoses* an *insured person* with a *covered condition* listed in this rider while this rider is in force, we will pay 100% of the *rider lump sum benefit* shown on the policy schedule. Once we have paid 100% of the *rider lump sum benefit* for an *insured person,* coverage for that *insured person* under this rider will end.

EXCLUSIONS AND LIMITATIONS

COVERED CONDITION LIMITATION

This rider pays benefits only for loss resulting from a *covered condition.* It does NOT cover any other type of sickness or *injury.*

EXCLUSION

We will not pay benefits for loss that occurs while this rider is not in force.

PRE-EXISTING CONDITION LIMITATION

This rider contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the Rider Date.

A pre-existing condition is a condition:

(a) for which medical advice, *diagnosis,* care, or treatment was recommended by or received from a *physician* within 12 months prior to the Rider Date; or
(b) which manifested itself within 12 months prior to the Rider Date in a manner that would have caused a reasonably prudent person to seek *diagnosis,* care or treatment by a *physician.*

30-DAY PROBATIONARY PERIOD FOR CANCER

This rider has a 30-day probationary period for *cancer.* Subject to the Pre-Existing Condition Limitation provision requirements, in order to be covered, *cancer* must be:

(a) *diagnosed* while this rider is in force; and
(b) *diagnosed* at least 30 days after the rider effective date or at least 30 days after any policy reinstatement date.

If an *insured person* is *diagnosed* with *cancer* during the rider probationary period, we will not pay benefits for that *insured person.* Coverage for that *insured person* will end as of the rider effective date. We will refund any unearned premium for that *insured person.*

RIDER REINSTATEMENT

This rider will lapse if you do not pay your premium before the end of the grace period. If we accept a late premium without requiring you to complete an application for reinstatement, this rider will be reinstated.

If we require you to complete a reinstatement application, we will reinstate this rider as of the approval date. If we do not approve your application within 45 days of the application date, we will reinstate this rider on the 45th day following the date of the application, unless we have previously given you written notice of its disapproval.

The reinstated rider will only cover loss that results from a *covered condition* that is *diagnosed* after the date of reinstatement. In all other respects, your rights and our rights will remain the same as before the rider lapsed, subject to any provisions noted on or attached to the reinstated policy. After the rider has been reinstated, the time period in the **Time Limit on Certain Defenses** provision will be measured from the date of reinstatement as to the statements contained in the reinstatement application. The **30-Day Probationary Period for Cancer** provision will also apply after any rider reinstatement date.

END OF RIDER

Your rider will end on the earliest of:

(a) the date we pay 100% of the rider *lump sum benefit* for all *insured persons* under this rider;
(b) the date we receive your written or verbal request to cancel this rider, or any future date you specify in your request (in either case, the grace period will not apply); or
(c) the date your policy ends.

In the event of cancellation or death, we will promptly refund the unearned portion of any premium paid.

The end of insurance will not affect any claim that began while your policy was in force.

MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

LUMP SUM HEART ATTACK AND STROKE BENEFITS RIDER

NOTICE TO BUYER: THIS IS A LUMP SUM HEART ATTACK AND STROKE BENEFITS RIDER WHICH PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date* if no date is shown) _____

Rider Premium (included in the policy premium unless a separate amount is shown on the policy schedule)

DEFINITIONS

The definitions shown in your policy apply to this rider. However, the definitions of *covered condition* and *diagnosed* or *diagnosis* contained in your policy are removed and replaced by the versions below for the purposes of this rider. The following additional definitions also apply to this rider.

Coronary angioplasty surgery means balloon angioplasty or other forms of catheter based percutaneous transluminal coronary artery therapy to correct narrowing or blockage of one or more coronary arteries. This surgery must be performed by a *physician* who is a duly licensed cardiologist.

Coronary artery bypass surgery means coronary artery revascularization surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. This surgery must be performed by a *physician* who is a duly licensed cardiothoracic surgeon.

Covered condition means any of the following medical conditions or surgeries (unless a condition is shown as not covered on the policy schedule).

(a) *Coronary angioplasty surgery*;
(b) *Coronary artery bypass surgery*;
(c) *Heart attack (myocardial infarction)*; and
(d) *Stroke*.

Diagnosed or ***diagnosis*** means the definitive establishment of a *covered condition* through the use of clinical and/or laboratory findings. The *diagnosis* must be made by a *physician* who is also a duly licensed specialist where specified under this rider.

In the case of *coronary angioplasty surgery* or *coronary artery bypass surgery*, the *diagnosis* includes the performance of the surgical treatment as defined in this rider.

Heart attack (myocardial infarction) means the death of a portion of the heart muscle, resulting from blockage of one or more coronary arteries. *Heart attack* includes ST elevation, non-ST elevation, Q wave and non-Q wave presentations. In order to be covered, the *diagnosis* of *heart attack* must be based upon a clinical setting consistent with such *diagnosis* and either:

(a) new electrocardiographic changes consistent with and supporting a *clinical diagnosis* of *heart attack (myocardial infarction)*; or
(b) a concurrent diagnostic elevation of cardiac biomarkers.

Rider lump sum benefit means the dollar amount we will pay in one installment for a single *covered condition* claim as described in the BENEFITS section of this rider. The initial *rider lump sum benefit* amount of 100% for the *primary insured* is shown on the policy schedule.

Stroke means a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis producing measurable, neurological deficit persisting for at least 24 hours following the occurrence of the *stroke.* Brain tissue damage must be confirmed by neuroimaging (CT, MRI, MRA, PET or similar imaging technique). *Stroke* does not include transient ischemic attack (TIA), chronic cerebrovascular insufficiency, or neurologic impairment from trauma, infection, hypoxemia or anoxia.

BENEFITS

If a *physician diagnoses* an *insured person* with a *covered condition* listed in this rider while this rider is in force, we will pay a percentage of the *rider lump sum benefit* shown on the policy schedule. The percentage payable for each type of *covered condition* is listed below. If we pay less than 100% of the *rider lump sum benefit* for a type of *covered condition,* the *rider lump sum benefit* remaining available for future claims for that *insured person* will be reduced by that amount. We will not reduce this rider's premium when a portion of the *rider lump sum benefit* is paid. Once we have paid 100% of the *rider lump sum benefit* for an *insured person,* coverage for that *insured person* under this rider will end.

Type of Covered Condition	**Percentage of Rider Lump Sum Benefit Payable**
Heart Attack (Myocardial Infarction)	**100%**
Stroke	**100%**
Coronary Angioplasty Surgery	**25% (payable ONCE per insured person during the life of your policy)**
Coronary Artery Bypass Surgery	**25% (payable ONCE per insured person during the life of your policy)**

EXCLUSIONS AND LIMITATIONS

COVERED CONDITION LIMITATION

This rider pays benefits only for loss resulting from a *covered condition.* It does NOT cover any other type of sickness or *injury.*

EXCLUSIONS

We will not pay benefits for loss that occurs while this policy is not in force.

PRE-EXISTING CONDITION LIMITATION

This rider contains a pre-existing condition limitation if such limitation is shown as applicable on the policy schedule. If applicable, the following applies.

We will not pay benefits for loss resulting from a pre-existing condition, unless such loss occurs 6 months or more after the Rider Date.

A pre-existing condition is a condition:

(a) for which medical advice, *diagnosis,* care, or treatment was recommended by or received from a *physician* within 12 months prior to the Rider Date; or
(b) which manifested itself within 12 months prior to the Rider Date in a manner that would have caused a reasonably prudent person to seek *diagnosis,* care or treatment by a *physician.*

RIDER REINSTATEMENT

This rider will lapse if you do not pay your premium before the end of the grace period. If we accept a late premium without requiring you to complete an application for reinstatement, this rider will be reinstated.

If we require you to complete a reinstatement application, we will reinstate this rider as of the approval date. If we do not approve your application within 45 days of the application date, we will reinstate this rider on the 45th day following the date of the application, unless we have previously given you written notice of its disapproval.

The reinstated rider will only cover loss that results from a *covered condition* that is *diagnosed* after the date of reinstatement. In all other respects, your rights and our rights will remain the same as before the rider lapsed, subject to any provisions noted on or attached to the reinstated policy. After the rider has been reinstated, the time period in the **Time Limit on Certain Defenses** provision will be measured from the date of reinstatement as to the statements contained in the reinstatement application.

END OF RIDER

Your rider will end on the earliest of:

(a) the date we pay 100% of the *rider lump sum benefit* for all *insured persons* under this rider;
(b) the date we receive your written or verbal request to cancel this rider, or any future date you specify in your request (in either case, the grace period will not apply); or
(c) the date your policy ends.

In the event of cancellation or death, we will promptly refund the unearned portion of any premium paid.

The end of this rider will not affect any claim that began while your policy was in force.